

RURAL **HEALTH** WORKSHOP

Documentation for Clinicians in a Live Access World



Speaker

- Jamie Lamb, AIC, INS, SCLA
 - Director of Claims Operations
 - LHA Trust Fund



Documentation in a Live Access World

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MALPRACTICE ■ GENERAL LIABILITY ■ WORKERS' COMPENSATION

Objectives

- Discuss the requirement for real-time access to providers' progress notes and the exceptions for the release of information.
- Understand the importance of documentation and adhering to clinical terminology.
- Understand documentation of patient contact through the live portal.



**21st Century Cures Act Formal Compliance
Deadline was October 6, 2022**

Expected Enforcement at the end of 2023

HealthIT.gov



**Office of the National Coordinator
for Health Information Technology**



What happens when a claim is submitted to the Information Blocking Portal?

*This guide is for informational purposes only.
The official requirements are contained in the relevant statutes and regulations.*

■ Points at which ONC communicates with submitter

ONC Scope



ONC may investigate and may take action under the ONC Health IT Certification Program*

***For example, ONC may issue a Notice of Non-conformity to the developer because the developer's actions did not conform to the Certification Program requirement in 45 CFR § 170.401. A developer may be required to submit a Corrective Action Plan and could also face suspension or termination of the certification.*

ONC acknowledges receipt of the claim and shares it with OIG.

Is it a claim against a Healthcare Provider?

Yes

No

Is it a claim against a Health Information Network/Health Information Exchange?

Yes

No

Is it a claim against an Offeror of Certified Health IT?

Yes

No

Is it a claim against a Health IT Developer of Certified Health IT?

Yes

Yes

Not an information blocking claim.
No information blocking authority for ONC or OIG. ONC informs the submitter.

OIG Scope



OIG Authority: OIG may investigate, and the HCP may be subject to appropriate disincentives.*

OIG Authority: OIG may investigate and may issue civil monetary penalties.

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**Appropriate disincentives will be established by HHS in a future rulemaking.*

Survey Reports on EHR Benefits

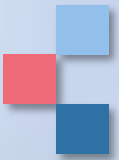
A survey of **58.4%** of parents reported that reading notes helped them to remember referral appointments and **43.3%** of adult patients and **44.8%** of parents reported that access helped them remember scheduled tests.

Bell SK, Folcarelli P, Fossa A, et al. Tackling ambulatory safety risks through patient engagement: what 10,000 patients and families say about safety-related knowledge, behaviors, and attitudes after reading visit notes. J Patient Saf. 2021; 17(8):e791-e799.



Purposes of Documentation

- Communication of patient information between HCPs
- Legal record
- Reimbursement and accreditation



What Is to be Available?

- Outpatient Progress
(at close of encounter)
- Emergency Notes
(at signature)
- Discharge Summary
(at signature)
- Patient Instructions
(at signature)
- Inpatient/Ed Progress
(at signature)
- Procedure *(at signature)*
- Consult *(at signature)*
- H&P *(at signature)*
- Labs and Radiological Scans



Will Non-Provider Notes be Shared?

- Yes. The Cures Act mandates that non-provider progress notes be made available to the patient via portal or HIM request. Non-Provider progress notes includes areas such as: nursing, respiratory therapy, physical therapy, occupational therapy, pharmacy, dietary etc.)



Exceptions To Information Blocking Rule

- **Preventing Harm**
- **Privacy**
- Security Exception
- Infeasibility
- Health IT Exception



Discussion Topics

- Diagnostic Testing Access
- Inaccuracies and Disputes
- Clinical Verbiage
- Audit Trails
- Follow up Documentation
- Other Records/Notations



Test and Lab Results and Exceptions

- **All test results are made immediately available** with possible exceptions that exist based on State Law or HIPAA.
- Common Application by HCP's in Louisiana currently: Select test results will allow the ordering clinician to delay delivery either 24 hours or 7 days.



