THE DARK SIDE OF EHR
What you don’t know CAN hurt you

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Purpose of this program

- To identify potential risks of EHR that might threaten patient safety
- To increase awareness of common pitfalls of electronic documentation
- To reduce risk of inadequate documentation commonly found in EHR
- To increase awareness of liability risks associated with EHR
Financial Disclosure

• Gerald Meltzer, MD is a consultant for iMedicWare

• Kirk Mack is a Senior Consultant for Corcoran Consulting Group

• Hans Bruhn is a Risk Manager for OMIC

• None of the presenters have any financial interest in the subject being presented
EHR – Friend or Foe

• Documentation Errors – increase or decrease?
• Malpractice Claims – increase or decrease?
• Legal Defense – help or hinder?
• Relationship between errors and liability claims is complex…we will explore that today
EHR are devices

• Valuable
  – Can improve safety and workflow
  – Augment your capabilities

• Vulnerable
  – Newton’s first law of computing – for every function, there is an equal and opposite malfunction
  – For each capability, imagine what would happen if it worked wrong
Electronic Communications

- You are responsible for any medical information for which you have reasonable access
  - eRX alerts
  - Patient information in questionnaires
  - Clinical Decision Support
Data Overload

This is probably the most important hazard of the EHR because it can interfere with almost any other healthcare function by almost any provider.
SO LETS TALK ABOUT THE ISSUES
THE ISSUES
LIABILITY RISKS

• eRX/CPOE
• Charting/Documentation
• Clinical Decision Support Systems
• HIPAA
  – Privacy
  – Security
• Liability Risk Analysis
• Communications/Patient Portal
• eDiscovery
• **AUTOFILL** -
  – Most Commonly Abused EHR functionality
  – AND most problematic to defend)
• Incomplete Documentation
• Absent/missing information
• Incorrect Data Entry
• Not seeing claims with EHR errors as central point.
• Remember: This is documentation!
  – Continuity of care
  – Billing
  – Defense of a claim
True Story #1

• Child presented to ER with dilated, non-reactive pupil with shallow laceration in the lower lid conjunctiva
• DX: traumatic hyphema
• ER physician contacted eye MD: Send child for next day outpatient appointment
True Story #1

- Eye MD’s office EHR indicates normal findings of round, reactive pupil, no APD, white and quiet conjunctiva
- Only abnormal finding: Cell and flare in anterior chamber
- Eye MD Dx: traumatic iritis
- Follow-up appointment scheduled to monitor condition
True Story #1

- Before appointment, parents called another ophthalmologist when child lost vision
- That MD elicited history of sickle cell anemia on phone so told to bring child in to the office the next day
- Pupil fixed and dilated, IOP 46, 4+ APD
- Parents sued when child ended up HM
True Story #1

• **EHR issues**
  • Child vomited just after noted high IOP
  ✔ *System populated his note with normal findings*
  • Intended to finish note and enter abnormal findings later
  • But the office got busy
  ✔ *Doc never even signed note*
True Story #1

- **Outcome of lawsuit**
- **Condition of records and decision to see in office rather than ER led to $380,000 settlement**
Copy/Paste Issues

- Use caution in copying and pasting patient notes
- Auto-populated fields lead to incorrect patient information
  - Patient with narrow angles
  - Doc skipped SLE and went to A and P….
  - System autofilled normal angles with deep anterior chamber
Copy/Paste Issues

- 72% of PIAA Companies concerned
- Incorrect Findings
- Discredit entire record
- Discredit care
- Make legal defense problematic
- Use of incorrect defaults
True Story #2

• Autofill – the Time Saver!
  – UNLESS SOMETHING HAS CHANGED 😞

• 35 year old body mechanic, gave story about hitting eye with autobody hammer
  – supposedly was wearing protective glasses

• Undocumented worker, concerned about losing job
True Story #2

- No patient information (and no insurance),
- MD did not order CT scan or x-ray
- Followed patient periodically
- 2 months later, vision deteriorating
- Anterior segment exam filled in at each visit – “Lens Clear” (copied forward)
- Day of referral to retinal specialist for 20/400 vision – “Lens Clear”
True Story #2

- Retinal doc
  - 3+ Cataract
  - Siderosis (metal dust)
- All prior entries were now suspect
- Case could not be defended
“Signed” chart but no assessment and plan for 1/11/2016.
This chart was even pre-reviewed 12/17/2015.
BEWARE: Many portals will automatically push your data (complete or not) after 3 days to meet meaningful use measures. Patients will receive uncompleted charts and can have documentation of it not completed.
New EHR?

