2013

Legal Issues with the Electronic Health Record

Hannah Jackson
University of Tennessee Health Science Center

Legal Issues with the Electronic Health Record

Hannah Jackson

Advisor: Sajeesh Kumar, PhD

University of Tennessee Health Science Center

Legal Issues with the Electronic Health Record

Introduction

The purpose of this paper is to make readers aware of the legal issues in the electronic health record (EHR) and the risks involved so they can be prepared. It is also to help provide solution to those who are already dealing with the risks. The goal of this Project is to reach out to health care facilities who are about to embark on a new chapter in health care that we call, the EHR. Everyone should know the risks of a product before purchasing and that is what my research will show.

Method

I used The Journal of American Health Information Management Association as a primary search engine for articles. I also used PubMed which comprises more than 23 million citations for biomedical literature from MEDLINE, life science journals, and online books, and the Journal of American Medical Association.

Results

From doing the research, I have found that there are not as many legal issues within the electronic health record that most people think. According to an article in the Journal of American Medical Association, one research letter published online in Archives of Internal Medicine found that the rate of liability claims when EHRs were used was one-sixth the rate when EHRs were not used (Dolan, 2012).

Conclusion

The Electronic Health Record is still fairly new to some facilities so people may not know all the risks. People are misinformed about the risks of the EHR and this paper will hopefully educate readers on the topic. People will be surprised to learn the risks are not as many as they think, in fact, implementing and EHR may actually decrease the legal risks and improve patient care.

Keywords: legal or ethical issues in the electronic health record, legal risks in the electronic health record, health record liability, electronic health record

Table of Contents

Chapter 1- Introduction

There are a few acronyms that people use interchangeably in regards to health records: EMR, EHR and PHR. Here are the definitions of each, according to the American Health Information Management Association (AHIMA):

- Electronic Medical Record (EMR): The Electronic Medical Record (EMR) is a digital version of the paper charts in the clinician's office. An EMR contains the medical and treatment history of the patients in one practice
- Electronic Health Record (EHR): The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.
- Personal Health Record (PHR): A personal health record (PHR) is a collection of important information that the patient maintains about their health or the health of someone you're caring for, such as a parent or a child, which they actively maintain and update.

The main differences between the three are that an EMR replaces a paper chart and consists of records from a single health care provider; a PHR is records created and updated by the patient themselves, and an EHR includes records from many providers shared across the field and is what the government is challenging providers to create.

With technology rapidly advancing, it only makes sense to transition from a paper medical record to an Electronic Health Record (EHR). However with this increase in advanced technology, come legal risks. System breaches, modification allegations and E-

discovery demands are issues becoming common courtroom themes as physician's transition from paper to EHRs, legal experts say (Gallegos, 2012).

The purpose of this paper is to make readers aware of the legal issues in the electronic health record (EHR) and the risks involved so they can be prepared. It is also to help provide solution to those who are already dealing with the risks. The goal of this Project is to reach out to health care facilities who are about to embark on a new chapter in health care that we call, the EHR. Everyone should know the risks of a product before purchasing and that is what my research will show.

Chapter 2- Review of Literature

The 2009 federal stimulus package provided federal funds for the creation of a health information technology infrastructure. Health professionals can receive up to $44,000 for Medicare or nearly $64,000 for Medicaid by adopting electronic medical records (Gallegos, 2012).

Studies are mixed about how EHRs will impact liability for physicians. A 2010 survey by Conning Research and Consulting, an insurance industry research firm, found that most insurers believe medical claims will rise during the move from paper to electronic records (Gallegos, 2012).

There is a growing body of knowledge reflecting the legal, regulatory, and compliance issues related to EHRs. Some information is anecdotal, some officially noted, and much of it kept confidential for risk management and settlement purposes (Dougherty & Washington, 2010).

Medical records are a vital part of any healthcare lawsuit because they document what happened during treatment. Paper medical records are relatively simple aspects of litigation. Health Information Management's staff pulls the requested chart, track down additional information as necessary, and sometimes provide a deposition on the record's accuracy (Dimick, 2010).

The process is far more complex with an EHR. The record of a patient's care that a clinician views on screen may not exist in that form anywhere else. When the information is taken out of the system and submitted into legal proceedings, the court has a very different view—one that often confuses the proceedings and, in the worst instances, raises suspicions about the record's validity (Dimick, 2010).

EHRs make patient information more readily accessible to far more people than any paper chart stashed away in a filing room. They also change how and to what extent medical professionals' document patient encounters and add in safety-related features such as clinical decision support (Versel, 2011).

Concurrent with increased EHR adoption, the courts have redefined the discovery process for claims involving electronic record systems. National organizations have also taken note of the medical liability dimensions of EHRs. Both the Certification Commission for Healthcare Information Technology, which certifies EHR products and their networks, and Health Level Seven, which develops standards for clinical and administrative data, are expanding their involvement in this area (Vigoda, 2008).

