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EHR Systems: Risk Management Strategies

July 2013

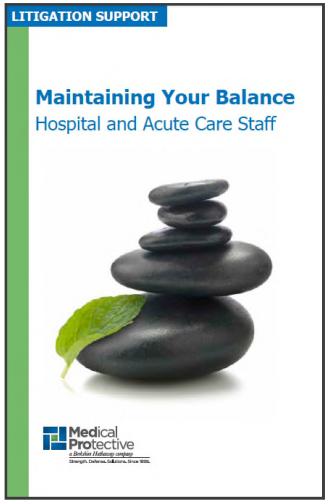
Today's host

Theresa N. Essick, RN, CPHRM
VP, Clinical Risk Management

- Ms. Essick has 35 years of experience in the healthcare industry and has a broad understanding of the unique obstacles that providers must address on a daily basis. During her years as a consultant, she became an expert in electronic health record implementation and industrial health issues, including workers' compensation and wellness program development.
- Ms. Essick has held a registered nurse license in North Carolina and Georgia during the course of her career. She is a member of the American Society for Healthcare Risk Management and the North Carolina Society for Healthcare Risk Management, and she has earned her designation as a Certified Professional in Healthcare Risk Management.

Do you know...

- How to access the PowerPoint presentation being used today?
- How you can use this program for future staff education?
- All of the risk resources available to you as a MedPro insured?



Learning objectives

At the completion of the program, each participant should be able to:

- Identify patient safety and compliance risks associated with electronic health record (EHR) implementation, use, and maintenance
- Discuss strategies and best practices to ensure safe patient care and an effective, efficient, and defensible medical record
- Explain how an EHR system can be used to support positive change in your practice through performance improvement activities

Pre-polling questions

- Is our EHR system customized to the practice patterns of our office?
- Before implementation of new system features, do we assess current clinical processes to ensure optimal workflow after implementation?
- Do we audit for consistent documentation practices in accordance with our organization's documentation policy?
- Do we have a performance improvement plan in place designed to assess high-risk issues specific to our patient population?
- Do we use system reports to check for receipt of test results?
- Is our EHR system's alert function tailored to our patient population?
- Have we developed evidence-based templates for use with our most frequently presenting health situations?

Survey results

Today's speaker

Beth Michel, MLD, CPHRM
Clinical Risk Management Consultant

Beth has more than 15 years of experience in medical malpractice litigation defense, data analysis, patient safety, quality improvement and risk management. She has served as a paralegal in the insurance industry and as an internal leader in hospitals.

Beth is experienced in directing root cause investigations of serious safety events, and she has led performance improvement efforts to implement and measure the effect of change on healthcare outcomes.

She is a graduate of Saint Mary-of-the-Woods College with a bachelor of arts degree in paralegal studies and a master of leadership development degree. She is a member of the American Society for Healthcare Risk Management and the Indiana Society for Healthcare Risk Management.

Today's speaker

Linda Kirchhof, RN, BE, CHCQM-RM, Senior Clinical Risk Management Consultant

Linda provides comprehensive services to healthcare systems, hospitals, clinics, and physicians throughout the middle United States. She has more than 35 years of clinical, administrative, and consulting experience in the healthcare industry. She has held administrative and consulting roles for providers, insurers, and management organizations.

Linda is an expert in managed care. She developed a risk management program for a large national physician staffing and contract management company. She implemented an award-winning risk management program at a community hospital, including physician monitoring and evaluation processes and introduction of new software. Linda also developed an innovative program for the alternate delivery of healthcare for a large national healthcare insurer.

Linda obtained her RN degree at the Toledo Hospital School of Nursing and her BE from the University of Toledo. She is a member of the American Society of Healthcare Risk Management, as well as the North Carolina chapter of that organization. She is board-certified by the American Board of Quality Assurance and Utilization Review Physicians, with sub-specialty certification in risk management.

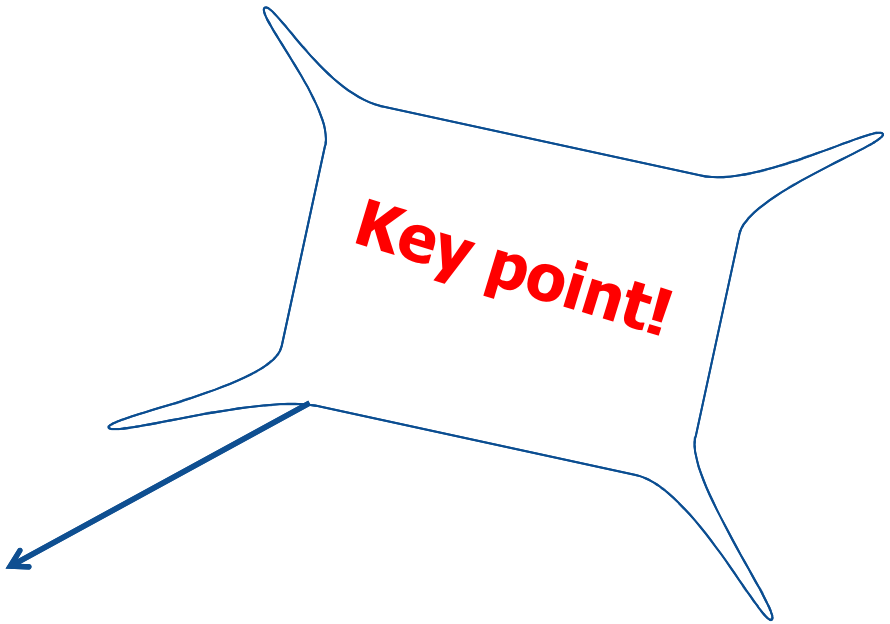
Mitigating overall risks

Factors Outside Your Control:

