Medico-legal and Privacy Aspects of HIT and Health Information

Exchange: Focus on the Physician

3rd Annual HIT Summit

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Past barriers

Barrier	
Confusion about quality of application	
Not knowing which EMR is best for which type of practice	
Wide variability in contracting and business practices	
Risk of implementation failure	
Difficult and expensive access to external information	

Past barriers – consensus on solutions

Barrier	Solution	
Confusion about quality of application	EMR product certification	
Not knowing which EMR is best for which type of practice	Trusted specialty-specific EMR guidance	
Wide variability in contracting and business practices	Standard contracting language, RFP guidance	
Risk of implementation failure	Trusted technical advice	
Difficult and expensive access to external information	Standards-based solutions for labs, imaging centers, etc	

Past barriers – resolved (or lessened)

Barrier	Solution	Current Work	
Confusion about quality of application	EMR product certification	Certification Commission on HIT (CCHIT)	
Not knowing which EMR is best for which type of practice	Trusted specialty-specific EMR guidance	Medical specialty societies; KLAS, HIMSS, others	
Wide variability in contracting and business practices	Standard contracting language, RFP guidance	eHealth Initiative	
Risk of implementation failure	Trusted technical advice	DOQ-IT	
Difficult and expensive access to external information	Standards-based solutions for labs, imaging centers, etc	California Health Care Foundation (eLINCS)	

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, ¹/₂ 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

	Information analysis	Information exchange	Personal health management	Enterprise	Ambulatory care
Across organizations		EHR	PHR		
Within one organization				CPR	EMR
	Not legal records		Legal r	records	

Moving back towards fuzziness

	Record	
CPR	Х	
EMR	Х	
EHR	Х	
EHR-S		

Moving back towards fuzziness

	Record	System	
CPR	Х	Х	
EMR	Х	Х	
EHR	Х		
EHR-S		Х	

Moving back towards fuzziness

	Record	System	Legal record
CPR	Х	Х	
EMR	Х	Х	
EHR	Х		Maybe
EHR-S		Х	Could maintain the legal record

EMR / CPR / EHR / EHR-S / ???

- 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

Hx Exam Diabetes Self Ed Diabetes Tx Insulin Diabetic drug class(s) patient is taking: Insulin None Values CHECKED NRED have been extracted from data in patient's chart. These values cannot be changed unless the appropriate chard data is changed first. SufforyNamea None Current HYPERTENSION & DIABETES medications ONLY listed below. Biguanides (Glucophage) Image content HYPERTENSION & DIABETES medications. Thirtscall grid sh Alpha C Therapeulic Recommendations: HTM dt 1) No Block Pressure recorded yet as of this vist. You may enter this on the EXAM Page of this form. Diabetic big Calaba 3) Patient is on Glucophage and serum creatime > 1.5. Consider stopping GLUCOPHAGE due to increased risk of lact: Acta: 3) Patient has a Diabetic Education Program. Bet kic 3) Patient has a disposis of Diabetes and is not currently on an ACE-1 or ARB. Should this be considered? Vascall 5) Space the patient is Diabetic, the following are now due: the base is the base only. BP SM Feature Alpha G-1 Meglitimide Lipid Medis Aspirin Medi List BP SM Feature Alpha G-1 Meglitimide Lipid Medis Aspirin Medi List BP SM Feature Alpha G-1	
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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?

E-Discovery / Fraud and Abuse Detection "Hmm.. The average E/M code" for all patients with a diagnosis "What can I do to of 250.xx went from a 2.5 to a improve care?" 3.5. Looks like F&A to me!" "Bingo! Look at all these "Wow! I can code this visit cases where she didn't get as a level 4. Maybe the a mammogram report EMR will pay for itself!" 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."



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MRI Cervical Spine With and Without Contrast	E E E E E E E E E E E E E E E E E E E
CLINICAL HISTORY:	
FINDINGS: There is spondylosis and disc disease at multiple levels	s throughout the cervical
spine. Mild canal stenosis extends from C3 through C7 secondary to	to diffuse posterior disc
there is diffuse spondylosis and disc protrusion narrowing the spinal	l canal and mildly impressing
anteriorly centrally on the surface of the spinal cord.	
At C4-5, there is again diffuse spondylosis and disc protrusion caus	ing overall canal narrowing
and stenosis with effacement of the anterior surface of the spinal con	rd and bilateral foraminal
narrowing.	
At C5-6, there is diffuse disc protrusion and spondylosis extending	into both lateral recesses
particularly on the right with bilateral foraminal narrowing. Cord c	compression along the right
edge of the cord is suggested.	
At C6-7, there is diffuse spondylosis and disc protrusion extending	into both lateral recesses
causing only mild canal narrowing. The spinal cord appears norman no abnormal areas of enhancement are identified.	u. Aner intravenous contrast,
CONCLUSION: MRI Lumbar Spine With and Withou	ut Contrast 08/17/2006
1) There is canal stenosis extending from C3 through C6 secondar	ry to diffuse disc protrusion,
spondylosis and possibly posterior longitudinal ligament hypertrop	hy. Effacement of the anterior
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New duties / exposures with HIE

- Duty defined by data received "you have it, you own it"
- Duty defined by data availability "you <u>can</u> / <u>could easily</u> 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?