Documentation errors can also occur in electronic health records; such as incorrectly recording the gender or age of a patient, documenting an incorrect diagnosis, or even incorrectly identifying the admitting physician on a patient's chart. Errors such as these can put the patient's health in jeopardy when not corrected immediately. In a paper record, authors may correct inaccurate documentation with a single-line strikethrough, then date and initial the entry. This will leave the original documentation intact. In the EHR, how authorized users change documentation, as well as how the changes are tracked and how they are displayed, will depend on the system and EHR functions (Wiedemann, 2010).

If system capabilities do allow for total elimination of information, Health Information Management (HIM) and appropriate professionals should ensure that audit trails are available within the system. All health records must be maintained in accordance with state and federal record-keeping guidelines (Wiedemann, 2010).

Summary List of the above mentioned Potential Legal Challenges in the EHR

1. Documentation Errors
2. Ability of Deletion of files in the EHR
3. Breach of patient information

As more and more health care facilities transition to EHRs, there continues to be legal issues that could affect both the patients and the providers.

Despite widespread agreement on the inherent benefits resulting from the integration of health information technology, there remain many legal challenges to the sharing of EHRs. The main concerns involve the Health Insurance Portability and Accountability Act's (HIPAA) privacy and security regulations, a federal provider Anti-Kickback law, and the Stark anti-referral rules. The Anti-Kickback statute prohibits the payment or solicitation of any compensation in cash or kind in exchange for referral of services such as Medicare or Medicaid. The federal Stark Law prohibits a physician from referring Medicare patients for certain patient services to an entity with which the physician has a financial relationship (Dunlop, 2007).

Chapter 3- Methodology

Electronic databases were used to search and identify articles related to legal issues in the electronic health record. PubMed, MEDLINE, National Library of Medicine, from the Journal of American Health Information Management Association and the Journal of American Medical Association were all used to conduct the literature searches.

PubMed is a free database accessing primarily the MEDLINE (Medical Literature Analysis and Retrieval System) Online database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine (NLM) at the National Institutes of Health maintains the database as part of the Entrez system of information retrieval. One article was selected from my Pubmed search.

The Journal of American Health Information Management Association (AHIMA) is the official publication of the American Health Information Management Association. It delivers best practices in health information management and keeps readers current on emerging issues that affect the accuracy, timeliness, privacy, and security of patient health information. The Journal is published 11 times a year and mails to more than 71,000 AHIMA members and subscribers. 4 articles were selected from The Journal of American Medical Association.

The Journal of American Medical Association (JAMA) offer enhanced access to the research, reviews, and perspectives shaping the future of medicine. Through a variety of innovative tools, The JAMA Network provides the insights that matter most to medical research and practice. 2 articles were selected from The Journal of American Medical Association.

The search terms used included *legal or ethical issues in the electronic health record, legal risks in the electronic health record and health record liability.*

Articles that were not relevant to topic were not included. The likeliness of an article being selected was determined from the title and abstract of the article. If they did not meet the selection criteria below after review the full article, it was not selected.

Selection Criteria:

The article was selected if it:

1. Pertained to the risks of the electronic medical record
2. Included a research study to include statistical data
3. Included suggested recommendations to eliminate risks

Chapter 4- Results

As Table 1 indicates, 3 studies were used after the search and screening of many articles. A survey from the Medical Records Institute indicated that nearly 20 percent of respondents reported receiving discounts from their malpractice underwriter as a result of having an EHR (Vigoda, 2008). Almost half felt that having an EHR reduced their vulnerability to malpractice claims. For the 20 percent who had an EHR and were involved in a malpractice case, more than half viewed the EHR as helpful to the defense (Vigoda, 2008).

As physicians and medical liability attorneys continue to weigh the potential risks involved with electronic health record use, some researchers say physicians can rest assured: EHRs will not increase their risk of malpractice claims. In fact, they can reasonably expect their risk to decrease, they said. But others say physicians should proceed with caution (Dolan, 2012).

A research letter published online in Archives of Internal Medicine found that the rate of liability claims when EHRs were used was one-sixth the rate when EHRs were not used. Researchers say their findings suggest there was a reduction in errors associated with EHR use (Dolan, 2012).

For this study, 275 Massachusetts physicians were interviewed in 2005 and 2007. Thirty-three had a total of 51 claims filed against them; 49 of the claims were related to events that occurred before EHR adoption. Two claims involved events that occurred after EHR adoption (Dolan, 2012).

The study was a follow-up to one conducted in 2008 by the same team who researched the same group of physicians. The survey, which looked at the number of

claims filed, said physicians using EHRs had lower rates of paid liability claims (Dolan, 2012).

