The Patient's Role in Ensuring Legal EHR Data Integrity
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For nearly 40 years I have served as an HIM and health IT professional, but for my entire life I have been a healthcare patient. My understanding of the processes that create medical records has helped me identify system and human mistakes in my own records. Consequently, I know well that the strength of an organization's legal EHR depends on the accuracy of its information-generating systems and how that information is reproduced for providers and patients.

Data integrity is vital to maintaining legally sound and court-ready EHR information. While routine audits of processes help, patients can also be a valuable partner in ensuring records are accurate and reproduced in human-readable format.

There are several benefits to developing processes for patients to make amendments to their medical records when mistakes are discovered. While changes to the record should be carefully considered, patients are usually more in touch with their care than busy healthcare professionals and HIM managers. Patients should be encouraged to review their medical data— through electronic portals or PHRs—for errors.

Open communication channels for patient-suggested record amendments should be maintained. Beyond the impact on patient safety and quality care, a correct medical record is a more legally sound medical record.

Digital Portals, PHRs Offer Windows to Mistakes
I've learned over the years the benefits and disadvantages of electronic health records. As a "power user" of many EHR systems over four decades of HIM/HIT work, I've seen EHR systems and components come and go. But interacting with EHR systems as a patient provides a different perspective and uncovers unique flaws.

I have maintained an analog PHR since the 1970s. Recently my healthcare providers have begun forwarding digital lab, radiology, and other files through a patient portal. As such I am in the process of converting pertinent portions of my analog PHR to a digital format. As part of this process I verify that my analog and digital health record information is correct. If the information is not correct, I contact the provider or provider organization to amend the information.

Many organizations have implemented EHRs, digital PHRs, and visit summary applications, and patients are beginning to use these systems. However, most patients don't know they can ask to amend their records. When releasing paper copies or uploading information to their patient portals, providers should encourage patients to report any incorrect information they view in their records.

In addition, organizations with these systems must contend with requests for corrections to system flaws, poor configurations, and outstanding training issues from outside of their internal users. External users such as health information exchanges will be requesting corrections to health records, system flaws, and poor configurations.

HIM and health IT professionals should make fixing these issues a priority, since the legal implications of any unintended consequences that come from faulty EHR usage can be overwhelming.

Personal Experience with Data Flaws
As an HIM and health IT professional, experience has taught me to have little trust in the data generated by my providers' EHR systems.

I am a patient at two separately owned and operated healthcare provider organizations that are within walking distance of one another. Fortunately, both organizations use the same suite of clinical information system modules for their "core" EHR system. Unfortunately, the two suites of clinical information system modules currently do not talk to one another or even look and act alike. While one organization provides access to records through a patient portal, the other relies on paper release processes.

As an HIM and health IT professional, I've found several flaws in these providers' EHR systems, including the one system's PHR provided through a patient portal. The organizations either do not know how to correctly configure their EHR systems or have failed to do so properly. I've also found that the organizations' staffs lack adequate training on the systems.

Below are some specific examples of record mistakes taken from personal experience that HIM professionals and patients should monitor in their systems.

Problem Example 1: Male with Cancer
I requested the release of my medical record from one of the organizations. The transcribed procedure report header listed my correct name, date of birth, and medical record number. However, the report body included two pages describing me as a male and having cancer. Neither of these statements is accurate.

This kind of mistake is common. Either the provider mistakenly dictated on the wrong patient under the correct header information sent by the EHR system, or the transcriptionist mistakenly keyed the wrong patient information under the correct header information.

After contacting the organization and asking for the record to be corrected, I donated a copy of the report to a local HIM program for student education purposes.

Problem Example 2: Changing Orders
One of my care providers repeatedly asked for lab work, even though the same lab work had been performed months ago and was stored in my PHR. Deleting the EHR order error and updating the system with the previous lab results required several handwritten notes, photocopies, and telephone calls to the provider.

According to two of the organization's staff members, these orders come from a "different database" than the "real" orders, which "are correct in the system, but don't print to the hard copy correctly." This is not possible, and likely the problem is a lack of staff training on the correction processes.

It's unclear whether this is an internal end-user training issue, a system flaw, or poor implementation of the system's function. Regardless, organizations should develop a process to

easily discontinue or cancel electronic orders that have been performed but, for some reason, are not automatically canceled as future orders.

The current process a patient must go through to correct order mistakes is laborious and should be simplified.

Problem Example 3: Duplicate Tests
EHR systems should be configured to alert providers of all tests performed in the past. Recently, when one organization's physician ordered a routine TB test, there was nothing in the EHR system to alert the provider that the organization performed the same test in July 2009. Consequently, the test was unnecessarily repeated in February 2010, costing an additional $398.

This could have been solved by a properly installed clinical decision support system. Either my provider's EHR system does not include this function or the system is being used improperly. After complaining about the duplicate test, the organization's end user said it is the provider's responsibility to look back at all the orders in the system to see if a TB test had been performed within the last several years. The provider can't be faulted for not wanting to scroll through several years of past orders to determine if a routine test was performed.

Instead, this should be a system function HIM professionals advocate for their systems. On the patient's side, the presence of a well-maintained PHR would've enabled the organization to avoid the repeated test. Unfortunately, my PHR was off site and not consultable.

Patients Keep the Records Honest
Reliable health records and data integrity are vital to maintaining legally sound EHR information. Ensuring electronic legal health record integrity and trust should not be a patient role, even though patients, like me, are finding themselves responsible for managing their provider records and their systems.

Industry professionals must begin to shift their focus from the technical and operational solutions that automate, send, and receive health information to the quality and accuracy solutions that manage the analog, digital, or hybrid information in our health records.

Best practices suggest designating HIM representatives to work with patients to ensure their analog and digital records are accurate when a change request is received. Providers should encourage patients to review their medical information for accuracy as well.

This role would be similar to financial bank representatives who resolve financial disputes and balance digital checkbooks.

The HIM department is in an excellent position to provide a mechanism for patients to flag and correct their health information. Not only are such initiatives beneficial from an HIM, HIT, data integrity, and legal point of view, but they are beneficial to patients' sense of confidence in their records and care.

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