

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

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Peter Basch, MD
Medical Director eHealth, MedStar Health

Jud DeLoss
Vice Chair, Health Information and Technology Practice Group, AHLA

Janlori Goldman, JD
Director, Health Privacy Project and Research Scholar, Columbia College of
Physicians and Surgeons

Marcy Wilder, JD, Partner, Hogan & Hartson LLP

Peter Basch, MD

- Practicing physician, Washington, DC
 - Medical Director, eHealth, MedStar Health
 - Chair, Maryland Task Force on EHRs
 - 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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Jud DeLoss, JD

- Attorney, Krahmer & Bishop
 - Has practiced health law for over a decade
 - Member of the bars of Minnesota, Maine, North Dakota, and South Carolina
 - Member of the ABA Health Law Section
 - Vice Chair of the HIT Practice Group of the American Health Lawyers Association
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Janlori Goldman, JD

- Director, Health Privacy Project
 - Research Faculty, Center on Medicine as a Profession, College of Physicians and Surgeons, Columbia University
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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
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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
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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
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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
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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
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“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
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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 records

Moving back towards fuzziness

	Record		
CPR	X		
EMR	X		
EHR	X		
EHR-S			

Moving back towards fuzziness

	Record	System	
CPR	X	X	
EMR	X	X	
EHR	X		
EHR-S		X	

Moving back towards fuzziness

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

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

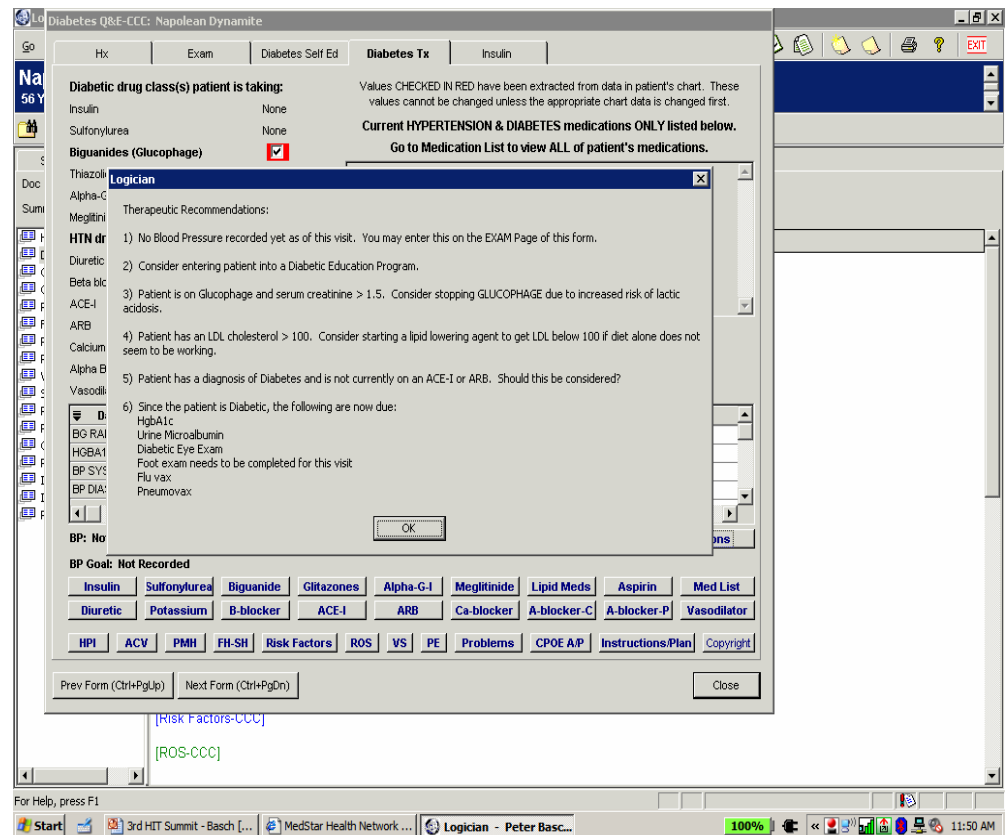
- Are there clear requirements for legal records that a provider / organization should / must follow?
- Are there attributes of an electronic system that would make it more or less likely to be able to be used (in lieu of paper) as a legal record?
- Are there attributes of an electronic system that would make it more or less likely to protect privacy? Which system / approach is preferable?



