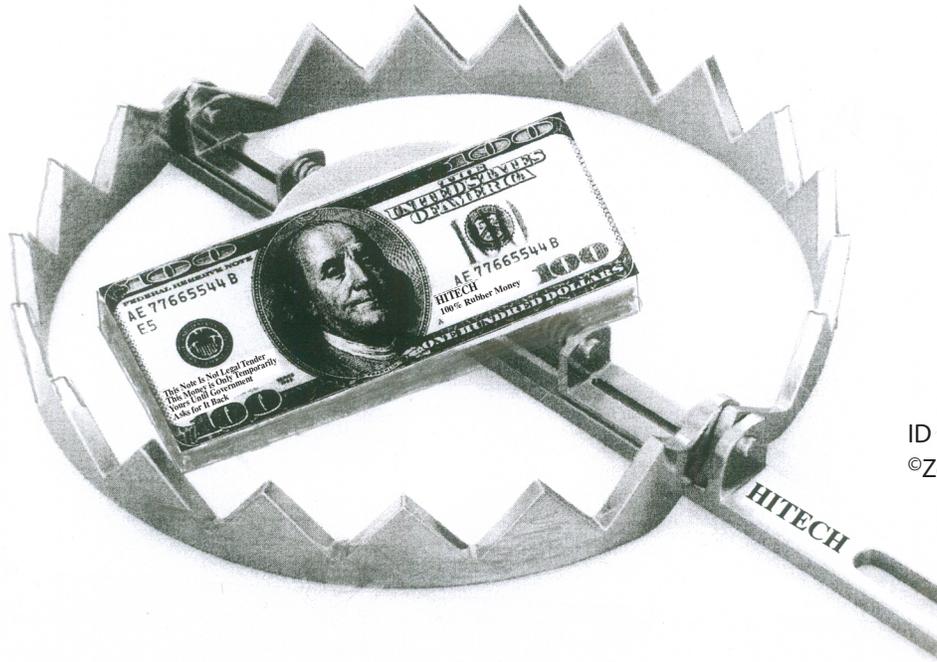


Editorial

The Disaster of Electronic Health Records

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EHR Incentive Program—Physicians Beware

Thousands of dollars were there for the taking. Government made it all sound so simple and easy:

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.¹

Now, five years later, specific guidelines for meaningful use (MU) are being applied retroactively, replacing the vague guidelines that were provided in the early years of the program, and the government wants its money back. Physicians who thought they were safe when they purchased a “certified” EHR system are finding otherwise.

The electronic data physicians supplied was mined and scrutinized by privately contracted firms whose agenda is to claw back incentive money paid to physicians.

Letters from the Centers for Medicare and Medicaid Services (CMS) now being sent to physicians are marked “First and Final Request for Repayment,” stating that:

The purpose of this letter is to inform you that

a Meaningful Use Audit determined a HITECH incentive overpayment in the amount of [\$xx,xxx.xx for Dr. DoRight (NPI# xxxxxxxxxx)] to be repaid to our office in full. The registrant is responsible for the registration and attestation surrounding the eligibility to participate in the HITECH Incentive program and has independently received a full audit notification of the denial. As a result of the meaningful use audit, an overpayment of HITECH funds has been determined and is owed. Please return in full the overpaid amount to us by June 1, 2016 and no interest will be assessed.... If you do not refund in full within 30 days: In accordance with 42 CFR 405.378 simple interest at the rate of 10% will be charged on the unpaid balance of the overpayment beginning on the 31st day.

These demand letters from CMS also make it clear the government means business getting its money back. If a physician does not pay in a timely manner, CMS refers the debt to the Treasury Offset Program so as to allow the government to confiscate any tax refund that may be due. If the physician is a salaried employee of the federal government, money will be confiscated from the physician’s salary to pay the debt.

The government apparently recognizes that solo and small group practices may not have sufficient cash flow to immediately pay the debt in full, or may go into bankruptcy as a result of the huge repayment amount, so they offer the option of a repayment plan if the physician is eligible.

To determine eligibility for a repayment plan (Refer to Financial Management Manual 100-06, Chapter 4, Section 50.2, Subsection 401.607(c) of Title 42 CFR.) [If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If a physician qualifies for a repayment plan, he essentially enters a period of indentured servitude with a crushing debt that may take years to pay off.

