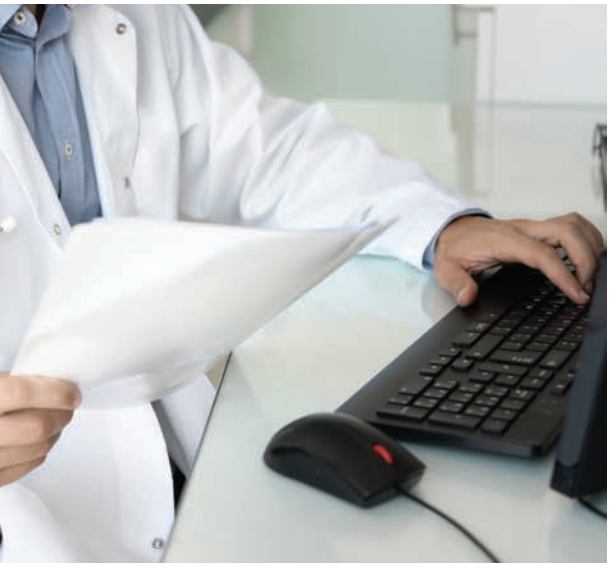

# Paper Charting vs. EMR

## Each method has its own pros and cons.

LAWRENCE F. KOBAK, DPM, JD

Most private medical practices use some form of electronic medical records (EMR). Laws such as the Health Information Technology for Economic and Clinical health Act of 2009 (HITECH) have provided money incentives for their adoption. However, there are still holdouts. Usually, but not always, they are older practitioners in smaller private practices. They are "analog" people living in a digital world. It is still legal to keep handwritten or typed charts in private practice in all 50 states. At this stage, almost all hospitals have adopted some form of EMR. If you are a podiatrist who practices, at least part-time, in a hospital or surgical center, it is virtually mandatory that you have a working knowledge of EMR.

But what about the stalwarts of paper? They are still practicing. Attorneys and auditors who review a copious number of medical records will tell you that they still see plenty of handwritten medical records.

**Paper-Based Records**

What are paper-based records? They include both handwritten records as well as typed records. They also include "hard copies" of x-rays, test results, and prescriptions. In short, they are physical records that require storage space. Believe it or not, the paper-based records have one very clear advantage over EMR… they cannot be hacked! No computer genius can do anything about hijacking the contents of a physical file. Short of photographing or copying a physical file, they are the ultimate answer to data theft. The fax machine, which had been collecting dust, has recently been reclaimed to keep health data private. You see, the fax machine is analog, not digital. It too cannot be hacked.

There is another advantage of using physical charts; the healthcare provider is usually better able to keep eye contact with their patients. They are not busy with keyboarding on their computers during a patient visit. It can be rather disconcerting when a healthcare provider has their back to the patient during most of the visit. Nobody likes talking to someone's back. It is not conducive to developing trust between the doctor and the patient. We will get to AI's cure for this problem concerning EMR later in this article.

Historians who have reviewed written medical records from the American Civil War era can tell you that handwriting was a prized skill at that time. Page-long operative records, written after a long day of amputations on the battlefield, truly are impressive as to both detail and legibility. That ability has decreased, to put it kindly.

Handwritten records cannot rely on "cut-and-copy" entries, as all entries are manually entered by hand, or dictated and typed. Yes, there are still typewriters available. Go online and see that they are available for purchase at affordable prices. Without the ability to copy whole paragraphs and pages, the physician fills out a chart—sometimes with higher-value words. This is a definite positive for paper-based medical records.

**It is still legal to keep handwritten or typed charts in private practice in all 50 states.**

Handwritten charts, by their very nature, can facilitate checklist-type templates. When judiciously and accurately used, templates can be very helpful in organizing medical information. A template cannot replace the otherwise accurate use of important information; but it can assist in using the information for evaluation and use in the diagnosis and treatment of a patient.

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**Disadvantages of Physical Charts**

The disadvantages of physical charts are many. They are generally organized by physical date, albeit, they often have various sections of which each is organized chronologically. The physical storage requirements can be expensive and require large amounts of space that could otherwise be used to greater advantage.

**One of the major disadvantages of handwritten charts is the legibility factor.**

One of the major disadvantages of handwritten charts is the legibility factor. When another set of eyes reviews the medical records and cannot understand it, or worse, misinterprets it, the results can be disastrous. As nothing is automated, recognizing allergies, various diagnoses, medication changes, might go unappreciated. More things can possibly "slip through the cracks". Additionally, it is difficult to search various terms or services in prior records. Data cannot be easily culled out of written records.

Another difference in physical charts involves patient privacy. The place where the charts are stored must be unavailable to the patients. Locks involving numbers or physical keys to open them are needed. You cannot leave the physical chart on the ledge unattended in the treatment room. It is physically more involved to make copies of a physical chart as opposed to an EMR.