Woman learns she has cancer through email, wants situation to be lesson to others

The 21st Century CURES Act permits allows information to be posted immediately.

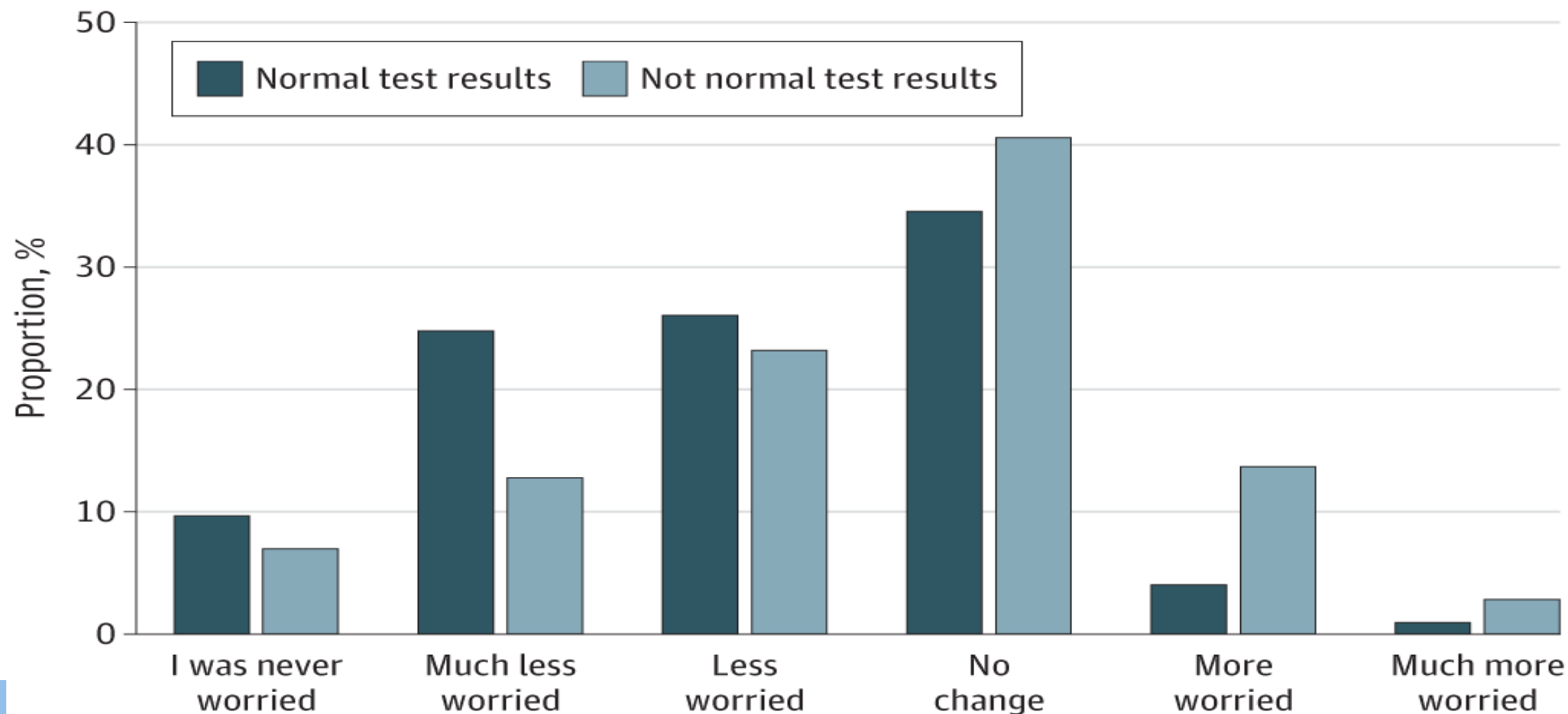


A law was passed last year that helps patients receive health information fast.

