POSTS MADE IN JANUARY 2012

THE OPPORTUNITIES AND THREATS WITH OPEN NOTES

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We know that more and more physicians are implementing electronic health records. (see post Thursday January 12, Update on EHRs). Now the question becomes how do patients share the information in those records so that they are better informed and can be empowered to do more about their health issues? Dr. Tom Delbanco at the Beth Israel Deaconess Medical Center in Boston (BIDMC) has come up with a solution entitled *Open Notes,* which would give patients access to the doctor's notes in their record through a secure online portal.

A pilot study of *Open Notes* that included 25,000 primary care physicians and patients from the BIDMC, Geisinger Health System in PA, and Harborview Medical Center in Seattle WA, and funded by the Robert Wood Johnson Foundation, concluded that patients really like the idea because they see this as a way to a greater understanding of their issues and more involvement with their care. Physicians on the other hand are less than enthusiastic and have concerns about accountability and privacy of patient information.

Patients do have the legal right to their health record. They can request copies and changes to them if they're inaccurate. With the digitization of health records the data included is readable , although not always understandable for the average individual. Historically, test results, lab reports, medication lists and medical history comprise the record turned over to the patient upon request. The copy does not include the doctor notes. Patient respondents who were very enthusiastic about *Open Notes* felt that reading notes taken during their visit with their primary care physician would help them grasp more thoroughly what the physician recommends and help in following the treatment plan. In addition, many patients indicated that they would share the notes with other physicians/specialists who were treating them concurrently. A third of the patients had concerns about the privacy of their health information.
http://www.annals.org/content/153/121.full

The issue here is how communication between doctor and patient is handled and the trust relationship that is in place with full disclosure of notes. Physicians must be protected from the litigious nature of many patients who might decide to challenge what is in the notes. This could be a problem since there is currently no legislation that specifically addresses this issue. Patients must be protected from the delivery of their notes to unauthorized individuals or inadvertently to social networks and other public exposure. There is also the issue of secure communication of this information. There are only a handful of physician practices or hospital physician groups that have the type of secure portals necessary for enabling the communication of notes in an environment where the privacy of this information is well protected.

As digital communication technology becomes more ubiquitous, empowered patients and

enlightened physicians have many practical and ethical considerations, including *Open Notes* policies, as we all strive toward the goal of better quality, safer medical practice.

UPDATE ON EHRS

Leave a reply

Nearly 57% of U.S. office-based physicians by the end of 2011 were using some type of electronic health record (EHR) up from 51% in 2010 and 48% in 2009. About a third of physicians (34%) report that they meet the criteria for a basic electronic health record system and 52% of physicians report that they will apply for meaningful use incentives this year, up from 41% in 2010. This means that giant health care physician networks as well as small independent primary care practices are finally agreeing on full adoption of electronic health records.

First introduced in the 1960s, the implementation of EHRs has been a long struggle because these systems are time consuming and costly for the overly cautious, over-extended physician who has resisted changing the way patient records are kept. One of the drivers persuading physicians to commit to EHR implementation is the 2009 federal economic stimulus package that stipulates that health care providers who demonstrate meaningful use of certified EHR systems qualify for Medicare and Medicaid incentive payments. The federal government is investing $20 to $30 billion in stimulus money to promote EHRs through a system of 62 regional extension centers. The centers are hosted by a variety of entities from government agencies to non-profit health care consortia. The extensions have been given the formidable task of selling and supporting the switch to EHRs across the country.

An EHR is an electronic version of a patient’s medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person;s care, including: demographics, progress notes, problems, medications, vital signs, medical history, immunizations, laboratory data and radiology reports. The EHR automates access to this information and has the potential to streamline the clinician’s work flow and make it possible for patients to share this information and thus share in decision making. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces including evidence-based decision support, quality management and outcomes reporting. The good news is that with an EHR there is no more missing information at the point of care ; no more searching through a paper file to look for the results of a previous test, while the patient is sitting and waiting; no more lost charts. Done correctly, EHRs streamline interactions between all players on the health care front from pharmacies and labs to ambulance crews and insurance companies.

EHRs are also the next step in the continued progress of the health care system to

strengthen the relationship between patients and clinicians and enable clinicians to make better decisions and provide better care. For example the EHR can improve patient care by:

- Reducing the incidence of medical error with the improved accuracy and clarity of data.
- Making health information available to patients
- Reducing duplication of tests and delays in treatment.