- MRR from pt (moving)
- Files not transferred completely.
  - Pt. care issues
  - State record retention requirements
- New EHR vendor responsible for transfer (not sure)
- Discovered after implementation window
- $$ to access old system
Risk Management Recommendations

- Weekly audits (missing charges and incorrect template entries, unsigned charts).
- Delay volume to review and difficulty recalling facts.
- Make yourself or assign someone accountable for reviewing your records at the end of the day.
- If you have scribe, ensure you review what the signed document will look like. Many fields are entered in each exam → have you reviewed them all?
Incorrect Information – Real Life Example

• GDD OD? → Actually Express Mini OD

• Error happened right after new device used. Noticed after 2 weeks.
Incorrect Information – Safe Guards

- Meeting about new procedures, review process and how we will document in chart.
- Protocol created for all appropriate abbreviations for surgeries.
  - Fixed Express/GDD issue but also able to better document all surgeries and standardize documentation for all doctors
- Forewarned, forearmed; to be prepared is half the victory. - Miguel de Cervantes
• Use of drop-down menus can facilitate improper data selection
  – QD becomes QID
  – Amoxapine becomes Amoxicillin

• Once it’s in the system, may not be corrected

• “Errata” supplements may not change data spread to other areas of the chart
  – Correct it in the “current meds”, but not in the “medication list”?
True Story #3

• Plaintiff alleged delay in diagnosis of RD
• Decisions contradicted findings
  • Cell and flare but discontinued steroid drops and gave a long follow-up period
  • Normal retinal vessels and clear vitreous yet diagnosis of retinal vasculitis and referral to retina specialist
• Eye MD deposition
  • Would never stop steroids if eye showed cell and flare
• EHR Issues
  • EHR’s carry forward function automatically populated records with previous exam’s findings
True Story #3

- **Lawsuit outcome**
- Testimony of retina specialist indicated RD was present for long time but not detected by defendant
- Failure to diagnose RD and state of records led to decision to settle for $290,000
DOCUMENTATION ISSUES

- Garbage In – Garbage Out
Problematic Chief Complaints

- “Decreased vision in both ears”
- “Patient complains, no complaints”
- “Diabetes in both eyes 4 years”
- “Borderline diabetes, it affects vision, not affected”
- “IOL eval in both eyes for one year”
HPI Challenges

• Expands on the CC
• Develops the CC
• Some EMR create a “narrative” or “paragraph”
• Read the final product – DOES IT MAKE SENSE?
They told me:

“I MUST GET 4 HPI ELEMENTS”

- Location
- Duration
- Timing
- Quality
- Severity
- Context
- Modifying factors
- Associated signs and symptoms
HPI Challenges

• CC
  – Location
  – Duration
  – Timing
  – Quality
  – Severity
  – Context
  – Modifying Factors
  – Associated Signs and Symptoms

• I GOT 7!!!!!!!
THE FINAL PRODUCT:

• 58 year old male presented for evaluation of Diabetes for 3 months. It affects vision not affected. The problem is constant. It occurs primarily when driving at night. Quality is fixed. Patient described the following signs and symptoms: none currently to report

• NOT OUR BEST EFFORT!!!
• 53 year old female complains of growth in left eye for 1 year. The timing is described as **constant**.

