HDM Feature: Why EHRs Wont Reduce Your Malpractice Premiums

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You're dozing off in front of late-night TV. An insistent voice jerks you awake. "Have you been injured because of your doctor or hospital's use of electronic health records?" asks the TV lawyer. "Call the number on your screen to see if you may be eligible to receive a monetary award!"

Nightmare or tomorrow's reality? EHRs, properly implemented, are generally considered a boon to care quality and safety, with their reminders, care protocols, and readability. EHRs can help providers avoid making the types of mistakes that can land them in court.

But experts say those characteristics won't automatically translate into fewer malpractice claims, easier defenses, or lower malpractice insurance premiums. In fact, EHRs may make malpractice claims more expensive to defend, and obscure the very facts they're supposed to confirm.

"If you live long enough you're going to goof and get sued," says Barbara Drury, president of HIT consulting firm Pricare, who serves as a technical expert to ONC on the unintended consequences of EHRs and as an advisor to COPIC, a Colorado malpractice insurer. "But it will be more difficult to tidy up the information when you have to produce it. It either won't be there, or there will be things happening under the bonnet that you never knew were happening."

Provider vs. EHR

Here are some EHR nightmare scenarios that can haunt providers during malpractice proceedings:

* A physician shares his password with several medical scribes to make it easier for them to keep up with his documentation. A plaintiff's analysis of EHR metadata shows that the physician was apparently logged into the system in three places at once-none of which was the location where he actually was at that moment.

* A hospital turns off some of the alerts in its clinical decision support system because they were firing so often physicians were ignoring them. A plaintiff's attorney shows that one of those alerts might have prevented injury to their client and asks why such a valuable tool isn't being used.

* A literature-checking function brings up a recent paper that confirms the wisdom of Decision A for a certain patient. Unfortunately, the physician made Decision B, because she read only the abstract of the paper and not the part of the discussion that pertained to her patient's exceptional situation. The EHR's audit trail shows she had access to the whole thing.

* A family practice physician uses an auto-complete function to fill out an encounter form, noting the exception that the patient has come to see him for: a sore shoulder. The auto-complete fills in a "normal" assessment for the patients' eyes, and the canned text in the EHR says he reports no floaters, flashes, or other problems. A few days later, the patient suffers a detached retina. Later, he testifies that the doctor never asked about his eyes.

While a few malpractice insurers gave premium discounts for EHR use early on, the field has pulled back from these discounts as adoption increases. The Doctors Company, a leading malpractice insurer, has decided not to make any EHR-based changes in premiums, though it is starting to collect information specifically about the role of EHRs in malpractice claims, says medical director David Troxel, M.D.

"It's difficult to make changes based on anything other than your actual experience, and no one really has enough claims experience to assess the risk," Troxel says.

The company recently started asking about EHR use in practices facing malpractice

claims, and Troxel estimates that by next spring he should have information on the EHR's role-if any-in about 3,000 claims.

One thing he does know: EHRs increase legal costs for both sides in a legal case. "Attorneys are experienced in reading paper records, but the EHR is totally new, and they're learning how to analyze the volume of information, and the metadata, and how to find certain pieces of information," Troxel says. "It's takes time, and we all pay by the hour."

So far, EHRs haven't had much identifiable impact on malpractice itself one way or the other. The limited literature is mixed: a study out of Colorado published in November 2012 showed no change in the number of claims, while one out of Massachusetts published in August 2012 showed a marked decrease.

Both looked at physician practices that adopted EHRs before the advent of the federal meaningful use program. Because there's typically a two-to-four year lag between an incident and the filing of a malpractice suit, it will probably be 2020 or later before a true assessment of the EHR/malpractice relationship will be feasible.

Moreover, malpractice premiums have gone down in the past 10 years, as states have enacted tort reform and patient safety efforts have paid off. These days, plaintiffs' attorneys only take cases they're absolutely sure they can win, says Paul Greve, executive vice president of healthcare practice for global insurance broker Willis. "Right now malpractice insurance is so competitive that carriers aren't jumping up and down to give additional credits," he says. "The malpractice atmosphere is the best it's been since the 1970s."

Here's why your malpractice costs may not go down, and could even go up, with EHRs.

EHR danger

As HDM has previously reported, EHRs can lead to situations that might endanger patients if information is entered incorrectly in any way, if interfaces don't work properly,

or if bugs attack. (To read the 2010 feature on the hazards of EHRs, click here)

One family practice in Colorado discovered that its EHR was accidentally deleting random crucial words-like "not"-when it printed out records to send to hospitals and other providers. The problem occurred when the person entering the note put two spaces between sentences instead of one-a common habit among oldsters who learned to type on typewriters.