A study by Win, K., Phung, H., Young, L., Tran, M., Alcock, C., Hillman, K. (2004) found the following:

> A case study was conducted at the Simpson Centre for Health Services Research, from the Maternal and Infant Network (MINET) database. MINET was selected as a case study for this research as it involves different electronic health data from different sources. The Simpson Centre uses data mainly for health services research, an important role, as it could affect public health research in, for example, healthcare processes, disease patterns, disease surveillance, and prevention of disease and health promotion. Data from MINET are used for health services research, and conducting a risk assessment study has had a positive effect, as inaccurate or incomplete information can have an impact on health outcome indicators. It is very important that electronic health data from MINET are complete and accurate, as MINET is used for data collection, analysis and interpretation of data for early intervention, planning, prevention and evaluation. Files cannot be linked if the system is unavailable due to such factors as power loss or application failure. Wrong data linkage can lead to incomplete and inaccurate data, and in the case of clinical data this could result in a significant and immediate impact on the patient. The Simpson Centre uses aggregated data for statistical analysis, and records not matched perfectly are excluded from the analysis. Disruption may occur in the scanning process due to mechanical problems with the machine, power failure, or inexperienced scanning operators.

When detected during the scanning process, the problem can be rectified to minimize impact on the system; the only impact would then be on the scanning task the person was performing at the time (Page 46-47).

Chapter 5- Limitations of this Review

Being that the Electronic Health Record is still somewhat new, there was some difficulty finding many studies that were performed on the legal and ethical risks that collected statistical data. All of the articles used in this project were extremely relevant to the topic however not all of them provided statistical research data.

Chapter 6- Conclusions and Recommendations

As physicians and health care facilities worldwide invest in and adopt electronic health records, it is critical that legal issues and risks be identified and discussed. The legal landscape related to EHRs is still surfacing and evolving, but important progress is being made. Research is being conducted, case law is emerging, and standards are being established. The full value of EHR systems will be realized when design and implementation support the physician's workflow and clinical needs as well as the record's legal needs.

At the beginning of my research I expected to find studies upon studies proving that the legal risks involved in the Electronic Health Record would heavily outweigh the non-risks however the research proves the opposite. Overall it seems the pros of the EHR prevail over the cons. In terms of improving patient care and accuracy of the patient record, having an EHR is a better idea than not having one.

Of course with anything there will be risks but the magnitude of the risks are not nearly as high as people, including myself, would assume. With something as important and advanced as an electronic health record, it is good to know that it is safer than I thought.

This research will benefit fellow HIM and health care Professionals interested in learning about the legal risks in using an EHR. Vendors of EHR software would also serve as an ideal audience for my topic as it pertains to their field of business and could possible help them better develop and market their product. I plan to present this project and my research findings at my local North Carolina Health Information Management Association (NCHIMA) chapter or Regional meeting.

Table 1:

Research Studies

Study	Journal	Hospital	Result
Vigoda, M. (2008). E-Record, e-Liability: Addressing Medico-Legal Issues in Electronic Records.	The Journal of AHIMA	Medical Records Institute	Nearly 20 percent of respondents reported receiving discounts from their malpractice underwriter as a result of having an EHR.
Dolan, P. (2012). EHR Use Linked to Fewer Medical Liability Claims.	The Journal of AMA	Internal Medicine	Researchers say their findings suggest there was a reduction in errors associated with EHR use.
Win K. et. al. (2004). Electronic health record system risk assessment: a Case Study from the MINET.	Health Information Management Journal	The Simpson Centre for Health Services Research	Wrong data linkage can lead to incomplete and inaccurate data, and in the case of clinical data this could result in a significant and immediate impact on the patient.

References

Dimick, C. (2010). EHRs Prove a Difficult Witness in Court. *AHIMA Blog Post, AHIMA Journal.*

Dolan, P. (2012). EHR Use Linked to Fewer Medical Liability Claims. *American Medical Association.* http://www.ama-assn.org/amednews/2012/07/16/bisa0716.htm

Dougherty, M., Washington, L. (2010). Still Seeking the Legal EHR: The Push for Electronic Records Increases, the Record Management Questions Remain. *Journal of AHIMA*, 81(2), 42-45.

Dunlop, L. (2007). Electronic Health Records: Interoperability Challenges Patients' Right to Privacy. Shidler Journal of Law, Commerce + Technology, 3(4), 16. http://digital.law.washington.edu/dspace-law/bitstream/handle/1773.1/400/vol3_no4_art16.pdf

Gallegos, A. (2012). Legal Risks of going Paperless. *American Medical Association. http://www.ama-assn.org/amednews/2012/03/05/prsa0305.htm*.

Versel, N. (2011). When EHRs Meet Malpractice Suits: New Concerns. *Information Week Healthcare. http://www.informationweek.com/healthcare/electronic-medical-records/when-ehrs-meet-malpractice-suits-new-con/231500140*.

Vigoda, M. (2008). E-Record, e-Liability: Addressing Medico-Legal Issues in Electronic Records. *Journal of AHIMA*, 79(10), 48-52.

Wiedemann, L. (2010). Deleting Errors in the EHR. *Journal of AHIMA*, 81(9), 52-53.

Win, K., Phung, H., Young, L., Tran, M., Alcock, C., Hillman, K. (2004). Electronic health record system risk assessment: a Case Study from the MINET. Health Information Management Journal. 32 (2), 43-48.