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Your Direct Link to Better Risk Management Practices

Electronic Health Records:
Can you Practice without Them?
Introduction to the Series on Electronic Health Records (EHRs)* and other Safety-Enhancing Technologies

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So why the ominous title of this article in *Risk Review*: "Electronic Health Records: Can You Practice without Them?" Especially for those physicians who didn't learn to type before they could write script, this is a real conundrum.

Will physicians be forced to implement them? Primary care physicians in the Partners HealthCare System who have not implemented Electronic Health Records (EHRs) by January 1, 2008, or committed to implement them by January 1, 2009, are out of the Partners network, according to Tom Lee, CEO of Partners Community HealthCare, the physicians network of the Boston-based hospital system (including Massachusetts General, Brigham & Women's and other Harvard-affiliated institutions).

Even in lieu of a mandate, will those who finance their care (both in the public and private sectors) reimburse preferentially those physicians who use EHRs (for prescriptions and other orders, production and release of quality and safety performance reports, etc.)? On October 26th, Department of Health and Human Services (HHS) Secretary Michael Leavitt announced a five-year pilot in which CMS will pay 1200 physicians in a dozen communities commensurately more (probably in the thousands of dollars annually) to physicians who use EHRs and other safety-enhancing electronic technologies (including ordering prescriptions or recording the results of lab tests). The highest payments will go to those physicians who most aggressively use these technologies and score the highest in an annual evaluation.

What is the difference between the EHRs' theoretical benefits and their
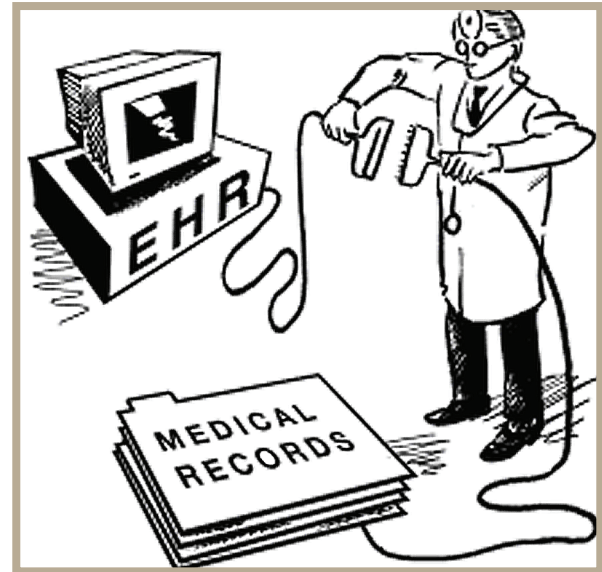
actual functionality? How can EHRs be used to decrease risk, and to avoid using them in ways that might increase risk?

The Practice of Medicine in the "Good Old Days"

For centuries, perhaps even millennia, communication in the practice of medicine has relied upon communication by word (whether in-person or on the telephone) or handwritten medical histories, physical examination findings, diagnostic impressions, therapeutic recommendations and orderings, progress notes and other components of a complete medical record.

Until fairly recently, the practice of medicine (and, more broadly, healthcare delivery) could be carried out successfully using these comfortably familiar communication vehicles and methods. Physicians and their patients were satisfied that they were providing and receiving good care, respectively. There was no compelling need to upset this equilibrium with any disruptive, expensive new technology, regardless of its purported potential to improve the safety, quality and efficiency of care delivery.

Because of the current, broader use of the term in the industry, the term "electronic health records"' or "EHRs" will be used in this article to include "electronic medical records" also (please refer to the discussion of the subtle differences between the two in this article in this edition of Risk Review)

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Enter the 21st Century

Unfortunately for many physicians, the healthcare industry (and the practice of medicine with it) is finally getting swept into the electronic information age. Because this change has been so delayed in health care (especially in medical practice) as compared to that occurring in other areas (e.g. financial and transportation services), the transformation is now occurring at warp speed. This is being driven by some of the major household names in information technology (e.g. Microsoft and Google, among many others), which have realized the tremendous opportunities in the (still) relatively undeveloped $2.3 trillion healthcare industry (see the article "Dr. Google and Dr. Microsoft" ; New York Times; August 14, 2007

In addition, those in the public and private sectors who ultimately pay for health care, including physicians' fees, have come together with unprecedented clout to demand that physicians demonstrate the value (i.e. quality and cost effectiveness) of the care that they provide. Not only the federal government, but almost 1000 major corporate purchasers of care (and the health plans they provide to their tens of millions of employees and their dependents) have joined in a "Value-Driven Healthcare Initiative" launched by President Bush and HHS Secretary Leavitt a little over a year ago now. (http://www.hhs.gov/valuedriven)

Like it or not, physicians who want to continue practicing medicine with any degree of financial success in the next decade and beyond must prepare themselves for the inevitable transition into this electronic information age. There can be real improvements in quality, safety and risk management for those making this transition. View this article in this issue of *Risk Review* for one physician's experience with EHRs. We will introduce some of these benefits below, as well as the key potential medical legal pitfalls and how to avoid them.

