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Legal Risks Facing Nursing Home Providers and Reducing Risk with Clinical Documentation

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Documentation in Electronic Health Records

- Nursing homes lag behind other providers in electronic health record system adoption
- Of 472 nursing homes in New York, there was a 7.7 percent increase in EHR adoption by nursing homes from 2012 to 2013, from 48.6 percent to 56.3 percent.
- The main barriers to nursing home EHR adoption were costs, lack of financial incentives and lack of technical staff.

Documentation in Electronic Health Records

- Electronic Health Records ("EHR") Documentation Bad Habits:
  - Shortcuts in electronic health records pose risk.
  - Habits such as copy and paste save valuable time, but they can ruin the record.
  - Unless you re-evaluate each entry you may inadvertently be copying forward information that is not accurate.

Documentation in Electronic Health Records

- Pasted documentation may also show providers repeatedly performing services they only performed once in the past, leading to over reimbursement.
- Pasted entries may also lead to regulatory issues.
- Documentation should be recorded for each specific time a task is performed.
- If the documentation represents that providers did more than they actually did, that is considered fraud.

Documentation in Electronic Health Records

- Generic Recording - Using "prebuilt" or "auto-filled/auto-populating" text can also cause problems in an EHR.
- If providers fail to review and edit the auto-filled data, documentation errors result.
- Errors caused by sloppy EHR documentation can cause risk to providers resulting in:
  - Malpractice claims
  - OIG investigations

Documentation in Electronic Health Records

- Errors caused by sloppy EHR documentation can cause risk to providers resulting in:
  - Survey deficiencies
  - Professional licensing board investigations
  - Significant financial recoupments
  - Increased liability due to the automated "audit" trail
  - HITECH violations
  - Adverse impact on 5-Star rating

Documentation in Electronic Health Records

- Best Practices in EHR documentation:
  - Avoid copying and pasting entire notes
  - Confirm that copied and pasted information accurately reflects patient's current condition
  - Be careful when using templates with check boxes, drop down menus, and auto-filled text
  - Don't let space limitations be an excuse, find a way to add to record if necessary for accuracy
  - Streamline documentation to avoid documenting in multiple areas and increasing chance of inconsistencies

Documentation in Electronic Health Records

- Best Practices in EHR documentation:
  - Select an EHR software that is fully integrated (financial and clinical)
  - Train staff on proper use of EHR documentation
  - Establish and train staff on facility's policy for use of electronic signature/password security measures
  - Regularly audit records for accuracy
  - Ensure sufficient access to surveyors

Examples of Legal Fallout from Inaccurate Documentation

- Investigations and lawsuits by government entities such as the Office of Inspector General and Office of Attorney General
  - False Claims Act litigation: If a nursing home's records show that a resident was provided certain services, that impacts the MDS level of care.
  - MDS levels drive nursing home reimbursement.
  - If services were not provided at the level of reimbursement, that constitutes a false claim.

Examples of Legal Fallout from Inaccurate Documentation

- New Mexico OAG False Claims Litigation
  - The NM OAG sued a nursing home company claiming that based on the levels of care for which the nursing homes were reimbursed as compared with the staffing levels, the services claimed to have been provided could not have been provided.
  - The NM OAG used "industrial simulation" programs to estimate the amount of time that would be required to provide the ADL services documented for which reimbursement was claimed.
  - The OAG claims that the facility staffing was not sufficient to provide the levels of care documented.

Examples of Legal Fallout from Inaccurate Documentation

- TDADS Survey deficiencies
  - We have all heard the phrase, "if it was not documented, it was not done."
  - However, it is just as bad from a survey point of view if a service was documented but was not done.
- RUGs audits
  - RUGS auditors from HHSC reduce RUGS levels based on inconsistencies between ADL documentation and the MDS evaluation .

Examples of Legal Fallout from Inaccurate Documentation

- Medical Malpractice Suits
  - Not as common since tort reform but still a major problem for nursing homes
- Malpractice lawyers look for red flags in the record such as:
  - Charting inconsistencies such as lapses in time
  - Delayed, substandard or inappropriate treatment
  - Late entries that are not documented as such or that appear to be self-serving
  - Alteration or destruction of records

MDS Focused Surveys

- A Focus on Staffing
  - Surveyors currently collect the CMS-671 [staffing] form in conjunction with Task 2 of the standard/annual survey process (SOM Appendix P). However, as this is the only "snapshot" currently collected, CMS is seeking more information on how staffing levels may fluctuate throughout the year.
  - The number of focused surveys conducted will vary from state to state.

MDS Focused Surveys

- Background of MDS Focused Surveys
  - In mid-2014, CMS piloted a short-term focused survey to assess MDS 3.0 coding practices and the relationship to resident care in nursing homes in 5 states.
  - Surveyors -- who received specialized training for these surveys -- reviewed the nursing home resident assessment processes in more depth than annual surveys. The pilot was completed in August of 2014.
  - Texas will be among the few states that will add the focus on MDS to the annual standard survey process

MDS Focused Surveys

- Findings from the 1st MDS Focused Surveys Pilot
  - Inaccurate staging and documentation of pressure ulcers.
  - Lack of knowledge regarding the classification of antipsychotic drugs.
  - Poor coding regarding the use of restraints.
  - Deficiencies were identified and cited on all but one survey (i.e., 24 of 25 surveys).