The extra space caused the first word of the next sentence to be deleted. "They called their vendor, who said, 'Oh, yeah-that problem,'" says Drury of Pricare. "Imagine if that information had gotten into a health information exchange without human review."

Glitches are inevitable, says Sharona Hoffman, a law professor at Case Western Reserve University who frequently studies implications of EHRs. "The meaningful use incentives have made people adopt systems quickly and vendors produce them quickly, and I'm not sure there's enough attention paid to quality," she says. Certification requirements don't include clinical testing, and Hoffman thinks they don't focus enough on safety and usability.

EHRs can easily be implemented in ways that give unwitting gifts to plaintiff's attorneys. It doesn't take much to impugn the credibility of a record: a progress note clearly cut and pasted over and over, a single menu item mis-selected, or the wealth of quasi-documentation that can come from auto-populating.

"A lot of attorneys will question whether the doctor actually asked all the questions [that are answered in the record]," says Jeff Topfer, president of Primedx Solutions, a vendor of physician office EHR systems, who also serves as a consultant to PRI, a large medical malpractice insurer. "The notes say they did, but you know they spent four minutes with the patient and it would have taken 25 minutes to go through all those questions."

One culprit is the menus and lists that are supposed to make charts more uniform and easier to analyze in the aggregate. Topfer says providers often think they have to fill out all of them just because they're there. "If you would have written three things down on

paper, you only have to check three boxes," he says.

Because payers reward thorough coding, those lists are even more tempting, but clinicians don't always understand how they translate into the EHR, says Ron Sterling of Sterling Solutions, which advises physician offices on information technology. "The EHR may plug in text that represents a finding of 'within normal limits'" even if the physician didn't specifically check, he says.

One bad apple

Like paper charts, EHRs may sometimes reflect bad care but most often just reflect sloppy documentation. Unlike paper charts, their sloppiness is contagious. "If I can pull out every chart [in an EHR system] and find errors, where else are they?" says Mark Anderson, CEO of HIT consulting firm AC Group. As a result, the plaintiff's attorney can use flaws in any record to indict all of them. (Anderson says that a few years ago, most of his work was in EHR selection-now it's in malpractice and vendor lawsuits.)

"Plaintiffs' attorneys look at things they can demonstrate are false in the documentation, and use them to demonstrate that your documentation practices are less than diligent," says Chad Brouillard, an attorney with Foster & Eldridge, Cambridge, Mass., who specializes in legal issues connected with EHRs. "They use your own record to try to impeach you."

Raising the bar

Clinical decision support systems may create a de facto standard of care. "I know a plaintiff's attorney who loves to ask doctors why they didn't order X test," says Dean Sittig, professor of biomedical informatics at the University of Texas Health Science Center at Houston, a leading researcher on EHR safety. "When they say they didn't think it was necessary, that attorney knows he's going to win, because it's in the order set for that condition. All they had to do was click it."

Ron Sterling says use of EHRs in general will change the standard of care, especially in

"meaningful use" areas. "If 370,000 physicians are getting money from the government for checking drug-drug interactions, how tolerant will patients be, and how sympathetic will the court be, with a physician who missed a drug interaction-especially if he cashed a meaningful use check?" he asks.

Nothing but the truth. EHRs can tell juries things that paper records never could-and clinicians may not be aware of all of those things.

"All alterations will be captured, as well as anything that a doctor reviewed, when they reviewed it, and for how long, every single time they look at the chart," says Greve of Willis. "A lot of EHRs will prompt them to look at a certain thing, and will capture how long they looked. That gets thrown in their face by a plaintiff's lawyer. The lawyer will look for any late entries, any corrections, everyone who accessed the chart."

A morass of paper

Once a case gets into litigation, the cost of "e-discovery"-producing all the relevant information from electronic sources-is formidable, and the results can defy interpretation by attorneys, the jury, or even the physician.

"Early on, I could see that EHR and e-discovery rules were going to be a bad collision, because meaningful use never contemplated the legal use of EHRs after the fact," says Brouillard.

The EHR is not a static document like the paper chart, but the discovery process in a lawsuit still revolves primarily around paper documents. "The graphical user interface lets you organize different types of data in a way that gives them meaning," Brouillard says.

A dashboard can pull data points from many places and juxtapose them to help clinical decision-making, but that representation can't be easily duplicated for attorneys. "When litigation comes around, the record exports into paper as a disorganized jumble of data," he says. "From an evidentiary standpoint, the forms used for care are not what's given to the attorneys, and that creates a great deal of distortion."

Michelle Dougherty, director of research for AHIMA, agrees. "EHRs haven't been good record management systems, because they're built on transactional databases," she says. "When two or three years go by and you have to reconstruct a record showing what transpired, you can't do it the way we used to do it with paper."

