

# Medical Records Law: Regulatory Issues – Meaningful Use? EHR v. EMR



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# Introduction

Meaningful Use – what does it mean to you?

Differences between EHR and EMR

# Meaningful Use – what does it mean to you?

1. History of Meaningful Use (MU)
  - a) February 2009 – American Recovery and Reinvestment Act (ARRA)
  - b) ARRA contained provisions related to Health Information Technology for Economic and Clinical Health Act (HITECH Act)
    - i. Provided for incentive payments to Eligible Professionals (EPs) and eligible hospitals that participate in Medicare/Medicaid programs who adopt and “meaningfully use certified electronic health record (EHR) technology
  - c) January 13, 2010, Centers for Medicare and Medicaid Services (CMS) publishes proposed rule addressing requirements for EPs and eligible hospitals to receive the incentive payments for use of EHR technology.
  - d) July 28, 2010, CMS issues final rule on “meaningful use” requirements under the EHR incentive program
  - e) September 26, 2010, final rule becomes effective
  - f) October 1, 2010, implementation of final rule

# Meaningful Use – what does it mean to you?

1. Evolution of Meaningful Use (MU)
  - a) CMS receives numerous comments to proposed rule.
  - b) American Hospital Association (AHA) commented on issues related to MU including:
    - i. Definition of hospital based professional – as written would severely limit # of docs eligible for MU
    - ii. AHA concerned about “all or nothing” approach to MU.
    - iii. Concern focused on EPs requirement to meet 25 objectives and eligible hospitals to meet 23 objectives to qualify for MU
    - iv. Most thought that CMS objectives were unattainable
    - v. Final rule addressed concerns:
      - a. CMS provided flexibility for EPs and eligible hospitals to meet MU requirements

# Meaningful Use – what does it mean to you?

1. Eligibility for MU incentive – who can get it?
  - a) A Medicare EP is basically a physician
    - i. Physician assistants, Nurse Practitioners, etc. are not eligible for Medicare EHR program
    - ii. Of note – Physicians who participate in Medicare EP cannot also take part in Medicaid EHR program
  - b) A Medicare eligible hospital is a hospital paid under the Prospective Payment System (PPS)
    - i. Unlike docs, hospitals can participate in Medicare fee-for-service EHR program, Medicare Advantage EHR incentive program, or Medicaid EHR incentive program.
  - c) Medicaid EPs include additional provider types:
    - i. Physicians, nurse midwives, dentists
    - ii. May also include physician assistants in Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)

# Meaningful Use – what does it mean to you?

## 1. Demonstrating MU – What must be done?

### a) HITECH sets out three requirements:

- i. MU requires the use of EHRs in a meaningful manner.
  - a. This requirement does not provide much guidance to providers
- ii. The use of certified EHR technology for the electronic exchange of health information
- iii. Certified EHR technology must be used to submit clinical quality data

# Meaningful Use – what does it mean to you?

## 1. Demonstrating MU – What must be done? (cont.)

- a) HITECH also provides:
  - i. CMS will define MU in three (3) stages over five (5) years.
  - ii. Current final rule – Stage One (1)
  - iii. Stage Two (2) – due at end of 2011
  - iv. Stage Three (3) – due at end of 2013

# Meaningful Use – what does it mean to you?

## 1. Demonstrating MU – What must be done? (cont.)

### a) MU Stage 1

- i. Proposed rule had 25 objectives for EPs and 23 objectives for eligible hospitals
- ii. Final Rule – provides providers with more flexibility
  - a. Divides objectives into two categories:
    - 1) “core” group of required objectives
    - 2) “menu set” from which providers choose five (5) to meet MU of certified EHR technology in Stage 1

# Meaningful Use – what does it mean to you?

1. MU Stage 1
  - a) Core Objectives –
    - i. 14 for eligible hospitals
    - ii. 15 for EPs
  - b) Menu Set
    - i. Both EPs and eligible hospitals must choose 5 to be eligible
    - ii. 10 total “Menu Set” options to choose from...
  - c) End result is more flexibility for providers in final rule of Stage 1
  - d) Stage 2 – Stage 3 – might require compliance with Menu set objectives but not certain at the moment