Blue Cross & Blue Shield of Rhode Island recently announced results of a multi-year pilot program designed to increase the use of electronic records , transform the way health care is delivered, improve members' health and help moderate health care costs. Results of the pilot which became the foundation of BCBSRI's patient-centered medical home model demonstrate the value in using health information technology to improve quality of care. Highlights of the pilot include the following:

- Lower monthly health care costs that averaged between 17 and 33 percent less per member than those receiving care at non-participating practices
- Improved health care quality with a 44 percent median rate of improvement in family and children's health, 35 percent in women's care and 24 percent in internal medicine
- Successful EHR implementations for 79 local physicians

A recent article in the New England Journal of Medicine (December 15, 2011) showed that EHRs improved the quality of care for patients with diabetes by reducing unnecessary testing, helping to prevent adverse events and improving patient care coordination as compared to practices that use paper-based methods.

http://www.nejm.org/doi/full/10.1056/NEJMsa1102519

All of these studies and examples would lead us to believe that the EHR has finally established its worth to the medical community and once we approach 100% participation, patients can be assured that they and their providers will have access to their health information at the point of care. The availability of digital health information will enable patients to use email, portals,. and e-visits to more effectively and efficiently communicate with providers and to use smart phone apps to monitor their health. As a result they will experience better, safer medical care.

CONTINUITY OF CARE, IT TAKES AN EMPOWERED PATIENT TO MAKE IT HAPPEN

5 Replies

Jane, who is 53 and lives in a rural community, is diagnosed with breast cancer spotted on her annual mammogram. Her primary care physician (PCP) refers her to a cancer center two hours away from her home for further screening. The doctors there decide that Jane needs surgery, followed by chemotherapy which will be done at the cancer center. Prior to visiting the cancer center, Jane is instructed to collect all of her medical records, including those held by her primary care physician, gynecologist, and the x-ray films that are filed at her local hospital. With the assistance of her PCP, Jane creates a personal health record that includes her family history of breast cancer, her own medical history and other scanned images. She shares the PHR with all of her doctors at the cancer center who also provide her with the surgery and pathology reports and specifics on her treatment. Thus, both her local doctors and the physicians from the cancer center are able to follow her progress and have all of the informtion on her treatment.

Patients are increasingly seen by a wide array of providers in a number of different locations, often raising concerns about fragmentation of care. When patients are most ill and need to be hospitalized, they are seen, not by their PCP who knows them well and who they trust, but by hospitalists and specialists who they have often never met. The way the system is now structured, the level of acuity of hospitalized patients has gone up drastically because insurance companies are increasingly refusing to pay for patients with lesser illnesses to be treated in the hospital. The hospitalist, who has day by day experience with in-patient care becomes the lead doctor.

According to the American Academy of Family Physicians, it is an obligation of physicians to provide continuity of care to their patients in all settings, both directly and by coordination of care with other health care professionals. Continuity implies a sense of affiliation between patients and their practitioners and the passing off of all necessary information..

When we think of continuity of care, we think of insuring that information is available at the point of care. But continuity of care is more. There are three facets: information continuity, management continuity and relational continuity in a care environment where patients and physicians collaboratlvely work together to deliver effective health care. This care must be coherent, connected and consistent. Information continuity means that all of the patient's medical history, conditions, treatments and related data are available at the point of care. Management continuity means that there is a consistent approach to treatment. This is

particularly important in chronic or complex diseases that require management from several providers who could potentially work at cross purposes. Plans and care protocols must be shared and agreed upon and ideally one gatekeeper (usually the PCP) oversees the patient and keeps all of the pieces in order. Relational continuity refers to a sustainable therapeutic relationship between patients and one or more providers and insures that bridges between past, current and future providers are in place.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC274066/

The situation where a patient who is hospitalized does not regularly see his or her PCP but is overseen by a hospitalist who the patient has not personally met, is just one example of how continuity of care is threatened and interrupted. Another example results from physician groups who rotate daily hospital rounding so the patient sees a different doctor every day. This makes patient care difficult since the doctor does not have the benefit of seeing what the patient looked like the day before and therefore does not have an essential benchmark to determine whether the patient is better, worse or unchanged.

Continuity of Care records, (CCR) developed jointly by ASTM International, the Massachusetts Medical Society, Health Information Management Systems Society (HIMSS) and the American Academy of Family Physicians, are intended to improve continuity of patient care, eliminate medical errors and assure that at least a minimum standard of health information is transported to a new health institution or physician with the patient. The CCR, which only provides a snapshot in time, includes a standard set of information that is organized, transportable and can be in electronic or paper format. It enables each provider that the patient sees to easily access information outlined in the record and update the information when the patient goes on to see someone else.

Although the creation and maintenance of a CCR is generally left to a patient's team of doctors, overseeing continuity of care is truly in the hands of patients. Not one else but the patient can be sure that information, continuity, management continuity and relationship continuity is maintained. and a part of the health care that they receive. Because we all have so many doctors involved in our care, it takes an empowered patient to assume the responsibility for insuring that the CCR or an equivalent personal health record is available at the point of care; that the care team knows the details of the case; and that medical decisions are coherent, consistent and communicated