



# The Report

## Electronic Health Record: Friend or Foe?

Kathleen Sutherland, MD, Vice-Chairman

The Electronic Health Record (EHR) is here to stay. The federal government has created a huge incentive for physicians to utilize EHR's through the passage of the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH). Healthcare systems have been pushed to utilize EHR's through the initiation of the Meaningful Use incentive program, the Pay for Performance program, among others, and through the development of Accountable Care Organizations which require structured electronic data. These financial incentive programs have successfully changed physician utilization of EHR's, such that in a 2014 survey, 75% of physicians were using an EHR compared to less than 20% in 2008. It is expected that most, if not all, healthcare will be documented in a digital format in the near future. Therefore physicians must determine how EHR's can best facilitate doctor-patient interactions and how to use them most effectively.

The overall goal of the EHR is to improve efficiency and quality of care while reducing cost.

Quality of care purportedly has improved as the EHR has allowed better tracking of chronic disease management over time and it has been beneficial for implementing prevention and screening targets. The improved access to laboratory and radiology data leads to less duplication of tests and therefore reduces costs. The EHR also improves communication between primary care practitioners and specialists within a healthcare system leading to more efficient patient information exchange. Remote access is an added bonus. Ultimately it is hoped the EHR will improve communication between doctor and patients though use of patient portals and personal health records. This will better engage patients and make them more responsible partners in managing their own care.

However, there are many drawbacks to the EHR. Many physicians feel it negatively impacts the doctor-patient relationship by bringing a "third party," the computer, into the exam room.

The EHR can lead to less eye contact with patients, making them feel alienated. Studies have shown physicians spend a significantly smaller proportion of the visit gazing at the patient when using an EHR compared to a paper chart.

Also many physicians are troubled by the amount of data entry they are now required to do. "I didn't go to medical school to become a secretary." Older and more clinically experienced physicians are less satisfied with the EHR than younger physicians, largely due to differences in technology skills. Certainly physicians' keyboarding skills and ability to navigate the computer are important factors for effective EHR use during patient visits, and these skills reduce physician need to focus on the computer and therefore positively influence communication.

Importantly, both young and old physicians complain about the time consuming data entry, interference with face-to-face patient care, and degradation of clinical documentation. EHR's need to do more than facilitate accurate coding and billing.

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### Special points of interest:

- *Using the PMP for safe practice*
- *Interstate Medical Licensure Compact*
- *New Telehealth Rules*

One physician complained, “the doctor's note has become a Christmas tree on which too many ornaments are hanging, because the note has morphed from what it used to be, a clinical communication to your colleagues or yourself, to a document designed for billing, for malpractice prevention, and to meet regulatory requirements, amongst other things”. The required data entry results in inadequate time to do full charting at the time of visit, so physicians are often required to do hours of charting at home at night that is not reimbursed.

Despite all these complaints, as Robert Wachter, MD, Professor of Medicine, UCSF has written,

“To most doctors it is apparent that EHR's are better than paper. But it's also clear to many doctors that there are losses they've seen as they've gone digital and the systems need to be and can be much better.”

So what is to be done?

- 1) The next generation of EHR's must be built more with the physicians in mind. The EHR's most critical function is to help physicians care for their patients. It is not just a coding and billing tool.
- 2) Templates must be built to match a physician's practice style and avoid inclusion of incidental data.
- 3) There should be options for less structured data and more free-texting.
- 4) Figure out efficient ways for medical assistants to enter some data when possible.
- 5) Teach office practices how to best configure the physician location of the computer in the exam room in order to facilitate the best patient-physician communication.
- 6) Teach physicians to engage patients in looking at data on the EHR together. Demonstrate for patients how the EHR is enabling physician to take better care of them.
- 7) Get different EHR's to talk to each other for quality information exchange. “Interoperability” must improve.
- 8) Teach physicians what is necessary to meet Meaningful Use Requirements and guide them to do this work in the most efficient fashion, with assistance of ancillary staff as much as possible.
- 9) Allow longer office visits to accommodate increased time needed for charting and insert EHR catch-up time slots during the work day.
- 10) Recognize that most physicians agree that it takes two years to be comfortable using the EHR and to be able to reach full functionality on the system.
- 11) Work with the AMA and others to insure that medical schools are teaching students to interact with the EHR and to teach integration of the EHR into the process of patient care. Physicians are concerned that there is not enough personal eliciting of a patient's history going on in medical school. Too much copying and pasting, as well as importing of data, without enough thoughtful interpretation of the data

