

ELECTRONIC HEALTH RECORDS WILL IT REDUCE MALPRACTICE CLAIMS?

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Electronic Health Records (EHR) are rapidly becoming standard office technology rather than the wave of the future. While its promise of revolutionizing medical care may still be years away, and issues of connectivity and information sharing remain, the fact is that the complexity of today's practice demands technology that integrates clinical practice, documentation and billing procedures.

Offices that do not integrate these processes face exposure as third party payors, including Medicare, continue to ramp up their auditing activities. When documentation doesn't match CPT codes, demands for huge repayment follow. As the technology becomes pervasive, failure to utilize it to avoid medical errors may also lead to malpractice claims. It will not be too long before EHR become "standard of care".

Because EHR offer great promise in reducing the risk of malpractice, failure to incorporate EHR into a practice may, in the not too distant future, be considered a deviation from recognized standards. When an EHR could, arguably, have avoided an adverse result, trial lawyers will be arguing that physicians were obligated to utilize this new technology. Since EHR systems can catch medication errors, adverse drug interactions, and make it far easier for a physician to review past medical history, failure to embrace it could be problematic.

However, like all new technology, it's not foolproof.

Too Much Information:

Because EHR allow physicians to document easily, paragraphs of information can be generated with a few keystrokes or even a checkmark. A comprehensive examination can be described in great detail, using pre-designed templates. Lists of negative findings can appear, neatly printed, with the push of a button. While this bevy of information may get breeze the physician through an audit, it can also create pitfalls.

Pages of repetitive documentation can be more time consuming to review than brief, handwritten notes. When important information is embedded in paragraphs of boilerplate, it can easily be overlooked. Picking the wrong template can generate documentation which is obviously inapplicable to a given patient.

Avoiding the Pitfalls:

A well structured EHR will allow the clinician to quickly locate important information within the record. Relevant past medical history and positive findings on examination should be clearly delineated, either in a separate section of the medical history and examination documentation, or highlighted within the body of the examination. A main purpose of EHR is to create efficiency.

If critical information can only be obtained by reading through pages of boilerplate, not only is efficiency lost, but the likelihood that critical data may be missed increases.

While extensive documentation may be required to satisfy the needs of third party payors, for purposes of clinical treatment, more is not always better. Important information must be readily identifiable.

Overlooking important information is, of course, a significant cause of malpractice. Any system which makes it more difficult to locate important information is a system to avoid.

While much of what a physician does is repetitive, and templates can be used to document repetitive acts, caution must be used when the examination or findings do not follow routine. In reviewing the records of a neurological examination of a one year old boy, the neurologist, who had just converted to a new EHR system, recorded, among other findings, that the boy was oriented as to time, place and person. Needless to say, the neurologist used his template for a normal neurological examination, without considering the fact that some of the language was not suitable for a year old child. Fortunately, the case did not evolve into a malpractice suit. Imagine the difficulty the neurologist would have had trying to defend himself from charges of documenting findings that were not medically possible to ascertain.

Conclusion:

It's not too soon to start implementing EHR. Under the recently passed American Recovery and Reinvestment Act, physicians who demonstrate meaningful use of EHR by 2011 will be eligible for full federal subsidies of up to \$44,000. By contrast, those who have not implemented EHR by 2014 will be penalized with a reduction in Medicare reimbursement, beginning in 2015. Failure to implement EHR may also result in increased malpractice premiums and increased exposure to malpractice claims.

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