• 66 year old female presented for evaluation of existing condition, ARMD. Timing is described as **all the time**. Severity is described as **unknown**.
64 year old male presents for evaluation of existing condition, GLAUCOMA in both eyes for several years. The timing is described as constant. Severity is described as unknown. Relief is experienced from timolol BID, latanprost in the evenings. Pt is here for IOP check and VF.
66 year old male presented for evaluation of existing condition, lattice degeneration in both eyes for a few years. The timing is described as constant. Severity is described as faint
Problematic Exam Documentation

- CVF – fixes and follows OU – patient is monocular
- Lens – “clear OD” – patient is scheduled for cataract surgery OD
- External / lids – “WNL OS” – Procedure note for epilation of lashes LLL
- SLE – blank – impression indicates corneal ulcer OD
- VA = 20/20 OS – Patient had enucleation OS 3 mos. Prior
- Retinal periphery – “360 degrees, no holes, detachments, breaks” (Patient not dilated.)
EMR Consequences

- What do these examples say about our records?
- Quality of the work?
- Integrity of the record?
- Is it believable?
- Can you defend it?
“We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG FY 2012 Work Plan
RAC Audits of E/M Services

• EHR users increase utilization of 99214, 99215 because physicians are able to document better

• RAC audits of these codes based on HHS OIG report – Coding Trends of Medicare Evaluation and Management Services, May 2012

• OIG states: “Although many EHR systems can assist physicians in assigning codes for E/M services, we found that most Medicare physicians manually assign E/M codes.”
## Office Visits

### Medicare Utilization Patterns Ophthalmology (18)

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>λ</th>
<th>CPT</th>
<th>Established Patients</th>
<th>λ</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Level 5 E/M</td>
<td>2%</td>
<td>99215</td>
<td>Level 5 E/M</td>
<td>1%</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 E/M</td>
<td>29%</td>
<td>99214</td>
<td>Level 4 E/M Comprehensive Eye</td>
<td>54%*</td>
</tr>
<tr>
<td>92003</td>
<td>Level 3 E/M Comprehensive Eye</td>
<td>62%*</td>
<td>99213</td>
<td>Level 3 E/M Intermediate Eye</td>
<td>42%*</td>
</tr>
<tr>
<td>92004</td>
<td>Level 2 E/M Intermediate Eye</td>
<td>6%*</td>
<td>99212</td>
<td>Level 2 E/M</td>
<td>3%</td>
</tr>
<tr>
<td>99201</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
<td>99211</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

*Combined utilization of E/M and eye codes

Source: CMS data 2014, 18 - Ophthalmology
### Office Visits

Medicare Utilization Patterns Ophthalmology (18)

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>λ</th>
<th>CPT</th>
<th>Established Patients</th>
<th>λ</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>Level 3 E/M</td>
<td>8%</td>
<td>99214</td>
<td>Level 4 E/M</td>
<td>8%</td>
</tr>
<tr>
<td>92004</td>
<td>Comp Eye Exam</td>
<td>54%</td>
<td>92014</td>
<td>Comp Eye Exam</td>
<td>46%</td>
</tr>
<tr>
<td>99202</td>
<td>Level 2 E/M</td>
<td>1%</td>
<td>99213</td>
<td>Level 3 E/M</td>
<td>12%</td>
</tr>
<tr>
<td>92002</td>
<td>Intermediate Eye</td>
<td>5%</td>
<td>92012</td>
<td>Intermediate Eye</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: CMS data 2014, 18 - Ophthalmology
“It codes for us!”

• Multi-specialty Eye Care practice
  – 6 MDs (Cornea, Glaucoma, Plastics, Comp)
  – 5 ODs
• Implemented EMR – December 2011
• EMR company told practice to let the EMR choose the codes
• EMR chose only E/M codes
  – Ignored Eye Codes
“It codes for us!”

• Significant increase in E/M 99215
  – 2011 - 99215 used 138 times
  – 2012 – 99215 used 5,889 times
  – 42X increase in 1 year
Office Visit – Established
Blepharitis

CC: Red Eyes (last exam 12 mo)

HPI: Patient c/o of very 1 itchy & burny 2 eyes 3 x 3 days 4.  AT help but not much 5.  D/C CL wear.  Red eye, OD x 2 days

Dx: Blepharitis OU

Tx: Lid scrubs and AT, NO CL for 2 weeks.  RTC 2 weeks

Hx: ROS, PFHS unremarkable

Exam: Comp Exam, DFE

WHAT CODE DID THE EMR CHOOSE?
“It codes for us!”

- What did the EMR choose for the blepharitis patient?
  - A. 99211
  - B. 99212
  - C. 99213
  - D. 99214
  - E. 99215
“It codes for us!”

• What did the EMR choose for the blepharitis patient?

• Of course - 99215
“It codes for us!”