# Meaningful Use – what does it mean to you?

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH))  
– 14 Core Objectives
1. Record patient demographics: More than 50 percent of inpatients' (and emergency room (“ER”) admissions) demographic data, such as gender, race, ethnicity, date of birth and preferred language, must be recorded as structured data.
  2. Record vital signs and chart changes in height, weight, blood pressure, and body mass index: More than 50 percent of inpatients (and ER admissions) two years of age and older must have these values recorded as structured data.
  3. Maintain an up-to-date problem list of current and active diagnoses: More than 80 percent of inpatients (and ER admissions) must have at least one entry recorded as structured data.

# Meaningful Use – what does it mean to you?

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 14 Core Objectives
  - 4. Maintain an active medication list: More than 80 percent of inpatients (and ER admissions) must have at least one active medication entry recorded as structured data.
  - 5. Maintain an active medication allergy list: More than 80 percent of inpatients (and ER admissions) must have at least one medication allergy entry recorded as structured data.

# Meaningful Use – what does it mean to you?

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 14 Core Objectives
  - 6. Record smoking status for patients thirteen years of age or older: More than 50 percent of inpatients (and ER admissions) thirteen years of age and older must have smoking status recorded as structured data.

# Meaningful Use – what does it mean to you?

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH))
  - 14 Core Objectives
    - 7. Provide an electronic copy of hospital discharge instructions at discharge, on request: More than 50 percent of all patients who are discharged from the inpatient or ER of a hospital, and who request electronic discharge instructions, must be provided with it. The purpose of this objective is to provide the option to patients to receive their discharge instructions electronically. Discharge instructions would not necessarily be included in a copy of health information and it is unlikely that a patient would request a copy of their health information at every discharge. Note that this requirement was 80 percent in the proposed rule.

# Meaningful Use – what does it mean to you?

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH))
  - 14 Core Objectives
  - 8. On request, provide patients with an electronic copy of their health information, including e.g., diagnostic test results, problem list, medication list and medication allergies: More than 50 percent of requesting patients must receive their electronic copy within three business days. Note that this requirement was 80 percent within 48 hours in the proposed rule.
  - 9. Use computerized provider order entry (“CPOE”) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines: More than 30 percent of patients with at least one medication in their medication list must have at least one medication entered through CPOE. Note that this requirement was 10 percent of any type of order in the proposed rule.

# Meaningful Use – what does it mean to you?

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 14 Core Objectives
  - 10. Implement drug-drug and drug-allergy interaction checks. Functionality must be enabled for these checks for the entire reporting period.
  - 11. Implement capability to electronically exchange key clinical information, such as the problem list, medication list or diagnostic test results, among providers and patient-authorized entities. Perform at least one test of the EHR's capacity to electronically exchange information.

# Meaningful Use – what does it mean to you?

## A. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 14 Core Objectives

12. Implement one clinical decision support rule related to a high priority hospital condition and ability to track compliance with the rule. Note that the proposed rule would have required implementation of five clinical decision support rules.
13. Implement systems to protect privacy and security of patient data in the EHR. Providers should conduct or review a security risk analysis, implement security updates as necessary, and correct indentified security deficiencies.
14. Report clinical quality measures to CMS or the State Medicaid agencies.<sup>48</sup> Clinical quality measures are discussed in more detail below

# Meaningful Use – what does it mean to you?

1. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 14 Core Objectives – comments
  - a) Number 9 – CPOE is defined as use of computer assistance to directly enter medical orders – medications, labs, consults etc.
    - i. Stage 1 does not require orders to be transmitted electronically
    - ii. CPOE requirement actually increase from proposed rule to final rule (10% to 30%) respectively and added Emergency Department (ED) orders
    - iii. Final Rule – limits CPOE to medication orders for patients with at least one medication on their medication list (so threshold is higher (30%) but relates to smaller set of transactions

# Meaningful Use – what does it mean to you?

1. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 14 Core Objectives – comments
  - a) Number 12 – MU requires that eligible hospitals and CAHs implement security measures – final rule does not specify the measures (except that they are HIPAA compliant – refers to administrative safeguards where security standards defined in HIPAA)
  - b) Number 14 – ties to HITECH requires EHR technology to be used to submit clinical quality data
    - i. 2011 – data does not have to be transmitted electronically
    - ii. Quality data must be tracked
    - iii. Electronic submission to begin in 2012

