Hot Topic in Risk Management

Electronic Health Records in the Medical Office

presented by
MICA Risk Management Services
Objectives

- Explore the risks and benefits associated with implementation and use of electronic health records (EHR) in physician offices.
- Discuss best practices for implementation and maintenance of an EHR.
- Describe risk management actions to reduce exposure related to EHRs.
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Electronic Health Records

- Congressional Budget Office estimates 90% of physicians and 70% of hospitals will be using EHRs within the next 10 years.
  - The American Recovery and Rehabilitation Act of 2009 is expected to increase use of information technology.
  - Allocates $19 billion for technology improvements.
Technology Offers Benefits

- Quick access to data.
- Receive potential life saving alerts.
- Notification of completed studies and follow-up reminders.
- Easy transfer of records.
- Electronic prescribing and renewal of medications.
- Improved legibility of the record.
But there’s another side...

- “As doctors use more devices, potential for distraction grows.” *The New York Times, 12/11*
- “My gut feeling is lives are in danger.” *Dr Peter Papadakos*
- "The iPatient is getting wonderful care.....the real patient wonders, ‘Where is everybody?’” *Dr Abraham Verghese*
- “I spend hours every night at home completing the EHR.”
- Plaintiff attorneys may have a field day until we work out some of the problems with our new technology.
Varying Degrees of Success

- To utilize EHRs to their full potential:
  - Invest time in planning and training.
  - Avoid pitfalls and manage risks.
Hospitals, Physician Offices, and the EHR

- Hospital resources:
  - IT department
  - More financial resources
  - Staff education depts
  - Implementation planning

- Physician Office resources:
  - One person may be designated as EHR coordinator
  - Selection process by physician? OM?
  - Staff training by vendor? By coordinator?
  - Implementation more likely to be rushed?
Selecting an EHR

- Involve future users in the selection and planning process.
  - Input may lead to positive changes in the system and better acceptance; build support.
  - What works in the hospital may not work in the office.
  - Needs of specialties different.
  - Avoid work-arounds. Patient safety issue!
- Review / redesign workflow.
  - The goal is to create an effective system making practice of medicine easier and less error prone.
Selecting an EHR

- Don’t rely on new technology to fix broken office systems.
- “junk in” equals “junk out”.
- What does the end product look like?
Examine Overall Workflow

● All systems should be reviewed.
  ▪ Use “big picture” thinking
  ▪ Look at physical lay-out of office

● Focus on areas that are not functioning smoothly or efficiently.
  ▪ For example – if filing doesn’t work efficiently, there will still be issues related to scanning of documents in an EHR.

● Fix the problems before you implement a new system.
Designate a Primary System Manager

● “Primary” doesn’t mean this is the only person who is knowledgeable about the system.

● Coordinates all selection efforts, implementation and utilization oversight.

● Should possess:
  ▪ Basic knowledge of computers and system operation,
  ▪ Willingness to keep abreast of changes and updates in the field, and
  ▪ Be able to effectively organize large projects.

● Must work with and listen to staff.

● A good sense of humor wouldn’t hurt!
Talk to Other Practices with EHRs

- Are they happy with their vendors?
- What changes do they wish they could make?
- How long does it take to obtain vendor assistance / IT help?
- Visit other offices if possible.
Other Resources

- Websites:
  - http://www.ucguide.org (AHRQ website)
  - Certification Commission for Health Information Technology (www.cchit.org).
    - Recognized by DHHS as the certification body.
Should be done on a frequent, regular basis.

Daily back-up with off-site storage can be an advantage over paper records.

Discuss with vendors how back-ups will be completed.

- Will back-up process include all data or just portions of the data?
- How long to obtain back-up data if needed?
EHR Reality Check

- Number 1.
  - Physician relied on vendor’s “promise” of daily back-up.
  - Vendor’s employee didn’t perform back-up on any of the data.

- Number 2.
  - Physician’s main and secondary servers went down.
  - When back-up tapes used to reconstruct records – found that tapes were corrupted so pieces of data were missing.
How Will the Finished Product Look?

- When considering various systems – look at the finished product.
  - How will it appear to reviewers?
  - Is business/non-clinical/QA data mixed with appropriate chart data?
  - Is information easily accessed?
  - How many screens need to be viewed to obtain basic information? Patient safety issue!
How Will the Finished Product Look?

