Electronic Health Records

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Session Objectives

• Accurately identify rules and regulations impacting electronic documentation
• Identify advantages and disadvantages of electronic documentation for rehabilitation practice
• Trial aspects of a commercially available rehabilitation electronic documentation platform

Definition

An EMR (electronic medical record) is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision making.

Source: http://healthit.hhs.gov
Definition

Electronic medical records, as a technology, are a logical progression in advancing the ability of the healthcare industry to provide more comprehensive care options more quickly. As EMR systems continue to proliferate...HIM becomes more agile and patient-centered.

Source: http://www.ahima.org

Electronic Signature

Any electronic sound, symbol, or process attached to or logically associated with a contract or record and executed or adopted by a person with the intent to sign the record.

Source: The Uniform Electronic Transactions Act

Learn the Language

- EHR-Electronic Health Record
- EMR-Electronic Medical Record
- HIE-Health Information Exchange
- HIT-Health Information Technology
- ONC-Office of the National Coordinator for Health Information Technology
- PHR-Personal Health Record
  - http://www.apta.org/PTinMotion/2012/Feature/Contemporary Topics in Healthcare
Technology Symposium 2013: Electronic Medical Records

Electronic Health Records (EHR)
Legislative Trends and HIPAA Compliance

EHR Data Usage History

2004
26% of therapy documentation electronic.

2006
<10% of hospitals had a fully integrated EHR.

2009
CDC reported EHR adoption rate had risen to 48.3%.

Source: Vreeman et. al., 2006 and, Smaltz et. al., 2007

EHR Data Usage History

2013
79% of all eligible hospitals have received an incentive for initiating or committing dollars to an EHR system.

55% of all Medicare eligible providers are meaningful users of EHRs.
Source: http://www.cms.gov/EHRIncentivePrograms/

2011
55% of physicians had adopted an EHR system.
One-half of those without an EHR plan to purchase/use by 2012.
### EHR Legislative History

- **2004**
  - Office of the National Coordinator for Health Information Technology
  - Exceptions to Anti-Kickback and Self-Referral Rules

- **2009**
  - Health Information Technology for Clinical and Economic Health (HITECH) Act

- **2010**
  - HIPAA Final Rule Initial Set of Standards for Products and Systems


### Medicare and Medicaid Incentives

- **Stage 1** *Data Capture and Sharing* (2011 & 2012)
- **Stage 2** *Advanced Clinical Processes* (2014)
- **Stage 3** *Improved Outcomes* (2016)

Meaningful Use Defined-Use of Health Information Technology such as electronic exchange of information and reporting of quality clinical measures

### EHR and Meaningful Use

- Track key clinical conditions
- Communicate information for care coordination
- Engage patients and families in their health care
- Submit patient care summaries across multiple settings
- Improve quality, safety, and efficiency leading to improved outcomes
- Decision support for national high priority conditions
- Access to patient data through patient centered health information exchange
- Improve population health
CMS EHR Incentive Program

2011: Financial incentives for meaningful use of health information technology in Stage 1. (Steinbrook 2009)

2013: CMS has paid $16.2 billion in incentives to providers and hospitals (CMS)

Active registrations: 175,776

2015: Physicians and hospitals that do not use certified products in a meaningful way will be penalized. (Steinbrook 2009)

Active registrations: 415,568

Example of Electronic Health Record in Action

https://www.thechristhospitalmychart.com/mychart/default.asp?action=login

What does this mean to us?

- Many of us are a part of the healthcare community
- We are expected to participate in the electronic health records system both as clients, family members and as health care providers

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2011 ASHA Health Care Survey

- 42% of SLP’s report “always” using EMR
  - Skilled Nursing 48.3%
  - General Medical 57.1%
  - Rehab Hospital 44.7%
  - Pediatric Hospital 64.2%
  - Home Health 28.4%


- Although PTs are not yet required or incentivized to adopt EHR systems for such initiatives as Medicare’s Meaningful Use Program, which in 2015 will penalize eligible providers that do not meet the requirements for “meaningful use,” physicians and facilities that are included in the program will expect the PTs with whom they share patients use compatible EHR systems.

