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Perspectives on clinical risk management

THE ELECTRONIC HEALTH RECORD In the Office Practice

Although the electronic health record (EHR) is not the most sophisticated technology in the arena of medical practice it may become the most ubiquitous. At a time when one medical practice may have three or more offices and patients may have professional relationships with at least that number of physicians, the EHR, also known as the electronic medical record (EMR), offers opportunities for communication that do not exist with the paper record. The following case from ProMutual Group's closed files offers ample evidence that there is a need for such communication.

Case Study: *A 64-year-old long-time heavy smoker had a routine preoperative chest x-ray performed the day before his left ruptured quadriceps tendon was to be surgically repaired. The chest x-ray revealed a rounded nodular density measuring 2.5 centimeters in the left lower lobe. A copy of the radiologist's report was sent to the surgeon in his principal office. The patient, however, saw the physician in a satellite office in another community. The practice did not transfer the records from one office to the other for appointments, and the patient was never told the results of the scan. The error was revealed two years later when a second chest film and CT scan revealed a large pulmonary mass, multiple nodules, and metastases to the liver and adrenals.*

If the surgeon's practice had had access to an EHR rather than depending upon the filing and transfer of paper, a 26-month delay in diagnosing the patient's cancer—and the medical malpractice suit that followed it—may have been prevented.

Increased accessibility is only one advantage of the EHR. The EHR is a considerable space saver, with offices now either digitally recording or manually filing old records. An electronic system permits the immediate recording of patient information as well as a compilation of data by problem, disease, or other variables. It creates an automatic tracking system so that neither patients nor their test results or referrals "fall between the cracks." It can alert the physician to tests to order, patients to contact, and follow-up to perform. It also allows for immediate coding so that billing is made simpler.

The EHR is not without its detractors. The learning curve for this technology is considerable, and many physicians, particularly those nearing retirement, prefer not to invest the time and energy it takes to be at ease with the new technology. Perhaps a greater deterrent to implementation is the fact that although some practices report substantial cost savings with EHRs over the longer term, the initial expenditures are considerable, and, in some small practices, prohibitive.

The EHR is not a panacea. It is a new attempt to streamline and improve the administrative aspects of medical practice in both the institutional and office settings. It offers a number of advantages over the old, manual system. Naysayers are quick to point out it also has its disadvantages. This issue of *Perspectives* looks at some of the considerations on both sides of the EHR debate.



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At its best, the medical record is a vehicle for understanding the healthcare history, needs, and concerns of each patient. It should not only allow each treating physician to review medications, family and personal history, and previous complaints, diagnoses and treatments, it should also contain enough information to allow the successful completion of such administrative functions as billing and the filing of insurance claims. In addition, it should provide a legal record of all the care rendered to the patient.¹ Historically, the paper record has met those needs—with more or less success, as the case study at the beginning of this article indicates. In the world of 21st century medicine, however, with multiple treating physicians an issue, satellite offices a reality, limited storage space a practical constraint, illegibility a litigation concern, speed a general expectation, and medical malpractice suits a major healthcare consideration, the paper record may often be found lacking. Seventy countries are now attempting to address this issue by implementing the EHR. The push for the EHR in this country is from the top: President Bush noted in his 2005 State of the Union address that the EHR is the key to decreasing both medical errors and costs.²

Why

By one estimate, use of the EHR could realize savings of \$112 billion per year in U.S. healthcare spending.³ To some physicians, however, the EHR is less an issue of national economics than a disruption in a smooth-running and well-established professional routine. To others the EHR represents little more than an unwelcome micro expense whose impact cannot be measured in macro terms. It is physicians who have been frustrated by their own inability to access patient information, healthcare professionals who have been involved in medical malpractice litigation, and those who are or have been challenged by some of the demands and expectations of patients, colleagues, and healthcare institutions who appreciate the several advantages of the EHR. They include:^{1,4,5}

- Creation and continuing availability of one organized, systematic and complete patient record, including x-rays and other graphics and such auditory data as heart sounds and oral notes