• Moral of the story:
  – **Most EMRs do not identify medical necessity**
    • Do you need comprehensive history for itchy eyes?
    • Do you need comprehensive exam for itchy eyes?
  – Medical decision making **must** be considered
  – What would you have chosen in the world of paper?
  – If it sounds to good to be true – it is
  – You are ultimately responsible
AND IF THAT WASN’T ENOUGH
• Information Errors – accepting information presented on screen which may lead to:
  – Wrong Medication being prescribed
  – Wrong dosage
• Community Medication Histories
• Failure to record medication was discontinued
Patient on Combigan

Combigan Discontinued

But on next visit Combigan still in medication list
A 3 Mon. old male patient comes in for evaluation for crossed eyes since birth.

No significant past ocular history.
Emerging Risks

• Alert Technology
  – Medication alerts warn prescribers of potential drug interactions and allergies
  – “Alert Fatigue” – too many irrelevant alerts lead prescribers to ignore or turn them off
  – In event of litigation – difficult to explain why a warning was ignored
Clinical Decision Support Systems

• Required in MU2
  – Standard order sets
  – Best Practices
  – Prompts, Reminders, Alerts
  – Diagnostic Suggestions

• What if ignored and injury occurred
DOCUMENETATION ISSUES

• Garbage In – Garbage Out
Risks during implementation(s)

• Inadequate Training
  – Liability for letting users use a device for which they have not be properly trained
  – DID YOU document staff training and competency?
  – DID YOU document retraining after updates?
  – DO YOU HAVE SUPERUSERS?
Security Risk Analysis

• HIPAA – conduct accurate and thorough analysis related to
  – Confidentiality
  – Integrity
  – Availability

• http://www.hhs.gov/ocr/privacy/hipaa/administrative
Security Risk Analysis

- Every covered entity is subject to an audit
- Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI
- Decide how to address findings
- Document what you did or implement alternate methods to reduce risk
Security Analysis

• Threat Analysis
  – Something that can damage an asset
  – Human error
  – Hardware Failure
  – Data Corruption
  – Theft
  – Malware
  – Natural Disaster

• http://csrc.nist.gov
Security Risk Analysis

• Business Associate Agreements
• Review Current System Risk
• Identify EHR vulnerabilities
• Document Corrective Actions
• Education of Staff
• Sanction Policies
• Repeat on ongoing basis
Security Risk Analysis

• If a problem was not identified – information may be filed. Keep for at least 6 years

• If problem identified – what was done. If nothing was done considered willful neglect
Security Risk Analysis - Training

• Written manuals not enough
• Keep records of Training
• ALL employees must be trained
  – Retrain old employees annually
  – All new employees must be trained
  – If changes in law, all employees must be retrained

• Health Care Compliance Pros
Guide to Privacy and Security of Health Information

The complete document (47 pages) may be downloaded from:

Version 1.1 022312

The information contained in this guide is not intended to serve as legal advice nor should it substitute for legal counsel. The guide is not exhaustive, and readers are encouraged to seek additional detailed technical guidance to supplement the information contained herein.

Putting the I in Health IT
www.HealthIT.gov
Liability Risk Analysis

- Backup
- Disaster Preparedness and Test
- Physical Security
- Update Testing
- User manual and training
- Encryption
Email Liability Issues

• EMAIL IS NOT HIPAA COMPLIANT
• Don’t use for medical emergencies
• Document all online patient communication.
• Limit Communications to existing patients
• You are responsible for information shared on your patient portal.
Practice Web Site Considerations

• You are responsible for any information you make available to your patients online
  – Either on website
  – Or in your email

• Marketing Information on website
  – Implicit guarantees
  – Implied warrantee

• Third Party Links - disclaimer
Patient Portal

- Secure
- Verify Identity
- Password validation
- Respond promptly to requests
- If used for acquiring patient data – make sure it is reviewed and validated
- Patients will read your notes … libel, defamation (demanding, non-compliant)
Social Media

• Sermo, You Tube, Facebook are public. You are on National TV

• Consumer Protection Laws

• Investigations have been triggered by:
  – Citing misleading information about outcomes
  – Using patient images without consent
  – Misrepresenting credentials
Electronic Discovery