By Morgan Newell

Published: May. 18, 2022 at 7:22 PM EDT

Patient Preference Study



JAMA Network March 2023



Inaccuracies and Disputes

- EHR Systems are voluminous
- Expansive Historical Data
- Addendums
- Over-reads
- Continuous reassessment and modification of the plan



Clinical Terminology

Yuo Cna
Raed Tihs



- Avoid troublesome acronyms S.O.B., F.U., D.I.N.K.
- Limit value-laden terms (disheveled, poor historian).
- Define medical terms/complex language instead of using abbreviations when feasible.
- Be careful with “sticky notes.”
- Document the patient’s BMI – not just morbid obesity.
- Document diabetes as a condition – not as an adjective.
- Instead of writing non-compliance, describe the actual behavior.



- Write only about things discussed with patient during the visit/exam; explain “negative” may be a good result.
- Use the same words in conversation that appear in notes, like “spontaneous abortion.”
- Instead of IVDA or alcoholic, use opiate use disorder, alcohol use disorder, or more generally, substance use disorder.
- Don’t import social history, if you didn’t elicit it or review it with the patient.
- Consider using specific language for billing and coding purposes.



- Be mindful of sensitive topics and avoid language that seems judgmental.
- Use language that describes your observations of behavior and avoid labels like “malingering” or “drug seeker.”
- Incorporate labs/study results into your notes to give the full picture.
- Use supportive language.
- Consider involving the patient while you write notes or giving them advance warning on lab results.



Audit Trails

Audit Trail

File Edit Filter View Window Help

Follow Up Documentation



Make An Appointment



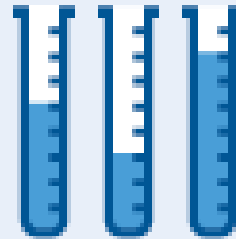
Request Refills



View Your Medical Records



Message Your Care Team



View Your Lab Results



Request and Access Referrals



Other Records

STICKY
NOTES

| Phone log | |
|-----------|---|
| | <div><div>Contact name:</div><div>Phone number:</div><div>Date and time:</div><div>Call summary:</div><div>Follow-up required: [Need another page? Click the bottom of this page, go to the Insert tab, click Table and then Quick Tables. To delete this tip, just click it and start typing.]</div></div> |
| | <div><div>Contact name:</div><div>Phone number:</div><div>Date and time:</div><div>Call summary:</div><div>Follow-up required:</div></div> |
| | <div><div>Contact name:</div><div>Phone number:</div><div>Date and time:</div><div>Call summary:</div><div>Follow-up required:</div></div> |



A blurred hospital hallway with medical equipment and a person in the background. The hallway has white walls, a blue floor, and a grid ceiling. On the left, there are white cabinets and a medical cart. On the right, there are white doors and a wall-mounted device. A person is visible in the distance. The text "Case Examples" is overlaid in the center.