- Elimination of record fragmentation
- Improved potential for continuity of care
- Capacity for instant consultation with a colleague
- Ability to read the notes of other physicians as soon as they are entered
- Ability to access the record at the same time another healthcare professional is reading it
- Elimination of illegibility and concomitant decrease in chances for treatment and prescription errors
- Elimination of misfiled records
- Retrieval of data for purposes of treatment, research, and statistical reporting
- Increased productivity resulting from the ability to access records from a number of different locations, including office, hospital, and home
- Increased revenue stemming from the improved ability to code accurately
- Decreased or eliminated transcription costs
- Increased storage capacity. One CD can store the equivalent of 100,000 pages of text.¹

The greatest advantage of an EHR is not administrative streamlining, however, but enhancing the ability to provide high-quality care. With one complete record potentially available to all providers, continuity of patient care is more readily realized; changes in the patient’s clinical condition over time can be visualized in one screen; and a patient’s complete medication history is instantly available. Depending upon the system they buy or the options they choose, physicians may be able to minimize their risk of failing to follow up with patients by automatically generating letters notifying patients of the need to schedule screening tests, annual visits, and/or follow-up appointments. At the same time, prescription drug order entry software can help prevent medication errors by checking the proper dosages of medications and warning of potential adverse drug interactions.¹

Who

With so many apparent pluses, one might ask why a summer 2004 study of 10,000 office-based physicians revealed that only 12 percent of ob-gyns, 16 percent of pediatricians, 20 percent of family physicians, and 22 percent of internists were using an EHR. Usage was found to be greatest among those under 35 years of age. There was a gradual decline by ascending decade until only eight percent of physicians 65 years and older were found to be EHR users. Solo practitioners accounted for only 10 percent of users, while groups with more than 21 accounted for 39 percent.⁴ Usage promises to increase, with one-quarter of primary care physicians stating that they planned to buy an EMR system by summer 2005.⁶

For the moment, however, many physicians have delayed their transition to an electronic system because of the complexity of the technology, confusion about purchase options, lack of standards and certification to help rank or rate the options, and cost.

What

Technology

One does not need to be a master of technology to be an effective EHR user, nor does one need to have advanced keyboard skills.¹ However, a minimal degree of comfort with and understanding of computer systems can prove helpful to the user of an EHR.

A system can do as much or as little as a practice needs or wants. The greater the number of features, the more complex the technology and the higher the learning curve. At its most basic, an EHR should allow the physician to chart electronically. However, physicians who believe it is simply a word processor that will help them document electronically the same data that have always been entered manually may find themselves languishing at the far end of a significant learning curve. Alternatively, they may lose out by misusing a system that is designed not to perform old tasks in new ways but to encourage the establishment of new

patterns and new capabilities. The EHR is not solely about entering data. It is also about using data, retrieving it, analyzing it,⁷ and through linkages with other facilities, sharing it to its fullest potential as permitted under state and federal privacy protections.

It is realistic to allot a year or more for the members of a practice to become effective EHR users.⁴ That time can differ

significantly between and among practices. During the implementation period, the practice's productivity—and revenue—may actually decrease.¹ In some cases, a return on investment has not been realized for 18 months or more. Some of those who have persisted through this period, however, have realized significant cost savings, principally through staff reductions and/or productivity improvements.⁴ To quote one successful user, "The experience requires fortitude, but is worth the effort."¹

Options

By one estimate, there are currently 270 vendors of EHR systems.⁴ Some are designed to meet all needs; others are geared more toward the particular needs of a practice. Some come with specialty-specific templates. Most, however, need some degree of customization.

For implementation to be successful, a number of issues must first be addressed—and resolved. Key among them are physicians' expectations of the system and the needs of the practice.

There are certain universal expectations of an EHR system:

- Electronic charting, prescribing, and billing
- Interface with a practice management system

- Electronic prescribing
- Ability to scan paper documents and to access them, once scanned

Some physicians also want the EHR to allow them to:^{4,8}

- Receive patient care alerts addressing such issues as the recent concerns about Vioxx

The EHR is not a panacea.

- Use diagnosis-specific templates
- List patients by clinical diagnosis
- Cross reference medications
- Be compatible with other electronic equipment such as personal digital assistants (PDAs) and dictating machines

From a risk management perspective, the system adopted or purchased by an office practice should enable, at the very least, the generating, recording, and updating of the following information:

- **Patient demographics**

The system should ensure space for entering and updating comprehensive demographic data including, at a minimum, name, address, e-mail address, telephone numbers (home, work, cell), patient's date of birth, and name of significant other.

