Medico-legal and Privacy Aspects of HIT and Health Information Exchange: *Focus on the Physician*

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- Co-Chair, Physicians’ EHR Coalition
- Board member, MD-DC Collaborative for HIT
- Board member and Leadership Council member, eHealth Initiative
- Member, Health Information Technology Advisory Panel, JCAHO
- Member, Workgroup on Privacy, Security, and Confidentiality, AHIC
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  - Has practiced health law for over a decade
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- Member of the ABA Health Law Section
- Vice Chair of the HIT Practice Group of the American Health Lawyers Association
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- Research Faculty, Center on Medicine as a Profession, College of Physicians and Surgeons, Columbia University
Marcy Wilder, JD

- Partner, Hogan & Hartson
- Member, Health Policy Subgroup of Connecting for Health
- Served as deputy general counsel of the U.S. Department of Health and Human Services
## Past barriers

<table>
<thead>
<tr>
<th>Barrier</th>
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<tbody>
<tr>
<td>Confusion about quality of application</td>
</tr>
<tr>
<td>Not knowing which EMR is best for which type of practice</td>
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<td>Wide variability in contracting and business practices</td>
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<td>Risk of implementation failure</td>
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<td>Difficult and expensive access to external information</td>
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# Past barriers – consensus on solutions

<table>
<thead>
<tr>
<th><strong>Barrier</strong></th>
<th><strong>Solution</strong></th>
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<tbody>
<tr>
<td>Confusion about quality of application</td>
<td>EMR product certification</td>
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<td>Not knowing which EMR is best for which type of practice</td>
<td>Trusted specialty-specific EMR guidance</td>
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<td>Standard contracting language, RFP guidance</td>
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<td>Standards-based solutions for labs, imaging centers, etc</td>
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## Past barriers – resolved (or lessened)

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<thead>
<tr>
<th><strong>Barrier</strong></th>
<th><strong>Solution</strong></th>
<th><strong>Current Work</strong></th>
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<tbody>
<tr>
<td>Confusion about quality of application</td>
<td>EMR product certification</td>
<td>Certification Commission on HIT (CCHIT)</td>
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<td>Not knowing which EMR is best for which type of practice</td>
<td>Trusted specialty-specific EMR guidance</td>
<td>Medical specialty societies; KLAS, HIMSS, others</td>
</tr>
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<td>California Health Care Foundation (eLINC5)</td>
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</table>
Remaining barriers…

- Slow adoption
- Interoperability
- Misaligned costs and benefits

- Time
- Continued hard work
- Aligning value
  - Pay-for-performance
  - Reimbursement reform
  - De-fragmentation
    - Waste & delay to one stakeholder ≠ source of profit to another
Remaining barriers…
Remaining barriers...to what?

- Adoption of HIT?
- Ubiquitous RHIOs and/or HIE?
- Infrastructure
  - May enable better/safer care
  - May enable faster mediocre care
- Transformed healthcare delivery
  - Safer
  - Timely
  - Effective
  - Efficient
  - Equitable
  - Patient-centered
Remaining barriers (after 100% adoption, interoperability, payment alignment and system “de-fragmentation”)

- Workforce
- Immature / wrongly focused software
- Documentation schema (worsened by E/M coding / payment rules) that is an extremely poor fit for longitudinal care and information mobility
- Lack of clinical protocols for interconnectedness
- Few (no) systematic strategies for anticipating / resolving new errors caused by HIT / HIE
- Unresolved (unasked) medico-legal questions concerning the adoption & use of HIT / HIE
Medico-legal questions

- Electronic ‘record’ with evolving definition
- New duties / risks with electronic records
- E-Discovery / Fraud and Abuse detection
- New duties / risks with health information exchange
“By 2014, ½ of all Americans will have an electronic health record.”

- Signal that the feds were ready to start a massive investment in EMRs
- Huh???
  - EMR was a record system – purchased and used by doctors / practices / enterprises. How could a patient have an EMR?
- But he didn’t say ‘EMR’ – he said ‘EHR’
  - EHR is a new term for EMR
  - EHR is a more advanced EMR (and thus more $)
  - EHR is a term for PHR
  - EHR means something entirely different
### Attempting to achieve clarity

<table>
<thead>
<tr>
<th></th>
<th>Information analysis</th>
<th>Information exchange</th>
<th>Personal health management</th>
<th>Enterprise</th>
<th>Ambulatory care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Across organizations</td>
<td></td>
<td>EHR</td>
<td>PHR</td>
<td></td>
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<tr>
<td>Within one organization</td>
<td></td>
<td></td>
<td></td>
<td>CPR</td>
<td>EMR</td>
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- **Not legal records**
- **Legal records**
## Moving back towards fuzziness

<table>
<thead>
<tr>
<th>Record</th>
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## Moving back towards fuzziness

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- CPR: Could maintain the legal record
Are there clear requirements for legal records that a provider / organization should / must follow?

