Patient Engagement and the Legal Electronic Health Record

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Learning Objectives

1. Identify common EHR and PHR documentation mistakes
2. Identify common EHR and PHR system flaws
3. Incorporate best practices for maintaining data integrity in the health record for legal purposes
4. Incorporate how healthcare facilities can work with patients to ensure their records are accurate and trustworthy

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Background

For nearly 40 years I have served as an HIM and HIT professional.

But for my entire life, I have been a healthcare patient.

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Background

Consequently, as an HIM and HIT professional, my understanding of the processes that create and use medical records has helped me, the patient, identify system and human mistakes in my own records.

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Background

Over the years, the key take-away that I have learned is that the strength of an organization's legal EHR depends on the accuracy and reliability of its information-generating people, processes and systems and how that information is reproduced for providers and patients, like me.

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Accuracy and Reliability

- IN ANALOG and/or DIGITAL RECORDS, INACCURATE & UNRELIABLE DATA ENTRY
  - Incorrect recording of the patient's demographic data
  - Documenting in the wrong patient record
  - Incorrectly identifying the ordering physician on a laboratory report
  - . . . .

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Accuracy and Reliability

- IN DIGITAL RECORDS, FAILURE TO
  - timely communicate relevant EHR information among caregivers
  - draw attention to clinically significant events within the EHR
  - identify EHR patterns suggesting potential risk to the patient
  - . . . .

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Accuracy and Reliability

- ## EHR Examples – Variation 1

User marks: "Normal" for "All systems reviewed"

Database records: "Normal" for "All systems reviewed" element marked; all others remain null

Review of Systems:

Normal	Abnormal
√ All systems reviewed	☐ ____________
☐ Constitutional	☐ ____________
☐ Eyes	☐ ____________
☐ Ears, Nose, Mouth, Throat	☐ ____________
☐ Cardiovascular	☐ ____________
☐ Respiratory	☐ ____________
☐ Gastrointestinal	☐ ____________
☐ Genitourinary	☐ ____________
☐ Musculoskeletal	☐ ____________
☐ Integumentary	☐ ____________
☐ Neurological	☐ ____________
☐ Psychiatric	☐ ____________
☐ Endocrine	☐ ____________
☐ Hematologic/Lymphatic	☐ ____________
☐ Allergic/Immunologic	☐ ____________

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Accuracy and Reliability

- ## EHR Examples – Variation 2

User marks: “Normal” for “All systems reviewed”

Database records: “Normal” for “All systems reviewed” element and “Normal” for all other systems marked

Review of Systems:

Normal	Abnormal
√ All systems reviewed	☐ ______________
√ Constitutional	☐ ______________
√ Eyes	☐ ______________
√ Ears, Nose, Mouth, Throat	☐ ______________
√ Cardiovascular	☐ ______________
√ Respiratory	☐ ______________
√ Gastrointestinal	☐ ______________
√ Genitourinary	☐ ______________
√ Musculoskeletal	☐ ______________
√ Integumentary	☐ ______________
√ Neurological	☐ ______________
√ Psychiatric	☐ ______________
√ Endocrine	☐ ______________
√ Hematologic/Lymphatic	☐ ______________
√ Allergic/Immunologic	☐ ______________

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Accuracy and Reliability

- **EHR Examples – Variation 3**

User marks:

"Normal" for "All systems reviewed"

Database records:

"Normal" for all systems

Database does <u>not</u> record:

"Normal" for "All systems reviewed"

<u>Review of Systems</u>:

<u>Normal</u>		<u>Abnormal</u>
?	All systems reviewed	☐ ____________
√	Constitutional	☐ ____________
√	Eyes	☐ ____________
√	Ears, Nose, Mouth, Throat	☐ ____________
√	Cardiovascular	☐ ____________
√	Respiratory	☐ ____________
√	Gastrointestinal	☐ ____________
√	Genitourinary	☐ ____________
√	Musculoskeletal	☐ ____________
√	Integumentary	☐ ____________
√	Neurological	☐ ____________
√	Psychiatric	☐ ____________
√	Endocrine	☐ ____________
√	Hematologic/Lymphatic	☐ ____________
√	Allergic/Immunologic	☐ ____________

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▪ EHR Examples – Variation 4

User marks:

"Normal" for "All systems negative"

Database records:

"Normal" for all systems with pre-set structured data elements

Database <u>might or might not</u> record:

"Normal" for "All systems negative"