- **Standardized templates**

The EHR system should allow the physician to enter all relevant personal, social, and family history, including medical, surgical, and obstetrical history; genetic history when appropriate; immunization history; and such relevant social history as smoking and use of alcohol and recreational drugs. A patient's medical, social, or family history may put

a patient in a high-risk category that requires earlier or more aggressive screening. This is a particular issue that has been noted in ProMutual Group's cancer claims.

The EHR system must allow the physician to enter the history of the patient's chief complaint, a pertinent physical examination that includes a review of systems, a comprehensive narrative progress note, and the treatment plan. Most visits to a physician's office are episodic. From a risk perspective, it is important for a physician to be able to show (a) that he/she fully assessed each complaint presented during an episodic visit and (b) that he/she used a systematic, reasoned process to arrive at a diagnosis.

The electronic system should remind the physician that an annual physical exam is due. It should also offer prompts to ensure that the exam is complete and completely documented. Defense experts have faulted some physician-defendants for never having performed a complete physical examination on a long-term patient.

Finally, EHR systems should permit documentation of all patient-related telephone calls, particularly those received after hours. Such records are important both in clinical care and in malpractice litigation.

- **Care plans, guidelines, and standards**

The system should offer prompts to support adherence to practice, screening, and disease management guidelines. ProMutual Group recommends that although these need not be those of a nationally recognized group, each practice needs to adhere to some guidelines, particularly in the area of cancer screening.

- **Problem/medication lists**

Medication errors accounted for almost 15 percent of ProMutual

Group's recent closed claims in internal medicine.

The EHR should allow the physician to develop and maintain for each patient a medication list that would include both prescription and over-the-counter preparations. It would also indicate refills to help alert physicians to the likelihood of a patient's misuse or abuse of a controlled substance.

Clinical support tools such as drug formularies and medication cross references are important additions to some systems.

- **Informed consents, refusals, and authorizations**

Informed consent is an issue, although not a primary allegation, in many medical malpractice suits, particularly those that arise in the surgical specialties. Patients may bring suit claiming they were "unaware" of the risks of a given procedure.

A good EHR system should allow the physician to create and distribute procedure- or medication-specific consent forms that may be further tailored to meet particular patient needs. The system should also allow the physician to create similar forms for the signature of patients who refuse care, tests, treatments, or medications.

- **Patient education**

The system should allow the physician to print out step-by-step instructions for the administration of medication; warnings concerning the possible need to curtail driving or alcohol consumption; detailed pre- and post-procedure care teaching; routine expectations; and follow-up, including indications for calling the physician.

Most patients today are educated consumers. The EHR needs to honor that fact.

- **Tracking**

The EHR system should allow the physician to create and send reminders for follow-up appointments and screening tests, notification concerning completed tests, and any requirement for follow-up. It should also permit physicians to communicate pertinent health information to consultants.

Inadequate follow-up is an issue in many malpractice cases. Specific issues include failure to follow up on missed appointments, test results, consultants' reports, and patients failing to have laboratory tests performed.

"I never saw the test result" or "The patient fell through the cracks" are not acceptable explanations or defenses in a medical malpractice case.

- **Confidentiality and Security**

The EHR system chosen by a practice should offer a means for both limiting access to patients' private health information to those legally authorized to have such access and for preventing tampering with data once it is made a permanent part of the medical record.

Requirements for respecting patients' privacy and the confidentiality of their medical information must be as strictly observed with an EHR as with the paper system. HIPAA provides the privacy guidelines in almost all circumstances. However, a state statute that is more stringent will prevail over HIPAA.

The security requirements for a practice that is converting to an electronic system include:

- developing policies and procedures that are consistent with HIPAA's privacy and security regulations
- educating staff members about the 'why' and 'how' of conforming to the policies and procedures

- controlling who among the staff has access to what confidential information
- conducting frequent drills to familiarize staff with all aspects of the security processes
- informing patients how the confidential information in an electronic file will be used
- adhering to an institutional or office policy addressing security breaches
- updating security standards as they are changed

In addition to the above, practices may find it prudent to develop and maintain a data back-up plan to prevent the loss of data resulting from a system-wide problem with or failure of the electronic record.

