EDITORIAL

STATE MEDICAL BOARDS AND REGULATION IN AN ELECTRONIC MEDICAL RECORD ENVIRONMENT

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After the State of the Union address in 2004, when President George W. Bush proclaimed, "By computerizing health records, we can avoid dangerous medical mistakes, reduce cost and improve care," an executive directive was given to move medical records to an electronic format and the Office of the National Coordinator for Health Information Technology was created. Currently, regulatory agencies and state medical oversight boards operate using paper medical records. The use of electronic medical records (EMR) poses a challenge for physician oversight boards to modify current medical records review paradigms to accommodate the type of information available with this new technology and the way the information can be accessed.

Even the thought process behind medical record review will need to be reconsidered, as the information repository of EMR is far different than the outdated format of the paper chart. Here are suggestions for steps medical boards can take to modify review processes to remain on the cutting edge of medical oversight.

Licensing and health care provider oversight boards will need to establish or affirm definitions for electronic health records (EHRs), electronic medical records (EMRs), computerized patient records (CPRs), continuing care records (CCRs), etc. Standards for other terminology will need to be defined and board policies must be established for evaluating such records. Many boards have begun to deal with the issues of telemedicine, but few, if any, have adjusted strategies in a structured fashion to handle reviews of completely electronic medical records. The term EMR will be used here to describe any electronic form of a medical record.

Additional terminology must also be established to identify security and backup systems. Recognizing the physical location of the electronic database may not even be in a physician's state, much less his or her office, can present additional challenges. Some medical record information systems reside on local servers, others may be Web-based, and some data elements will be retrievable through health information exchange engines (electronic portals for information exchange), while the entry information actually resides elsewhere.

Boards will need to become comfortable with issues regarding the exchange of information to and from various data sources that contribute to medical records, and establishing standard terminology will be critical. Such organizations as the Healthcare Information Technology Standards Panel (HITSP) have provided information standards, and the use of currently recognized standards by all boards should be encouraged. Efforts to incorporate standardized terminology into statutes, guidelines and regulations will pay great dividends in future communication and oversight.

One error some boards could make involves a desire to stay with what is comfortable and what has worked in the past. In the most draconian (and ironic) fashion, this would include someone with an EMR being forced to produce a printed version of the record. This error obviates accessibility of valuable information that will never be manifested in printed form. The EMR, in an optimal format, involves a relational database and far more information than would appear in the type of records kept in the day of Sir William Osler and still used today by many physicians. An electronic version can provide information identifying who entered information and when — even if there was not a conscious action to record the date and time. It can track what information was reviewed, by whom and when such reviews took place. Orders, correspondence and billing information may be readily accessible electronically when not available on traditional paper charts. Medical records will begin to be viewed less in a SOAP-format mindset, and

more as an all-encompassing assessment of patient data with much greater access to information. In the ideal EMR, there will be portal access to authorized information, allowing oversight of who else reviewed various record elements.

Thus, boards will need to establish protocols for examining EMRs. For some systems, the major elements reviews may be able to take place before the reviewer/investigator ever has to venture into the field! A paperless office also means there would no longer be the need to cart reams of paper charts from one location to another, medical practices would not be handcuffed by lack of records and, perhaps most importantly, there would not be the need for almost incessant photocopying and reproduction of paper charts.

Such protocols for EMR review should also foster more timely reviews. To ensure security in such reviews, reviewers will need to be able to receive encrypted versions, or have some other way to review electronic medical information. One such mechanism is for the board to establish a secure website to allow reviewers to examine electronic medical records. This could be done with an infrastructure similar to that used by many medical journals for manuscript review. Ideally, a reviewer would be able to access the actual electronic medical information in a "read-only" form. It also may be desirable to have protocols in place based on the nature of the health concern immediately at hand. In some circumstances only limited access to parts of the EMR may be needed.

For many boards this would mean a restructuring of personnel as EMR use became more widespread. Fewer field personnel and staff would be needed to haul, reproduce and disburse materials. Such staff positions would need to transform into information technology positions to facilitate record review.

While current estimates indicate about 20 percent of physician offices are currently using some EMRs, most estimates predict more than 75 percent of physicians offices and a greater number of hospitals will eventually rely on EMRs. Currently, state medical boards are ill-equipped to handle this transition. Few have planned financially for the transition, either with the increased cost of adapting to the additional expertise required for EMR reviews or the potential reduction in costs associated with a preponderance of future EMR reviews.

A final consideration must be interoperability between private practice EMR system selections and monitoring systems by state oversight boards. There will be great incentive for practicing physicians and other licensed health care providers to use systems that are compatible with interfaces at oversight agencies. On the other hand, state agencies will want to be sensitive to adopting systems most likely to provide the greatest access to commonly used systems in their respective regions.

EMRs are coming and promise to revolutionize health care. Medical oversight boards that have not begun to prepare for the impact of this revolution in health care provider oversight will find increased strain from provider tensions, consumer dissatisfaction and staff stress.

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