AUDITING EMR DOCUMENTATION

TRINA BIRINGER, BSN, RN, CCRC
SENIOR CLINICAL AND RESEARCH NURSE AUDITOR
THE NEMOURS FOUNDATION
Contact Information:

Trina L. Biringer, BSN, RN, CCRC
- Senior Clinical and Research Nurse Auditor
- Occupational Safety and Health Specialist

10140 Centurion Parkway North
Jacksonville, FL 32256
Office 904-697-4289
Trina.Biringer@Nemours.org
My Life outside of Audit.

When I am not reading protocols and reviewing EMR’s, I enjoy spending time with my 2 energetic boys.
Auditing the EMR

What's Your VIEW?
EMR- The Journey......

Tribute to EMR and Journey’s Don’t stop believin’

Epic user group meeting skit
Audit Type

- Clinical/Operational
- Research Specific
EMR: The Documentation per OIG

- OIG Importance of Documentation
Auditing the EMR Documentation

- Identifying the Key Stakeholders:
  - Who
  - What are YOUR organizational expectations?
  - What type of EMR system (Epic, Meditech etc)
Why we Audit-Implementation of EMR

- Quality & Safety

- Efficiency

- Clinical decision support/Improve care coordination

- Engage patients and families in their care
Why we Audit-continued

- Improve population and public health
- Electronic reporting
- Privacy and security protections
- Compliance
It’s the Law

- Electronic medical records, like other medical records, must be kept in unaltered form and authenticated by the creator. [1]
Auditing Challenges

□ Is it a roadblock?
EMR Auditing Challenges

- Integrity of the record
- Controls around access
- Who documented what?
- Signatures/authentication
Challenges-continued

- Cut/copy/paste features
- Cloning (defaulted documentation)
- Macro’s
- Transparency of the provider
How Documentation is inputted in the EMR

- Documentation may be:
  - dictated, typed, handwritten & or computer generated.

- Supporting documentation may be:
  - scanned, faxed, a “snapshot”, electronically copied from original source or a combination of multiple styles.
Smart Text Language and Templates

- “Make Me the Author” feature

- Template by provider, department, specialty or regulatory guidelines and standard of care practices
EMR Automatic Pathways

- Check your software’s default settings

- Can the provider override default settings when they don’t apply to a particular patient or service

- Don’t be afraid to use templates but be sure to individualize for each patient

- Can the Provider modify or delete template language when it does not apply
EMR Automatic Pathways-continued

- Was the organization diligent in the training efforts on how to document in the EMR

- Does the EMR select codes based upon “key words” in the documentation fields

- Is the EMR set up to default information from previous entries to the current provider note?
Scope of the EMR

- HIPAA and HITECH.
- Access and transport medical information across organizations
- Interfacing with other systems and entities that link to the internet.
Ranking of Hospital EMR Installations by Vendor per Modern Healthcare (2011-2012)

TOP 10 VENDORS OF ENTERPRISE EMR SYSTEMS

- Meditech Westwood, Mass. 1,155 meditech.com
- Epic Systems Corp. Verona, Wis. 678 epic.com
- Cerner Corp. Kansas City, Mo. 634 cerner.com
- McKesson Provider Technologies Alpharetta, Ga. 471 mckesson.com
- CPSI Mobile, Ala. 393 cpsinet.com
Top 10 Vendors continued

- Healthcare Management Systems Nashville 352 hmstn.com
- Siemens Healthcare Malvern, Pa. 310 medical.siemens.com
- Self-developed — 260 —
- Healthland Minneapolis 230 healthland.com
- Allscripts Chicago 178 allscripts.com
Meaningful Use impact, is there any?

☐ Tis the season of electronic health records (EHR), now that both hospitals and physicians can qualify to earn incentives from the federal government when they implement these solutions and meet “meaningful use” criteria.
US Government Incentive Categories

- Improve care coordination
- Reduce healthcare disparities
- Engage patients and their families
- Improve population and public health
- Ensure adequate privacy and security
### EMR and EHR Screenshots

#### Patient Encounter List

<table>
<thead>
<tr>
<th>Patient</th>
<th>First</th>
<th>M I</th>
<th>Sary Date</th>
<th>Visit Type</th>
<th>Referrer</th>
<th>Performing Dr</th>
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<th>M I</th>
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<th>Options</th>
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<td>Sample, John, M.</td>
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<td></td>
<td></td>
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<td>02-14-10 15:17</td>
<td>Billing Encounter</td>
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</table>
A Provider may take authorship of a note by opening the note by the Edit button. When exiting the note, it becomes the providers.

Review of Scanned information on the Chart Review’s Media tab
**Patient Header turns yellow when Type is changes to Research**

### Separation of notes by author

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<tr>
<th>Nelly Mauras, MD</th>
<th>Physician</th>
<th>Sign at close encounter</th>
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</thead>
<tbody>
<tr>
<td><strong>Alpha</strong></td>
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</tr>
<tr>
<td><strong>LOCATION</strong>: right posterior calf</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>QUALITY</strong>: intermittent, dull</td>
<td></td>
<td></td>
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</table>

<table>
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<tr>
<th>Tina Ewen</th>
<th>Sign at close encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOCATION</strong>: right posterior calf</td>
<td></td>
</tr>
<tr>
<td><strong>QUALITY</strong>: intermittent, dull</td>
<td></td>
</tr>
</tbody>
</table>
A NoMoreClipboard.com account is not linked to this patient.