Case Examples

Common Case 1

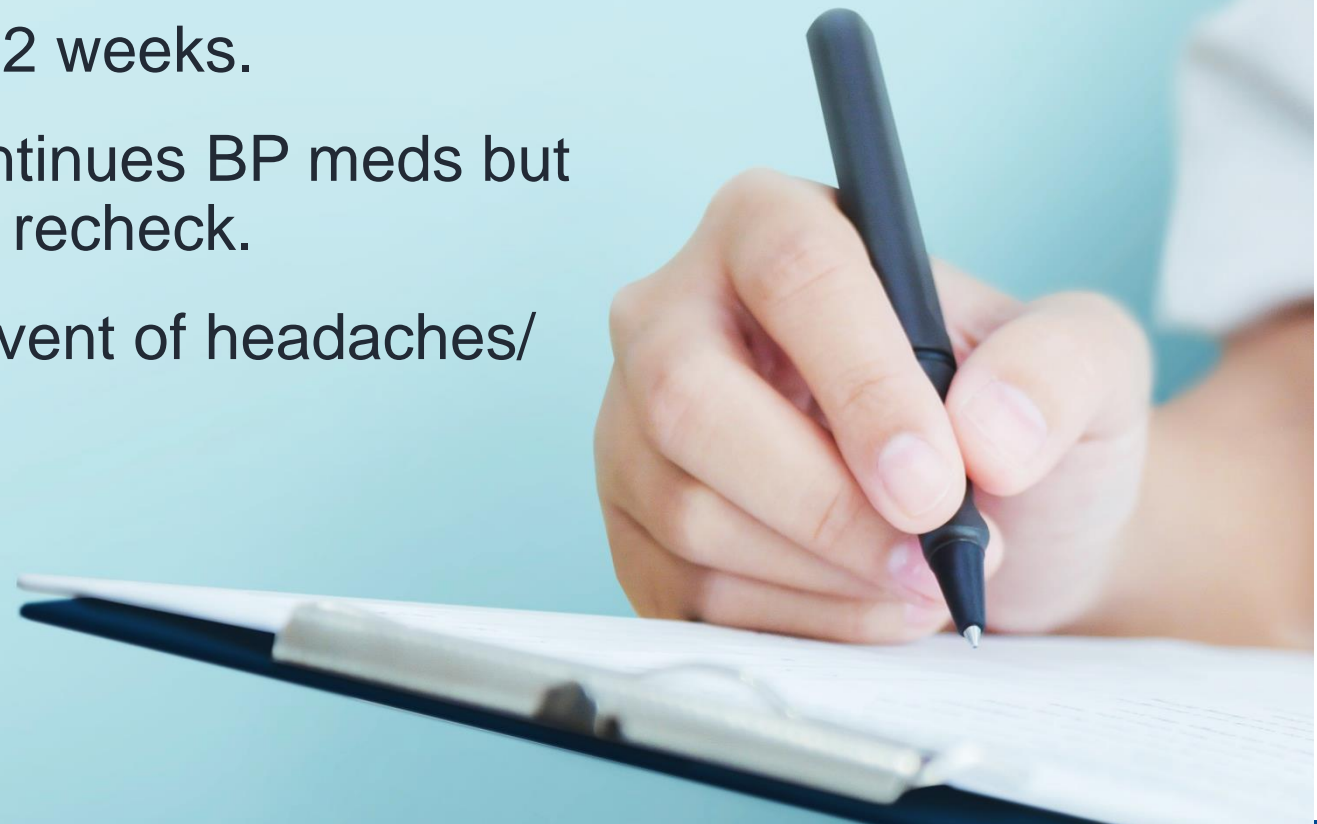
- Labs were ordered in the Emergency Room.
- Patient was admitted and care transferred to Hospitalist or another specialty.
- Labs returned to ED Physician.
- No documentation that critical labs were sent to other providers.