# Meaningful Use – what does it mean to you?

1. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 15 required to submit clinical quality measures – See Core Measure Number 14
  - a) Quality measures fall into three categories:
    - i. ED
    - ii. Stroke
    - iii. Venous Thromboembolism prevention treatment

# Meaningful Use – what does it mean to you?

- A. 15 quality measures Eligible Hospitals must report:
1. ED Throughput – median time from ED arrival to ED departure for patients admitted to the facility from the ED.
  2. ED Throughput – admission decision time to ED departure time for admitted patients.
  3. Ischemic Stroke – Discharge on antithrombotics.
  4. Ischemic Stroke – Anticoagulation for A-fib/flutter.
  5. Ischemic Stroke – Thrombolytic therapy for patients arriving within two hours of symptom onset.
  6. Ischemic or Hemorrhagic Stroke – Antithrombotic therapy by day two.
  7. Ischemic Stroke – Discharge on Statins.

# Meaningful Use

- A. 15 quality measures Eligible Hospitals must report:
8. Ischemic or Hemorrhagic Stroke – Stroke education.
  9. Ischemic or Hemorrhagic Stroke – Rehabilitation assessment.
  10. Venous Thromboembolism (“VTE”) prophylaxis within 24 hours of arrival.
  11. Intensive Care Unit VTE prophylaxis.
  12. Anticoagulation overlap therapy.
  13. Platelet monitoring on unfractionated heparin.
  14. VTE discharge instructions.
  15. Incidence of potentially preventable VTE.

# Meaningful Use

1. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 10 Menu Set Objectives
  - a) Some Menu Set Objectives are new in Final Rule
  - b) Menu Set Objectives have lower threshold than in proposed rule
  - c) Allows for flexibility
  - d) Hospitals need only choose Five (5) of the Menu Set Objectives to be in compliance for MU

# Meaningful Use

## A. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 10 Menu Set Objectives

1. Implement drug formulary checks.
2. Incorporate clinical laboratory test results into EHRs as structured data.
3. Generate lists of patients by specific condition to use for quality improvement, reduction of disparities, research or outreach.
4. Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.
5. Perform medication reconciliation between care settings.

# Meaningful Use

- A. Eligible Hospitals (includes Critical Access Hospitals (CAH)) – 10 Menu Set Objectives
  - 6. Provide summary of care record for patients referred or transitioned to another provider or setting.
  - 7. Submit electronic immunization data to immunization registries or immunization information systems.
  - 8. Submit electronic syndromic surveillance data to public health agencies.
  - 9. Record as structured data whether a patient 65 years or older has an advanced directive.
  - 10. Submit electronic data on reportable laboratory results to public health agencies.

# Meaningful Use

1. How does Hospital demonstrate MU?
  - a) From October 1, 2010 through September 30, 2011, hospital must meet MU requirements for ninety (90) consecutive days
  - b) Hospitals can still implement MU program if begin MU demonstration by July 1, 2011
  - c) 2012 – hospitals must also submit quality measures electronically as well as meet MU requirements
  - d) Stage 2 – not known what will follow at this time

# Meaningful Use

## 1. Hospital Incentive

- a) How are incentives calculated under MU/EHR program
  - i. Medicare FFS hospitals – incentive calculated by adding together a base amount of two (2) million dollars per eligible hospital plus a per discharge amount and multiplying that number by a “Medicare share” times a applicable transition factor
    - a. The per discharge amount is zero for the first through 1,149<sup>th</sup> discharge
    - b. The per discharge amount is \$200 for the 1,150<sup>th</sup> through the 23,000<sup>th</sup> discharge
    - c. Discharges in excess of 23,000 the amount is zero – effectively capping discharge incentive to hospital