• Queries

The EMR should permit a practice the ability to obtain data by disease, clinical problem, or other parameters in order to (a) notify patients of new treatment options, (b) remind patients of the need to update screening tests, (c) report statistical data to local, state, and federal agencies, and (d) trend data in an attempt to identify and correct risk issues.

Cost

The implementation of an EHR system is costly. In fact, it is cost prohibitive to some solo practitioners and small group practices. By one estimate, the cost of a system for a private practice may range from \$15,000 to \$35,000 or even more per physician in a small practice.¹⁹ To make the possibility of conversion to an EHR more attractive to these practitioners, some companies are now making more affordable models available to small practices and solo practitioners.¹ The overall cost of a system usually depends on variables that include practice size, the number of users, the number of sites in which the system will function, and the breadth of the features and functions the system will

include.⁸ Large practices can realize initial economies of scale that have not been available to smaller practices—and are likely to realize a cost savings before smaller practices because of their higher patient volume.

Some hospitals are now offering both large and small practices financial incentives to convert to an electronic

tions. They might also consider determining:⁶

- Which system allows a **free flow of information** between the health record itself and whatever practice management modules are used. Some systems share a single database. If that is not possible, the systems need to be able to interface smoothly.

Implementation of an EHR system is a process, not an event.

system.¹⁰ Because of the risk of running afoul of federal anti-kickback and anti-referral statutes, practices should consult an attorney before entering into such a financial agreement.

No matter the size of the practice, all users can expect to pay a monthly fee for ongoing support and maintenance of the system. Again, larger practices have a considerable edge in this area because of their ability to hire an in-house information technology (IT) support person or staff.

Over time, physicians can realize a return on their investment. That might not occur, however, for 18 months or more after implementation.⁸

Purchase

At the time this article is being written, processes for certifying EHRs are being developed both by the Centers for Medicare and Medicaid Services (CMS) and by the Healthcare Information and Management Systems Society (HIMSS).⁶ Until certification is in place, physicians must become educated consumers. Before purchasing an EHR system, they need to define their expectations of an EHR and the specific features they need and/or want. They need to determine which system can help them meet the specifications noted above as risk management recommenda-

- Which system has the most effective **audit tool** for detecting the errors that may occur if two systems cannot communicate with each other.
- The system that most readily permits **conversion from a paper record**. Some physicians may choose to convert the entire record; others may be more selective in the kind of information they want to have available in the EHR. No matter the amount of information to be converted to electronic format, physicians should determine, before purchase, how conversion will be effected. Some systems have an embedded tool for scanning paper; others require an interface with a separate scanning program.
- The **technical support** that will be required to maintain a system and the availability of both within—or outside—the practice.⁸ Will current staff need to be trained or will additional staff need to be hired? Alternatively, is technical support available on a 24/7 basis through the EHR company? Because of the interrelatedness of all aspects of the EHR system, the failure of one part can negatively impact all others. It is crucial to budget adequately for whatever technical support may be needed to maintain the system both

during and after office hours. Failure to do so could lead to system errors and an increased risk of liability for physicians.

- The **budgetary constraints** within which the practice is operating.

Ideally, the vendor of the proposed system should be experienced. That is, he or she should currently serve a large number of clients. He or she should also be able to demonstrate a willingness to meet new standards as they become available.⁶

Physicians who are contemplating purchase of an EHR system may wish to consult some websites that are available. Among them are:

- [www.bphc.hrsa.gov/chc/CHC Initiatives/emr.htm](http://www.bphc.hrsa.gov/chc/CHC_Initiatives/emr.htm) — Included in this website of the federal Bureau of Primary Health Care is a checklist entitled “EMR Functional Requirements.” It is a comprehensive document that allows the practitioner to determine his or her minimum and optimum standards and to weigh them against the offerings of any particular vendor.
- www.aafp.org — The site of the American Academy of Family Physicians. The Center for Health IT section, under “Practice Management” offers helpful steps in preparing for the transition to a paperless office.
- www.acgroup.org — The website of ACGroup, a consulting firm in Montgomery, Texas. This site lists, rates, and ranks almost 50 different EHR products on the basis of their functionality.

Implementation

Implementation of an EHR system is a process, not an event. As noted previously, it can take up to one year or more, with physicians making the transition at different paces. During the very earliest phases, workflow is likely to be slowed. It is not unreasonable to plan to see fewer patients during this time period.

