EHRs and E-Prescribing
Risk Management Pros and Cons

As healthcare providers and facilities move toward electronic healthcare records (EHRs), there is a wide continuum between the early adopters and those resisting the move. There is also widespread debate about who is reaping the benefits of EHR digitalization.

Third-party payers and insurance companies clearly benefit as they reduce billing and claim processing costs while simplifying claims management and prescription drug services. EHRs also give third-party payers the ability to more easily evaluate physician practices for outcomes and quality performance, which can help them initiate pay for performance or punitive measures. In addition, patient safety and overall office efficiency may be improved through EHR's automated processes and procedures such as billing, scheduling, prescribing and test follow-ups.

However, many physicians argue that having to input patient data into a laptop or e-notebook during a patient visit has a negative impact on the physician-patient relationship. Not only does it require more time and attention to document the patient's visit, it can depersonalize physician-patient interactions.

Government Encouragement

In 2006, the Department of Health and Human Services (HHS) recognized initial criteria for certification of EHR systems. Certified products will help doctors feel confident that products meet self-referral laws and anti-kickback statute rules.

Congress committed $34 billion to be distributed to qualified providers who adopt and use the certified EHRs beginning in 2011. The goal is to achieve nationwide usage of electronic health records by 2014.

In addition to the government's interest in e-prescribing, several states have sought to prompt the adoption of EHR by mandates, initiatives or funding programs.¹ From a risk management perspective, there are pros and cons to digitalizing patient health information. Proponents argue that processes like scheduling and appointment and test result follow-up are facilitated and improved by electronic record systems. Built-in clinical guidelines and “prompts” remind the physician about drug contraindications and overdue patient screenings. And, some of the documentation problems that can make or break the defense of a medical malpractice case can be avoided by using EHRs.

Nonetheless, EHRs cannot solve all documentation problems. For instance, sloppy entries in the e-records due to poor typing skills wouldn’t benefit from the EHR and may still result in patient safety and litigation issues. What’s more, plaintiffs will still take an “if it’s not in the record, it didn’t happen” stance.
Pros and Cons

As EHR use becomes more widespread and electronic systems and digitalized devices interact, it’s likely that additional benefits and new unforeseen risks will come to the forefront. Here are some of the pros and cons currently being identified with EHR use:

PROS

Connectivity anywhere/anytime with web-based programs. Access to electronic medical records 24/7 enables remote consultation, diagnosis and monitoring. This can lead to early detection of medical problems, as well as quicker, targeted therapeutic intervention and improved outcomes. What’s more, the physician may be more effective in handling after-hours calls as a result of the records being remotely accessible.

Multiple user/multiple location access. This allows more than one healthcare provider to access an e-record at the same time. For example, physicians can check lab values from home, enabling them to put information in the chart quicker for better coordination and continuity of care.

Improved documentation:

- **Consistent charting across providers.** The use of one EHR system throughout a practice means consistent and standardized records for items such as the placement of the history and lab results. Aggregate clinical information is quickly available.

- **Facilitated use of patient problem and medication lists.** Templated problem lists and medication lists are in a consistent place and format in the chart.

- **Fewer legibility issues.** While typo graphical errors can occur, the risk of illegible entries is reduced with EHRs.

- **Built in patient safety features and alerts.** For example, EHRs can reduce the risk of prescribing a medication to a patient with a known, documented allergy or a drug interaction.

- **Built in scheduling features.** Patient reminders and follow-up systems for appointments, prescribed tests, consultations, and missed or cancelled appointments can improve physician office staff efficiency. Moreover, these features help ensure that test results don’t fall through the cracks and result in missed or delayed diagnosis/treatment.

- **Automation of requests.** Lab, imaging and other diagnostic test notifications and results can be integrated into patients’ e-medical records. This can improve test and appointment scheduling, as well as allow for better tracking of patient compliance. Most important, the physician can see the results of those tests and notify the patient of the results.

- **Built-in e-prescribing features.** E-prescribing is becoming the norm, especially with incentives such as the Medicare Quality Reporting Incentive Programs for e-prescribing. In 2010, eligible physicians may earn an incentive of 2 percent of the total estimated Medicare Part B allowed charges for covered professional services in 2010. In 2011 and 2012, incentive payments drop to one percent, and in 2013, to 0.5 percent. E-prescribing has the potential to reduce the number of adverse drug events and provider uptake—one study estimates it could eliminate 200,000 adverse drug events in hospitals and 2 million adverse in ambulatory settings. E-prescribing also may improve physician office efficiency, patient safety, compliance and satisfaction.

Integration of disease management and clinical decision-support systems.

These systems provide physician support at various stages in the care process—from prevention through diagnosis and treatment to monitoring and follow up.

The ability to “weather” disasters. With a web-based EHR system in place, interruption of a practice’s day-to-day activity from fires, floods, tornados or other disasters is minimized with the ability to quickly retrieve financial and

Though moving to an EHR can be costly, it may be more cost efficient in the long term.
patient information and resume patient care—even in a completely different location. The caveat is the practice’s clinical and financial data must be routinely backed-up and stored safely off site.