# Meaningful Use

## 1. Hospital Incentive

- a) “Medicare share” is calculated as follows:
  - i. Numerator is the estimated Medicare Part A and Medicare Advantage inpatient-bed days
  - ii. Denominator is total number of inpatient-bed days multiplied by a charity care ratio
- b) The effect of this factor would be to decrease denominator as the proportion of charity care increases (increasing Medicare share factor) – thereby increasing incentive payments to hospitals for increasing charity care

# Meaningful Use

## 1. Hospital Incentive

- a) Transition factor calculation
  - i. Decreases the incentive payment each consecutive year
  - ii. Equals 1 in 1<sup>st</sup> year
  - iii. Equals  $\frac{3}{4}$  in 2<sup>nd</sup> year
  - iv. Equals  $\frac{1}{2}$  in 3<sup>rd</sup> year
  - v. Equals  $\frac{1}{4}$  in 4<sup>th</sup> year
- b) In 2015 – HITECH provides for market based update to Inpatient Prospective Payment System (IPPS) rate for those eligible hospitals not in EHR program complying with MU
  - i. Reduction will apply to  $\frac{3}{4}$  of % increase otherwise applicable
  - ii. Reduction will be phased in over 3 years
    - a. 2015 – reduction =  $\frac{1}{4}$  %
    - b. 2016 – reduction =  $\frac{1}{2}$  %
    - c. 2017 – reduction =  $\frac{3}{4}$  %

# Meaningful Use

## 1. Hospital Incentive

- a) CAHs are paid incentives differently than PPS hospitals
- b) CAH receives an incentive for its reasonable costs incurred for purchasing of certified EHR technology
- c) Final rule – Stage 1 sets reduction of payment for CAHs beginning in 2015 if CAH is not MU for a payment year

# Meaningful Use

## 1. Eligible Professional (EP) Incentive Payment Requirements

### a) Core Objectives

- i. Largely resemble Hospital Core
- ii. EPs have 15 Core Objectives – which all must be satisfied as opposed to 14 for Hospitals/CAHs
- iii. 15<sup>th</sup> Core Objective unique to EPs is:
  - a. EPs are required to provide a clinical summary to the patient within three (3) days of a visit for at least 50% of patient visits.
- iv. A variation for EPs not in Hospital Core Objectives is that EPs are required to submit 40% of “permissible prescriptions” electronically

# Meaningful Use

1. Eligible Professional (EP) Incentive Payment Requirements
  - a) Permissible Prescriptions
    - i. Exclude Schedule II controlled substances
      - a. However, DEA interim final rule published March 2010 indicates Schedule II drugs are now “permissible”
      - b. CMS commented that Stage 1 will not require compliance with DEA regs – this might change in Stage 2 with CMS continued efforts to work interagency on regulations
  - b) Final Rule reduced EP threshold for satisfaction of CPOE criteria to 30% of medications ordered must be through CPOE
    - i. Differs from eligible hospitals – which was increased in final rule (10% to 30%)

# Meaningful Use

1. Eligible Professional (EP) Incentive Payment Requirements
  - a) Final Rule – created more flexibility with EP
  - b) Menu Set objectives for EP
    - i. Must select five (5) of ten (10) to be MU for EHR Incentive Program

# Meaningful Use

1. Eligible Professional (EP) Incentive Payment Requirements
  - a) Menu Set objectives for EP (unique to EP)
    - i. Requirement that physicians must distribute reminders to patients electronically (must be provided to more than 20% of patients – in appropriate population sets).
    - ii. EPs must provide 10% of all patients with information such as lab results and patient education materials
  - b) In order to be eligible for MU incentive payments EPs must see at least 50% of patients in facility with EHR capabilities
    - i. If EP sees patient in facility without EHR capability – such services are excluded from numerator and denominator in determining any rate-specific EHR use requirements for calculation of incentive payment

# Meaningful Use

1. Eligible Professional (EP) Incentive Payment Requirements
  - a) EPs must simply submit an attestation claiming compliance with Stage 1 Medicare Payment Criteria in 2011
  - b) EPs must also submit the required clinical quality data by attestation in 2011
  - c) 2012 – EPs must be prepared to electronically report clinical quality data

# Meaningful Use

1. EP quality data – required for eligibility
  - a) General and Specific
    - i. General – core measures
    - ii. Specific – as to specialty
  - b) Though required to report – nothing in final rule requires EP to meet certain quality thresholds to be in compliance

