PRACTICAL PITFALLS OF THE ELECTRONIC MEDICAL RECORD

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ACLM 57TH ANNUAL MEETING
FEBRUARY 25, 2017

TERMINOLOGY

- Electronic Medical Records (EMRs)
- Electronic Health Records (EHRs)
- Personal Health Records (PHRs)
- Hospital-Based Systems
- Office-Based Systems

VENDORS

- Meditech
- Cerner
- McKesson
- Epic Systems
- Siemens Healthcare
- VistA—Veterans Affairs
- AHLTA—U.S. Military
- And Hundreds More

HEALTH INFORMATION TECHNOLOGY LEGISLATION

- American Recovery and Reinvestment Act—ARRA
- Health Insurance Portability and Accountability Act—HIPAA
- Health Information Technology for Economic and Clinical Health—HITECH
- Affordable Care Act—ACA
- Food Safety and Innovation Act—FSMA
their families in their care

Measures and Public Health Information

Managing the reporting of clinical quality coordination processes

Communicating that information for care conditions

Using that information to track key clinical a standardized format

Electronically capturing health information in

Different From Specialty Offices Which May See a Large Number of Similar Conditions

Ugly When > 50% of Providers Note is Copy/Paste. Metadata & Plagiarism Software Picks This Up Easily

Unnecessary Loading of Detailed Information From the Past Lessens Credibility of the Note/Provider "Note Bloat" Makes it Tougher to Find Clinically Relevant Information Related to Current Visit

Also Bad When Copied Material is Not Properly Edited to Accurately Reflect the Current Encounter

"Note-Blaze" Makes it Tougher to Find Clinically Relevant Information Related to Current Visit

Vagaries —reading of Detailed Information From the Past, Accuracy of the Form/Reader

Ugly When ISB/MH Provides create a Copy/Paste Metadata & Plagiarism Software Flags This Up Easily

Different from Specialty Offices Which May See a Large Number of Similar Conditions

Must Ensure "Workarounds" by Providers Do Not Compromise Patient Safety or Validity of EMR

Must have Robust Training and Real Time Support 24/7

Dated, Timed and Authenticated in the EMR

Hospital Committees Determine the Continuing Usefulness and Safety

Periodic and Regular Review by Medical, Nursing and Pharmacy Staffs

Standardized Order Sets—Reviewed and Approved by Medical, Nursing and Pharmacy Staffs

Orders, Sets and Protocols Consistent with Nationally Recognized and Evidence Based Guidelines

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Potential Problems During an Audit

Progress Notes with Physical Exam Nearly Identical or Subsequent Visits Over Time or Changes in Dx

Multiple Patients with Nearly the Same Findings

Extraordinarily Long and Detailed Progress Notes Not Necessary to Address the Problem

Pre-POPULATION AND INFORMATION PULLED FORWARD

Demographics

Past Surgical History

Past Medical History

Allergies

Review of Systems Update

Prescribe for Appropriate Date

Limit the Types of Relevant Pull Forward Demographics and Relevant Info/Procedures/Reports, etc.
TEMPLATES AND AUTOMATED TEMPLATES
- Good as They Facilitate Uniformity and Ease of Retrieval
- Need Room to Free Text and Personalize the Encounter
- Problems Arise When:
  - The Note Appears to be “Canned”
  - Default Sections are Normal or “Auto negative”
  - Was Every Note Explored?
  - Were They All Really Normal?
  - Looks Bad When Caught Red-handed: Normal Neuro Exam on Paraplegic Patient

FREE TEXT AND DRAGON
- Allows the Provider to “Personalize” the Note
- Templates Should be Adjustable
- Some Templates are Designed to Capture a Level of Care Rather Than Address the Problem
- Need Complete Collection of Information to Achieve Such Level of Care
- However, is the Problem Appropriate to Justify the Level of Care?
  - i.e. - Documenting Minor Cuts/Cuts Rather Than with Reasonable and Necessary Under the Circumstances, Code 1 for Minor Laceration of Finger
- Authentication: Diagnosis, Level of Complexity, and Care, Is it Correct? - Is it Warranted?
- Machine Generated Level of Care Code - Frequent Use of Time Spent With Patient Over Time to Increase Code

CLONING
- Suspicious When Every Entry in EMR is the Same or Similar to the Previous Entries
- Between Entries of the Same Patient or Between Entries of Different Patients
- Medicare Audit - Cloning: Misrepresentation of Medical Necessity Requirement of Services
- Office of Inspector General (OIG) - Over-documentation: Inserting False or Irrelevant Documentation
- Concern Over EMR Facilitated Entries That Generate Extensive Documentation With a Single Click of a Checkbox

USER INTERFACE ISSUES
- Menus and Checkboxes
- Real “Inadequate Time” Checking the Box Means to the Practitioner
- Concerns: Structuring the Menu lists by forcing Choices of More Remunerative Services or Creating False Documentation
- More Time Spent Face to Face with Lab/Minors Less Time Face to Face With Patient
- When to Document/Dictate into the Note?
ALERTS, PROMPTS, AND WARNINGS

