



10 things

April 9, 2014, 7:29 a.m. EDT

10 things medical records won't tell you

By [Jonnelle Marte](#), MarketWatch

John Ueland

1. We come with a large price tag.

Doctors are being encouraged by the federal government to ditch their messy handwritten paper records, replacing them with sleeker, quicker electronic health records that should improve [patient care](#) and reduce health spending. More physicians are coming on board: in 2013, 78% of doctors' offices said they were using some form of electronic health records, up from 18% in 2001, according to the [Centers for Disease Control and Prevention](#).

But so far, the transition to electronic health records hasn't delivered the ease of use and savings advocates promised — and the choppy transition is having a ripple effect on consumers. Critics say the systems burden doctors with more administrative work and leave them with less time to see and treat patients. People seeing several doctors often still have to request paper copies of lab results or repeat the tests altogether. And record-keeping mistakes, which can threaten patients' health, remain a nagging problem.

Since 2009, the federal government has been paying medical providers who make the switch. Total incentive payments topped \$20 billion this February, according to the Centers for Medicare and Medicaid Services, and starting next year, doctors who don't meet certain requirements will need to pay a penalty.

Turns out, most doctors and hospitals could use the financial help. Implementing electronic medical records can cost \$5 million to \$10 million in the first year for a hospital with about 200 beds depending on the size and complexity of the electronic system, estimates Roen Roashan, a health-care analyst with IHS Technology, a market research firm. A hospital twice that size could see a price tag ranging from \$20 million to \$30 million, he says. "It's an expensive investment," he adds.

But some smaller hospitals and doctor's offices find they can't afford to make the investment. About 6% of roughly 5,400 U.S. hospitals are still using paper records, according to the latest figures from HIMSS Analytics, a not-for-profit group that supports the health information industry.

2. Pardon the communication gap.

Electronic health records are supposed to make doctors feel connected by giving them instant access to patient information. But in reality, as more doctors go digital, rules for categorizing and organizing the data are being set on an ad hoc basis, making it difficult for medical providers to share information, according to a report released in March by the [Government Accountability Office](#). For patients seeing multiple doctors, the communication issues could require them to re-take certain medical exams or to wait longer for test results — the kinds of hassles that the new electronic records were supposed to help prevent.

A study published in the Journal of the [American Medical Association](#) in January 2013 offered some examples of how doctors' differing rules are

[causing confusion](#) . For one: Some offices classify allergies as a "side effect" by explaining how patients react to certain foods or medications, while other offices create a separate category for allergies. That lack of coordination can lead to duplication of tests and procedures — a broader problem that costs the medical system \$148 billion to \$226 billion a year, according to the report. And some hospitals may find their systems aren't technically compatible, so that "switching records between [hospitals] requires you take the records with you," says Roashan.

The Department of Health and Human Services is working to close these communication gaps by introducing standards for how information should be recorded and by requiring doctors who want to receive incentive payments to use only vendors pre-approved by the department. Starting this year, medical providers who want to use electronic health records must use technology that was approved by the department. The rules create a structure for how patient summaries should be presented and how messages should be transmitted from one office to another. Still, the GAO report notes that health officials won't know how helpful the standards will be until more providers get on board and use electronic records.

Migraine-relieving headband approved by FDA

The Food and Drug Administration approved the first medical device used as a preventative to ward off migraine headaches: A headband that electrically stimulates nerves before the onset of pain. Tom Burton reports. Photo: Cefaly.

3. Psst...Your doctor hates us.

While most doctors like the idea of electronic health records, many are much less enamored with the reality. A survey released last year by the American College of Physicians and AmericanEHR Partners, a membership group for medical providers implementing electronic records, found that 34% of doctors using electronic records were "very dissatisfied" with the ability of their systems to decrease workload, up from 19% in 2010. What's more, 32% of doctors said they couldn't return to their normal level of productivity after rolling out the systems, up from 20% in 2010. And the share of doctors who said they would not recommend electronic records to a colleague increased to 39% from 24% over that same time period.