Post a Summary to NoMoreClipboard.com

Unrecognized Summaries

306
03-31-2010
Displaying 1-1
Show All

Vitals

- Height: 66 in (07-15-2010)
- Weight: 178 lbs (07-15-2010)
- BMI: 28.73 kg/m² (07-15-2010)
- Blood Pressure: 120 / 80 (07-16-2010)
- Pulse: 52 (07-15-2010)
- Temp: 98 F (07-15-2010)
- Resp: 22 (07-15-2010)

Service Date Doc Type By
03-16-2010 Lab Results Test System
03-02-2010 Lab Results Test System
02-10-2010 Lab Results Test System
01-27-2010 Lab Results Test System
01-19-2010 Lab Results Test System
12-28-2009 Lab Results Test System

Contraindication

- Coumadin/Hypertension Dismiss

Drug Interaction

- aspirin Oral/Coumadin Oral Dismiss
- Lisinopril/Lasix Oral Dismiss
- Lisinopril/aspirin Oral Dismiss

Duplicated Therapy

- aspirin Oral/Coumadin Oral Dismiss

Guideline

- Rate Control for A-Fib: Amlodipine HCl, Verapamil HCl, Diltiazem HCl, Beta-Blockers, Digoxin/Digoxil, Pacermaker Dismiss
- This patient is past due for a PSA Dismiss

Care Plan/Standing Orders

- Other Ultrasound: (Requested: 07-15-2010; Frequency: 30)

Medical History

- CA - Lung Cancer (Father)
- Cancer (Parent)
Warning-Pop Up
Radiology
Audit Trails: The Why

- An audit trail is a safeguard built into an electronic medical record (EMR) that keeps an electronic record of who accesses an EMR, the time and date the record is accessed, and what record is accessed (and what specific portion(s) of the record is accessed), and what notes are added, if any. Essentially, audit trails act as an electronic log-book.
Often, hospitals use different audit trails for different aspects of medical care. There may be separate audit trails for patients' medical records and for specific departments such as radiology and pharmaceuticals.
Under the Health Insurance Portability and Accountability Act (HIPPA), hospitals and other medical providers that use EMRs must take steps to ensure the privacy and security of the EMRs.
Potential Audit Trail Fields

- Timeframe
- Patient
- User
- Action
- Module
- Encounter type
- Additional information
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>User</th>
<th>Action</th>
<th>Module</th>
<th>Encounter</th>
<th>Add/Info</th>
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<tbody>
<tr>
<td>7/11/2013 9:25:29 AM</td>
<td>Exit</td>
<td>Notes Section</td>
<td>TELEPHONE</td>
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<td>[TELEPHONE; 7/11/2013]</td>
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Fueling the risk: Hot Topics in the EMR

- “cloned” notes (carry forward)
- Copy n paste (aka Plagerism)
- Short cuts
- Overuse/Misuse of generalized templates
- Automated charge capture functions
- Scribing and Documenting by exception
- Addendum use
Monitor for “cloned” notes
Vendors often boast about the automated feature that “pushes or pulls” the History of Present Illness (HPI) forward from the previous visit. In theory, this allows physicians to simply review and update the visit—saving them from lengthy dictation or note taking.
“Most doctors copy and paste old, potentially out-of-date information into patients’ electronic records, according to a new study looking at a shortcut that some experts fear could lead to miscommunication and medical errors.”

Rutgers Health
EXPERTS SUGGEST THAT COPYING SIGNIFIES A SHIFT IN HOW DOCTORS USE NOTES - AWAY FROM BEING A MEANS OF COMMUNICATION AMONG FELLOW HEALTHCARE PROVIDERS AND TOWARD BEING A BARRAGE OF DATA TO DOCUMENT BILLING.
How to identify and stop the documentation domino effect?

What 4 criteria for documentation would limit the domino effect from occurring?
Short cuts

Templates:

- diagnosis driven
- physician specific
- procedures/tests
- open ended versus pre-populated
Generalized templates

Why should templates have text boxes?

Patients and families are not all alike, even with the same diagnosis.
Automated charge capture

PROBLEMS:
Checklists calculate based on how many “boxes” were checked by the provider, not necessarily based on relevance to the presenting condition(s).
Scribing and Documenting by Exception

- What is the Risk?

- Why do we test the documentation for authentication?
Addendum’s

- Separate box—clearly identify a change or addition
- Generate a watermark in the background
- Generate an email notice to the attending physician when a “late entry” is added
Look for Documentation that is:

- Accurate
- Timely
- Complete and factual
- By appropriate provider
In Review:

What did we learn?
It is all about the VIEW.

Auditing the EMR
QUESTIONS OR CONCERNS?
Additional Resources

- [1] National Archives and Records Administration (NARA): Long-Term Usability of Optical Media
- FDA Regulation Title 21 CFR Part 11-Electronic Records; Electronic Signatures
- “Off the Record-Avoiding the Pitfalls of Going Electronic”: New England Journal of Medicine; Volume 358:1656-1658, April 17, 2008, Number 16
- “Guidelines for EHR Documentation to Prevent Fraud”; Journal of AHIMA/January 2007
- “Practical EHR, Electronic Record Solutions for Compliance and Quality Care”; Stephen Levinson, M.D.; AMA 2008
- Biancheria & Maliver P.C (audit trails)
- November 19, 2012 • Modern Healthcare 33 (top vendors of Enterprise EMR systems)
- Rueters Health Fri Jan 4, 2013 Copying Common in electronic medical records
Save the Date
September 21-24, 2014

33rd Annual Conference
Austin, Texas
Thank You!