- Does the chart tell the story of the physician’s thought process for the plan of care?
- Will the vendor work with you to customize the system?
  - Each specialty has its own needs.
  - Reports needed? (meaningful use; prescriptions; other)
  - Tracking requirements?
  - Volume and types of tests?
  - Ease of entry for “non-canned” comments.
“There are so many lines of “canned text”, I don’t read the chart as thoroughly as I once did...All the notes look the same.”

“I no longer review the nursing notes because they are so hard to access.”

A 39 year old female was misdiagnosed in part due to a family history of AAA being missed. The on-call physician had difficulty locating the initial history when he reviewed the chart.
Agreements with Vendors

- Get specifics on back-up; response time frames
- Look at insurance coverage; indemnification language
- Obtain specific information on up-dates and costs
- Look for written completion time frames for installation
System Security

- Obviously, system should permit only authorized user to access records.
- It should also maintain a record of all access.
- Authorized users should only have access to those portions of the record relevant to their job.
- Systems should automatically log off after the station has been inactive for a specific period.
Encryption Capabilities

- Sending information electronically is becoming commonplace.
- Review processes for electronic transfer of information to ensure patient information is encrypted before transmission.
- No patient information should be transmitted electronically without appropriate security.
A Word about Vendors

- Technical support is critical to the success of an EHR!
- Ask for references and inquire about their satisfaction with support issues.
- How long have they been in business?
Once Vendor and System Selected

- Design the program to fit the needs of the practice.
- Develop policies and procedures to promote security, confidentiality and patient safety.
- Plan how to support and utilize the system to include sound risk management principles.
Implementation Planning

- Adequate time for training
- Extra staff during start-up
- Check and re-check
  - Test back-up
  - Review documentation
  - Monitor security procedures
  - Re-evaluate regularly
Missed or Inaccurate Information

Three main concerns

- Previous data input not easily found.
  - Can be caused by a confusing template or data storage program.

- Trended information located in one area of paper record (e.g., vital signs, lab studies, allergies) but various places in EHR.
  - Requires scrolling or located in section that is rarely accessed. Patient safety issue!
Accuracy Concerns

- Wrong information repeated again and again.
  - Inaccurate data creates “chart lore”.
    - Perpetuated by self-populating fields.
    - Less likely to be corrected as it is carried into different sections and onto a variety of screens.
Integrity of Record Entries

- Whether electronic or paper – any appearance of an alteration is extremely difficult to defend.
- Information should be stored in a manner which can be retrieved and read but cannot be altered. “WORM”
- Addendums should be made without obliterating or destroying the original entry.
Reality Check

- “Only the manager can go in and change an entry after sign-off.”
- “It’s OK if we change something because you can always go into the system and review who made the change and when they made it.”
- “They’ll ask me about this in a deposition? What am I supposed to say?”
Policies and procedures are needed to promote accuracy of the record.

Build steps for proofreading in the data entry process.

Clinicians and staff should all be accountable for the accuracy of the information entered.

Whether or not the clinician reviews the documentation, he/she is responsible for it once it is “signed”. “Dictated but not read” doesn’t help.
Standardized Templates

- Limited opportunity for physician to demonstrate "cognitive thinking"
  - Critical to a correct diagnosis.
  - Patient safety issue!
- May provide fields to document what the patient doesn’t have but omits specific information which allows physician to formulate a working diagnosis.
- System should make it easy to add extemporaneous notes when appropriate.
Standardized Templates

- Auto-population may be a problem
  - Some systems automatically fill in blanks as “WNL”
  - Credibility can be attacked:
    - “WNL” for an area not likely to have been assessed based on reason for visit
    - The fact the system can do this may give credence to a plaintiff attorney attacking reliability of chart
EHR Reality Check

- Bowman v St. Luke’s-Roosevelt Hospital Ctr / NY
  - Pt to ED with c/o calf pain/edema
  - d/c’d with dx gastroenteritis
  - Died 36 hrs later—necrotizing fasc
  - Court indicated EHR template part of problem; limited entry of information and differential choices
  - Physician indicated a template had to be selected among pop-up choices
  - Limited ability to gather information for variety of differential dx

Medical Economics
K Rashbaum, JD 1/12
A 13 yr old pt was seen for a minor cut on the hand. The assessment form reflected a full head-to-toe exam.

