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EDITOR'S LOG

Moment of Truth Edges Closer for Electronic Records Mandate

By Daniel Redwood, DC

Electronic health records (EHR) have burst onto the scene as a central component of efforts by federal and state governments to streamline the nation's health care system. Ideally, EHR promises to improve quality and decrease cost by enabling providers to organize and communicate patient-related information with levels of speed and efficiency only dreamed of in the past.

Over the next few years, individual chiropractors (and other health professionals) face a stark choice: either become players in this integrated system or be consigned to an island status outside the mainstream, facing not only isolation but escalating penalties for failure to participate. Whether doctors like it or not, the evidence is now overwhelming that during the next decade EHR will become as commonplace at American health care facilities as computers or telephones.

High Hopes, Pragmatic Goals

The goals of health information technology (HIT) enthusiasts extend far beyond saving one's office notes in an electronic format instead of a handwritten paper-based chart. Among the purposes of EHR are to format patient information so that the doctor can instantaneously bring desired data to the top of the chart as needed; to have built-in prompts and reminders to improve quality of care; to enable seamless two-way transmission of information among doctors, hospitals and others with a legitimate need to know; to prevent and detect fraud; to provide an opportunity to reimburse providers for best outcomes; and to enable researchers to access large quantities of data in efforts to determine the relative effectiveness of competing treatments. What remains unknown is the extent to which EHR can live up to these high hopes while keeping unintended side effects to a minimum.

Carrots and Sticks

Economic stimulus legislation signed into law by President Obama in early 2009 set in motion procedures that will enable many doctors to be reimbursed for investing in health information technology. In some cases, this could reach as high as $44,000 per physician. But according to current plans, there will be a limited window of time during which such reimbursement will be available and then only for software that meets the government's exacting specifications for interoperability.

From the perspective of new chiropractors or those with smaller practices, one possible sticking point is that it is not yet clear whether doctors must surpass a minimum $25,000 per year threshold in approved Medicare billings in order to qualify for reimbursement from the federal government. If, as early reports indicated, such a threshold were to be included in forthcoming federal regulations, it would run counter to the legislation's stated intent of removing financial impediments for all providers to go digital, as it would make conversion easier for those who can afford it most without helping those who can afford it least. As we go to press, it appears possible that the regulations will include reimbursement on a pro-rated basis for doctors not meeting the $25,000 threshold. Such a policy decision would be both effective and just.

If stimulus funds for doctors implementing EHR are the carrot, then laws punishing noncompliance are the stick. A handful of states have passed statutes requiring all health providers to implement a certified EHR system within the

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next several years as a condition for being able to continue to practice. Minnesota, for example, has mandated a 2015 deadline. "Chiropractic clinics" are specifically included on the long list of provider types that will need to implement EHR or shut down.

Questions Not Yet Answered

There is clearly a mystique surrounding EHR. Listening to its proponents, one hears promises of a glittering future in which clarity, speed, and organization will lead to enhanced quality of care, improved health outcomes and substantial cost savings across the health care system.

But whenever I hear such visions of a coming golden age, particularly one that is dependent on the legally mandated purchase of a very expensive product, I find it helpful to look beneath the shining surface and to ask whether an unexamined shadow lurks below.

In this case, a number of potential pitfalls are worth exploring. The most obvious is privacy – will EHR lead to an erosion of centuries-old protections of doctor-patient confidentiality? The answer appears to be that safeguards are currently in place, but none are fully tamper-proof. Even if we judge that the current political climate in the United States supports an adequate degree of confidentiality, who can say with assurance that creation of permanent electronic health records will not open the door to future abuses in an era less tolerant of individual liberty?

But there is an even more significant and pressing question about going nationwide with EHR. Are these highly touted systems as functional as their proponents claim, particularly proponents who have a financial or career-building stake in closing the biggest sale of their lives? In the rush toward across-the-board EHR, the voices in favor are currently drowning out those expressing serious doubts. One has to dig deep to find out why anyone would oppose these massive changes.

Rather than attempt to cover the full range of questions raised by those skeptical of the EHR juggernaut, I want to suggest as a starting point two sources to examine and consider. These were recommended to me by Marc Micozzi, MD, PhD, a member of our *Health Insights Today* editorial board. The first is an article by Koppel and Kreda[1] published in the *Journal of the American Medical Association* in March 2009, which notes that "health care information technology (HIT) vendors enjoy a contractual and legal structure that renders them virtually liability free—"hold harmless" is the term of art—even when their proprietary products may be implicated in adverse events involving patients. This contractual and legal device shifts liability and remedial burdens to physicians, nurses, hospitals, and clinics, even when these HIT users are strictly following vendor instructions." This is reminiscent of the legal immunity granted to manufacturers of vaccines and nuclear power plants. Why are EHR software companies being granted similar protections? I'm not certain, but the question clearly needs to be asked. And answered.

The second source I recommend for clues as to how things can go wrong is a chilling and intentionally provocative eight-part blog post by Scot Silverstein, MD, a medical informatics specialist at the College of Information Science and Technology at Drexel University in Philadelphia. Dr. Silverstein is alarmed by EHR program dysfunctions he has witnessed in hospitals, some of which involved life-threatening risks. He asserts that these dysfunctions are the rule, not the exception, and provides specific examples to buttress his case. He sees current moves to take EHR system-wide as constituting "an outrageous cross-occupational piracy with doctors' time, professions, and ability to deliver care held hostage … It is unbelievable to me that a system like this could be put into production in a hospital. Simply unfathomable … These 'user experiences from hell' are causing clinician cognitive overload, distracting

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and tiring them, and due to violations of fundamental good practices in information display, actually **promoting error** [emphasis in original].” Read Silverstein’s full commentary, click on his links, and then ask yourself how it all squares with government and vendor descriptions of EHR functionality.

Good policy results from thoroughly examining all sides of an issue. Despite the “freight train barreling down the track” nature of the current push for system-wide implementation of EHR, I remain hopeful that current problems can be corrected. What concerns me most is that we may not know the full ramifications of the shift until it is too late to make a smooth course correction.

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Reference

1. Koppel R, Kreda D. Health care information technology vendors’ “hold harmless” clause: implications for patients and clinicians. *JAMA*. Mar 25 2009;301(12):1276-1278.