- Legal system
- Bad outcomes
- Plaintiff attorneys
- Litigious patients
- Healthcare reform/changes

Factors Within Your Control:

- Practice culture and processes
- Documentation
- Informed consent
- Communication and relationships
- Follow-up of diagnostic tests



Different worlds

Information management systems

EHRs are essential for:

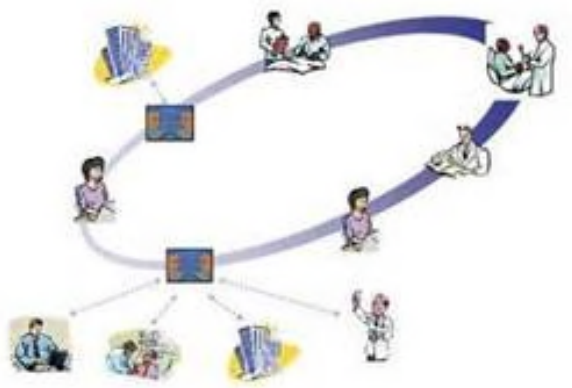
- **Patient safety**
  - Continuity of care
  - Immediate access to patient information
  - Decision guidance
  - Templated information (evidence-based medicine)
- **Quality initiatives**
  - Both internal and external
- **Practice management and compliance**
  - Includes performance improvement, compliance and productivity reports, and data analysis
- **Reimbursement**
  - Electronic submission of billing information and treatment data
- **Legal defense**

Certified EHRs support patient safety efforts

- Improved aggregation, analysis, and communication of patient-level information
- Evidence-based diagnostic decision support
- Therapeutic decision support via formularies and standardized practices/education methods
- Prevention of adverse events
- Clinical alerts and reminders
- Data reports to support performance improvement activities
    - Any information in a discrete data field can be pulled into a report
- Use of EHR for clinical quality improvement research

System implementation/management

Workflow analysis



Train staff for system knowledge

Integration with current systems

Implementation/maintenance strategies

- Establish a process for managing paper records once the EHR system is in place.
- Spend time up front developing templates that are meaningful to your practice. Review templates periodically.
- Use information summaries/flow charts to enhance critical thinking.
- Review alert settings and mandatory fills.
- Ensure privacy and security of protected health information (PHI).

Implementation/maintenance strategies

- Lost data
  - Transition
  - Hybrid systems
  - System failures
  - System processes — e.g., test/consult results
- Process/workflow changes — new error pathways
- Stringent documentation guidelines — no workarounds
- Documentation
  - Overreliance on templates and "check boxes" — the disappearing narrative
  - Array of patient data not conducive to critical thinking

Documentation risks and strategies

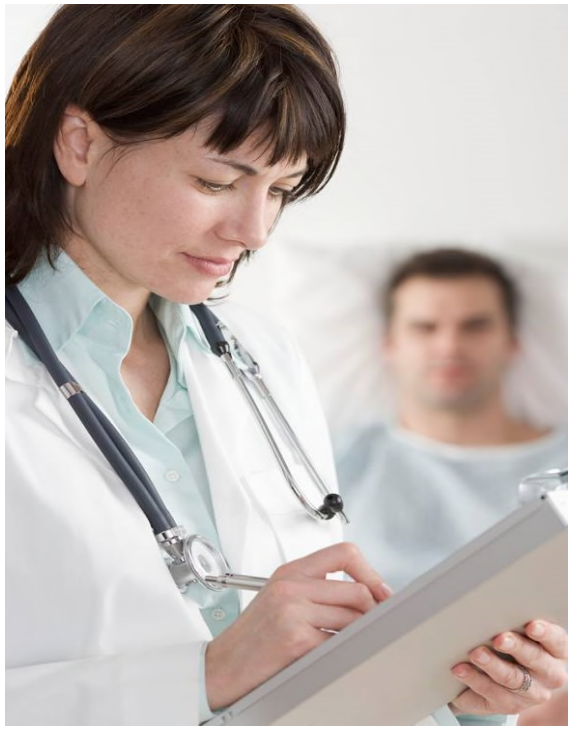
- Assessment and comparison of findings from previous visits
  - Problem list
- Known or suspected allergies: alerts
- Medication list/ reconciliation: alerts
- Documentation should reflect critical thinking and treatment plan

Documentation risks and strategies

- Patient education
  - Patient and family involvement/special circumstances
  - Specific instructions/education given
  - Preprinted/computerized
  - Clear, specific, and explained
- Document receipt and *understanding* with copy in chart
  - Language
  - Literacy
  - Culture