In summary, the government's EHR Incentive Program for some physicians was nothing more than a giant bear trap with a wad of cash in the middle for bait.

EHRs Have Failed to Improve Patient Care, Patient Safety, or Efficiency

The main purpose of a medical record is to provide a physician or other person taking care of the patient with information about what is going on with the patient. It allows a physician to track the patient's diagnoses, treatment, and progress from one encounter to the next. And, should something happen to the treating physician, the medical record should contain sufficient information such that another physician can take over the patient's care. Unfortunately, due to the intrusive power of government and other third-party payers, the medical record has been bastardized into a billing record that often has little or no clinical relevance. The emphasis is on complying with "bulleted" points so as to justify a certain level of billing to the third-party payer.

Anyone who has had the misfortune of reading a printed copy of an electronic health record knows that it is often an agrammatical, incomprehensible mess. Spelling errors are pervasive, clearly erroneous information is included and propagated from one patient encounter to the next, and information is often contradictory.

Below is a fictional example, based on my experience, of an emergency department encounter as documented by an EHR:

9:00 Acuity: Non-Urgent. Care prior to arrival: None. Observations: 9:00 MOA Walk-in. 9:00 Pt arrived in ED. 9:02 Pt moved to pre-waiting area. 9:03 Pt visited by registration. 9:04 Triage completed. 9:05 Demographic sheet handwritten by scribe to registration. 9:06 Consents signed to registration. Interventions: Pt placed in waiting area pt notified of wait time. 9:10 Pt moved to Rm 1. 9:10 Pt has correct armband on for positive identification. Bed in low position. Call bell in reach. Side rails up. 9:45 Screening: Exposure risk/travel Screening None identified. Abuse screen: Denies threats or abuse. Denies injuries from another. Fall risk: None identified. Social History: Personal Habits: Cigarette Use: Pt denies smoking. Comments: continued efforts to stop

smoking completely (**Tobacco Use Disorder, 305.1**) reviewed with pt. No changes at this time—continued daily xcise and good nutrition. 9:46 Pt visited by Dr. I. Pad PA. 9:46 Dr. I. Pad PA is PCP. 9:47 Pt moved to Rm 2. 9:47 Pt visited by Nurse Ratched a.k.a. Big Nurse. 9:48 Dr. Ann Droid is Referral physician. 10:04 Pt visited by Dr. I. Pad PA. 10:05 Presentation: 24-year old White Male presents to ED via horse with complaints of **Head Injury—side undetermined (500.00 unspec superf inj scalp initial encounter)**. 10:06 The pt /guardian reports discomfort/pain. The complaint(s) affect(s) head. Context: The problem was sustained at home in field under tree. Head trauma: Foreign Object: Fruit fell on head. Onset: Sudden—the symptoms/episode began/occurred yesterday. Modifying factors: Patient appears delusional, insists on being called Sir, and is ranting about something called gravity. Associated signs and symptoms: Pt. ate apple. Pertinent negatives: vision, hearing, speech no LOC. 10:08 ROS: Musculo: Pt denies pain/headaches. 10:09 Social history: speaks Queen's English, denies drinking ale. Advance Directives: Pt has no advance directives, states she wants to go home. 10:11 The history from nurses notes was reviewed: and my personal history differs from that reported to nursing. 10:12 Ob/Gyn: LMP 03/02/1643. 10:13 Examination: Head: TTP convexity. Psych: Mood: pensive and anxious. Thought Content: delusional, claims discovered something called gravity. 10:15 Procedure: head wrapped with gauze. 10:16 Discharge ordered by PA. 10:17 Discharged to home ambulatory. Condition: good. Ambulatory Assistive Devices: none. 10:17 Discharge instructions: advised not to sit under fruit tree. 10:18 Discharge Instructions given to pt. 10:18 Pt demonstrated understanding of instructions. 10:19 Pt left ED.

Compare this with an old-fashioned typed medical record:

A 24-year-old white male presents to ED complaining that an apple fell on his head while he was sitting under an apple tree. The apple hit him on the top of his head, produced no loss of consciousness and resulted in mild pain. Examination revealed mild tenderness to palpation on the top of his head. Neurologic examination was normal. The patient expressed pride that he discovered the concept of gravity. His head was wrapped with gauze, and he was discharged to home in good condition with instructions to watch out for falling apples.

