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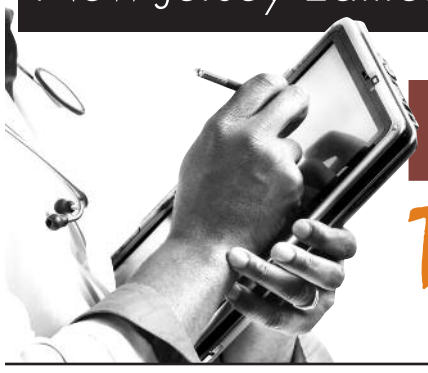

ELECTRONIC HEALTH RECORDS:
The Good, The Bad, and the Uncertain

By Patricia A. **Costante**

A nation-wide system of electronic health records (EHRs) is not a new idea. The concept appeared on the horizon in 2004 when President George W. Bush announced a plan to ensure that all Americans' health records would be computerized within ten years. Now, the concept appears to be on the verge of reality, as President Obama's American Recovery and Reinvestment Act of 2009 (ARRA) is preparing to provide substantial financial incentives ($19.2 billion over five years) to assist physicians with the adoption and implementation of EHRs.

The goal is to improve the quality of healthcare and reduce costs by replacing complex, inefficient, and stagnant paper health records with electronic records. In an ideal world, by 2014 every person in the U.S. would have an electronic health record that is standardized, easily stored, and efficiently transferred from one care provider to another. However, the plan is an ambitious one, with a great many details still to be ironed out. What is clear, though, is that despite the many remaining legitimate concerns about EHRs, physicians must pay careful attention to the standards that are set on EHR systems eligible for the financial incentives, and must start planning now.

U.S. IS SLOW TO CATCH ON

In its 2000 report "Improving Health System Performance," the World Health Organization has ranked the U.S. healthcare system 37th out of 191 countries. The report identified poor use of information technology as the primary reason for this poor rating.

In 2008, a national survey of U.S. physicians, led by Catherine DesRoches at the Institute for Health Policy, Massachusetts General Hospital and printed in the July 3, 2008 issue of the New England Journal of Medicine, confirmed this assessment by uncovering exceptionally low usage rates of EHRs by surveyed physicians. The survey found that only 4 percent of physicians had a fully functional electronic-records system, and only 13 percent had a basic system. Further analysis of the respondents found that physicians who practiced in groups of more than 50 were three times more likely to have a basic electronic-records system and more than four times more likely to have a fully functional electronic-records system than were physicians in groups of 3 or fewer. However, even in large groups, only a small minority (17 percent) had a fully functional system, and 49 percent had no electronic-records system at all. Given the expected value of EHRs, this reluctance to use modern technology may at first seem at odds with physicians' desire to deliver quality healthcare.

THE VALUE OF EHRS

The electronic health record appears to be an efficient way to improve healthcare delivery by tracking information generated by one or more providers. Some industry experts have even predicted that the U.S. could save up to $150 billion annually with Healthcare IT adoption. Among physician respondents in DesRoches' survey who had fully functional electronic-records systems, most reported the following positive effects:

- **improved** quality of clinical decisions
- **improved** communication with other providers and patients
- **improved** number of prescription refills
- **timely** access to medical records
- **avoidance** of medication errors
- **improved** delivery of long-term and preventive care that meets guidelines

Respondents also reported that the use of EHRs assisted in patient care in specific ways, including: averting a known drug allergic reaction or a potentially dangerous drug interaction, being alerted to a critical laboratory value, ordering a critical laboratory test, and providing preventive care.

Physicians with EHRs may be less likely to pay malpractice claims than physicians without EHRs. A recent Harvard Medical School study (published in the November 27, 2008 issue of Archives of Internal Medicine) examined survey responses from 1,140 practicing physicians in Massachusetts and compared the presence or absence of malpractice claims among physicians with and without EHRs. The study revealed that 6.1 percent of physicians with EHRs paid malpractice settlements in the preceding ten years, versus 10.8 percent of physicians without EHRs. However, the results of this study were inconclusive, and confirmatory studies are needed before these results can have policy implications.

