Tackling the Electronic Medical Record Obstacle Course

by Deborah Ward

Implementation of electronic medical records (EMR) has presented new barriers for both healthcare and legal professionals alike. The national movement toward full transition to EMRs impacts the efficiency and cost of case development. Additionally, reviewing these extensive records can be a daunting task for many attorneys. A lack of proficiency navigating the obstacles of EMRs can lead to litigators overlooking details that win cases along with wasting time and money.

Although the implementation of EMRs has become mainstream, each EMR system is unique. Systems can create different reports, resulting in even more data for review. Evaluating EMRs, which often consist of hundreds if not thousands of pages, for medically related cases can be very time consuming. Not to mention there is still a large volume of hybrid records used in clinical practice. Many healthcare providers still use both paper and electronic documents, either for their convenience or the inevitable event of electronic program crash requiring the temporary use of paper back up. Understanding how providers manage their records is crucial to ensure complete discovery.

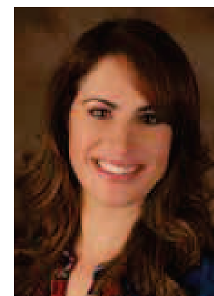
EMR has also affected the process of documenting medical events. Previously, providers used dictation systems or written notes to document each patient encounter. However, as EMRs are now living documents, providers can copy and paste portions of other notes, tests, lab results, vital signs, and any other available data in the EMR. This creates lengthy notes that often contain repetitive data throughout the medical record. As a result, it can be difficult to determine the original author or what is factual and contemporaneous with the event. The "copy and paste" method often leaves telltale signs, such as misplaced punctuation or extra spacing.

In addition, data is sometimes entered in the EMR by a provider on behalf of a colleague. Completion by someone who did not perform the event complicates documentation. Unlike paper records, correcting errors in data may include deletion from the record or documented elsewhere in the web of data. If not specified by providers, late entries may be recorded by the system at the time of entry as opposed to the actual time of the event.

EMRs also present attorneys with issues relating to protection and security of personal health information.. The "Final Rule" added to the Health Insurance Portability and Accountability Act (HIPAA) in 2013 requires many legal professionals, as well as their teams including subcontractors and vendors, to abide by HIPAA regulations.

There are some benefits to EMRs and recent legislation regarding PHI. Use of electronic text has alleviated the challenge of deciphering healthcare provider's notoriously illegible handwriting.. Also, understanding technology that can be used for EMR review allows for individualized organization of discovery. With the "Final Rule" addition, patients have the right to their PHI upon their request and can authorize in writing to have their records sent directly to another person, including their attorney.

As EMRs become more prominent components of litigation, attorneys and their legal teams must understand how to address challenges of the EMR. Someone with expertise in EMRs and navigating their challenges can determine the details and breaches in documentation and patient care standards; therefore, improving efficiency and quality of case development. B



Deborah Ward, MSN, ARNP is a board-certified nurse practitioner working as a legal nurse consultant. Her nursing expertise and legal nurse consultant services assist attorneys with full case development of a wide range of medical related cases. Deborah can be contacted at deborah@drwardconsulting.com or (954) 290-7311