# Meaningful Use

1. EP quality data – must report on at least six (6) measures
  - a) Three (3) core measures – EPs must report level of screening and treatment for the following:
    - i. Hypertension
    - ii. Tobacco use assessment and cessation
    - iii. Adult weight screening
  - b) Three (3) specific – as to specialty
  - c) If 3 core measures do not apply to EP practice
    - i. EP must then choose 3 alternate core measures to report including:
      - a. Adolescent weight assessment
      - b. Adult influenza immunization
      - c. Childhood immunization

# Meaningful Use

1. EP quality data – must report on at least six (6) measures
  - a) Three (3) specific – as to specialty
    - i. Specialty Specific Measures – 38 of them in final rule
    - ii. Each EP must select 3
    - iii. For example, EP may select the following specific measure:
      - a. Diabetic BP management
      - b. Diabetic eye exam
      - c. Diabetic foot exam

# Meaningful Use

1. EP quality data – Specific measures
  - a) Intended to give EP flexibility
  - b) MU EHR Program is NOT tied to outcomes for EPs
    - i. Program is totally “voluntary”
    - ii. Reporting is all that is required

# Meaningful Use

## 1. EP Incentive Payment Calculation

- a) Must satisfy Stage 1 EHR use and quality reporting requirements
- b) Incentive payment calculation:
  - i. =  $\frac{3}{4}$  of EPs allowed annual Medicare charges
  - ii. Capped on the high end
  - iii. 2011 – capped at \$18,000
  - iv. Cap is similar to eligible hospitals except that EP cap is expressed as a defined monetary sum as opposed to 23,000 discharges

# Meaningful Use

## 1. EP Incentive Payment Calculation

- a) Incentive payment calculation:
  - i. Program decreases rewards to EP over five (5) years
  - ii. Illustrated decreases as follows:
    - a. Year 1 - \$18,000 – 2011
    - b. Year 2 - \$12,000 – 2012
    - c. Year 3 - \$8,000 – 2013
    - d. Year 4 - \$4,000 – 2014
    - e. Year 5 - \$2,000 – 2015
  - iii. So for EP demonstrating compliance with program in 2012 would be eligible for a total of \$44,000 in incentive payments

# Meaningful Use

## 1. EP Incentive Payment Calculation

### a) Incentive payment calculation:

i. EPs demonstrating compliance with program AFTER 2012 experience comparatively reduced eligibility for incentive payments

a. For example, EP demonstrating compliance in 2013

- 1) Payments initially will be capped at \$15,000
- 2) 2014 – drops to \$12,000
- 3) 2015 – drops to \$8,000
- 4) 2016 – drops to \$4,000

b. Thus a 2013 EP compliant will only collect a total of \$39,000 in incentive payment as opposed to 2012 EP compliant who will be paid \$44,000

# Meaningful Use

## 1. EP Incentive Payment Calculation

### a) Incentive payment calculation:

i. EPs demonstrating compliance with program AFTER 2012 experience comparatively reduced eligibility for incentive payments

a. For example, EP demonstrating compliance in 2014

1) 2014 –\$12,000

2) 2015 – drops to \$8,000

3) 2016 – drops to \$4,000

b. Thus a 2014 EP compliant will only collect at total of \$24,000

c. EPs compliant in 2015 get no incentive payment

# Meaningful Use

## 1. EP Incentive Program

- a) Post 2015 – Failure of EP to adopt EHR technology will subject EP to penalties
  - i. EPs can expect to see reduction in Medicare fee schedule payments
    - a. Reimbursement for non-compliant EPs will be reduced by 1% at that time
    - b. EPs not compliant with EHR technology as well as not compliant with electronic prescriber provisions by 2014 receive 2% reduction in 2015