Moving from paper to electronic records

Informational medicine is suboptimal

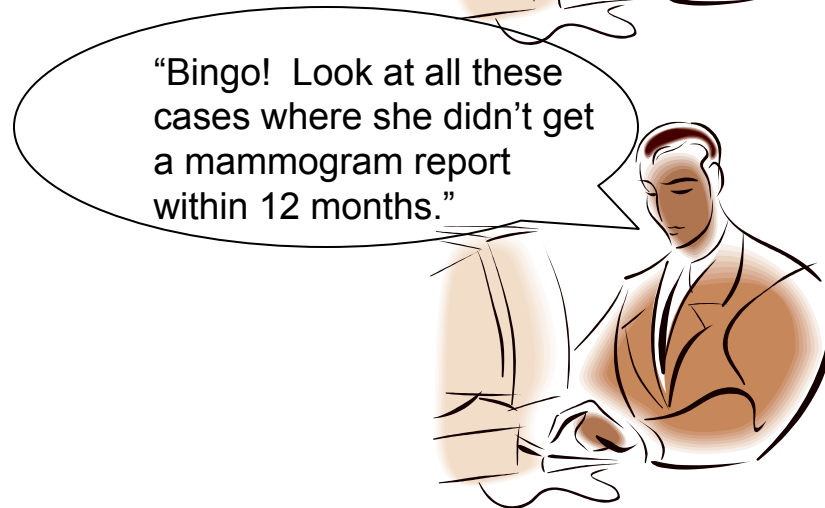
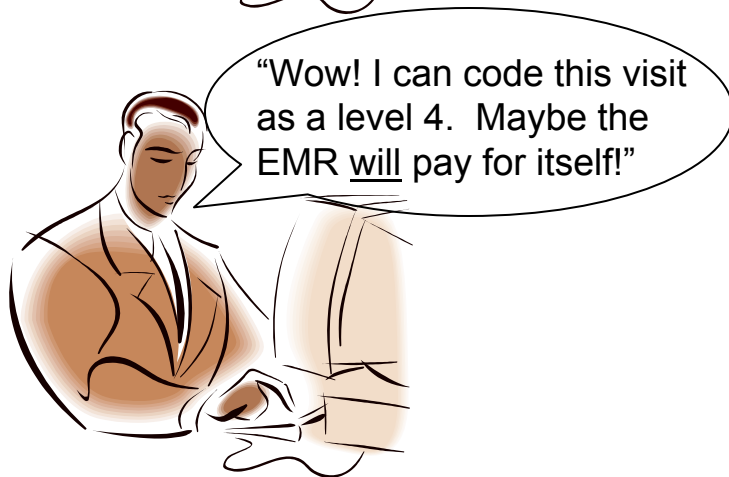
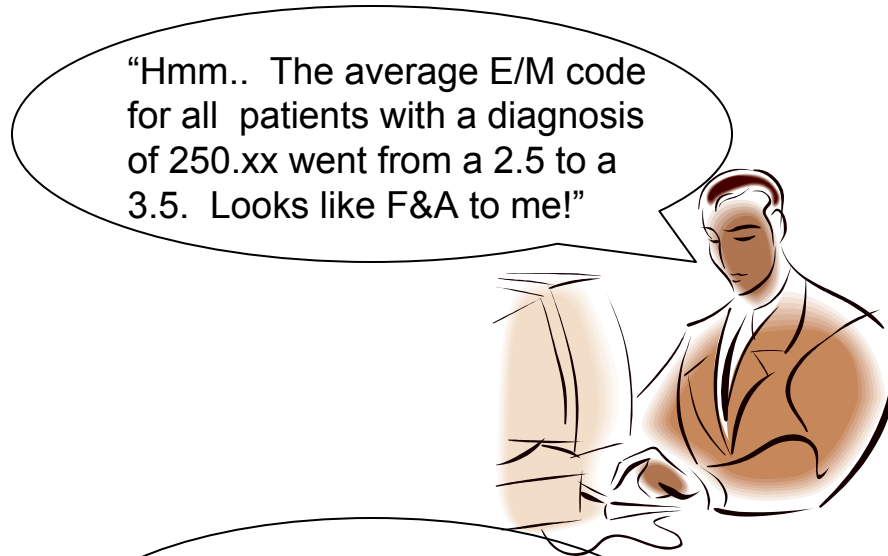
- Preventative services done ~ 50% of the time
- Chronic care management done well < 50% of the time
- “44,000 – 98,000” deaths/yr from medical errors



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?
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E-Discovery / Fraud and Abuse Detection



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?
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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 spondylosis 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 spondylosis and possible posterior longitudinal ligament hypertrophy. At C3-4, there is diffuse spondylosis 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 spondylosis 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 spondylosis 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 spondylosis 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, spondylosis 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
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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?
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Questions?