Ultimately, the EHR will become more useful and usable, but physicians will need to be engaged, and help vendors build the systems we need. There will need to be more individualized system builds. The EHR is in its infancy. It is not yet cost effective in many settings. Hopefully the next generation of EHR's will be able to respond more quickly to physician needs, leading ultimately to more efficiency and reduced costs.

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- Asan, O. Smith PD. Montague, E. More screen time, less face time – implications for EHR design. *J Eval Clin Practice*, 2014: 1-8.
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**The following rule changes are pending with the Legislature:**

IDAPA 22.01.01– Changes to the requirements for international graduates in Idaho residency programs.

New rule IDAPA 22.01.15– Rules Relating to Telehealth Services-guidelines for providers in Idaho under the new Telehealth Access Act

Full text of the proposed rule changes are included on the following pages.

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**IDAPA 22**  
**TITLE 01**  
**CHAPTER 01**

**IDAPA 22 - BOARD OF MEDICINE**

**22.01.01 - RULES OF THE BOARD OF MEDICINE FOR THE LICENSURE TO PRACTICE  
MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY IN IDAHO**

**(Only those Sections being amended are shown.)**

**051. LICENSURE FOR GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS LOCATED OUTSIDE OF THE UNITED STATES AND CANADA.**

**01. International Medical Graduate.** In addition to meeting the requirements of Section 050, graduates of international medical schools located outside of the United States and Canada must submit to the Board: (3-26-08)

**a.** Original certificate from the ECFMG or original documentation that the applicant has passed the examination either administered or recognized by the ECFMG and passed an examination acceptable to the Board that demonstrates qualification for licensure or successfully completed the United States Medical Licensing Exam (USMLE). (5-8-09)

**b.** Original documentation directly from the international medical school which establishes to the satisfaction of the Board that the international medical school meets the standards for medical educational facilities set forth in Subsection 051.02, and that both the scope and content of the applicant's coursework and performance were equivalent to those required of students of medical schools accredited by the LCME; (3-26-08)

**c.** Original documentation directly from the international medical school that it has not been disapproved or has its authorization, accreditation, certification or approval denied or removed by any state, country or territorial jurisdiction and that to its knowledge no state of the United States or any country or territorial jurisdiction has refused to license its graduates on the grounds that the school fails to meet reasonable standards for medical education facilities; (3-26-08)

**d.** A complete and original transcript from the international medical school showing successful completion of all the courses taken and grades received and original documentation of successful completion of all clinical coursework; and (3-26-08)

**e.** Original documentation of successful completion of three (3) years of progressive postgraduate training at one (1) training program accredited for internship, residency, or fellowship training by the ACGME, AOA or the Royal College of Physicians and Surgeons of Canada, provided however, residents who are attending an Idaho based residency program may be licensed after successful completion of two (2) years of progressive post graduate training if the following conditions are met: ( )

i. The resident must have the written approval of the residency program director; ( )

ii. The resident must have a signed written contract with the Idaho residency program to complete the entire residency program; ( )

iii. The resident must remain in good standing at the Idaho based residency program; ( )

iv. The residency program must notify the Board within thirty (30) days if there is a change in circumstances or affiliation with the program (for example, if the resident resigns or does not demonstrate continued satisfactory clinical progress); and ( )

v. The Idaho residency program and the Idaho Board have prescreened the applicant to ensure that they have received their MD or DO degree from an approved school that is eligible for Idaho licensure after graduation. ( )

**f.** ECFMG. The certificate from the ECFMG is not required if the applicant holds a license to practice medicine which was issued prior to 1958 in one (1) of the states of the United States and which was obtained by written examination.(3-26-08)