Potential financial savings. Though the upfront and ongoing costs of moving to an EHR are considerable, the resulting efficiencies may yield a positive return on investment. Plus, government incentives to subsidize some of the costs will lessen the initial expenditure.

CONS

Security/privacy issues. An increasing number of security breaches have been reported in the media, especially the theft of laptops containing patient information. There have been calls to regulate personal health information downloaded onto hand-held electronic devices by hospitals, physicians and their employees. Monetary penalties have been increased under HIPAA and HITECH so failure to protect the information can be costly. Any EHR system must include a high-level security system to protect the patient, avoiding the possibility of any health or financial information getting into the wrong hands.

Lack of compatibility between systems or electronic devices. An EHR is of little value to the practice and its patients if it cannot communicate with other systems. Potential systems need to be thoroughly reviewed to determine compatibility with existing practice systems, as well as other entities that exchange e-data with the practice. These include in-hospital, interdepartmental, inter-hospital, hospital–physician office, hospital–pharmacy and physician office–pharmacy compatibility.

Data transmission issues. There remains uncertainty as to whether information sent via an EHR was actually transmitted. Was the sent information actually received? Was it received by the intended recipient? Were there delays that may have adversely affected patient care? Was the data received accurately, or did transmission result in data distortion?

“Cookbook” medicine. This term was first coined to describe clinical practice guidelines, and there is also the potential for “cookbook medicine” with built in disease management and medication management systems. That’s why the physicians in a practice must review any systems to ensure they reflect their practice style and standard of care. Another downside is that if practice guidelines in an EHR are not followed and an adverse outcome and lawsuit result, the plaintiff attorney has nicely packaged ammunition to use against the doctor in the case.

Uniform templates limit documentation flexibility. There are specific templates for specific types of visits and specialties. Using the wrong template can lead to patient harm, as well as fraud and abuse violations. In addition, some physicians believe that templates “lead” the documentation, rather than providing physicians with the latitude to lead the input of patient-specific information as appropriate. Adding an option for free text can help personalize patient visits as appropriate.

E-Prescribing Resources:


Physician disregard of systems alerts and prompts. When systems have too many prompts and alerts, there is the potential for physician alert overload. Some physicians report they tune out alerts after a while without consciously thinking about them. Obviously, not all alerts will be applicable to the patient at hand and may be overridden by the physicians, but the physician must guard against ignoring all alerts.

Required computer literacy. The technical skills and readiness of all practice physicians and staff must be honed before going live with a system. This includes system navigation skills, typing/entering data into a system, file management and more. Many physicians are unable or unwilling to develop the
skills needed, for example, to type patient visit notes and orders vs. dictating them. However, there are often work-arounds, e.g., using dictation or voice recognition software that links to an EHR template.

Lack of standardization of definitions and processes. There is often variation in how patient identification numbers are used by different departments or systems. This can lead to different ways of entering patient information (e.g., John Smith vs. John Q. Smith), resulting in problems such as patient misidentification, wrong data in the wrong e-chart and incorrect prescriptions.

Potential for problems with accessing or losing patient records. This can include issues with system failure, loss of data, computer viruses, hacking and more. Security is a major concern that must be addressed before the system is put in place. Ongoing monitoring by an information systems specialist is necessary to ensure the system is protected against new viruses and increasingly sophisticated hackers. Plus, automated systems can fail on occasion.

Garbage in, garbage out. Obviously, any system can only be as good as the information put into it. In a recent malpractice case, a positive biopsy report was put into the wrong patient’s EHR. Discussion of the case noted:

“…computers can be extraordinarily efficient error propagators—incorrect data flows as easily as valid data.”

E-prescribing without pharmacy readiness. Pharmacists must then re-enter the e-script into the pharmacy’s system—increasing the opportunity for errors.

Update on EHR Incentive Program

Financial incentives will soon be available to healthcare providers who adopt EHRs and meet Health Information Technology for Economic and Clinical Health Act requirements.

To receive the incentive payments, the provider must be able to demonstrate “meaningful use” of certified EHR technology in the practice, which includes:

- Electronically capturing health information in a coded format
- Using the captured information to track key clinical conditions
- Communicating information for care coordination
- Initiating the reporting of clinical quality measures and public health information

The regulations spell out the objectives that eligible physicians and hospitals must achieve in payment years 2011 and 2012 to qualify for incentive payments beginning in mid-May 2011.

The rule divides the objectives into a “core” group of required objectives, as well as a “menu set” of procedures from which providers can choose. This approach was designed to ensure that providers who qualify for the incentive payments meet basic elements but still have the flexibility to address their varying EHR needs.

For more information on the incentive program including registration and objectives, go to www.cms.gov/EHRIncentivePrograms/.

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