

Electronic Health Records & You – Be Very Afraid

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In 2004 President Bush set a goal for every American to have an electronic health record (EHR) by 2014. The goal was to improve quality and reduce healthcare cost. He set up the Office of the National Coordinator for Health Information Technology and the American Health Information Community to oversee this new policy.

EHR programs started as clunky attempts to re-create the paper chart. Doctors were slow to sign on. That changed with 2009 legislation that used financial incentives to entice administrators to champion EHRs and prod doctors to use them.

Congress put up \$30 billion to incentivize physicians to adopt digital medicine as a means to measure quality, improve safety, facilitate coordinated care (called interoper-ability) and move payment schemes away from costly pay-per-visit care. Administrators worship them as a means to increase reimbursement, prove compliance with ‘best practice’ guidelines and enable them to survive quality reviews. Health analysts and scientists like the access to patient data to assess changing health patterns.

Caregivers appreciate ready access to test results and, if the stars align properly, enable retrieval of patient data from other health facilities. Patients like the ability to see their results online without waiting weeks to see the doctor.

In practice, though, there are serious problems, which make them a perfect target for criticism, encapsulated in the “EHR State of Mind” video by LetDoctorsBeDoctors.com’s ZDoggMD at https://www.youtube.com/watch?v=xB_tSFJsjsw. This Alicia Keys’ song parody makes a plea for an

EHR that works better for patient care. My favorite line is, “**Just a glorified billing platform with some patient stuff tacked on.**”

As EHRs evolved to complex databases that meet regulatory requirements and improve revenue stream, they drifted away from an efficient means for doctors to care for patients. Patient ‘care’ now consists of thousands of computer clicks and responding to dozens of ‘best practice alerts’ (BPAs) which warn about potential problems that have a remote chance of becoming reality. Health ‘care’ now entails more computer-time, less patient face-time and less satisfaction by doctors and patients.

The major problem is that EHRs use computer programmer/administrator logic, not the patient or problem-oriented flow of a medical mind. Even if all the data is there, it is disconnected and it’s nearly impossible to see the big picture.

Since medical professionals are no long the target users, EHR logic doesn’t match medical logic and the technology hasn’t reached a level of usability that is acceptable to its core users, even computer savvy clinicians are unhappy with its use. A recent RAND corporation report compares the EHR situation to what would happen if the aviation industry sold new airplanes without pilots having extensively tested them.

EHRs can be harmful to your health:

Time: In the past, doctors opened up patient’s chart and wrote the history, exam, assessment and plan. Now we log on to a computer and log on to the EHR program. We make more clicks to access the day’s schedule and find the patient or search for the correct “James Smith” among hundreds in the database. Just starting to produce a progress note takes 2 clicks and more to choose a standardized note format. One study found that the average ER physician in a community hospital makes up to

4000 mouse clicks per 10-hour shift, most to navigate complicated sequences towards outcomes that in the past were simple.

Not only are there clicks, but there are also searches for stuff that is hidden or isn't where it should be. Pieces of information sequestered in illogical locations are useless. Some lab result reports are full of monotonous print, within which the test name, collection date/time and actual result are submerged among details of specimen acquisition, insurance coverage, laboratory location, and result release date – as if all of it is equally important.

We have the ability to comment about results, but those entries are in tiny print in locations few visit. To see explanatory comments one must know to look for them.

The drop-down menu choices for adding a diagnosis or placing an order don't match a medical mind. Sorting through the options to pick the least worst takes time – a lot of time for an unusual patient or non-standard prescription.

“Best Practice Alerts” (BPAs) are pop-ups that warn the EHR user about everything from potentially dangerous drug interactions, to it being time to remove a catheter, to demanding to have a reason that a medication is being stopped. They necessitate multiple clicks before the program allows us to continue. They are so numerous and often so inconsequential that doctors suffering from ‘warning fatigue’ click “override and accept” automatically, potentially missing important safety items.

All of this short-changes the patient: Time on the computer means less time available to get an accurate history and examine, educate and explain the plan.

Patient harm:

Padded notes: To save time doctors often automatically import large chunks of data into their progress notes and tack on a ‘template’ physical exam or import someone else’ exam into your note. What makes this worse is that few doctors actually

do decent physical exams these days and may have lost the skills.

You may have been asked five questions to clarify your problem, but the note looks like all organ systems were reviewed in detail. For example, your actual exam may have consisted only of listening to heart and lungs, but what's documented is a completely normal, full examination, in spite of the fact that you have left-sided weakness from a past stroke and a glass eye.

The provider may not have reviewed all the imported test results and information obtained by other providers. Not reviewing all the data usually means it's not considered when arriving at a diagnosis and plan. Billing for visits that look like a lot of work was done when it wasn't is essentially committing fraud.

Volumes of imported data bulk up notes with repetitive information, discouraging anyone else from reading them. If no one reads your information, that's not good for patient care. Knowing that few read doctors' notes leads to even less effort to make them useful. Inaccurate notes make it difficult for anyone reviewing your chart to figure out what's going on and what they should do next.

Diagnosis lists: An accurate diagnosis list is important to patient care. Choosing a diagnosis code that most closely matches a real patient takes time, especially if it requires typing to explain the details. For example, if you used marijuana in adolescence and not since, you wouldn't want your doctor to choose the easy-to-find listing ‘History of Drug Abuse,’ but that is what will likely appear.

Some choose to guess at a disease, for example ‘migraine’ instead of the symptom ‘headache’, before ruling out other diseases, like temporal arteritis or brain tumor. A subsequent doctor sees ‘migraine’ and doesn't consider alternate diagnoses.

Problem lists these days are devoid of specifics and nuance – you are sanitized. It leads to stereotyping and missing details that may be important to your care. Adding descriptors to specify severity, when

it occurred and cause and effect take time and many doctors aren't doing it.

Erroneous entries sometimes appear also. Because they are "in the computer" doctors are more likely to believe them than you and possibly act on them. Or your lack of knowledge about a pneumonia 3 years ago may lead to a dementia diagnosis rather than someone correcting the mistaken entry.

What about interoperability, the ability of EHRs to communicate? Except in rare cases, it doesn't happen. EHRs almost always use different digital formats that just don't communicate. There are some standard formats, like how a birthdate is displayed, but not ones for large pieces of the record like lab or scan results.

What about the projected cost savings? Padded notes, with imported information and template physicals leads to higher coding for billing, proven to *increase* healthcare cost. One would think that ready access to past test results might prevent duplicative testing. But doctors who have spent too much time on clicks and BPAs don't take the time to review what's already been done. Duplicative tests are ordered and office visits are wasted on doctors going through a diagnostic path that's already been done. Number-crunchers have totally debunked the cost-saving claim.

How can you avoid bad EHR outcomes?

Do a lot of reminding: Doctors forgot things in the past, but it takes more effort now to see specifics that are sequestered in digital pockets.

Be very specific about your complaints, without guessing at the cause, so the symptom makes it into the problem list, not an erroneous diagnosis.

Insist on an exam that addresses your problem. Make a note of what was examined and found.

Reduce fraud by complaining to the insurance company that there was a very big bill for a very short visit.

Ask your primary doctor about signing up for Internet access to your medical record. Ask them to correct faulty problem lists. If test results are flagged as abnormal and you don't hear from the doctor, call and ask. If test results are normal and the problem that prompted the test hasn't resolved, call to ask for the next plan.

All in all, EHRs aren't all they are cracked up to be. Assume that you have to take an active role in your care and that you can't necessarily trust the computer.