Overview

- Medical record
- Documentation standards
- Maintaining integrity in your EHR
- Challenges and opportunities

Medical Record

- Continuity of care
- Patient safety
- Professional requirement
- Quality review
- Accreditation
Medical Record

- Business record
- Reimbursement
- Compliance
- Litigation — legal defense

Defending Malpractice Claims

- No Problem
- Problem

Medical Record

- Health information management
  - Internal data
  - External data
  - Retention and destruction
- Efficient EHR systems
  - Accessible
**Documentation Standards**

- The same standards apply to paper and electronic records
- Deficiencies can lead to:
  - Patient injury
  - Malpractice claim
  - Difficulty defending a claim

**Medical Record**

- Direct data entry
- Scanned documents
- Imported information
- Interfaced information

**Documentation Standards**

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Complete
Frequently Missing, Incredibly Necessary

- Past medical history including family history
- Pertinent negative findings on exam
- Complete and accurate listing of meds
- Follow-up instructions
- Health maintenance advice
- Indications that previous problems are addressed in subsequent visits

Documentation Standards

- Complete
- Consistent

Inconsistent Documentation

Beware of “exploding” notes that are not reflective of exam or patient
Documentation Standards

- Complete
- Accurate
- Consistent
- Legible

Inaccurate Documentation

- Wrong date
- Wrong body part
- Wrong medication
- Wrong lab results
- Wrong patient

Documentation Standards

- Complete
- Accurate
- Consistent
- Legible
Illegible Documentation

- Major source of patient harm
- Not just a physician problem
- Focus of national attention

Documentation Standards

- Complete
- Accurate
- Timely
- Consistent
- Legible

Untimely Documentation

- Causes patient injury
- Causes difficulty in defense
Documentation Standards

- Complete
- Accurate
- Timely
- Consistent
- Legible
- Objective

What Not to Put in Record!

S: “A very complicated situation or at least overly complicated in her description... voices complaints of poorly informed consent regarding the procedure... it is to the point that the story is rather cumbersome here on a Sunday afternoon in Urgent Care. Eventually I just had to ask her what her primary problem was...”

Documentation Policies

- Many policies are the same
- Workflow different
  - Defining complete
  - Drafts
  - Amendments
  - Corrections
  - Using templates
  - Using abbreviations
Patient Safety

- Audits — design an audit program that ensures standards are met
  - Use an audit tool
  - Engage providers & staff in audits
  - Regularly scheduled
  - Provide audit results feedback
  - Enforce compliance

Record Integrity

- Record completion
- Audit trails
- Version management

Integrity
**Authenticity**

- Identify the original record
  - Imaged documents
  - Electronic documents
  - Paper documents
- Assurance that electronic information hasn’t been altered

**Accuracy**

- Validation of identity — each entry linked to specific patient
- Information from other systems
- Chronology
- Automated and default settings

**Authorship**

- Authorized persons who may document in EHR
- Access level
- Unique ID
- Copy and paste functions
  - Wrong patient or encounter
  - Inadequate ID of original author and date
Attestation

- Security process
- Verifying identity
- Signature process
  - Intent
  - Identity
  - Integrity
- Multiple providers

Amendment

- Amendment
- Addendum
- Correction
- Late entry
- Patient amendments

Amendment Definitions

- Amendment: To clarify information in the record
- Addendum: To add information to the original entry
- Correction: To change information in the medical record – clarify inaccuracies
Amendment

- Understand system capabilities
- Date and time
- Name and title
- Why making amendment, addendum or correction
- Reference to original entry

Protecting Integrity

- Look at current policies
- Identify gaps
- Develop policies
- Educate staff
- Consult legal counsel

EHR Policies

- Team membership
- Stakeholders/EHR implementation team
  - HIM
  - IT
  - Risk management
  - EHR users
EHR Policies

- Authenticity
- Accuracy
- Authorship
- Attestation
- Amendment

EHR Policies — Integrity

- Record completion
  - When
  - How
  - Individual components
- Audit trails
- Version management

EHR Policies — Authenticity

- Specifically define
- Describe assurances
- Inconsistencies
- Destruction and retention policies
EHR Policies — Accuracy

- Describe validation
- Define appropriate use of default settings
- Describe system interfaces

EHR Policies — Authorship

- Define access level
- Sign on requirements
- Password requirements
- Copy and paste functions

EHR Policies — Attestation

- Define attestation within your system and practice
- Describe the process of attestation
EHR Policies — Amendment and Correction

- Establish definitions used in your organization
- Define who can make changes — when, how and why
- Describe minimum requirements
- Understand your EHR system's capabilities

Emerging Technology

- Information challenges
- Increased expectation
- Increased time
- New skills for physicians and other providers

Opportunities and Challenges

- Internet presence
- Patient portals
- Patient emails
- E-visits
Opportunities and Challenges

- Clinical decision support
- Downtime documentation
- Legacy systems
- Electronic discovery
- Corporate liability

Resources

- MMIC Group website
  www.mmicgroup.com
- American Health Information Management Association
  www.ahima.org

Thank You