AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Advanced IRF Boot Camp

June 24-25, 2025

EMR Compliance in the Age of AI

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Speakers

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Michael Sperl, DO, *Essentia Health Miller-Dwan Rehabilitation Services*

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The "Official Birth" of electronic involvement in our clinical documentation

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HITECH Act – 2/17/2009

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- Intent
  - Secure and protect health information
  - Improve quality of health care
  - Reduces health care costs resulting from inefficiencies, medical errors, duplicative care and incomplete information
  - Provide appropriate information to guide medical decisions
  - Improve coordination of care (internally and among healthcare providers)
  - Improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies
  - Facilitate research and quality
  - Promote early detection, prevention and management of chronic diseases
  - Promote a more effective marketplace

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The Growth of the EMR

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Templates

Smart Phrases

Copy Forward (Cloning)

Cut/Paste

Artificial Intelligence

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The Purpose of the EMR and all of the "additional features" are to give the Physician resources at his/her fingertip but NEVER to replace clinical thinking.

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Inherent Risks with the Increased Use of AI and Features of the EMR

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- Including patient specific information in an AI application
- Cloned/copied information is duplicated on multiple days
- Templated information is used for multiple patients regardless of diagnosis/reason for the IRF admission
- Duplication of statement of facts without patient specific clinical thinking
- Templated information is a great narrative but doesn't reflect the individual patient

Example #1

REHAB PLAN – *Risk for Clinical Complications and Medical Necessity for Inpatient Acute Rehabilitation Care:*

Management of DVT/PE, pain management, anemia management, constipation, wound care, falls, UTI, Leukocytosis, sleep/wake cycle disturbances, skin breakdown, joint contracture edema, hypotension, management of INR, arrythmia

Example #2

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- **ROS**

  (Negative unless bold or otherwise indicated)
  Constitution: ever, chills itch/rash
  HEENT: Headache, blurry vision, double fision
  Cardiovascular: chest pain, palpitations
  Respiratory: cough, sputum, wheeze
  GI: Dysphagia, nausea, vomiting
  GU: Dysuria, hematuria
  MSK – joint swelling, joint pain
  Skin – wound, incisions
  Neuro: numbness, tingling, weakness

Hypothetical Question

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- Rehab physician face-to-face notes should contain content that reflect the current medical status, functional status and clinical management of the two
- Would the following reflect compliance with that expectation:
  - "I have reviewed the therapy notes" followed by cutting/pasting the therapy notes of that day in the note?
- Would the previous statement reflect compliance if the same note was written 5 days later (with the therapy notes copied as in the previous statement)?

Conclusion

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- The EMR (and it's benefits) and AI provide great opportunities as clinical resources but should not replace the reflection of the rehabilitation physician's clinical thinking in clinical management of the patient, supervision/coordination of the team and demonstrating compliance with the regulations governing inpatient rehabilitation.

How Artificial Intelligence is used today

Current State AI options (Epic EMR)

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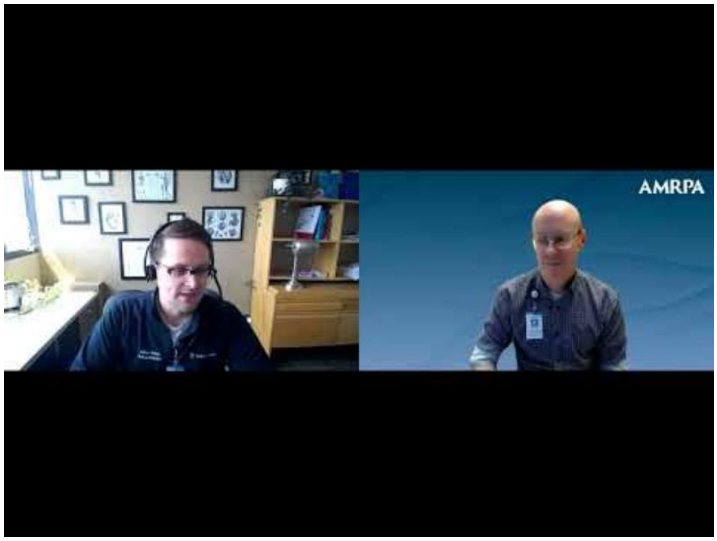
- Before seeing a patient
  - Note summarization- Outpatient
  - Inpatient Summarization
  - End of Shift Notes- Nurses
- During a visit
  - Ambient listening documentation
  - AI Text Assistant
  - Discharge Summary
  - Ambient Listening Ordering- medications, DME, etc.
- After a Visit
  - Level of Service Code suggestions
  - Risk Adjustment accuracy improvement
  - Electronic Prior Authorization
- Options appear to be similar across most EMR platforms
- First step often is early-adopters piloting & sharing their experiences with co-workers

Physician Experience Piloting Ambient Listening Documentation



Question & Answer with Michael Sperl, DO

Questions?

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