- Alert Fatigue—Desensitized to Alerts Either Ignored or Silenced
- Clinical Decision Support (CDS)—Review CDS Prompts Annually Update and Edit Prompts Weeded Out Inexcess One or Reinforce the Critical Ones
- Access and Navigation Controls—Don’t Want Too Many Patient Charts Open at Same Time—Prevent Falling Notes on Other Tabs in the Wrong Chart
- Search and Retrieval Capability—Design and Modify Systems to Facilitate Ease of Access to Providers
- User “Unfriendly” Systems Lead to Increased Risk of Frustration and Errors and Potential Patient Harm

PROVIDER AWARENESS OF OTHER DATA IN EMR

- Screen Shots of What the Provider Viewed
- Results Visible in One Program But Not in Another
- Provider Not Aware of Data Labs/Radiology Results/Other Providers Notes in the EMR
- Changes, Corrected Results and Critical Results Missing The Results Were Seen and Acted Upon By The Provider
- Are All The Functionalities Being Offered in the EMR/Can’t Find Radiology Tab
- EMRs—You Get What You Pay For—And None are Cheap

AUTHENTICATION ISSUES

- Log-in Controls
- User Identity
- Risk of Record Authentication
- Providers With Same Last Names Gauging Each Others Results
- Privacy, Security, Unauthorized Release of Medical Information
- Provider Relying on EMR for All Care—Is the Hospital and (or) EMR Liable?

CLINICAL DECISION SUPPORT (CDS) FUNCTIONALITY

- Recommended Course of Action
- Alert
- Ask
- Assist
- Altogether Applying Treatment Guidelines Using Evidence-Based Sources
- Algorithms—“Cook Book Medicine”
- Algorithms—“I Know What to Do”
- Autonomy in Clinical Reasoning and Automated Alerts
- Essenced—Alerts Physicians to Ask For Assistance
- Hard Stop Prevents an Error WHO Can Be Importuned
- Act Still Must Ablaze in Contingency For Non-Standard Orders

CODING AND BILLING SUPPORT FUNCTIONALITY

- Concern—Geared to Maximize Reimbursement
- Embrace Providers who Have EMR Documentation to Justify Greater Reimbursement
- Software Accuracy and Reliability of the Recommended Coding is Problematic
- Implementation Policies and Procedures Adopted by the Providers
- Programs Cannot Evaluate the Medical Necessity of the Elements Listed In the EMR
- Question Why Is Reasonable and Necessary to Constitute Those Organs Systems?
RECOMMENDATIONS TO IMPROVE CODING

- EMR Generates a Suggested Code and Preliminary Recommendation. Provider Can Accept or Edit.
- EMR Suggests Diagnosis Codes Which Provider Can Accept or Edit.
- Coding Teams Are Ubiquitous in Hospitals and Offices Today.
- Diagnosis Coding Drives Hospital Reimbursement.
- Crucial that the Charge Capture System Only Bills for Services Rendered and Not All Things Ordered.
- Now the Move Towards Documenting Outcomes as Reimbursement Will Be Tied to That Metric.

EMR

- Connectivity to Other EMRs
- Labs and Imaging Results
- Viewing Images
- Addendum to the Note
- Editing the Note
- Comparing With The Note-Screen-Shots Metadata
- Educating the Provider Improves Competence—Draft the Charting To Your Practice
- Artificial Intelligence, Clinical Decision Making, Diagnosis, and Coding Assistance

NOTIFICATION OF RESULTS ORDERED

- Labs
- Imaging
- Cultures
- Specimens to Pathology
COMMUNICATIONS WITH OTHER PROVIDERS

- Office Notes and Labs referring from Referring Providers
- Consultant Notes from Specialists
- Confirmation that Referral was Received by Other Office and Appointment was Made
- Notification: The Patient could not be Reached or Missed Their Appointment

NOTIFICATION TO PATIENTS OF RESULTS

- Who is responsible to “Ask For” vs. “Notify” the Patient of All Test Results?
- List of “Tickler File” of Patients Who Have Pending Test Results
- Who is taking care of and notifying the Patients?
- Are They knowledgeable of what is “normal” and “abnormal”?
- Memorization of the Acknowledgment and Notification to the Patient of the Test Results
- Memorization of the Plan of Treatment or Follow-up
- Memorization of Patient Discussions Regarding Treatment Plan or Informed Consent

CONCLUSIONS

- Technology Continues to Advance and Improve
- EMRs Are Not Foolproof—Will Always Have Human Error and System Errors
- Certain Aspects of EMRs Can Open Providers up to Increased Liability
- Providers Should Take EMRs to Their Own, Unique Practice Habits

REFERENCES

- Challenges With The Electronic Medical Record. Robert H. Ossoff, Christopher D. Thomason, Julie Apperton. 12 No. 6 J. Health Care Compliance 51
- Electronic Medical Record Documentation: Inherent Risks and Inordinate Hazards. Timothy P. Andreason, Margaret M. Manning. 2006 Health & Law Handbook
- The Legal Challenge of Incorporating Artificial Intelligence into Medical Practice. Amanda Laxman. 14/25. J. Health & Elem. 1 L. 20

SCANNING INFORMATION INTO THE EMR

- Converting From Paper to Electronic Initially
- What to Import and What not to Import?
- Entering Received Results—Labs, Imaging, and Clinic Notes, Discharge
- Reviewing Newly Received Data Prior to it Being “Filed”
THANK YOU