The study authors, led by Anunta Virapongse, MD, MPH, proposed that possible reasons for the decrease in paid malpractice claims are logical outcomes of electronic record keeping. Easy access to patients' history may result in fewer diagnostic errors, improved follow up of abnormal test results, and better adherence to clinical guidelines. In addition, it may also be true that electronic documentation, over often illegible and unorganized paper files, can bolster legal defenses if a malpractice claim is filed. But despite the advantages of EHRs, physicians who have not made the move from paper to computer have valid concerns.

VALID CONCERNS

Legislators recognize the financial barrier to a national EHR system, and so the ARRA includes monetary incentives. Starting in 2011, providers deemed to be "meaningful users" of certified EHR systems will receive reimbursements from the Centers for Medicare and Medicaid Services. (The Department of Health and Human Services has until January 2010 to set specific guidelines for determining what constitutes a "meaningful user"; however, the department has specified that e-prescribing, electronic exchange of medical records, and interoperability of systems will be determining criteria. The definition may also include reporting requirements on quality measures.) Physicians who are not hospital-based are eligible for Medicare incentive payments based on an amount equal to 75% of the allowed Medicare Part B charges, up to a maximum of $18,000 for early adopters. Incentive payments would be reduced in subsequent payment years, eventually phasing out. Incentives under the Medicaid program are also available for physicians that meet the volume requirements for treating Medicaid patients; however, physicians who qualify for more than one incentive are eligible to receive only one. Practices with multiple physicians will be eligible to receive incentive payments for each provider.

However, even with these financial incentives, there will be significant costs to physician practices associated with converting to an EHR system, which include not only financial costs, but time and resources as well. Physicians will need to make decisions about how to incorporate training into the daily activities of a medical practice, how to handle the disposition of paper medical records, and how to approach ongoing maintenance and support. And even setting costs aside, physicians still have many concerns about the implementation of EHRs.

Top among them are the unanswered questions regarding patient privacy, security and physician liability. On the one hand, interoperable electronic health records give physicians easy access to a patient's medical history and give the patient a sense of power and control over personal health. On the other hand, both patients and physicians need protection from record tampering by external parties. At this time, these safety and liability obstacles to a national electronic health record are being reviewed with the hope that legislators in partnership with private-sector security and liability contractors can find acceptable answers to these open questions.

THE NEXT STEP

If EHRs are to be used to their optimal potential, with protections in place for both physicians and their patients, much work needs to be done. However, while waiting for the details to be worked out, physicians are encouraged through the parameters of the stimulus package to take the next step now: No incentive payments will be offered to physicians who first become eligible after 2014, and physicians who fail to qualify as meaningful users will face decreases in Medicare and Medicaid payments. Call this an incentive or call it a penalty, it's time for all physicians to accept the inevitable. The future of healthcare includes electronic health records.

Although 2014 seems far away, now is the time to begin considering going electronic, if you haven't already. You will need time to research systems, contact vendors, negotiate terms, and complete implementation and training. You should begin evaluating your patient population to see for which of the incentive programs you qualify, and you should ensure that your billing system will be prepared to handle Medicare electronic prescribing codes and possible new codes that will be required for ARRA incentives. If you already have an EHR in place, you will want to make sure your system meets the new requirements.

Finally, make sure you keep current on the new guidance on EHR system requirements as they develop. Refer to resources such as the American Medical Association (www.ama-assn.org), the New Jersey (www.njhimss.org) and national chapters (www.himss.org) of the Healthcare Information and Management Systems Society and the U. S. Department of Health and Human Services Health Information Technology website (www.healthit.hhs.gov). Your medical professional liability carrier can also be a valuable source of information on how to avoid liability issues as you modify the operating procedures of your practice. For example, MDAdvantage recently made available to its policyholders an online physician advisory on medical records retention that addresses both paper and electronic medical record retention.

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