A separate 2013 study of 30 physician practices by the Rand Corp. found that many doctors reported a dip in overall work satisfaction after implementing the electronic systems. Doctors said the systems increased their administrative workload, took away from time with patients and didn't always mesh well with their other computer systems.

Still, even doctors who criticize the systems say the move to electronic records has largely helped their practices by giving them greater access to a patient's medical histories, helping them spot potentially dangerous drug interactions and making it easier to order prescriptions or book appointments.

4. You'll get even less face-time with your doctor.

Patients often complain that they don't get enough face time with their doctors. And now, because of the transition to electronic health records, some patients may wind up competing with a computer screen for their doctor's attention, doctors and consumer advocates say.

Doctors who accessed electronic records during a patient visit spent roughly a third of the appointment time looking at a computer screen instead of interacting with their patients, according to a study by [Northwestern University](#). The research, which was published last December in the International Journal of Medical Informatics, analyzed 100 patient visits with primary care doctors.

The time spent looking at their computers was time that doctors would typically use to visually examine a patient and chat about how they're feeling, says Enid Montague, lead author of the study and an assistant professor in medicine and engineering at Northwestern. Those moments are vital to establishing trust with the patient and spotting nonverbal cues that might signal a health issue, she says. "It is possible you can miss things about the patient that are clinically important by not engaging in that longer conversation," says Montague.

What's behind the rising risk of osteoporosis?

Osteoporosis is thought of as a bone-weakening ailment that is mostly a problem for older women. But now doctors say it's striking younger patients. Informed Patient columnist Laura Landro reports on Lunch Break. Photo: Getty Images.

On the bright side, the study didn't find that doctors skipped any steps during the examinations. And some doctors are looking into new ways to incorporate electronic medical records without alienating patients. For example, some physicians take notes on paper during the visit and then update the computer systems later in the day. And some doctors are calling for a new computer interface with larger font and a simpler display that would make it easier for physicians to go over important

information during a visit while still building a rapport with patients.

5. Pay no attention to that stranger in your exam room.

To avoid cutting into time with patients, some doctors and hospitals are outsourcing the administrative work of typing up medical notes and updating charts — hiring workers to shadow physicians and document what doctors and patients say.

These workers are called "medical scribes," but they are usually not medically licensed professionals. Scribes will sit in the examination room typing up a patient's medical history as the patient recites it to the doctor, says Michelle Holmes, principal at ECG Management Consultants, a firm that helps doctors implement electronic health records. They can also record a patient's vitals, like their blood pressure and heart rate and other observations noted by the doctor.

Some patients may be uncomfortable with having a third person in the room who isn't a medical provider, Holmes says. And some doctors worry information can get lost in translation if scribes mix up medical lingo or take down the wrong information. (Medical scribes are paid between \$8 and \$16 an hour, according to career site Glassdoor.com.)

That said, scribes can help improve care by giving doctors more time "to be a doctor," notes Holmes, by freeing up time for them to see and chat with patients. Doctors are still involved in the data entry process, since any notes entered by a scribe need to be reviewed for accuracy and approved by physicians, says Holmes.

6. We make everything easier — including mistakes.

Electronic health systems enable doctors to place orders for tests and medication with just a few clicks. But that ease also makes it easier for doctors

to mess up, by placing a status update or an order under the wrong name, says Heather Farley, assistant chair of the department of emergency medicine for the Christiana Care Health System, a network of hospitals based in Delaware, and the lead author of a 2013 report on the quality and safety implications of emergency-department information systems.