Documentation risks and strategies

- Patient compliance, including missed/cancelled appointments
- Treatment plan changes
    - Receipt of diagnostic results
    - Follow-up
    - Patient response
    - Telephone conversations
- After-hours contact
- Consults



Documentation risks and strategies: red flags

- Additions/deletions
- Late entries
- Omissions/incomplete records
- Failure to document follow-up
- Identifying generation of occurrence/incident report
- Inconsistent/contradictory entries
- Subjective remarks/finger-pointing

The medical record: robust EHRs as a defense partner

A well-documented patient chart within an EHR system:

- Demonstrates adherence to the best evidence-based practices
- Produces a complete, legible record readily available for the defense
- Verifies discussion of treatment with the patient

Electronic discovery

- In 2006, e-discovery amendments were made to the Federal Rules of Civil Procedure.
  - Require production of electronically stored data and metadata if requested.
    - ✓ Metadata is the "hidden data" in other files, such as author of the entry, timestamp, changes to the record, etc.).
    - ✓ Metadata may not be easily accessible.
  - May include requests for email.

- Risk strategy discussion:
  - Maintenance, retention, and destruction of records

Defining the legal EHR

- A legal EHR is an official record of patient care, with specified content and required by regulation.
- Develop a policy statement that defines what your practice considers to be a legal patient record.
    - When is the record considered complete for accreditation/compliance purposes?
    - What data are disclosed upon request for medical records?
- Know what the printed copy of the legal EHR record looks like.

Emerging issues and data requirements

- Compliance plans
- Fraud and abuse surveillance
- ICD-10 conversions
- Value-based reimbursement
  - Bundled payment and utilization decisions
  - Incentives to avoid admissions/readmissions
- Medical home
- Population management (by zip code)
- ACOs — gaps in coverage
- Electronic patient communication
- New challenges: cloud computing, mobile devices, social media, data backups/archives

Federal audit programs — A-Z

Federal Government Audit Entities	
Acronym	Program Name
CERT	Comprehensive Error Rate Testing Program
DOJ	Department of Justice
HEAT	Health Care Fraud Prevention and Enforcement Action Team
MAC	Medicare Administrative Contractor
Medicaid RAC	State Medicaid Recovery Audit Contractor
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MIP	Medicaid Integrity Program
OIG	Office of Inspector General
OMIG	State Office of Medicaid Inspector General
PERM	Payment Error Rate Measurement Program
RAC	Medicare Recovery Audit Contractor
ZPIC	Zone Program Integrity Contractor

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/

Performance improvement: use of the EHR

- Performance improvement — equal parts philosophy and process.
  - Focus is on continuously identifying opportunities to improve outcomes and taking proactive steps to mitigate risk.
- Underlying principles of performance improvement:
  - Errors are more likely the result of process breakdowns than human missteps.
  - Evaluating data via critical thinking strategies is the best way to identify and solve problems.
  - Those who own the process should be involved with developing solutions to problems.

Performance improvement: audits and high-risk metrics

- Consider quarterly report of amended records and daily/weekly report of open records
- Billing/coding audits
- Practice management
  - Patient population profiling
  - Frequently used drugs/supplies
  - Reconciliation of test results
  - Status of incomplete charts
  - Amendments (number and kind)
  - Release of PHI and HIPAA compliance

Performance improvement: resources and recognition

- Summer 2013 *Protector*: Managing Risks Associated With Electronic Health Records
- EHR Premium Credit Program

Risk-reduction strategies

- Adopt collaborative strategies to include all users of the system when evaluating the need to make changes or updates.
- Set stringent documentation guidelines and eliminate workaround processes.
- Tailor the system's alert function to specific patient populations.
- Use system reporting functions to support an active performance improvement plan for risk reduction.
- Develop a comprehensive policy to define the legal patient record.

Resources

- **Websites**
  - www.ahima.org (see HIM Body of Knowledge® tab)
  - http://www.healthit.gov/
  - www.ihi.org (see Knowledge Center tab for performance improvement resources)
- **Articles**
  - AHIMA e-HIM Work Group on Maintaining the Legal EHR. (2005, Nov/Dec) Update: Maintaining a legally sound record—paper and electronic. *Journal of AHIMA, 76*(10), 64A-L.
  - AHIMA Workgroup. (2011, Sept). Problem list guidance in the EHR. *Journal of AHIMA, 82*(9), 52-58.
  - Dimick, C. (2008, June). Documentation bad habits: Shortcuts in electronic records pose risk. *Journal of AHIMA, 79*(6), 40-43.
  - Dougherty, M., & Washington, L. (2010, Feb). Still seeking the legal EHR: The push for electronic records increases, the record management questions remain. *Journal of AHIMA, 81*(2), 42-45.
- **Handouts**
  - Self-Assessment Checklist: Efficient Use of Electronic Health Records
  - Guideline: *Using an Electronic Health Record System as a Risk-Reduction Tool*
  - Performance Improvement Template








What questions do you have?

Thank You!

Disclaimer

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THANK YOU for your participation!

Please take a few minutes to answer the polling questions.

Watch for our next webinar in November 2013.