**Medical Transcription**

As a subset of physical medical charts, some practices use transcriptionists. The first hurdle is the method by which the transcriptionist receives the dictation from the practice. Often, the provider dictates into a digital recorder. This can in turn be emailed to the transcription service. One problem is that the provider's accent may be hard to understand; this can impact the accuracy of the finished product. The transcription should be reviewed and signed by the provider prior to it being printed out and made part of the medical record. Software that prints the dictation automatically must use noise-cancelling equipment with a high-quality microphone. Background noise can impact the accuracy of the transcription. Regardless of the transcription system being used, even if 98% accuracy is claimed, the 2% that is not accurate can have a devasting result if not corrected. The transcription for each patient must be reviewed prior to signature. This is facilitated if the transcript is provided in *Word* format for editing within your software.

**EMR**

An EMR can organize the electronic record by areas of topic rather than chronology. Search terms can be applied when searching each patient's record. Something that occurred years prior, which otherwise might be overlooked, could be discovered. One's ability to track treatment results or data management and trends will enhance patient treatment and diagnosis.

**EMR is expensive to buy and expensive to maintain. It requires updates to the software. Sometimes it requires expensive replacement of the hardware.**

This very same ability can often limit the auditor's ability to do the same. The physician usually electronically provides the chart in a certain format. The auditors often do not look beyond the treatment dates under review. That means that the reviewer is not reviewing the "whole story" on the dates in question. The electronic format is often not conducive to tease out the various elements that are needed for documentation that will justify the codes used.

You might have terrible handwriting. With EMR, there is a level playing field. Everyone has perfectly legible handwriting. Every chart is signed and dated, or the dated progress note could not have been closed. With EMR, you have automated alerts as to patient allergies, incorrect dosages of medication, and drug allergies.

The physical space required for storage ceases being an issue. However, with the importance of being able to access a back-up copy, every physical external hard drive or a back-up on the cloud becomes of paramount standing. Safety from hackers is a major issue in today's environment, especially with privacy laws and their severe penalties.

EMR is expensive to buy and expensive to maintain. It requires updates to the software. Sometimes it requires expensive replacement of the hardware. A power outage, brownout, or loss of Internet connection can cause a big headache in your EMR system. The actual access to input the information needed for accurate EMR record-keeping is a factor. You need convenient data input stations in several areas.

Conversion of paper records through scanning can involve a mind-boggling amount of time, even with a high-speed scanner. Additionally, when transferring from one EMR to another brand of EMR, the conversion of your records can be expensive and very frustrating. Attorneys have gotten involved with more than one EMR company who promised conversions and other functions that it could not deliver.

Speaking of YOUR requirements for an EMR system, it is of the utmost importance that you let the prospective EMR company know beforehand what you require it to do. If you need to segregate out the patients from each of the various nursing homes where you render treatment, do not

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forget to get it in writing before you sign any contract. You don't want to find thousands of dollars and dozens of hours later that certain prior records cannot be converted for use in the way you require.

Some EMR companies have required an initial contract for as long as five years! If you need to change companies for any reason during this time, you will have to buy out the contract or resort to expensive litigation. Have a knowledgeable healthcare attorney review this contract before you sign it.

**EMR and AI**

Artificial intelligence (AI) is already integrated into many EMR systems. It can produce excellent medical documentation. AI can automatically place the important information in the appropriate part of your patient record, without manual input. This will substantially decrease your time creating your records. Additionally, your back will no longer be facing your patient. The improvement can be startling. However, the chart should still be reviewed for accuracy. Medical billing codes can also automatically be assigned, based upon your record. Again, the codes should be checked by a human.

**AI can automatically place the important information in the appropriate part of your patient record, without manual input.**

**Conclusion**

There is no perfect medical chart. Each technique of memorializing the patient's visit comes with its own shortcomings and advantages. We are still relatively early concerning AI and its use within EMR. The medico-legal world will be watching its developments in the upcoming months and years. In the end, you, the practitioner, are responsible for what goes out under your name. A fault in your EMR or AI will not be an acceptable excuse when your records are under scrutiny. Your poor handwriting will not be a defense when it is questioned as part of an investigation. In the end, take charge of your own patient records no matter what method you choose. **PM**

**Dr. Kobak** is Senior Counsel in Frier Levitt's Healthcare Department in New York. Larry has extensive experience representing physicians in connection with licensure issues, as well as successfully defending physicians before Medical Boards, OPMC, OPD investigations, as well as Medicare Fraud, Fraud & Abuse, Hospital Actions, RAC Audits, Medicare Audits, OIG Fraud, Healthcare Fraud, Medical Audits, and Health Plan Billing Audits. As a licensed podiatrist prior to becoming an attorney, he served as the international president of the Academy of Ambulatory Foot and Ankle Surgery.