**IDAPA 22**  
**TITLE 01**  
**CHAPTER 15**

**IDAPA 22 BOARD OF MEDICINE**

**22.01.15 - RULES RELATING TO TELEHEALTH SERVICES**

**000. LEGAL AUTHORITY.** Pursuant to Section 54-5613 and Section 54-1806(2), Idaho Code, the Idaho State Board of Medicine (Board) is authorized to promulgate rules relating to telehealth services. ( )

**001. TITLE AND SCOPE.** These rules shall be cited as IDAPA 22.01.15, "Rules Relating to Telehealth Services." ( )

**002. WRITTEN INTERPRETATIONS.** Written interpretations of these rules in the form of explanatory comments accompanying the notice of proposed rulemaking that originally proposed the rules and review of comments submitted in the rulemaking process in the adoption of these rules are available for review and copying at cost from the Board, 1755 Westgate Drive, Suite 140, Box 83720 Boise, Idaho 83720-0058. ( )

**003. ADMINISTRATIVE APPEAL.** All contested cases shall be governed by the provisions of IDAPA 04.11.01, "Idaho Rules of Administrative Procedures of the Attorney General" and this chapter. ( )

**004. PUBLIC RECORD ACT COMPLIANCE.** These rules have been promulgated according to the provisions of Title 67, Chapter 52, Idaho Code, and are public records. ( )

**005. INCORPORATION BY REFERENCE.** The Idaho Telehealth Access Act, Chapter 56, Title 54, Idaho Code is incorporated by reference into these rules. ( )

**006. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.** The central office of the Board shall be in Boise, Idaho. The Board's mailing address, unless otherwise indicated, shall be Idaho State Board of Medicine, Statehouse Mail, Boise, Idaho 83720. The Board's street address is 1755 Westgate Drive, Suite 140, Boise, Idaho 83704. The telephone number of the Board is (208) 327-7000. The Board's facsimile (FAX) number is (208) 327-7005. The Board's website is www.bom.idaho.gov. The Board's office hours for filing documents are 8:00 a.m. to 5:00 p.m. MST. ( )

**007. FILING OF DOCUMENTS -- NUMBER OF COPIES.** All documents in rulemaking or contested case proceedings must be filed with the office of the Board. The original and one (1) electronic copy of all documents must be filed with the office of the Board. ( )

**008. -- 009. (RESERVED)**

**010. DEFINITIONS.**

.01 "Board" means the Idaho State Board of Medicine. ( )

.02 The other definitions applicable to these rules are those definitions set forth in the Idaho Telehealth Access Act and in Idaho Code Section 54-5603. ( )

**011. IDAHO LICENSE REQUIRED.** Any physician, physician's assistant, respiratory therapist, polysomnographer, dietician or athletic trainer who provides any telehealth services to patients located in Idaho must hold an active Idaho license issued by the Idaho State Board of Medicine for their applicable practice. ( )

012. **PROVIDER-PATIENT RELATIONSHIP.** In addition to the requirements set forth in Idaho Code Section 54-5605, during the first contact with the patient, a provider licensed by the Idaho State Board of Medicine who is providing telehealth services shall: ( )

01. Verify the location and identity of the patient; ( )

02. Disclose to the patient the provider's identity, their current location and telephone number and Idaho license number; ( )

03. Obtain appropriate consents from the patient after disclosures regarding the delivery models and treatment methods or limitations, including a special informed consent regarding the use of telehealth technologies; and ( )

04. Allow the patient an opportunity to select their provider rather than being assigned a provider at random to the extent possible. ( )

013. **STANDARD OF CARE.** A provider providing telehealth services to patients located in Idaho must comply with the applicable Idaho community standard of care. The provider shall be personally responsible to familiarize themselves with the applicable Idaho community standard of care. If a patient's presenting symptoms and conditions require a physical examination, lab work or imaging studies in order to make a diagnosis, the provider shall not provide diagnosis or treatment through telehealth services unless or until such information is obtained. ( )