Some may claim that electronic health records were really not designed to be read in a printed format and that viewing the electronic health record in its native electronic format makes it easier for clinicians to find relevant content quickly.

I once asked a medical resident to tell me the diagnosis of a severely debilitated patient who had been in an intensive care setting for months. After about five to ten minutes of playing with the computer, the resident could not provide the patient's diagnosis. He had been treating a critically ill patient in the

ICU for his entire rotation yet did not know the patient's actual diagnosis. EHR clearly did not improve quality of care or patient safety in that situation.

EHRs Frequently Document Events That Never Occurred

Office visits frequently contain full documentation in the electronic health record of medications (which the patient no longer takes and hasn't taken for a long time), past surgical history (PSH) (which has been unchanged for years), a full review of systems (ROS), social history (SH), family history (FH), and a complete head-to-toe examination.

Although the physician entering the data into the EHR didn't actually ask about the ROS, PSH, SH, and FH on every single office encounter, and didn't actually perform a complete head-to-toe exam on every encounter, the EHR contains these fraudulent entries so as to justify a higher level of service for billing purposes.

Cloned records—cutting and pasting information from one patient encounter to the next (often containing the same misspellings or punctuation errors)—is also a significant problem. Cloned records often contain information that is false or no longer applicable to the patient's current clinical situation. Some physicians apparently think that providing false information via cloned records is acceptable as long as they include boilerplate at the end of the record acknowledging that the record was dictated but not read.

So, in many cases the EHR has become a completely fictitious record. An EHR consisting mainly of fictitious, fraudulent entries does not improve quality of care or patient safety, and is not efficient or relevant.

The EHR Often Results in Patients Talking to the Physician's Back

In the "olden days" patients and physicians talked face to face. Facial expression and body language provided additional cues to what the patient was really experiencing. And, patients felt that their doctors actually cared about them enough to look them in the eye while they were explaining a problem of concern.

With the "new and improved EHR," however, the physician frequently turns his back on the patient and is focused on the computer, making sure to enter information in all of the fields so that payment can be secured. The physician may not even be listening to what the patient is saying because he is distracted by the requirements of the EHR.

Turning one's back to a patient for the majority of an office visit is not only an insult to the patient, but it does not enhance patient care or patient safety.

EHRs Have Led to Increased Identity Theft and Destruction of Patient Privacy

Electronic health records have been easy targets for hackers, who have caused irreparable harm to millions of patients. An article in the *Washington Examiner* noted:

Health record security breaches have soared this year [2015], with more than 94 million electronic medical records compromised so far. That's more than double the total number of records compromised over the six years before 2015... [The] dramatic increase in the average number of records compromised in a single breach is alarming and may be a consequence of the more connected health care system for which we are striving.²

A patient's most private and confidential medical information is not only easily accessible to hackers, but the number of "authorized" personnel who have access to the patient's private information has expanded greatly in the era of interoperable networked EHRs.

Destroying the privacy and lives of millions of patients does not advance patient care or patient safety.

EHRs Are a Major Contributing Factor to Physician Burnout

Physician frustration with poorly designed EHRs, which consume an inordinate amount of time and offer little or no benefit for patient care, is a major contributory factor to physician burnout. Physicians who are burned out provide poor patient care and have worse patient outcomes.

Power Outages and Software Crashes—No Access to Patient Records

Power outages and software crashes can also make access to critical patient information impossible. If a patient presents to the emergency department in a comatose state, and the EHR goes dark because of a software crash, the EHR has not improved patient care and patient safety.

Conclusion

EHRs, which promised the benefit of better patient care, increased patient safety, and increased efficiency, have failed miserably and have harmed patients and physicians alike. Billions of dollars have been spent on encouraging physicians to adopt a system that works poorly and degrades the practice of medicine to the extent that the doctor literally turns his back on his patients so as to better serve the EHR.

To make matters worse, the government now wants the EHR incentive money back from many physicians who took the bait. Given the harm EHRs have done to people, perhaps citizens should demand that government return tax money to them for the government-subsidized EHR debacle.

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