What's more, physicians who try to save time by using copy and paste functions within electronic medical systems have a greater chance of entering the wrong information into patient records, according to a warning issued in March by the American Health Information Management Association (Ahima), a group that represents health information professionals and sets best practices for electronic health systems. Doctors who accidentally only copy a part of a patient's records may also change the course of treatment, says Diana Warner, director of health information management practice excellence for Ahima. (Picture, she says, a doctor who copies "a history of breast cancer" into another part of a patient's chart instead of a longer note saying the patient's "family has a history of breast cancer.")

To be sure, many of the errors doctors make using electronic medical records are much like the mistakes they might make when using paper records, says Farley. But a 2012 report from the [Institute of Medicine](#) on health information technology and patient safety found that "health IT can create new hazards" and that the "potential for health IT induced medical error, harm or death has increased significantly" as these products have become more commonplace.

Some hospitals are trying to prevent mix-ups by including more identifying information in a patient's file, such as a photo or their room number, says Farley. Others are limiting how many charts doctors can have open at the same time or are requiring doctors to enter another piece of information, such as a patient's initials, before completing an entry, according to ECRI Institute, a nonprofit organization dedicated to patient safety. "Electronic health records are going to make us a lot safer than we are with paper, but it's going to take some time to get there," says William Marella, director of operations for the institute.

7. Sometimes, more information is a bad thing.

One of the perks of switching to electronic health records is that doctors can be alerted when test results come in, when there is a sudden change in a patient's condition and when a drug they prescribe may not interact well with other medications the patient is already taking. But critics say such alerts can set doctors up for an information overload.

The range of information and updates instantly showing up on a patient's chart make it possible for physicians to miss important information or to start ignoring the updates altogether. "The sheer volume of alerts makes it hard to distinguish the life threatening alerts from irrelevant ones," says Farley, who looked at the problem, dubbed "alert fatigue," in her report on the unintended consequences of electronic medical records.

Past studies have found that only a small percentage of drug interactions that generate alerts are actually dangerous and that doctors often override the majority of alerts they receive. For that and other reasons, Farley and other reformers are calling for hospitals and doctors to cut down on the alerts.

8. Identity theft is one of our side effects.

Big retailers that employ hundreds of security experts have been hit by hackers who steal their electronic records — so it's hardly surprising that the same thing can happen at your little neighborhood medical practice. According to cases tracked by the Privacy Rights Clearinghouse, a nonprofit group that works to raise awareness of consumer privacy issues, doctors' offices and other medical providers experienced 276 data breaches in 2013, up 24% from 2012 — a time period when the overall number of data breaches nationwide was declining.

Sometimes records get exposed when thieves swipe thumb drives, computers and phones that contain patient records. Indeed, 83% of all patient records breached since 2009 were due to theft or loss of a physical device, according to a report by HackSurfer, a cybercrime consulting firm.

To cite one recent example: In February, the records for 168,500 patients from Los Angeles County and 55,900 patients in San Francisco were exposed after thieves broke into the offices for Sutherland Healthcare Solutions, a billing and collections contractor in Torrance, Calif. The records contained personal identifying information such as Social Security numbers, birthdays, addresses and first and last names. Sutherland says it is offering the affected patients free credit monitoring services along with identity theft insurance coverage of up to \$20,000. The San Francisco Department of Public Health said in a release it would notify patients of the break in by mail and that there was no confirmation that the data had been accessed or used by the thieves.

Doctors' offices and hospitals also have to protect against so-called "insider threat," or the concern that an employee may steal records or sell sensitive information to identity thieves — an old problem that has become a greater issue now that electronic health records make it easier to discretely walk out with a greater amount of data says Jason Polancich, co-founder and lead architect for HackSurfer. Hospitals and doctors can beef up their security by conducting more background checks on workers, placing restrictions on which devices can be used to transfer patient records and encrypting data that gets stored. □

9. We're a gold mine for marketing executives.

Of course, long before doctors' offices started going digital, another industry was eagerly sharing medical records — the pharmaceutical industry. And the push toward electronic medical records is creating more opportunities that can help these folks make money.

