25ᵗʰ Annual National Educational Conference

Professionalism and Productivity

1:00 PM

General Session

Pacific Ballroom

The Computerized Medical Records: 11,000 Pages and Counting - Taking Shortcuts, Using Staff Summaries, or Plodding Through

Changes in ODAR/SSA – HALLEX I-2-8-20; Submission of Medical Evidence

A Panel Discussion

MODERATOR

Hon. Jennifer Horne

PRESENTERS/SPEAKERS

Hon. Michael Brownfield
Hon. Glynn F. Voisin

Computerized Medical Records,
and the impact on our ALJs and our mission of providing timely and legally sufficient hearings and decisions

Background
And
Discussion

Today, we, as ALJs face the challenge of the electronic environment that has grown substantially over time.

It is reported that one ALJ was presented with a case file that had more than 11,000 pages in the F section. And, files with 1,000 and even 2,000 pages of medical records are not uncommon.

However, Chief Judge's Bulletin 10-03 now allows case pullers to leave in duplicate pages, leave exhibits in an out-of-order state and leave irrelevant documents within an exhibit.

SSA's new policy governing the submission of medical evidence allows representatives to submit large volumes of documents into the file. These submissions often have immaterial records, and often have records that were are already in the exhibit folder. Overlapping sets of medical records are not uncommon. Mixing providers is also not uncommon.

At times, exhibits are out of order, contain irrelevant material, duplicate material, and sometimes records of a person unrelated to the case.

In the old days, files were neatly assembled and records were placed into date order; duplicates and extraneous materials were removed.

The transition from hand-written and hand-typed treatment notes to new *computerized medical records* has not been smooth and flawless. Some medical records software create records that are simply horrible.

"EMR [electronic medical records] problems relating to usability and safety are quite serious. The EMR market is relatively dysfunctional with almost 450 vendors." Nicolas P. Terry, *Pit Crews With Computers: Can Health Information Technology Fix Fragmented Care?*, 14 Hous. J. Health L. & Pol'y 129, 169 (2014). Many doctors are unhappy with the format of electronic records and the time restraints placed on them by the software. "As noted by one physician, 'many electronic health record systems have pull-down screens listing each of the 68,000 possible diagnosis codes ... and 87,000 possible procedure codes.'" Terry, at page 173.

"A 2013 RAND study summarized the adverse impact of the current generation of EMRs on physician professional satisfaction as follows: 'Poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products, and degradation of clinical documentation were prominent sources of professional dissatisfaction.'"

Terry, id.

It looks as if the tail is wagging the dog. Although EMRs were supposed to improve the doctor-patient relationship, the opposite has occurred in a many instances. One study showed that doctors spent "44% of their time on data entry, 12% reviewing test results and records, and only 28% in direct patient care." As a consequence, "'the real patient in the bed often feels neglected, a mere placeholder for the virtual record.'" Terry, *id*. at 174.

If the doctor does not take the time to fill in all the blanks, or to choose an entry in the numerous drop down menu choices involved in creating a note, many software programs will make the choice for the doctor – often will inaccurate results. One study of medication errors showed "in some cases, default settings were not adjusted for specific patients, complete data were not entered, causing the system to fill in the blanks, or information entered by users was overwritten by the system". Alex Nixon, *Errors in default settings of electronic medical record systems raise risks for patients*, Trib Live (Sept. 6, 2013), http://triblive.com/business/headlines/4654582-74/errors-patient-patients#axzz2ePbBawnA (last visited July 3, 2016).

Causes of Errors in Electronic Medical Records.

Professor Sharona Hoffman has detailed
three primary sources for error in EHRs:

Input Errors

*Data Entered Into Wrong Patient
Charts*

Copy and Paste Problems

She explained these sources of errors as
follows.

1. *Input Errors.* Clinicians entering data into EHRs often mistype words, invert numbers, or select wrong menu items from drop-down menus. They may also choose erroneous diagnosis codes, check boxes incorrectly, or uncheck boxes inappropriately if the default setting has all boxes checked.

2. ***Data Entered Into Wrong Patient Charts.*** Data can be entered into the wrong patient chart if multiple patient charts are open at the same time or if a prior user did not log off properly after viewing another patient's EHR.

3. ***Copy and Paste Problems.*** The EHR copy and paste feature is notorious as a source of errors. It is designed to save time, allowing physicians to copy narrative from a prior visit and paste it into new visit notes. However, if the copied information is not carefully edited and updated, the physician will inadvertently introduce errors into the record.

Former SSA Commissioner, Michael Astrue, predicted that the computerized medical records campaign would revolutionize disability adjudication. Illegible handwriting would be replaced by typewritten text. Records would be more comprehensive. Records requests would be almost instantaneous, with the records being transmitted electronically. It has also been argued that electronic medical records will allow "practitioners to access patient information wherever it may be located, and help researchers better understand the human body, share information, and ultimately develop more beneficial treatments to keep Americans healthy." Nicolas P. Terry, *Pit Crews With Computers: Can Health Information Technology Fix Fragmented Care?*, 14 Hous. J. Health L. & Pol'y 129 (2014).

What proponents did not foresee were the numerous problems that some computerized records would engender. Consider the following.

First, we now see treatment records that contain the statement, "dictated but not read." Do these doctors who issue notes with this caveat really think this will protect them when they are later sued? Doubtful.

Second, many of the old hand-written and typed treatment notes followed a simple format: SOAP, or Subjective, Objective, Assessment, and Plan. Now, this simple format has given way to pages and pages of "stuff." Adjudicators have to sift through pages of repetitive information containing prescription history, lab test results, and any other "data" the medical records software chooses to include. This may include information reported at prior visits, and information that is simply the default finding per the software protocol.

Third, language used in an early note seems to recur again and again, in circumstances where it is doubtful that this language was repeated by the patient over and over again. An example of this is sometimes seen in pain clinic notes where note after note the following comment appears: "Patient's medications are effective in controlling his pain and allow him to be more functional." When asked about this language at the hearing, claimants will often appear dumbfounded and say that specific discussion did not come up and even of it did, it did not come up every visit.

Fourth, some computerized records contain a format that contains all possible symptoms and when the patient answers affirmatively to one or more symptoms, the doctor will highlight the symptom in an effort to indicate a positive response, But by the time the records make their way to the electronic file, distinguishing the positive from the negative can be very difficult.

Fifth, some records are created on a colored or patterned background, which may be great for the original copy maintained in the doctor's file. But when copied and then scanned, become almost impossible to read, and they cannot be OCR'd for conversion to WORD format, which some judges like for their notes.

Sixth, it looks like records software
expect a doctor to do a complete physical
exam every time a
patient is seen. This is obviously not the
case, but it looks like the software will
just create an exam showing either the
results of the last known exam, or will
report a negative physical exam.

Talking Points in conjunction with Computerized Medical Records

1. The 1,000 page case summary initiative.

2. CJB 1-13; Perhaps, we need to institute a policy calling for case pulling that befits a judicial system that has due process as its primary mission.

3. Perhaps, we need to institute a policy requiring reps to submit appropriate sets of medical records; records are in order and do not contain duplicates and which do not mix providers; allow staff to reject non-conforming submissions; give ALJs the power to "fine" non-compliant reps up to $200 per infraction.

4. Use of OCR, PDF formats for medical records which would allow ALJs to search the contents of medical records.

5. Assign specific attorneys to ALJs to work on complex files.

6. Give claimants an opportunity to address problems in their medical records, i.e., inaccuracies, nonsensical entries.

7. Have agency work with HHS to address shortfalls in electronic medical records.

Thanks

Questions

Comments