Evolution of Health Care

• Began with chants and herbs
  ▪ Focus on the perceived forces affecting the patient

• Moved into science and surgery
  ▪ Identified a touchable cause and cure
  ▪ Data driven

• Now includes the electronic sphere
  ▪ Combines the “untouchable” with facts
Hippocrates Led the Way

• First medical record developed by Hippocrates in 5th century B.C.

• Two goals:
  ▪ Accurately reflect the course of disease
  ▪ Indicate the probable cause of disease
From Paper to Electronic Charting

- 1960–first electronic records appeared
- Functionality far exceeded ability to meet Hippocrates goals
- Old and new risks with use of electronic health record persists
Objectives

• Identify four risks unique to electronic documentation
• Recognize two discoverability issues related to electronic data
• Describe three methods to improve electronic charting habits
• Discuss risk management strategies for reducing liability associated with electronic media
Figure 1. Percentage of office-based physicians with electronic medical records/electronic health records (EMRs/EHRs): United States, 2001–2009 and preliminary 2010

NOTES: Any EMR/EHR is a medical or health record system that is either all or partially electronic (excluding systems solely for billing). The 2010 data are preliminary estimates (as shown by dashed lines), based only on the mail survey. Estimates through 2009 include additional physicians sampled from community health centers; prior 2008 combined estimates were revised to include those physicians (4). Estimates of basic and fully functional systems prior to 2006 could not be computed because some items were not collected in the survey. Fully functional systems are a subset of basic systems. Some of the increase in fully functional systems between 2009 and 2010 may be related to a change in survey instruments and definitions of fully functional systems between 2009 and 2010 (see Table for more details). Includes nonfederal, office-based physicians. Excludes radiologists, anesthesiologists, and pathologists.

SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey.

The EHI Age: Challenges and Risks / 6
Case Study:
Accessing EHR for Prior Treatment
Case Study: Accessing EHR for Prior Treatment

- Child brought to ER with reports of fever
  - Blood cultures obtained
  - Admitted for further work-up

- Hospital day three, child discharged
  - Afebrile
  - Preliminary blood cultures negative for growth

- Final blood cultures positive for bacterial growth
  - Results communicated to ER
  - Not clear if reported to PCP
Case Study: Accessing EHR for Prior Treatment (continued)

- Child presents to Pediatric Clinic several days later with reports of fever
  - Released as afebrile during visit
  - EHR not accessed

- Child presents to ER two days later with fever
  - EHR reviewed with finding of positive blood culture
  - Child succumbed to infection several days later
Case Discussion Points

• What is the impact of the audit trail?
  ▪ Subsequent treating physician’s failure to access prior records during the clinic visit

• What is the exposure of the ER physician?

• What advice would you offer to a physician during deposition preparation?

• What recommendations would you offer to the clinic to improve communication?
The Audit Trail

• A “digital fingerprint” of EHR access

• Includes:
  ▪ Date
  ▪ Time
  ▪ Specific information accessed
  ▪ Time spent in each section
  ▪ Changes to entries

• Used too often as a “catch all” for EHR functionality flaws
Patient Safety Considerations

- Discharge occurred prior to validating final blood culture results
- Available test results not reviewed
  - During clinic visit
- Test results not provided to applicable providers

Source: EIS Data
“A Rose by Any Other Name”

- As with paper charting, electronic charting must be:
  - Objective
  - Factual
  - Complete
  - Chronological timeline of care and treatment provided
  - Reflect course of disease
  - Indicate probable cause of disease
EHR Documentation Features

- Templates
- Menus, radio buttons, check boxes
- Copy/Paste
- Actions/Alerts
Benefits

• Efficient
  ▪ Quick entries
  ▪ Reduces need to re-enter information
• Increase in consistent documentation habits
• Triggers and supports clinical decision making
• Provides reminders for tracking care and treatment
Pitfalls

- Incorrect information entered
  - Auto-populated fields
  - Copy/Paste information

- Information not reviewed for accuracy

- Number of steps to completion can be cumbersome

- Limitation on “free text”

- Lists can become overwhelming
Patient Safety Tips

- Review entered data before finalizing an entry
- Employ “free text” to individualize information
- Consider disabling “copy/paste” feature
- Conduct scheduled review of “to-do” lists
- Assign auditor to check for overdue “alerts”
Case Study:
Copy and Paste
Case Scenario: Copy and Paste

- 77-year-old admitted to teaching hospital with diarrhea and dehydration
  - Completed fifth cycle of chemotherapy
  - Past medical history includes pulmonary embolus following hip surgery
- Intern documented in progress notes patient would receive subcutaneous heparin for venous thromboembolism (VTE) prophylaxis
  - Heparin prophylaxis not entered as an order in EHR