Case 2

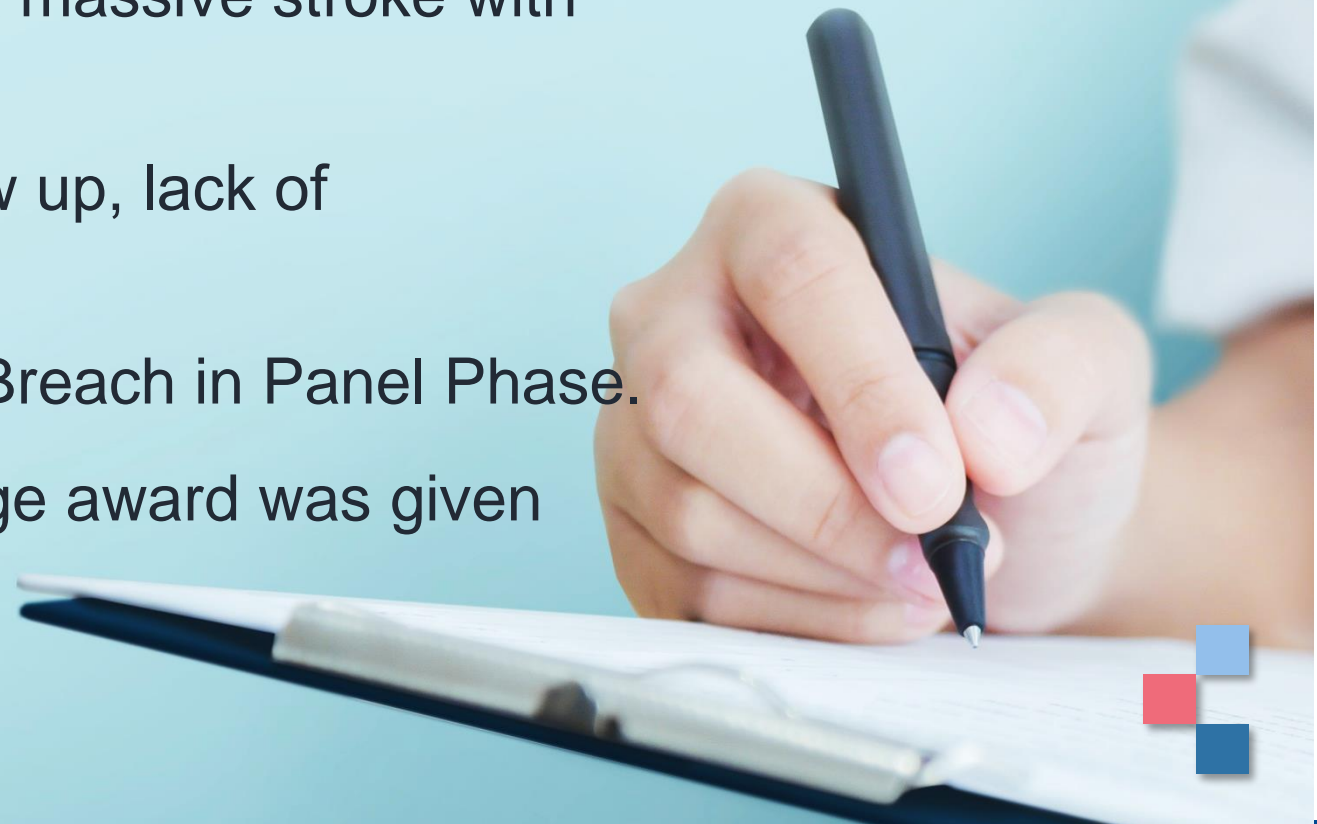
65 yr. old male presented to clinic with history of hypertension/hyperlipidemia for BP check and refill

- BP normal on visit.
- Patient advised off his BP meds for 2 weeks.
- PCP does not refill BP meds, discontinues BP meds but advises to return in two weeks for a recheck.
- No documentation to return in the event of headaches/dizziness.



Case 2

- Weeks later, the patient experiences headaches, dizziness, and blurred vision. He does **not** call the clinic or attempt to make a follow-up appointment, **but he did send a portal message that was unanswered.**
- While at work patient experiences a massive stroke with paralysis on the right side.
- Plaintiff's theory was failure to follow up, lack of documentation.
- Physician received a finding of No Breach in Panel Phase.
- Jury rejected the defense and a large award was given including future medicals that exceeded the cap.



Disclaimer

The information contained in this presentation has been prepared and presented with the understanding that the presenter is not engaged in rendering legal, financial, medical, or other professional advice. The presenter has exerted her best skills to assure the accuracy of the information, however, the source materials should be consulted prior to reliance on cited sources to ensure the material has not been repealed, modified, or changed since the date of this program. If legal, medical, financial, or other professional advice is required, the services of a competent professional should be retained.



Questions?

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We want to hear from you!

<https://www.surveymonkey.com/r/RCYLXYT>



RURAL **HEALTH** WORKSHOP

Lunch and Learn: 12:00 p.m. – 1:15 p.m.

