EHR and Medical Malpractice: The Changing Face of Vulnerability
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Learning Objectives

▪ Understand how use of an EHR changes malpractice vulnerability
▪ Gain awareness of how malpractice risk changes as overall EHR adoption changes
▪ Gain awareness of how malpractice risk changes at the various phases of practice EHR implementation
▪ Know how to protect yourself when you release information from your EHR
Disclaimer*

*Information in this presentation does not constitute legal advice.
Legal Implications of EHRs

- Changes in malpractice liability
- Potential liability under privacy & confidentiality laws
- Disputes over ownership of data
- Heightened vulnerability to fraud claims as a result of improved information on services rendered vs services billed
Overall EHR Adoption: Changing Risk

- Initial Transition to EHRs: predictable implementation snags may heighten provider’s liability risk
- After initial period: potential to reduce injuries & claims but create new opportunities for error (alters the context for proving/defending malpractice claims)
- Widespread adoption: potential shifts in legal standard of care
Initial EHR Adoption: Paper to Electronic

- Documentation gaps
- Failure to implement procedures that a “reasonable” provider would implement to avoid errors
- Inadequate training creating new error pathways
- Errors by new users incorrect/incomplete data entry
- Failure for clinicians to use consistently create gaps in documentation & communication
- Bugs/failures adversely affect care
As EHR Adoption Matures

- Messaging/email advice increases the number of “clinical encounters” that may lead to claims & may heighten the risk of advice without full exam, etc.
- More extensive documentation creates more discoverable evidence for plaintiffs, including metadata
- Temptations to copy/paste risks missing new information & perpetuates prior mistakes
As EHR Adoption Matures (cont.)

- Failure to respond to messaging in a timely fashion could constitute negligence
- Information overload may cause physicians to miss important information
- Departures from clinical decision support guidelines could bolster plaintiff’s case
Rapid pulse, sweating, shallow breathing. According to the computer, you’ve got gallstones.
Better access to clinical information could create legal duties to act on the information.

Wide-spread use of clinical decision support could solidify “standards of care” which might otherwise be subject to debate.

Rise of HIEs may heighten clinician’s duties to search for patient information generated by other clinicians.

Failure to adopt and use electronic technologies may itself constitute a deviation from the standard of care.
Shifting Vulnerabilities

**PAPER**
- Handwriting
- Timing of information availability & documentation
- Human processing

**EHR**
- Legible but extraneous info?
- Audit trail
- Computer processing
<table>
<thead>
<tr>
<th>Percentage</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>Incorrect information</td>
</tr>
<tr>
<td>16%</td>
<td>Hybrid records</td>
</tr>
<tr>
<td>12%</td>
<td>System failure: Electronic routing of data</td>
</tr>
<tr>
<td>10%</td>
<td>System failure: Unable to access data</td>
</tr>
<tr>
<td>10%</td>
<td>Pre-filled forms or copied and pasted text</td>
</tr>
<tr>
<td>9%</td>
<td>Failure of system design to meet need</td>
</tr>
</tbody>
</table>

Results are from a 2013 study by CRICO of 147 medical malpractice claims in which EHRs contributed. Source: Boston Globe
Liability Implications Vary over Time

- Initial Transition
- The Honeymoon Phase
- New Features
- Upgrades/New Versions
- Interfaces
Initial Transition

- Implementation Chasm: moving from a familiar system to a new one
- Individual User Mistakes
  - Incorrect data entry
  - Misunderstanding of system functionality
  - System downtime
- Hybrid Paper/EHR world
  - Parallel systems lead to gaps/missing information
- Mental Fatigue of learning new information while practicing medicine
The Honeymoon: “We’re All Good!”

- Knowing what you don’t know
- What’s slipping through the cracks?
- Who isn’t using the system the way it was intended?
- What portions of the software are you not using?
- Where are your vulnerabilities?
The Only Constant is CHANGE!

- New Features & New Versions/Upgrades introduce…….
  - New workflows
  - Need for new learning curve
  - New buy-in
  - New vulnerabilities
  - New risks
I’m telling you, they turned on my patient portal and I have no clue how it works…
Interfaces

- **Labs**
  - Interface down, practice unaware, abnormal results not reviewed/acted on in timely manner
  - Practice doesn’t have established workflow for reviewing labs for provider on vacation

- **Patient Messaging**
  - Practice has no established method or education for patients regarding urgent messaging and expectation of responses
  - Practice does not follow uniform workflow for handling of messages or covering for provider out of the office
Interfaces

- HIE
  - Practice doesn’t “sanity check” information before it’s imported into EHR
    - Wrong patient
    - Imports conflicting/invalid data
    - Duplicate entry
  - Practice has no established workflow for “sanity checking” information on an ongoing basis
    - Conflicting data exists on patient chart
    - Invalid/incorrect data goes to outside entity (HIE or patient portal)
    - Invalid/incorrect data gets propagated
Common Areas of Risk

- Not understanding how your EMR works
- Not using the EHR as intended and trained
- Documentation/note finalization
- Conflicting information
- Using templates without review
- Ignoring/overriding alerts
- Not understanding the audit trail
Malpractice Record Request

- “Complete” records vs notes
- Audit trail/metadata
- Printed records ≠ information visible on chart when seeing patient
- Version now ≠ version available when care occurred
- Reports vs “saved” notes
Is There an Upside to EHR Use?

Good News!
Potential Benefits of EHR Technology

- May reduce discontinuities & errors care, reducing adverse events & claims
- CDS may improve care and reduce adverse events & claims
- Better documentation of clinical decisions & activity through user-entered data & metadata, may improve the ability to defend against malpractice claims where care was appropriate
Potential Benefits of Technology (cont.)

- Compliance with CDS care guidelines may constitute helpful evidence that legal standard of care was met
- Secure messaging may improve patient satisfaction, improve communication & reduce the propensity to sue
- Secure messaging may improve patient communication of clinically significant information, reducing adverse events & claims
How Do I Protect Myself?

- Know how your system works
- Be **actively engaged** in training & implementation
- Make sure everyone is using the EHR correctly & consistently
- Agree on an office workflow & make sure it is being followed
- Commit to ongoing practice change
- Speak with your attorney to find out what they need & call OP for assistance **before** you release records (most lawyers gladly pay for good information)
Sources/Resources

- Medscape: 8 Malpractice Dangers in Your EHR, Neil Chesanow, August 26, 2014
Questions
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We want your feedback!