Producing a chart for evidence in a malpractice proceeding isn't a simple matter. Primedx Solutions' Topfer says many practices think all they have to do is press "print chart," but what they'll get is a continuity of care document designed for other providers. No lab results, no phone messages, no details of who did what when-all the things that attorneys seek.

Full-blown e-discovery can be so onerous as to put a small practice out of business. Brouillard recounts one case where attorneys needed to review 75 charts in their native electronic form, and made the provider recreate exactly what the physicians had seen. "It took them a month to respond to all of it."

Topfer says the demands of e-discovery may lead to a drop in litigation. "If I could settle a case for $1 million, or litigate it for $35,000, I'd litigate, but if the cost of discovery skyrockets to $500,000, then I might as well see if I can settle."

While other industries, like banking, have spawned a cottage industry in e-discovery software designed to pull the relevant data out of institutional databases, Brouillard says EHRs and related systems are too varied and complicated to inspire the same kind of activity anytime soon.

Simplifying the legal discovery process is yet another reason why it would be useful to have data standards that apply across all systems. "I've talked with e-discovery vendors wanting to develop tools for health care, but when I explain the environment, they just scratch their heads and say, 'Yeah, great market, but we don't know how to do that,'" Brouillard says.

Protection Tips

Experts say providers can take several key actions before, during and after their EHR implementations that will help keep the EHR squarely on their side during a malpractice suit.

* **Work with your vendor.** EHR vendors have been notorious for indemnification clauses in their contracts that absolve them from any responsibility for patient harm resulting from a system malfunction. That's already changing, says Lorraine Possanza, patient safety risk and quality analyst at ECRI Institute, which operates a patient safety organization that collects de-identified data on safety incidents related to EHRs. "Vendors are changing the agreements on their own because they are participating in patient safety projects and want to know about incidents," she says.

Pressure from clients may also encourage vendors to think ahead about legal challenges and provide an easier way to produce records for lawsuits. "We have to ask for the system to address not only the front-end user, but also the other business uses of the record," says AHIMA's Michelle Dougherty. "It's not logical to think that the users of the data will be looking at them only in the EHR environment."

Keep an eye out for workarounds that can compromise how the record was intended to be used. If nurses are scribbling vital signs on Post-Its and adding them to the system later, they will routinely distort the care timeline recorded by the system. "Make corrections mid-course so that the staff doesn't resort to workarounds," advises Cindy Wallace, senior risk management analyst at ECRI.

* **Stop password-sharing by any means necessary.** Don't wait for a malpractice suit to show clinicians that their electronic signature is sacred. "I've seen clinicians who appear to be logged in at multiple places, or processing 60 reports at once, because they've given their password to their scribes," says Chad Brouillard, an attorney with Foster & Eldridge, Cambridge, Mass. Sometimes medical assistants "tee up" orders under their sign-ons, and then assume, wrongly, that the physician will OK the orders using his own password. "Sometimes the system makes it look like the MA is putting the order in, which may be beyond the state's license restrictions." Set things up at the beginning so that staff don't have to share passwords to get the job done. That may entail establishing a

special class of passwords for assistants or scribes acting on behalf of a certain physician.

* **Watch those interfaces.** Computers and medical devices can compromise the credibility of a record all on their own. Brouillard recounts a case where a clinician questioned the evidentiary value of a medical record that had his electronic signature all over it-because the system was automatically combining his signed notes with vital sign information that he hadn't reviewed. "Clinicians have to be vigilant about what's going under their signature, and change their documentation practices accordingly," he says.

* **Justify clinical decisions.** In the days of paper records, plaintiffs' attorneys had to call expert witnesses to describe the standard of practice. Now, the EHR is apt to do it for them, in the form of order sets, rules, and alerts from clinical decision support systems. If your clinicians routinely override standard order sets or the CDS, train them to document their reasoning. "If you ignore alerts, override them, set the thresholds too high, or don't install them because it will disrupt your workflow or create additional expense, and then something happens," you'll make the plaintiff's attorney's job very easy, says James Crouch, M.D., CMO at Patient Safety Solutions, a safety consulting firm. (He's also a lawyer.)

David Troxel at The Doctors Company adds that physicians should understand where the rules come from in the CDS. "It's useful to know if they're based on your own specialty society's recommendations, or just from one or two cardiologists working with the EHR vendor," he says. The same goes for drug interaction databases and other resources. Physicians are less likely to override the CDS if they trust the source of the rules.

* **Disable cut and paste.** "If a plaintiff's attorney sees 20 identical progress notes with different dates, he's going to ask why you wrote a note, and ask you to show where the differences are," Brouillard says. Plus, the risk of endlessly duplicating an incorrect piece of information is not worth the convenience. Sit down with your malpractice attorney, and review how your EHR might appear in a lawsuit. "The worst time to learn about the defects of the system is while you're in litigation," he adds. "Print out your record and see what's being created."