014. **INFORMED CONSENT.** In addition to the requirements of Idaho Code Section 54-5608, evidence documenting appropriate patient informed consent for the use of telehealth technologies must be obtained and maintained at regular intervals consistent with the community standard of care. Appropriate informed consent should, at a minimum, include the following terms: ( )

01. Identification of the patient, the provider and the provider's credentials; ( )

02. Agreement of the patient that the provider will determine whether or not the condition being diagnosed and/or treated is appropriate for telehealth services; ( )

03. Information on the security measures taken with the use of telehealth technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy and notwithstanding such measures; ( )

04. Disclosure that information may be lost due to technical failures. ( )

015. **MEDICAL RECORDS.** As required by Idaho Code §54-5611, any provider providing telehealth services as part of his or her practice shall generate and maintain medical records for each patient. The medical record should include, copies of all patient-related electronic communications, including patient-physician communications, prescriptions, laboratory and test results, evaluations and consultations, relevant information of past care, and instructions obtained or produced in connection with the utilization of telehealth technologies. Informed consents obtained in connection with the provision of telehealth services should also be documented in the medical record. The patient record established during the provision of telehealth services must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records. ( )

## BOARD POLICY FOR TREATING CHRONIC PAIN WITH OPIOID ANALGESICS

In late 2014, the Board adopted the Federation of State Medical Boards policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain.

Please review the Board's policy [at this link](#).

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## FREE CME CREDIT!

Have you read the Federation of State Medical Boards (FSMB) model policies on Data 2000 and the Treatment of Opioid Addiction in the Medical Office and the Use of Opioid Analgesics in the Treatment of Chronic Pain adopted by the Idaho Board of Medicine? You can obtain CME credit thanks to the FSMB for each policy here:

- 1) [At this location](#); and
- 2) [Another one here](#).

## The Interstate Licensure Compact

Twelve states including Idaho have joined the Interstate Medical Licensure Compact, and the Commission has been formed. To learn more about the compact please see these websites:

<http://licenseportability.org/>

<http://www.csq.org/ncic/>

Also, the Board maintains links to meeting notices, minutes, and press releases relating to the Interstate Medical Licensure Compact Commission (IMLCC) [at this link](#).

Each state in the IMLCC has two commissioners. The commissioners for Idaho are Board of Medicine Chair Robert Ward, MD, and Anne Lawler, Executive Director for the Board of Medicine.

## Rx Profiles

Please access the Board of Pharmacy Prescription Drug Monitoring Program (PMP) to review your patients' profiles. In a single minute you can improve the safety and efficacy of the care you provide your patients.

For information on how to access the PMP, visit the Board of Pharmacy website <http://bop.idaho.gov/>.



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## BOARD WELCOMES NEW MEMBERS

Steve Malek, MD, Board of Medicine

Erich Garland, MD, Board of Medicine

Erwin Sonnenberg, Public Member, Board of Medicine

Renee Watson, Public Member, Dietetic Licensure Board

Carla Miller, RT, RPSGT, Respiratory Therapy Licensure Board

# Board Actions

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## BOARD ACTIONS

### PLEASE NOTE:

Some physicians have similar names, please verify information by license number on our [web site](#). Details of the action are available on the web site.

#### Explanation of terms:

- Stipulation: an agreement, admission, or concession.
- Stipulation and Order: an agreement between the Board and the practitioner regarding authorization to practice or placing terms or conditions on the authorization to practice.
- Suspension: temporary withdrawal of authorization to practice.
- Reprimand: a formal admonishment of conduct or practice.
- Revocation: cancellation of the authorization to practice.

**Stephen De Nagy, MD**  
**M-4915 AMMON, ID**  
**Board Action-Stipulation and Order**

**Laurence V. Hicks, DO**  
**O-180 Twin Falls, ID**  
**Board Action-Stipulation and Order**

**Patrick Gorman, MD**  
**M-8388 Idaho Falls, ID**  
**Board Action-Administrative Fine.**



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- Erica Mazzarella, RT

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