Are there attributes of an electronic system that would make it more or less likely to be able to be used (in lieu of paper) as a legal record?

Are there attributes of an electronic system that would make it more or less likely to protect privacy? Which system / approach is preferable?
Moving from paper to electronic records

Informational medicine is suboptimal
- Preventative services done ~ 50% of the time
- Chronic care management done well < 50% of the time
- “44,000 – 98,000” deaths/yr from medical errors
New duties / risks with electronic records

- Does (could) adoption elevate the standard of care?
- Most doctors (and health systems) who adopt electronic records iteratively enable clinical decision support. While this may help with training and buy-in – does it expose doctors and health systems to added liability?
- Clinicians who use electronic records with CDS often “drop their guard” and assume that the CDS always works, and always works perfectly. Who is responsible for errors that occur when CDS fails – the doctor or the vendor?
- The new Stark and Anti-Kickback exceptions allow hospitals to “donate” eRx and EMRs to their affiliated (non-employed) medical staff. While this may lead to more rapid adoption – will it also create a quality of care duty over private medical staff?
“What can I do to improve care?”

“Wow! I can code this visit as a level 4. Maybe the EMR will pay for itself!”

“Hm.. The average E/M code for all patients with a diagnosis of 250.xx went from a 2.5 to a 3.5. Looks like F&A to me!”

“Bingo! Look at all these cases where she didn’t get a mammogram report within 12 months.”
E-Discovery / Fraud and Abuse Detection

- Should physicians be concerned that the same types of systems that suggest optimal billing codes for us, may be used by payers and the OIG to support “fraud and abuse” detection and prosecution?

- Will (could) e-discovery lead to mass solicitations for ‘substandard’ care malpractice suits.

- Will (could) e-discovery threaten, or help to protect patient privacy?
Existing case law on duty / responsibility

- When duty starts / stops
- Community standards
- Reasonableness
- “You order it – you own it.”
MRI Cervical Spine With and Without Contrast

CLINICAL HISTORY:

FINDINGS: There is spondylolisthesis and disc disease at multiple levels throughout the cervical spine. Mild canal stenosis extends from C3 through C7 secondary to diffuse posterior disc protrusion and spondylolisthesis and possible posterior longitudinal ligament hypertrophy. At C3-4, there is diffuse spondylolisthesis and disc protrusion narrowing the spinal canal and mildly impressing anteriorly centrally on the surface of the spinal cord.

At C4-5, there is again diffuse spondylolisthesis and disc protrusion causing overall canal narrowing and stenosis with effacement of the anterior surface of the spinal cord and bilateral foraminal narrowing.

At C5-6, there is diffuse disc protrusion and spondylolisthesis extending into both lateral recesses particularly on the right with bilateral foraminal narrowing. Cord compression along the right edge of the cord is suggested.

At C6-7, there is diffuse spondylolisthesis and disc protrusion extending into both lateral recesses causing only mild canal narrowing. The spinal cord appears normal. After intravenous contrast, no abnormal areas of enhancement are identified.

CONCLUSION: MRI Lumbar Spine With and Without Contrast 08/17/2006

1) There is canal stenosis extending from C3 through C6 secondary to diffuse disc protrusion, spondylolisthesis and possibly posterior longitudinal ligament hypertrophy. Effacement of the anterior
**New duties / exposures with HIE**

- Duty defined by data received – “you have it, you own it”
- Duty defined by data availability – “you can / could easily see it, you own it”
  - Further delineated by specialty – only applies to
    - Relevant specialties
    - PCPs
New duties / exposures with HIE

- Does receipt of data establish duty?
  - In the paper world, MDs can get rid of paper reports they don’t want in the chart – possible in the electronic world?
  - Should a patient be allowed to designate that someone other than the ordering MD be the recipient of a result?
    - What are the implications for establishing duty?
  - Do I have a duty to the patient whose MRI report I just displayed?

- Does ready access to data establish duty?
  - For all MDs / just certain specialties?

- Do certain models of HIE make patient privacy more or less protected? Is there a preferred approach?
Questions?