ELECTRONIC MEDICAL RECORDS

Many physicians are considering (or may have already instituted) electronic medical records (EMR) in their medical practices. Recognizing the extreme importance of the medical record to patient care, physician reimbursement as well as the defense of professional liability cases, we provide in this section, some recommendations on this issue.

These recommendations assume that physicians have explored the various options for hardware, software, etc., with experts in computer technology and particularly in the area of patient care records, with its particular sensitivities.

Legal/Department of Health Considerations

- Physicians are required by New York State Education Law (32) to maintain a record, for each patient, which accurately reflects the evaluation and treatment of the patient.

- New York State Public Health Law also requires that physicians are able to comply with patients' requests to transfer their records to other designated physicians or hospitals and to provide access to, and/or copies of records to patients or other qualified persons.

- Medical records must be available in a readable form to be inspected by Department of Health personnel during investigations.

- Physicians must assure the integrity of their medical records maintenance systems to ensure that the records are not lost, destroyed or altered and that the confidentiality of all patient related information is protected.

With regard to the integrity of the electronic medical record, it is absolutely essential that the physician uses a system that allows for entries to be "time stamped" in such a way that they cannot be said to have been retroactively changed. The physician should be sure that with the system (s)he plans to use, it will be possible to prove the integrity of the date that entries into the records were made. The office policy must also include the authentication of entries with the author's name or initials.

Other Risk Management Considerations

Telephone Information

Just as with paper records, the practice with electronic medical records must also develop a procedure that allows for the documentation of telephone contacts with patients and other providers.

Laboratory and Other Reports

Even though a practice may choose to scan the findings from incoming laboratory reports, EKG tracings, etc., into the electronic record, this does not obviate the need to maintain the paper documents, or at a minimum, a scanned copy of these reports. There are many situations in which it is important that the practice is able to produce the actual report from another practice, laboratory etc. The physician's position in the defense of a claim may be compromised without such documents, and it may not be possible to obtain copies from the laboratory or other provider at the time a case is brought.

Other material such as operative reports, discharge summaries, records from other providers, etc. will still be received on paper and provision must be made to retain/store all such documents. This points out the need for certain material to be maintained in hard copy if the computer system does not allow for them to be "scanned in."

Confidentiality of Information

Consideration must be given to the accessibility of the electronic medical records by persons other than those authorized to access this information. This should begin with the use of access codes (passwords) and should be further defined by a strict internal policy which prohibits the disclosure of access codes. The system would be further protected by the changing of codes at reasonable intervals. Staff should be advised against leaving information on screens as well as leaving their terminals "logged in". The physician/practice should obtain the advice of their computer consultant with regard to the security of the EMR.

Accuracy of Information

Some EMRs include pre-programmed information, such as physical exam findings. The physician must be certain that each finding included in his/her exam for a particular patient, is indeed accurate for that patient.

Technical Considerations

If EMRs are to be effective tools in the physician's practice, adequate pre-planning and ongoing refinement are important.

Procedures should address what is to be done if there is no access to the EMR, for example, during periods where the system is temporarily non-functional. Of course, provisions must also be made for the entry of information received during those periods.

- It is also important that the specific periods at which back-ups are performed are clearly defined and communicated to staff. At a minimum, daily back-up is recommended and system back-ups should also be done at regular intervals. The backed-up files must be maintained in a secure location, with off-site storage being preferable.

- Experts in the field of electronic medical records also recommend that back-ups are done prior to servicing of the system, to ensure that information is not lost.

- Measures must also be taken to protect systems from power surges and failures.

Conclusion

Much will continue to change in the way medical records are developed and maintained. However, what remains constant are the basic principles regarding the necessity for medical records that are:

- complete
- accurate
- unaltered
- available
- confidential

Any recordkeeping system instituted in the medical practice must conform to these principles.