The exam template for a middle-aged male showed “WNL” for a body part congenitally missing.
Copy and Paste Features

- Allows physician to reproduce an earlier note or portion of a note.
  - Easier to cut and paste history and physical exam findings from prior visit than to document current findings.
- Notes may appear “canned” when phrases or progress notes are repeated on successive office visits.
  - May suggest to a jury the care wasn’t individualized.
  - When evident over multiple visits the credibility of the physician and record may be called into question.
Automatic Prompts and Alerts

- Recommendations or alerts that pop-up on the screen.
- Prompts or alerts may require a documented explanation of why it was not followed.
- Plaintiffs’ attorneys will question “Why?” if prompts or alerts are ignored.
- Remember – they are there to “prompt” you to think.
  - Document reason(s) for override.
Address this issue in the planning stages

- How many alerts do we need?
- Consider “alarm fatigue” factors.
- It is difficult to defend an alteration from the norm (even an appropriate one) when an alert was totally ignored, or a clinician says it occurred because there were too many alerts to pay attention to during the day.
- Patient safety issue! 
Security

- Passwords combined with varied levels of access help protect information from unauthorized access or tampering.
  - Strict enforcement of password security.
  - Confidentiality statements that include agreement not to share passwords.
  - Remote access via internet should be closely monitored.

- Access to records should be removed ASAP after employment ends.
In July 2009, the US Department of Justice and the FBI announced a physician and two hospital workers in Arkansas pled to misdemeanor violations of HIPAA. Each admitted to violating the information privacy provisions of HIPAA by accessing a patient’s record without any legitimate purpose. They face a maximum penalty of 1 year imprisonment, a fine of not more than $50,000, or both. The US Attorney handling the cases stated, “The HIPAA privacy protections are real, and we hope that through vigorous enforcement of HIPAA’s right-to-privacy protections and swift prosecution of those who violate HIPAA, we can deter those in the medical industry who have access to protected health information from searching others’ medical records merely to satisfy their own curiosity...”
Security

- And what about all those portable devices?
  - Where can they be taken?
  - How are they password protected?
  - What can be stored on them?
  - Will they be left on the front seat of a car?
What to Do with Paper Records?

- Scanning paper records into EHR.
  - Provides easy access to patient’s history.

- Combination of paper and electronic record.
  - Need to review both paper and electronic record may lead to workflow problems or reluctance to review paper records.
Imaging Paper Records

- Once electronically imaged, some practices and imaging companies destroy the original records.
  - EHR then becomes the “original” record.
- The vendor scanning the records should provide a certificate or other document certifying:
  - All pages of the EHR are an accurate scanned reproduction of the original record.
  - Neither the paper record nor EHR were in any way altered or modified before or after imaging.
Electronically imaged paper records should include:

- Same print size,
- Color,
- Any loose papers and/or post-it notes,
- Handwritten notes on file covers, and
- Writing on the front or back of lab sheet or other document.
While you watch your computer, it is watching YOU
Legal Discovery of EHRs

- Electronic discovery rules allow plaintiffs’ attorneys to request the raw data (metadata).
  - Metadata is embedded electronic data typically hidden from view and unavailable to end users.
  - Shows when user logged into system, what portions were reviewed and how long they were reviewed.
  - Shows what additions or changes were made, if any.
  - Shows when EHR was closed.
For Example

Metadata can reveal a pop-up alert appeared and was closed seconds later.
Electronic Discovery

- Has the ability to:
  - Request emails (even deleted ones),
  - Not just on office computers but also on iPhones, PDAs, Blackberrys and other types of communication devices.
Electronic Discovery

- Your EHR will record when a key is pressed, when a mouse is moved; when a screen is changed.
- What about those intra-office communication applications?
- Will there be a record of how thoroughly previous records were reviewed?
- Metadata can tell whether or not “cloned” notes were utilized.
Reality Check ✓

**Case 1**
- Entry error made re: procedure to be done
- Correction made several lines later
- Set-up for wrong procedure until noted by nurse

**Case 2**
- Order for IV fluids entered into EHR for a newborn
- Pharmacy tech “re-entered” order incorrectly into automated compounding system
- Decision support system had been disabled
- Infant died
Technology Offers Benefits

Now Let’s Look at the Risks

- Quick access to data.  
- Receive potential life saving alerts.  
- Notification of completed studies and follow-up reminders.  
- Easy transfer of records.  
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Key Points

- EHR potential benefits are significant and should not be overlooked by fear of the risks.
- Like any new process in healthcare, we are “learning as we go”.
- Physicians, other healthcare clinicians, and organizations need to stay ahead of plaintiff attorneys in evaluating risk.
- EHR technology should be integrated with basic principles of patient safety, such as good communication, human factors engineering...
Key Points

- Physician office needs will be different from a hospital.
- Integration of hospital technology and office technology must take the physician users into account.
- End users who find a system unworkable will develop “work arounds”.

A sense of humor doesn’t hurt.
Questions?