Legal Implications of Electronic vs. Paper Charts

Helen A. Zamboni, Esq.
hzamboni@underbergkessler.com
(585) 258-2844
Underberg & Kessler LLP

Paper vs. Electronic Records

Are digital records better than paper records?
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

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?

- 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 any 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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