Legal Implications of Electronic vs. Paper Charts

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Paper vs. Electronic Records

Are digital records
better
than paper records?

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Paper vs. Electronic Records

Advantages of electronic records

- Easier to read
- Subspecialty notes are grouped together
- Improved confidentiality
- Electronic prompts help assure that medications and care are timely
- Can be accessed from more than one location
- Entire record is available all the time
- Includes decision support tools

Paper vs. Electronic Records

Disadvantages of electronic records

- Not as much detail recorded
- When there is nothing new, there is nothing recorded
- Entries can look repetitive
- Digital entries do not trigger memory of events as well as personal handwriting
- Not all modules are reviewed by or accessible to all staff
- Automation bias can cause dependence on prompts and alerts
- Alert fatigue can cause users to ignore prompts and alerts
- Information overload

Paper vs. Electronic Records

But are the applicable laws different for digital records
and paper records?

Good Documentation Matters

- Good communication
  - Clinically relevant information is effectively transferred between shifts and staff
- Good patient care
  - Good documentation focuses the entire team on clinically relevant changes
  - More likely that a patient's condition will be properly diagnosed and treated
- Good reimbursements
  - Accurate documentation supports proper reimbursement

Good Documentation Matters

- Good defense of care
  - Providers can defend themselves if care is properly documented
- Good risk management
  - Accurate and timely records reduce risk of fraudulent billing
- Poor/false documentation risks civil and criminal liability
  - Can result in fines, loss of employment, loss of license, prison
- Corporate compliance, professional conduct
  - Accurate and comprehensive documentation honors concepts on which best practice is based and demonstrates the basis for professional and clinical decisions

Good Documentation Matters

- A good chart helps to defend provider
  - 35-40% of medical cases become indefensible because of problems with documentation
  - If it is not charted, lawyers will argue that required care did not happen
  - Documentation is scrutinized by the family and the family's lawyer
  - Jury will assume that sloppy documentation means sloppy care

Good Documentation Matters

- FACT Formula
  - Factual
  - Accurate
  - Clinically relevant and complete
  - Timely

FACT Formula

- Factual
  - Objective, not subjective
    - What user sees, hears, smells, not what user supposes, assumes, guesses, believes or feels
    - E.g. write “wound is 4cm x 2.5cm, with red and brown edges and without any odor”
    - Do not write “wound is ugly”

FACT Formula

- Accurate
  - User should document own observations
  - User should not copy someone else's notes
  - User should take care to accurately describe "left" or "right" sided complaints
  - User should use only approved abbreviations
  - User should NOT use texting abbreviations

FACT Formula

- Clinically relevant and complete
  - Use terms that have clinical significance
    - E.g. "moderate amount" of bleeding, not "a lot"
  - Use terms that other medical personnel will easily understand
  - Complete all related portions of the record

FACT Formula

- Clinically relevant and complete
  - Document all phone calls, meetings, conversations
    - To whom did user talk?
    - Did user leave a message or speak personally to that person?
    - If information relayed at a meeting, who else was there?
    - What specifically did user talk about?
    - What did user learn during the interaction with others?
    - Did user write or modify orders as a result?

FACT Formula

- Timely
  - Notes should be made contemporaneously (ASAP)
    - The longer the wait after encounter, the less detailed, the less complete and the less accurate the notes will be
  - If entering a late note, make sure record is clear about the time and date of the earlier event
    - Electronic charts log time of entry for audit trails
  - Try not to wait until the end of a shift to document
  - Some documentation is better than none
    - "The palest ink is stronger than the strongest memory"

So…

Are these concepts any different when applied to electronic vs. paper charts?

Criminal and Civil Penalties

- Criminal liability for false records
  - Penal Law Section 175.05
  - Class A misdemeanor
  - Violator can be sentenced to jail
  - Terms of probation can limit practice

Criminal and Civil Penalties

- A person is guilty of falsifying a business record in the second degree with the intent to defraud if:
  - Makes or causes a false entry in a business record
  - Fails to make a true entry in a business record in violation of duty to do so
  - Prevents a true entry
  - Causes the omission of a true entry
  - Alters, erases, obliterates, removes or destroys a true entry in a business record

Criminal and Civil Penalties

- Violation of Public Health Law
  - Anyone who violates, disobeys or disregards <u>any</u> term or provision of the Public Health Law shall be liable to the State of New York for civil penalty up to $2,000 per violation

Criminal and Civil Penalties

- Revocation of license for unprofessional conduct may occur for:
  - Failure to maintain accurate records reflecting evaluation and treatment of the patient
  - Failure to comply with federal, state, or local law, rules or regulations governing your practice
  - Filing of false report
  - Failure to file or impeding or obstructing filing of report required by law

Criminal and Civil Penalties

- Revocation of license for unprofessional conduct may also occur for:
  - Disclosure of personal identifying facts, data or information obtained in professional capacity without the patient's consent
  - Delegation of professional responsibilities to a person not licensed or qualified by training, license or experience to perform them

Paper vs. Electronic Records (Again)

- HIPAA applies to any health care provider "who transmits any health information in electronic form"
- HIPAA has enforcement "teeth" that can be very costly, hence the impression that legal issues are different
- Reality is that changes in business process caused by use of electronic records may result in increased legal risks

Business Process Changes

- EHR systems designed to capture data from many encounters over long time periods
  - Designed to track and report outcomes and trends
  - Driven by changes in national health care policy intended to reduce costs and improve quality
  - Checkboxes for "within defined limits": are limits well documented and known by staff?
  - Has loss of extensive narrative resulted in decrease in quality of care?

Business Process Changes

- EHR systems enable real-time charting
  - Anyone in care team can see patient's current status and take appropriate action
  - Trade-off between giving care and documentation (like distracted driving)
  - Location of charting changed from office to exam room
  - Potential increased risk of unauthorized disclosure of PHI (in institutional setting, where visitors to patient or roommate may be present)

Business Process Changes

- EHR systems accessible via mobile devices
  - Supportive of real-time charting
  - Screen size may discourage detailed charting and increase risk of error in entry selections
  - Potential loss or misplacement of device carries enormous risk of unauthorized disclosure of PHI

Business Process Changes

- Increased use of scribes
  - Demonstrates recognition of potential legal risk
  - Allows medical professional to pay attention to patient without distraction from need to chart
  - Enhances patient/professional connection

Business Process Changes

- Conclusions
  - Applicable laws not really different, but…
  - Consequences of failure to comply higher than before EHR systems
  - Focus of managers should be less on training in use of EHR systems and more on changes in business process that increase legal risk

Questions?

Thank you!

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