Benefits to Physicians Using Electronic Health Records and Other Safety-Enhancing Technologies

To be successful in this emerging era of value-driven health care, physicians will need to embrace the following functionalities of EHRs and other safety-enhancing technologies:

• **Improved aggregation, analysis and communication of patient level information —** permitting the consideration of all aspects of a patient's condition prior to making diagnoses, or decisions to hospitalize, discharge or to obtain additional tests, procedures or consultations;

• **Diagnostic decision support —** providing instantaneously accessible results from laboratory, radiology and pathology, as well as procedures and consultations from a wide range of sources;

• **Therapeutic decision support —** integrating EHRs which have been certified by the Certification Commission for Healthcare Information Technology (CCHIT) with the best evidence-based clinical decision support systems to ensure the delivery of the most appropriate therapies;

• **Prevention of adverse events —** by building in guards against prescribing drugs and other treatments, which, based on patients'

current medications, lab results, kidney function, body weight, age, allergies and other factors captured in the electronic database, could result in adverse events, preventable injuries and the medical legal basis for possible litigation;

• **The employment of clinical alerts and reminders —** providing the latest indicated screening tests to detect life-threatening conditions in early, treatable forms or adequately monitoring chronic ailments to prevent their complications; and

• **The use of the electronic record for clinical quality improvement research —** to keep ahead of the ever-increasing standard of care by electronically capturing, monitoring, evaluating and improving clinical practices continuously. *(Couch, J.B, CCHIT Certified Electronic Health Records and other Safety Enhancing Technologies: Medical Legal Risk Management Benefits, Pitfalls and Safeguards; CCHIT; Chicago (2007))* at;

   http://www.cchit.org

Some Risks in Using Electronic Health Records and How to Avoid Them

In addition to the benefits of using EHRs, there are also some definite risks. The following section will introduce those as well as some safeguards for avoiding them.

Some of these risks (and potential safeguards) include:

• **New federal rules permitting the broad discoverability of electronic records in legal actions,** which were recently adopted by New Jersey. In general, EHRs are to be treated as "business records" so that they are admissible in legal actions under the business records exception to discoverability. Some exceptions to discoverability include those reproduced for infection control and other peer review committee meetings, draft electronic documents (e.g. e-mail, voice mail, e-annotations, instant messages, etc. and personal health records or PHRs).

   When drafting policies and procedures for the EHR, some areas need special attention if the electronic record is to be defined as the legal health record for a patient… For example, cutting, copying and pasting may be efficient for the clinician, but there are risks associated with it. The note may go into the wrong patient's chart. If another person composed the original entry, the original author may object to having her written material used without knowledge or permission. Before organizations create a policy on cutting, copying and pasting, they should investigate limitations of the technology to ensure software compatibility and avoid the production of unreadable notes. Quinsey, CA, Policies and Procedures for a Legal EHR; Journal of AHIMA; 78(4):62-63 (April, 2007)

   Similarly, organizations' policies should detail how digital photographs and videotapes concerning a patient's condition are to be stored for safekeeping or disclosed. In addition, all verbal orders will be accurately time- and date- stamped, making it

clear when, according to federal and state laws and accreditation requirements, they need to be signed. Finally, there must be policies for physicians to electronically acknowledge their review of test results, which guide their clinical decisions (see below). *Quinsey, CA, Policies and Procedures for a Legal EHR; Journal of AHIMA; 78(4): 62-63 (April, 2007).*

• **Easily demonstrable deviations from best evidence based practices,** especially when physicians delete, change or otherwise ignore these safety features. Doing so may produce an easily discoverable audit trail for a plaintiff's attorney in cases arising from failing to respond to clinical alerts or easily accessible best practice guidelines (see the preceding section of this article for these and other features of certified electronic health records). According to Marilyn Lamar, Esq., a leading healthcare IT attorney, to minimize this risk, physicians must be able to use electronic systems that permit them to document their rationale for not taking into account available online data, provide prompts to discuss certain information with patients at every visit, and to periodically review and read just the controls on these alerts and those warning of potential adverse reactions. This, she says, will avoid building up a discoverable electronic record documenting the ignoring of these risks.

> Physicians need to know how to use their electronic systems as a justifiable shield against unwarranted medical liability claims. They need to document their clinical rationale for not following alerts or tamping down their sensitivity. Electronic health records must have required prompts for physicians to justify clinically their overriding of alerts or practice guidelines.

Physicians also need to be able to use the graphics capabilities of electronic health records illustrating patient care results to document the effectiveness of the care provided and justify the subsequent clinical decisions made or not made. All of these features need to be available in electronic health records *(Cf. Couch citation, above).*

• **Inappropriate altering of electronic health records,** which, as with paper records, could raise the issue of a potential "cover up" (that can be even worse legally for defendant physicians than their underlying negligence, if any even exists). According to Mark Leavitt, M.D., Ph.D., Chairman of the Certification Commission for Healthcare Information Technology (or CCHIT), the latest CCHIT-certified electronic health records "….have the capability to prepare an audit of who has accessed the medical record and the ability to 'lock' the record once it is created, not allowing an alteration of the record without leaving a record of the alteration." This feature of certified electronic health records should provide an opportunity to physicians needing to alter a medical record to justify a clinical course of action subsequently taken, providing a more defensible record *(see Couch citation, above).*❖

Happy Holidays!