Case Scenario: Copy and Paste (continued)

- The progress note copied and pasted on four consecutive hospital days
- Patient discharged without ever receiving prophylaxis anticoagulant therapy
- Two days later the patient developed acute shortness of breath and hypoxia
- Returned to hospital with diagnosis of pulmonary embolus
Case Discussion Points

• How will a jury interpret the copy/paste feature?
  ▪ Lack of attention
  ▪ Lack of initiative

• What have you seen as to frequency of copy/paste issues?
Patient Safety Considerations

• Validate all information before copy/paste
• Avoid use completely if only use is to fill space
Additional Functions and Considerations
Internal Messaging

• Benefits
  ▪ Quick turnaround of orders and action

• Pitfalls
  ▪ Loop closure often not evidenced in EHR review
  ▪ Over reliance on feature when verbal exchange is a better method

• Patient Safety tips
  ▪ Include all steps into the electronic record
  ▪ Audit internal messages to ensure compliance
E-Prescribing

- **Benefits**
  - Legibility
  - Avoids oral miscommunication
  - Warning and alert systems
  - Greater prescriber convenience via laptop, PDA
  - Improved drug surveillance and recall ability
E-Prescribing (continued)

- **Pitfalls**
  - Controlled substances prescribing
  - Medication reconciliation may not be complete

- **Patient safety tips**
  - Review all current medications with the patient
    - Do not rely entirely on the system for such information
Electronic Signature and Attestation

• Shows authorship and legal responsibility for entry
  ▪ Digitized image of a signature
  ▪ Biometric identifier
  ▪ Secret code or PIN
  ▪ Digital signature

• Concerns
  ▪ “Dropped off” signatures
  ▪ Printed output may not contain the e-signature

• Example
  ▪ Electronically signed by Dr. John Doe on 6/1/09 at 0115
Form and Substance Updates

• Substance benefits and pitfalls
  ▪ Amendment clarifies the previously entered information
  ▪ Addendum adds new information to the original entry
  ▪ Late entry applies to previous documentation
  ▪ Can be misconstrued as alteration

• Form pitfalls: paper to electronic format
  ▪ Not all information included into electronic record

• Patient Safety tips
  ▪ Develop policies and procedures for use
  ▪ Consult with risk manager for guidance
Case Study: Early EHR Adoption Glitch
Case Study: Early EHR Adoption Glitch

- Patient seen in specialty medical practice
  - EHR newly adopted
  - Chief complaint of tongue irritation

- Diagnostic tests performed
  - Positive for malignant carcinoma
  - Lesion excised
Case Study: Early EHR Adoption Glitch (continued)

- Symptoms persisted post excision
  - Additional lesion defined as benign
  - Follow-up office visits occurred

- Subsequent pathology report in paper form
  - Not reviewed or scanned into the EHR

- Patient succumbed to the disease and died several months later
Case Discussion Points

• How will absence of hardcopy documents in the EHR be seen by the jury when the information was available at the time of care and treatment?

• How would the repeated inaccuracies in the record be perceived by a jury?

• What recommendations would you offer for amendments to a record?
Patient Safety Considerations

- Hardcopy data should be scanned into the electronic system
- Assign staff to monitor and ensure *all* data is in EHR
Case Study: Inconsistent Timeline
Case Study: Inconsistent Timeline

- Foot fracture surgically repaired
- Patient sustained debilitating nerve damage
- H&P documentation extensive
  - Included statement regarding foregoing surgery
- Nurses’ notes indicated H&P in chart prior to surgery
- During litigation
  - Audit trail accessed
  - H&P discovered to be entered after physician served with lawsuit
Case Discussion Points

- What is the effect of inconsistencies in the record on a case?
- What would you advise the physician to do once questionable entries are identified?
- Would you recommend settling of this case?
- Would punitive damages be a concern with alteration of the record?
Patient Safety Considerations

• Lock out for later entries
• Audit of entries as part of quality improvement
• Human factors
  ▪ Identify factors in record alteration
  ▪ Examine time constraints for accurate documentation
New Age Communication Forums in Today’s Health Care
Electronic Communication Exchanges

- Correspondence about patient care and treatment using any electronic media format must be included in the medical record
  - E-mailing
  - Texting
  - Instant messaging (IM)
  - Electronic tablet use (iPad, Vizio, Droid platform)
New Era of Discoverability

- Electronic communication data is discoverable
- IT experts can and will uncover information in these media formats
- Definition of medical record has expanded since the advent of electronic health care systems
  - No communication exchanges are off limits
New Era of Discoverability (continued)