To make the transition as smooth as possible, one person in the office should be assigned primary responsibility for implementation. This is likely to require an expenditure for additional upfront education. It is a worthy investment, however, for without one educated, knowledgeable person in charge, conflicting ideas and priorities can lead to chaos. Additional financial outlays may be required for the education of *all* staff, both professional and support. Some will require administrative training allowing them to make structural changes to the system; others will need training only in basic operations.

To keep implementation on schedule, the practice may wish to establish performance benchmarks that can be monitored on a regular basis to determine the existence of slowdowns and to determine how best to manage them.⁸

To keep tempers in check during implementation, regular staff meetings may prove helpful.¹¹ Differences in clinical and administrative styles will come to the fore when, working in an unfamiliar environment, everyone may feel they are doing more and accomplishing less. Allowing physicians, nurses, and staff to vent their concerns in a single forum is one way of defusing the situation before it becomes counterproductive.

Every office needs to define upfront how it will manage the situation in which one or more physicians in the practice refuse to participate in the implementation process.

Conclusion

The EHR is more than a new way of charting. It is a new way of practicing the business, but not the art, of medicine. The EHR promises improvements in the quality and safety of patient care, increases in operating efficiencies, and savings in both time and resources. These benefits come at a price. The EHR is costly to implement and to support; it requires a dedicated staff to persist through a long

and steep learning curve; and, until everyone in the office feels comfortable with the system, it requires sacrifices of time and revenue. Is it worth it? The federal government thinks so. President Bush has announced a goal of ensuring that most Americans have an EHR within the next decade, and the Centers for Medicare and Medicaid Services (CMS) are now working on establishing standards for the new technology.¹² Physicians need to identify their needs and their budgets and then determine not if, but when and how they will implement an electronic system. To the extent that risk management can play a role in the process, ProMutual Group’s Risk Management Department will be available to its insured physicians.

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THE ELECTRONIC HEALTH RECORD IN THE OFFICE PRACTICE
Questions for AMA PRA Category 1 Credit (Risk Management)

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Are you licensed to practice medicine in the U.S.? ____ Yes ____ No

- | | |
|---|--|
| <p>1. The advantages of an EHR include all EXCEPT which of the following:</p> <ul style="list-style-type: none">a. increased potential for continuity of careb. immediate cost savingsc. increased productivityd. elimination of misfiled records <p>2. One CD can store the equivalent of how many pages of text?</p> <ul style="list-style-type: none">a. 100,000b. 125,000c. 150,000d. 250,000 <p>3. The learning curve for mastering the EHR:</p> <ul style="list-style-type: none">a. is flatb. is steepc. is in direct proportion to the cost of the systemd. is in inverse proportion to the complexity of the system | <p>4. From a risk management perspective, an EHR should permit all EXCEPT which of the following:</p> <ul style="list-style-type: none">a. documentation of patient-related telephone callsb. development and maintenance of medication listc. creation and sending of reminders for screening and follow-upd. timely mailing of bills <p>5. Before purchasing an EHR system, physicians should determine:</p> <ul style="list-style-type: none">a. number of physicians willing to use the systemb. availability of technical supportc. space saving that can be realizedd. number of months required for implementation <p>6. The refusal of one physician in a group to use an EHR should be dealt with by:</p> <ul style="list-style-type: none">a. patienceb. financial incentivec. decision of the practiced. termination |
|---|--|

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This program meets the criteria of the Massachusetts Board of Registration in Medicine for risk management study.

Target Audience: Physicians, all specialties

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Needs Assessment: The electronic health record offers physicians opportunities to enhance physicians' ability to provide high-quality care, consolidate patient care information, save space, and increase productivity and revenue. Conversion to an electronic system, however, requires a considerable outlay of both time and money. Before committing to an EHR system, many physicians are now grappling with such questions as: What do we need? How do we choose? What can we expect? How should we proceed? This article offers some steps to help ease the transition process for physicians.

- Learning Objectives:** After reading this article, physicians will be able to:
- Name at least 10 advantages of the EHR
 - Identify four expectations of the EHR that almost all physicians voice
 - List at least five risk management considerations that should be factored into the decision to purchase an EHR
 - Name seven security requirements that an EHR system should meet

ACTIVITY EVALUATION

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