MDS Focused Surveys

- Findings from the 1st MDS Focused Surveys Pilot (cont'd)
  - Disagreement between MDS and medical record:
  - 25% of MDS 3.0 assessments reviewed for falls
  - 18 % of MDS 3.0 assessments reviewed for pressure ulcers
  - 17% of MDS 3.0 assessments reviewed for restraints
  - 15% of MDS 3.0 assessments reviewed for late loss ADLs

MDS Focused Surveys

- How the MDS Focused Surveys Will Work
  - Similar to the 2014 pilot, states will be expected to allocate 2 surveyors for each survey, for an estimated 2 days on average.
  - Record review, augmented by resident observations and staff and/or resident interviews, will be used by surveyors to validate MDS 3.0 coding and staffing levels.

MDS Focused Surveys

- While on-site, surveyors will ask a series of questions regarding staffing and MDS-related practices of the facility staff, leadership, and others as appropriate.
- CMS will work with states to determine how many surveys should be conducted, and when they should take place throughout the year.
- Deficiencies identified during surveys will result in relevant citations and enforcement actions.

MDS Focused Surveys

- MDS 3.0 inaccuracies and/or insufficient staffing noted during the survey will result in relevant citations, including those related to quality of care and/or life, or nursing services.
- If patterns of inaccuracies are noted, the case will be referred to the CMS RO and CO for follow-up.
- In the event that care concerns are identified during on-site reviews, the concerns may be cited or referred to the SA as a complaint for further review.
- Accurate documentation will be key to passing MDS focused surveys.

MDS Focused Surveys

- Immediately on entrance, provide facility census number, an alphabetical resident census with room numbers.
- Residents who are not in the facility and their whereabouts must be noted, i.e., hospital, etc.
- Access to resident medical records, including MDS 3.0 must be provided throughout survey.
- Facility is also requested make available a staff member familiar with MDS 3.0 process who is able to explain all information used to support MDS coding.

MDS Focused Surveys

- The facility has one hour from survey entrance provide the following:
  - The 10 most recent MDS assessments for current residents
  - Copies of policies and procedures related to RAIs including the MDS, and the Quality Measures.
  - Staffing schedules for the past 18 months
  - Identify staff involved in scheduling, coding, and transmitting the MDS
  - Name and contact information for the QA&A coordinator
  - A list of all residents who fell in the past 12 months showing date of fall, resulting injury or no injury

MDS Focused Surveys

- One hour documents (cont'd):
- MDS Worksheet #1 (next slide) listing current residents and room numbers for residents with the following within the previous 90 days:
  - Pressure ulcers
  - Indwelling catheters (including urethral, suprapubic, and nephrostomy tubes)
  - Restraints other than side rails, including PRN restraints
  - Antipsychotic medications
  - Additional focus will be placed on conducting significant change in condition MDS based on previous survey citations

MDS Focused Survey

Focused Survey Facility Worksheet (MDS Worksheet #1)

Instructions to the facility:

- This worksheet is to be completed to reflect a list of current residents and their room numbers with any of the noted conditions and/or devices in use in the **last 90 days** and provided to the survey team **within one hour of entrance.**
- **How many total residents currently in the facility are Medicare_____ Medicaid_____, Other insurance_____**

Resident Room	Resident Name	Restraints	Falls with major injury	Pressure Ulcer	Urine Cath	UTI	Antipsychotic Medications	Ext. Assist of 2 or more	SKILLED	LTC

Texting and Emailing: Good for Tweets not Medical Information

An attending physician insists that when one of his patients has a problem, you email or text him and receive care instructions. Great idea, right? What's the problem?

- Emails and phone texts are not encrypted and are on insecure lines or servers
- Phones, laptops, and Ipads can be stolen
- If the message is on a personal phone of one of your employees, what happens if the employee is fired or quits?

Texting and Emailing: Good for Tweets not Medical Information

- Additional problem is that texts and emails do not automatically become a part of the medical record.
- An email could be printed out and put in the medical record, a text cannot.
- If the communication is something that would be put in the medical record if it came by fax, it should be in the record if it comes by email or text.
- If a lawsuit arises, employees' personal cell phone may be discoverable

Texting and Emailing: Good for Tweets not Medical Information

- Texting is not per se violative of HIPAA, but it's difficult for texting to be HIPAA compliant.
- The covered entity must have safeguards in place, and must have done a risk analysis and determined whether and when texting is allowed, how to do it, how to ensure sufficient protections are in place, etc.
- All workforce members of the covered entity should be following the policy adopted by the covered entity.

Texting and Emailing: Good for Tweets not Medical Information

- The covered entity can decide that doctors can text but nurses can't, for example, but needs to have policies and procedures in place
- Policies should be developed after a risk analysis considers the risks, possible mitigating strategies, costs, and options.
- If there is a HIPAA violation and confidential patient health information (PHI) is leaked to unauthorized persons, HIPAA remediation can be expensive and difficult.

Texting and Emailing: Good for Tweets not Medical Information

- General advice is don't text or email PHI.
- If you have to text, don't send PHI, use some other identifier ("your 4:00 appointment," "your second patient today").
- If you need to use more of an identifier, limit the PHI sent ("check up on patient J.D.).

Texting and Emailing: Good for Tweets not Medical Information

- If you really need to incorporate texting into your life, use a secure texting program.
- TMA endorses DocBookMD, but there are many others.
- For the nursing home, it would be best to have a dedicated phone (under the control of the home, stays at the home, locked up when not in use, other safety precautions) for texting.

Texting and Emailing: Good for Tweets not Medical Information

- Email is preferable to text.
- A secure email system with a good security system cures a lot of the problems with basically the same functionality as texting (with a couple extra steps like entering a login code or fingerprint scan).
- If you use email, it is critical to make sure that communication is put into resident record.