# Meaningful Use

## 1. EP Incentive Program

- a) 2016 – Failure of EP to adopt EHR technology will subject EP to penalties
  - i. Continued failure to be compliant post 2015 – subjects EPs to 2% reduction in Physician Fee Schedule (PFS) in 2016
  - ii. Breakdown for reduction of reimbursement for non-compliance by EPs under PFS is as follows:
    - a. 2015 – reduced by 1%
    - b. 2016 – reduced by 2%
    - c. 2017 – reduced by 3%
    - d. 2018 – reduced by 4% (could be 5% if not electronic prescriber)
    - e. CMS can reduce physician payments by 5% in 2018 if total % of EPs who are MU is below 75%

# Meaningful Use

## 1. EP Incentive Program

- a) Hospital Based Eligible Professionals (HBEP)
  - i. HBEP – are not eligible to receive MU incentive payments
  - ii. How is HBEP determined?
    - a. Much controversy
  - iii. HBEP – not eligible because they practice in hospital setting
    - a. Relies on hospital to purchase technology – no risk to HBEP

# Meaningful Use

## 1. EP Incentive Program

### a) Hospital Based Eligible Professionals (HBEP)

#### i. Determination of HBEP status:

- a. Resolves around practice location/site of service
- b. Originally (Proposed Rule) HITECH
  - 1) HBEP was defined as “all physicians providing substantially all services in the hospital, either IP/OP”
  - 2) Final Rule re-defined based on comments
- c. Subsequent rule making (April 2010 Continuing Extension Act) – removed EPs practicing in HB outpatient settings from definition of HBEP (this is definition in final rule)

# Meaningful Use

## 1. EP Incentive Program

### a) Timing Issues

- i. CMS began registration in program in January 2011
- ii. Both EPs and eligible hospitals must register with CMS to participate
- iii. Prospective EPs and eligible hospitals will be able to register through CMS' registration and attestation system, part of the EHR Incentive Program website
- iv. Determinations of MU in 2011 simply require EP/hospital submission of attestation of compliance
  - a. Can be done on CMS EHR Incentive Program Website  
<http://www.cms.gov/EHRIncentivePrograms>
  - b. Can be submitted in April 2011
  - c. Incentive payments expected to begin in May 2011

# EHR versus EMR

- Health care people use EHR and EMR interchangeably
  - However, each is quite different
  - EMR – “Electronic Medical Record”
  - EHR – “Electronic Health Record”
- EMR
  - First introduced – used by clinicians for Dx and Tx
  - However, the word “health” relates to:
    - The condition of being sound in body, mind, or spirit, especially...freedom from physical disease or pain...the general condition of the body.”
    - In short, the word “health” covers more than “medical” – it stands to reason then that EHRs are more detailed than EMRs

# EHR versus EMR

- What is the difference then between EMR/EHR?
  - EMRs
    - Are a digital version of paper charts in the clinician's office.
    - EMRs contain the medical Tx history of the patients in one practice.
    - EMRs have advantages over paper records that allow clinicians to do just a few of the following:
      - Track data over time
      - Easily identify which patients are due for preventative care
      - Check patient outcomes
      - Monitor overall care of patient within the practice
    - BUT – information does not flow easily out of the “practice” setting. EMRs might have to be printed/delivered to other clinicians outside of the practice – big disadvantage.

# EHR versus EMR

- What is the difference then between EMR/EHR?
  - EHRs
    - Do everything an EMR can do +
    - Focus is more on total health of patient – broader view of patient’s health status
    - Designed to reach beyond the boundaries of the “practice” (unlike EMRs)
    - Designed to share information across platforms and amongst many health care providers
      - Including labs, specialists, other hospitals etc.
    - In this case, the medical information moves with the patient – not with the practice
    - Both clinicians (across the board – from different states etc.) and patient has access to information in EHR.
    - Assists with team approach to health care treatment!

# EHR versus EMR

- What is the difference then between EMR/EHR?
  - EHRs cont.
    - When multidisciplinary approach toward health care treatment is applied (best practices) and health information is able to be shared across platforms and with the various providers – allows for more patient-centered care.
    - EHRs can:
      - The information gathered by a PCP can tell an ER physician about patient's allergies – even if patient is unconscious
      - A patient can log on to his or her own record and see the trend of lab results over time – which might help from motivation standpoint
      - Lab results are instantaneous
      - Physician notes are immediately accessible for discharge use – no discharge delays

# Questions or Comments Please contact:

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