<u>Review of Systems:</u>

<u>Normal</u>

✓ All systems negative

- Constitutional negative for fever, chills, sweats, unexpected weight loss or weight gain, activity tolerance changes, or dizziness
- Eyes negative for visual disturbances, floaters, flashes, blurred or double vision.
- Ears, Nose, Mouth, Throat negative for hearing changes, tinnitus, vertigo. No mouth lesions, dental caries, tongue masses or irregularities. No sore throats, hoarseness, or nasal drainage.
- Cardiovascular negative for palpitations, angina, peripheral swelling etc.
- Respiratory negative for productive or non-productive cough, dyspnea on exertion, pain with cough, snoring, or shortness of breath
- Gastrointestinal negative for W, X, Y, and Z
- Genitourinary negative for W, X, Y, and Z
- Musculoskeletal negative for W, X, Y, and Z
- Integumentary negative for W, X, Y, and Z
- Neurological negative for W, X, Y, and Z
- Psychiatric negative for W, X, Y, and Z
- Endocrine negative for W, X, Y, and Z
- Hematologic/Lymphatic negative for X, Y, Z
- Allergic/Immunologic negative for W, X, Y, and Z

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Accuracy and Reliability

- EHR Documentation

Advantages

- Less likely that important documentation will be inadvertently lost or destroyed

Disadvantages

- Clinicians can select wrong patient record from drop-down menus

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Accuracy and Reliability

- EHR Documentation

Advantages	Disadvantages
• Illegible handwriting eliminated	• Some clinicians are poor typists, resulting in typos
• System can issue alerts for allergies, drug-drug interactions, drug-food interactions . . .	• If alerts are ignored, might create an issue that must be explained

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Accuracy and Reliability

- EHR Documentation

Advantages	Disadvantages
• Templates can guide documentation so elements essential to demonstrating appropriate care are not ignored	• Templates might contain elements not relevant to care of a patient and, therefore, might cause the narrative of the patient's care to be lost in extensive, irrelevant documentation

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Accuracy and Reliability

- EHR Documentation

Advantages	Disadvantages
• Structured documentation is critical for retrieval, reporting, data mining, health information exchange, etc.	• Some clinicians are reluctant to document patient encounter information directly into EHR templates . . .

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Inappropriate Record Corrections

- When errors occur, providers might be inclined to **delete** the erroneous information to:
  - avoid adversely affecting the care of the patient
  - mitigate risk to the provider / organization

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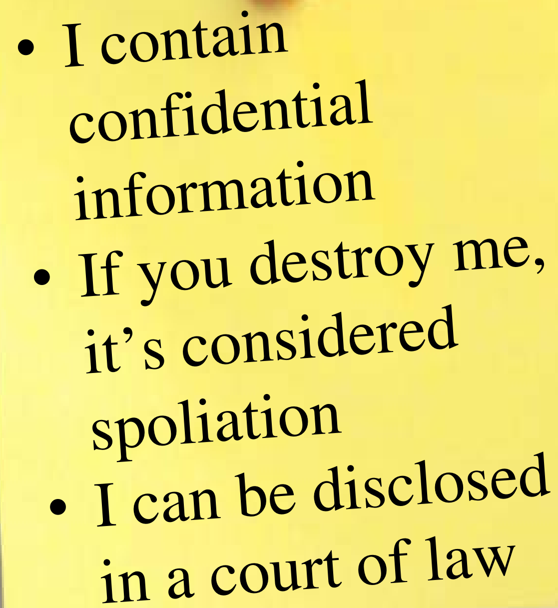
WRONG!

EHRs
are Legal, Business Records!



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Those who are authorized to document within the EHR are accountable for every EHR entry made, including errors.

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Appropriate Record Corrections

MAINTAINING
THE ORIGINAL,
<u>INCORRECT</u> ENTRY
AND ADDING
A CORRECTION
WITH AUTHENTICATION

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Appropriate Record Corrections

- 1996 HIPAA Privacy Rule
  - requires Covered Entities to **APPEND** health record information, not delete

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Appropriate EHR Corrections

- **How authorized users correct / amend entries (including authentication) varies by information system.**

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Appropriate EHR Corrections

- Incorrect information can be removed from view but the information must be maintained in the system so that it can be retrieved through document versioning or metadata
  - DELETION FUNCTIONALITY
  - RETRACTION FUNCTIONALITY

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Appropriate EHR Corrections

- Monitor appropriate audit trails on a routine basis.
  - Audit trails should include:
    - User name
    - Application triggering the audit
    - Workstation
    - Specific document
    - Description of event (incorrect usage of DELETION functionality)
    - Date / time
- Immediately follow-up and educate the user!

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Appropriate EHR Corrections

While routine audits of processes help,
the healthcare patient
also can be
a valuable partner
in ensuring that health records are
accurate
and reproduced in human-readable format.

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Appropriate Record Corrections

- 1996 HIPAA Privacy Rule
  - allows individuals to request health record amendments
- Most patients don't know they can ask to amend their records.