http://www.apta.org/EHR/

Clinical Application

Advantages and Disadvantages
Advantages

- Reduces cost
- Access
- 2014 HITECH
- Interaction with patients and families
- Increases accuracy
- System alerts
- Medicare compliance
- Consolidation of patient information
- Improves efficiency
- Streamlines reimbursement
- Reduces billing errors


Disadvantages

- Resources needed to develop and pilot
- Cost of transition
- Training time
- System and network failures
- Technology barriers
- Non-compatible systems
- Litigation
- Improper edits
- Inadequate security


Disadvantages

- Data integrity
- Corrupted or misplaced information
- Work-arounds created by system user

Current Trends in Rehab e-Doc

Systems, Hardware and, Mobile Devices

Desktop/Laptop

• Advantages:
  – Large storage capabilities
  – Cost
  – Laptop – limited mobility

• Disadvantages:
  – Desktop - Not mobile
  – Laptop – limited mobility

Tablets

• Advantages:
  – Mobile
  – Patient-centered documentation
  – Patient education opportunities

• Disadvantages:
  – Cost
  – Training for users
  – Technology barriers by users
Handheld Devices

- Advantages:
  - Mobile
  - Allows for patient-centered care
  - Real time billing/documentation
  - Increased efficiency

- Disadvantages:
  - Cost
  - Training
  - Technology barrier

Software-Consoles

The information displayed here is for training purposes only and does not reflect actual patient information.

www.quickemr.com
www.compulinkadvantage.com

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Software - Consoles

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Software - Scheduling
Software - Scheduling

Software - Scheduling

Software - Reports
The information displayed here is for training purposes only and does not reflect actual patient information.
Documentation

• Tasks to be completed on PC or Laptop:
  – New Patient Intakes completed
  – Projections completed
  – Patient Appointments completed
  – Assignment Board completed
  – Clinician’s E-Signature must be populated

• Tasks to be completed on Mobile Device:
  – Daily treatment encounter notes
  – Same day documentation
  – Point of service documentation
  – Clinician’s E-signature

The information displayed here is for training purposes only and does not reflect actual patient information.
Documentation – Mobile Device

Adding a Treatment Encounter Note

Documentation

Purpose of Customized Documentation:

- Support Evidence-Based Practice
- Support and promote sound clinical reasoning
- Promote integration of relevant standardized tests and measures into goal setting, treatment planning, and discharge planning
- Provide meaningful clinical outcomes
### Documentation

**Customized Documentation:**
- **Physical Therapy – Evaluations:**
  - General Eval
  - Cervical Thoracic Eval
  - Hip Lumbar Eval
  - Knee Eval
  - Shoulder Eval
  - Foot/Ankle Eval
  - Pediatric Eval

**Physical Therapy – Embedded Evaluations:**
  - Wound
  - Incontinence
  - Lymphedema
  - Vestibular

**Occupational Therapy:**
  - OT Practice Framework Language
  - Specialty sections modified and included in the comprehensive assessment:
    - Continence Management
    - Lymphedema
    - Low Vision
    - Fall Risk Management
    - Positioning
Documentation

- Customized Documentation:
  - Occupational Therapy:
    - Created supplemental documents to capture data/assessment of specific clinical areas:
      - General Assessment
      - Positioning
      - Dementia
      - Lymphedema
      - Pre-driving

- Customized Documentation:
  - Speech Therapy:
    - Sections are organized and grouped by clinical practice areas
    - Created supplemental documents used to assess specific areas:
      - Speaking Valve Assessment - Tracheostomized Patient
      - Swallowing Assessment – NPO patient with Tracheostomy
      - Swallowing Assessment – NPO status
      - Voice Assessment
      - AAC Evaluation

- Customized Documentation:
  - Speech Therapy:
    - Cueing hierarchy has been modified to reflect SLP practice with inclusion of:
      - Sentence completion/Open Ended cues
      - Descriptive cues
      - Semantic cues
      - Phonemic cues
      - Gestural cues
Documentation

• Outcome Measures specific to each discipline:
  – Physical Therapy:
    ➢ Physical Performance Mobility Exam (PPME)
  – Occupational Therapy:
    ➢ Modified Barthel Index (MBI)
  – Speech Therapy:
    ➢ American Speech Language Hearing Association, National Outcome Measurement System (ASHA NOMS)
    ➢ Functional Oral Intake Scale (FOIS)

Interactive Lab Session

• Let’s practice...

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Any questions?