- Rules to follow
  - Include any correspondence in the EHR that affects a specific patient
  - Do not include personal exchanges within professional ones
    - Text from nurse to physician: “Linda Jones called, she has a temperature of 102.1. By the way, what would you like for lunch?”
  - Consider all keystrokes, clicks, taps, and voice-recognition to be discoverable
Social Networking

• **Types**
  - Facebook
  - Twitter
  - LinkedIn
  - Personal blogs
  - Foursquare
  - YouTube

• **Benefits**
  - Marketing tool
  - Can communicate current events in medical group
  - Consumer education
Social Networking: Risks

- Physician/Patient exchanges
  - HIPAA/Privacy Practices
  - Misused for urgent communication by patient
- Potential for breach in professional boundaries
- Purpose of sites misunderstood by both parties
Case Study: Misuse of Social Media
Case Study: Misuse of Social Media

- Emergency Room physician fired
  - Posted patient information online
  - Although de-identified, patient identity recognized by local community
- Medical Board reprimand followed

Adapted from Health Law Update, Shuttleworth & Ingersoll, P.L.C. June 2011
Case Discussion Points

• How helpful are guidelines/policies on access or use of social media by clinic personnel?

• What is the effect of any such guidelines/policies on a case?

• How do state medical boards react to these issues?

• Credentialing

• How does a HHS investigation affect a provider personally?
Patient Safety Considerations

- HIPAA/Privacy Practices must be followed
- Develop and implement policies and procedures for social media
- Password protected is *not* sufficient
- Must be encrypted
- Human factors
  - Identify and address propensity to share sensational information
  - Rationalizations occur to deny professional responsibilities
Social Media: Strategies for Success

- Identify goals for use of social networking
- Develop and implement policies and procedures
- Educate staff and providers
- Include HIPAA/Privacy Practices training
- Utilize Employee Confidentiality statements
- Assign a Social Media Administrator to manage media sites
AMA: Professionalism in the Use of Social Media

- **AMA Policy states:**
  - Be cognizant of standards of patient privacy and confidentiality
  - Use privacy settings to safeguard personal information and content
  - If interacting with patients on the internet, maintain boundaries in accordance with professional guidelines
  - Consider separating professional and personal content online
  - If you see unprofessional content posted by a colleague, you have a responsibility to bring it to his/her attention
  - Postings may negatively affect your reputation

Source: American Medical Association (www.ama-assn.org)
Consumer Review Sites (CRS)

- YELP.com, VITALS.com, RATEMD.com, AngiesList.com, etc.

- Public forums for consumers (patients)
  - Used for posting experiences with physicians
  - Commonly used for negative comments
Consumer Review Sites (CRS) (continued)

- Considered a positive marketing tool
  - Until a negative review is posted

- Challenging to get posts removed
  - Various companies act as paid watchdogs, but post removal remains a challenge

- Strong urge to respond to negative post

- Limited case law on successful litigation
Case Study: Defamation Suit 2011

- Physician files $1 million defamation suit against former patient
  - Allegations of “bad-mouthing” physician on YELP.com and other review sites
- Consumer prevails in lawsuit
  - Physician ordered to pay $20,000 in attorney fees
Case Discussion Points

• What can a physician do to decrease a patient’s reason to post a bad review?
• What can a physician do when it does occur?
• How have “gag” agreements that the physician has the patient sign played out in a lawsuit?
• Do you see a future for proactive actions by physicians to have legal recourse with bad reviews?
Patient Safety Considerations

- Review physician/patient communication
  - Encourage open communication before a negative posting

- Consider utilization of patient satisfaction questionnaires
  - Identify areas for improvement
Consumer Review Sites: Strategies for Success

• Develop a “Patient Relations” program
  ▪ Respond to all concerns, complaints, or grievances regardless of validity

• Utilize patient welcome letters
  ▪ Include information on how to communicate concerns to the office/physician
  ▪ Avoid “gag” order statements

• Utilize patient satisfaction surveys
  ▪ Act on opportunities for improvement
Consumer Review Sites: Strategies for Success (continued)

• If a negative posting occurs
  ▪ Resist urge to respond
  ▪ Determine if post has affected the practice
  ▪ If patient can be identified, follow up with letter encouraging contact with you to discuss
Resources

• “Electronic Medical Record and Social Media Malpractice Risks” The Doctors Company
  ▪ www.thedoctors.com

• “Professionalism in the Use of Social Media” American Medical Association
  ▪ www.ama-assn.org

• CDC Health Communicators Social Media Toolkit
  ▪ http://www.cdc.gov/healthcommunication/ToolsTemplates/SocialMediaToolkit_BM.pdf
Conclusions
Mission Statement

Our Mission Is to Advance, Protect, and Reward the Practice of Good Medicine

For additional Patient Safety information, please visit our Web site at: www.thedoctors.com