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The Patient-Centered Model of Healthcare

In many instances, patients are more in touch with their care than busy healthcare professionals and HIM managers.

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The Patient-Centered Model of Healthcare

Therefore, patients should be encouraged by providers to review their medical data for accuracy.

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Appropriate Patient EHR Corrections

1. Develop open communication processes for patients to make amendments to their medical records when mistakes are discovered.

2. Attention to these issues should be a priority for HIM and HIT, since the legal implications of any unintended consequences that come from faulty EHR usage can be overwhelming.

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Appropriate Patient EHR Corrections

3. When releasing paper copies or uploading information to patient portals, encourage patients to report any incorrect information they view in their records.

4. Allow patients to interact with EHRs to view and to make amendments!

5. Organizational digital portals and PHRs offer excellent windows for patient interaction.

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Appropriate Patient EHR Corrections

Interacting with EHR systems as a patient provides a different perspective and uncovers unique system flaws.

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Personal Experience with Data Flaws

- I am a patient at two separately owned and operated healthcare provider organizations that are within walking distance of one another.
- Both organizations use the same suite of clinical information system modules for their “core” EHR system.
- While one organization provides access to records through a patient portal, the other relies on paper release processes.

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Personal Experience with Data Flaws

- The organizations either do not know how to correctly configure their EHR systems or have failed to do so properly.
- I've also found inadequate EHR systems training by end users within the organizations.
- The EHR systems' functions might be flawed or not available.

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Problem Example 1: Male with Cancer

- I requested the release of my medical record from one of the organizations. The transcribed procedure report header listed my correct name, date of birth, and medical record number.
- However, the report body included two pages describing me as male and having cancer. Neither of these facts is accurate.

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Problem Example 1: Male with Cancer (con't)

- This kind of mistake is common. Either the provider mistakenly dictated on the wrong patient under the correct header information sent by the EHR system, or the transcriptionist mistakenly keyed the wrong patient information under the correct header information.
- After contacting the organization and asking for the record to be corrected, I donated a copy of the report to a local HIM program for student education purposes.

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Problem Example 2: Changing Orders

- One of my care providers repeatedly asked for lab work even though the lab work had already been performed months ago and was stored in my PHR.
- Deleting the EHR order error and updating the system with the previous lab results required several handwritten notes, photocopies, and telephone calls to the provider.

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Problem Example 2: Changing Orders (con’t)

- According to two of the organization’s end users, these orders come from a “different database” than the “real” orders, which “are correct in the system, but don’t print to the hard copy correctly.”

- This is not possible, and likely the problem is a lack of staff training on the correction processes.

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Problem Example 3: Duplicate Tests

- Recently, when one physician ordered for me a routine TB test, there was nothing in the EHR system to alert the provider that the same test was performed at their organization in July 2009.

- Consequently, the test was unnecessarily repeated in February 2010 costing me an additional $398.

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Problem Example 3: Duplicate Tests (con't)

- After complaining about the duplicate test, the organization's end user said it is the provider's responsibility to look back at all the orders in the system to see if a TB test had been performed within the last several years.

- The provider can't be faulted for not wanting to scroll through several years of past orders to determine if a routine test was performed.

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Patients Keep Records Honest

Industry professionals must begin
to shift their focus
from the technical and operational solutions
that automate, send, and receive
health information
to the quality and accuracy solutions
that manage the analog, digital, or hybrid
information in our health records.

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Patients Keep Records Honest

- The HIM department is in an excellent position to provide a mechanism for patients to flag and correct their health information.
- Best practices suggest designating HIM representatives to work with patients to ensure their analog and digital records are accurate.
  - This role would be similar to financial bank representatives who resolve financial disputes and balance digital checkbooks.

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Patients Keep Records Honest

- Not only are such initiatives beneficial from an HIM, HIT, data integrity, and legal point of view, but they are beneficial to a patient's sense of confidence in their records and care.

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Concluding Thoughts

- If the EHR does not present a clear picture of the patient's clinical course, it might be difficult to demonstrate that care rendered met professional standards.

- Deficiencies in EHR systems might make it necessary to settle or loose an otherwise defensible case.

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Concluding Thoughts

- Beyond the impact on patient safety and quality care, a correct medical record is a more legally sound medical record.
- Data integrity is vital to maintaining legally sound and court-ready EHR information.

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Future …

- In early July, ONC's Health IT Policy Committee approved the following two privacy and security Tiger Team recommendations:
  - **For Stage 2** of the MU program, certified EHR systems should have the ability to support changes to medical data as well as a healthcare provider's compliance with HIPAA when responding to patient requests to amend information.
  - **By Stage 3** of the MU program, certified EHR tools should have the capability to send edited information to healthcare providers to whom the data already had been sent.

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Discussion

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