Drugmakers can use the information to know which doctors are prescribing their product and which doctors are fans of a competitor. IMS Health Holdings (NYSE:IMS), a firm that compiles prescription drug information from pharmacies and sells it to pharmaceutical companies, disclosed in its filing for an initial public offering this year that it made close to \$2 billion during the first three quarters of 2013 from selling the drug data, according to a ProPublica report.

The information is stripped of identifying details such as names and addresses. But privacy advocacy groups say there should be greater restrictions on how prescription data — and other health records — are shared, arguing that it's still possible to piece together a person's identity using their zip code and age. Latanya Sweeney, a government and technology professor at [Harvard University](#), was able to match patient names to medical records for 35 out of 81 patients in a public database of hospitalizations compiled by the state of Washington in 2011 based on their zip code, age and the hospital they were admitted to.

One concern among privacy experts is that corporations could use these records to create profiles for patients that include sensitive medical information such as the medications they take and what illnesses they suffer from, says Nathan Wessler, a staff attorney with the American Civil

Liberties Union. In a nightmare scenario, consumers targeted based on those illnesses could receive mailings that say "dear HIV patient" or "dear person with diabetes," says Wessler, or they could be charged different prices for medication based on how badly they need it. "There really is a lot at stake when we talk about data bases that start aggregating people's health information," says Wessler. In 2011 the U.S. [Supreme Court](#) upheld IMS Health's right to package and sell the information based on the First Amendment. IMS Health said in a statement that it collects anonymous health-care data and that it is important for patient health information to be "properly protected from inappropriate access, use and disclosure."

10. And we make it easier for the government to track you.

Some state and local governments are increasing their surveillance of health records from pharmacies and doctor's offices, hoping the data will help them track infectious diseases, chronic health conditions, drug use and other health behaviors. The New York City Health Department, for example, has been analyzing information from doctor's offices and emergency departments to track flu-like illnesses and gastroenteritis. Now the city wants authority to access to prescribing data from pharmacies that have electronic health records in place, in addition to the data it receives voluntarily from two retail pharmacy chains. "As pharmacies may be the first and only contact with the health care system for individuals with early or mild symptoms of a disease, having greater access to sales data can help the department detect outbreaks promptly," the department told MarketWatch in an emailed statement, adding that data would be kept confidential and wouldn't have any personally identifiable information.

Such data collection may improve public health by helping government agencies prepare for and prevent the spread of contagious diseases, says Orentlicher. But some groups are calling for greater restrictions on which agencies can access medical databases. For instance, some law enforcement agencies are digging into prescription records for drug investigations without first obtaining warrants, says Wessler of the ACLU. Last year the ACLU joined the State of Oregon in suing the federal Drug Enforcement Administration, which claimed it had the right to subpoena a database containing the names of patients taking medication to treat acute pain, anxiety and other conditions. In February, a federal judge in Oregon ruled the DEA needs to obtain a warrant before searching confidential prescription records in that state. The DEA previously argued in court documents that an administrative subpoena is a valid way to collect evidence during drug investigations.

Copyright © 2014 MarketWatch, Inc. All rights reserved.
By using this site, you agree to the [Terms of Service](#), [Privacy Policy](#), and [Cookie Policy](#).

Intraday Data provided by SIX Financial Information and subject to [terms of use](#). Historical and current end-of-day data provided by SIX Financial Information. Intraday data delayed per exchange requirements. S&P/Dow Jones Indices (SM) from Dow Jones & Company, Inc. All quotes are in local exchange time. Real time last sale data provided by NASDAQ. More information on [NASDAQ traded symbols](#) and their current financial status. Intraday data delayed 15 minutes for Nasdaq, and 20 minutes for other exchanges. S&P/Dow Jones Indices (SM) from Dow Jones & Company, Inc. SEHK intraday data is provided by SIX Financial Information and is at least 60-minutes delayed. All quotes are in local exchange time.