• Printed Record of EHR
• Raw data for metadata analytics
  – Log time
  – What was reviewed and for how long
  – Changes
• Smartphone and email also discoverable
• Remember all interactions with EHR are time tracked and discoverable
Why Cyber Risk Insurance

- Data Breach
- Sharing of Passwords leading to data corruption
- Removing Patient Data
- Lost Thumb Drive/Laptop
- HIPAA Complaints
  - Inadvertent release of information

*Are example of events not covered by your malpractice insurance*
Cyber Risk Insurance

- Multimedia Insurance
- Security and Privacy Insurance
- Privacy Regulatory Defense
- Network Asset Protection
- Cyber extortion/Cyber Terrorism
- Privacy breach response
- Customer notification expenses
- Ransomware
OTHER ISSUES
Integrating EHR Into the Practice

- Training
- Understanding Limitations – What it can and cannot do
- Proper use of Access Portals and Passwords
- Accessing and incorporating prior data
If get some data via paper, how integrate it, and when?

- A-scan IOL sheet taken to OR
- Left in stack, circulator uses it to pick NEXT patient’s IOL
- Doctor recognized error

Correspondence from another office arrives, is scanned, and entered into patient file

- Doctor can’t “see” it, as with a paper file, misses data when patient comes in.
Something new is in the room
Demanding – MUST be attended to
Can’t attend simultaneously to both the patient and the device \textbf{SCRIBES?}
Picking from menus while the patient is talking
Communication – Words are a small fraction, where does intonation, body language fit in?
The importance of the Human Touch
• Mostly non-verbal
• Nuanced
• What does EHR provide?
  – Canned, sometimes awkward language
  – Words and phrasing that EHR elects, not what patient used
  – Failure to diagnose cases often turn on subtleties of language used in the chart
COMMUNICATION

• How does patient respond to questions?

• What are they communicating non-verbally?

• What does patient think about a caregiver who is asking questions, but not looking at them?
  – Reassuring?
  – Feel understood?
EHR improves legibility and thoroughness of documentation, BUT:
- Chart is full of irrelevant documentation
- Risk of loss of NARRATIVE documentation
- End up with a chart full of repetitive, formulaic statements about patient’s History, Physical exam
What EHR Cannot Do

- Won’t do your thinking for you
- Won’t do the examination for you
- Won’t do the informed consent for you
  - (but may document it better)
What EHR Cannot Do

- Won’t do your examination for you
- Clicking a button that “forwards” prior history and exam data completes the form, but not the exam
- “no change in vision” when primary complaint is complete loss of vision.
What EHR Cannot Do

• Follow-up on patient complaints

• “Do you feel safe at home?”
  – What is your plan to follow-up on a negative response?
  – Call social services?

• “Have you had recent falls”
  – What is your plan to follow-up on an affirmative response?
  – Arrange for neurologic/orthopedic referral?
What EHR Cannot Do

• Clinical Decision Support (CDS) provides alerts, warnings or reminder – “prompts” BUT IF

• Prompts in the record are overridden or ignored
  – Remember that any time a “prompt” is ignored or overridden, document WHY
  – BECAUSE discovery during litigation will print out “prompts” in “native” format
What EHR Cannot Do

- So DON’T forget to keep your curiosity
- DON’T let the EHR supplant your judgment
- The EHR doesn’t know everything, either
What EHR Cannot Do

• Handing the patient a form or an iPad may inform the patient, may not

• Provide Informed Consent
  – Legal requirement
  – But will it will also:
    • Establish rapport with patient
    • Reduce surprises for the patient
    • Fully inform the patient

• Just clicking the menu item “consents” does not inform the patient
TAKE AWAYS

• Document ONLY what you do
• Use Shortcuts Carefully
• Careful Regular Chart Reviews
• Document Training
• Think Security – Remember HILIARY
• Document Security Analysis
• Check to see if you have Cyber Insurance
Like all technology (such as the autocorrect that turned EHR into HER on this presentation), sometimes it is helpful, sometimes not.

Need to be TRAINED in how to enter and retrieve data.

Need to be CAREFUL about selecting entries.
TAKE AWAYS

• Need to be ATTENTIVE to what is entered
• Be careful about using COPY and PASTE
• And finally - Don’t forget the PATIENT!