

## **How the SRS EHR Mitigates Malpractice Risk: A Guide to Negotiating Discounted Premiums**

SRS clients have successfully negotiated reductions in their malpractice insurance premiums based on their use of the SRS EHR. This validates SRS' longstanding contention that the design and features of its EHR help practices provide the highest quality of care in the most efficient and safest manner.

The American Medical Association released a study indicating that EHR utilization may have an impact on malpractice settlements<sup>(1)</sup>. The data revealed that physicians with EHRs had fewer claims than physicians without EHRs. The researches suggest that the active use of an EHR likely results in fewer diagnostic errors, improved follow-up of abnormal test results, and better adherence to clinical guidelines, thereby reducing the potential for medical negligence, the basis for the majority of successful malpractice claims.

Of particular interest to users of SRS, which has a 100% successful adoption rate among its physicians, is that the greatest risk-reduction benefits accrue to physicians who embrace and use their EHR successfully.

Although these findings are preliminary and additional studies are needed to confirm the conclusions, a formidable argument can be made to justify a request for a reduction in malpractice premiums. The following specifics about the SRS EHR represent some of the most significant ways in which SRS mitigates malpractice risk:

- On-demand access to complete and accurate patient information, 24/7/365, allows for informed decision-making at any time of day or night, from anywhere, by any authorized provider.
  - Charts are always complete, accurate, and up to date.
  - Charts are always available, i.e., no lost or temporarily missing charts.
  - On-call physicians, who may be unfamiliar with patient histories, have access to full information when making decisions or responding to patients.
- The potential sources of medication errors are eliminated through ePrescribing.
  - Prescriptions are not written without access to patient Rx history, medical conditions, and allergy information.
  - Prescriptions are printed accurately and legibly so there is no chance of misinterpretation by the pharmacist.
  - All prescriptions written by physicians or providers “on behalf of physicians” are automatically documented and become part of the patient’s Rx history.
  - Physicians can consider potential drug interactions.
  - Patients seeking to misuse or abuse drugs can be identified.

- The entire test-ordering and reporting process is automated, allowing for immediate identification and consistent follow-up of patients requiring treatment.
  - Test results are in the chart as soon as received.
  - Abnormal results are identified as soon as they are received.
  - Results are automatically routed to the designated professional for review and sign-off.
  - Outstanding test results are identified by aging report for follow-up.
  - Patient compliance is tracked.
  - Follow-up calls to patients regarding compliance are documented.
  - Lab results are graphed and trended, assisting with diagnosis.
  
- Communication among caregivers is enhanced, ensuring that patient care is coordinated and nothing falls through the cracks.
  - All messages are automatically accompanied by the complete patient chart.
  - Written “conversations” between providers are documented.
  - Patient-care tasks can be assigned to specific providers or to pre-established pools of providers through the messaging system, and responses are tracked.
  
- Complete documentation is available for decision-making; it also improves the physician’s legal defense should a claim be filed.
  - Documentation is automatic and consistent.
  - Transcriptions and chart notes are directly filed and available in real-time; missing transcriptions are identified.
  - Complete information is saved in the patient’s chart regarding all tests ordered.
  - All prescriptions are documented in the patient’s chart.
  - 100% of conversations with patients are documented in real-time, regardless of where the caregiver is located (main office, satellite office, hospital or home).
  - Messages and responses are documented with date, time, and content.
  - Phone conversations with patients are documented with date, time, and content.
  
- HIPAA compliance is maintained and an audit trail is available for back-up.
  - Charts are never removed from the office, minimizing risk to patient privacy.
  - HIPAA audit trail identifies the particular staff members who have looked at or taken action on specific parts of specific charts.
  - Audit trail allows a misplaced document to be traced, located and filed correctly.
  
- Patients who like their physicians and feel that they are getting good care are less likely to sue. SRS helps practices create happier, more satisfied patients.
  - Physicians are freed to spend more “quality” time with their patients due to increased efficiency and the availability of information “at their fingertips.”
  - Physicians appear to know/remember the patient and the pertinent details of their health care.
  - Test results are always in the chart (filed and routed automatically) during a patient encounter or when a patient calls.

- Patient feels the physician is concerned when the office calls to follow up on a test not completed.
- The office appears calm, organized, and highly professional, inspiring patient confidence.
- Patient requests/calls are responded to very quickly, if not immediately; no need for repeat calls.
- Patients are never put on hold while staff “finds their chart.”
- There are no lost messages, and a message aging report assures that all messages are responded to in a timely manner.
- Increased convenience—prescription pick-up requires only one trip to the pharmacy, with no waiting, since prescriptions are at the pharmacy before the patient even leaves the office and are filled before the patient gets there.
- Patients have increased confidence in the care they receive from physicians whose offices are technologically up-to-date.

Busy, successful practices adopt the SRS EHR to enhance patient care, efficiency, productivity and practice growth. Malpractice insurers recognize the value as well, and the ability to negotiate a discounted premium is another benefit that accrues to practices with SRS.

<sup>1</sup>Virapongse, MD, MPH; Bates, MD, MSc; Shi, MA; Jenter, MPH; Volk, MHS, Kleinman, ScD; Sato, MD; Simon, MD, MPH. Electronic Health Records and Malpractice Claims in Office Practice. Arch Intern Med. 2008;168(21):2362-2367.