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Electronic HEALTH RECORDS BRIEFING

Your guide to transitioning from a hybrid to a paperless environment

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Happy
New Year
from
EHRB!

Combat reluctant clinician buy-in

Get nursing on board with EHR implementation

Physician buy-in may be the EHR catch phrase of the decade, but nurses are the ones who hold the key to buy-in success. With 2.8 million nurses and more than two million nurses' aids in the United States, these clinicians comprise more of the healthcare system than all other clinicians combined.

Despite being the largest group of EHR end-users, nurses are too often neglected in this process. If you can convince nurses to buy in to your

EHR project, your chances of success increase dramatically.

With a new EHR system, you'll no longer have to ask nurses about the origin of an obsolete form when you find one during scanning. This also means that you won't have to tell nurses that they can no longer use certain forms or confiscate all of the renegade forms to bar code them.

To top it off, by including **> p. 2**

Follow these five fool-proof EHR system selection strategies

Be up-front about your needs and do your homework

With more than 100 EHR solutions available and tens of thousands of organizations planning implementation, the challenge now is to choose the best solution for your operation's needs.

To help organizations find the right vendor, the Medical Records Institute (MRI) hosts a Clinical Documentation Challenge (CDC) as part of its traveling EMR Road Show™.

The CDC puts HIT vendors on the spot—each has a set time to demonstrate how its solution would best document a mock physician/patient encounter, including the following components:

- Clinical documentation
- Prescription writing, transmis-

sion, storage, medication lists, and drug interaction

- Querying capability

The MRI hosted the first CDC in Boston on November 16, 2005. In addition to creating a forum in which vendors can compete, **C. Peter Waegemann**, president and CEO of the MRI, offered the following strategies when selecting your vendor:

1. Determine critical functions.

Figure out exactly what functionality you need in new solutions. Once you know which functions you want your system to perform, compare how they will fit with your current processes and how **> p. 4**

EHR buy-in

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nurses, you avoid the risk of missing something essential in the EHR implementation process.

No other team members fully understand the scope of the nursing practice, workflow, and value that nurses bring to patient care, says **James A. Cato, RN, CRNA, MHS, MSN, CPEHR**, vice president and chief nursing officer (CNO) for Boca Raton, FL–based Eclipsys Corporation. And by failing to include your nurses' knowledge during EHR development, you may compromise rather than enhance care delivery.

Realize the worst-case scenario

An EHR designed without nursing in mind can contribute to a patient's injury or death. Cato attributes this to nursing "workarounds," which are alternative ways of getting a job done. Because nurses historically haven't had enough resources to do their jobs, they developed workarounds to save time, maximize efficiency, or accomplish a task—even if they don't have the proper tools.

Developing an EHR module (e.g., a medication administration system) without input from nursing may inadvertently create a dangerous situation because of these workarounds. It is possible that the EHR team doesn't fully understand the workflow that a nurse follows to administer medication to a patient. The new process within the EHR may involve too many steps that the nurses deem unnecessary.

This tacit disagreement could have devastating results. For example, suppose that a nurse opens an online chart to access the medication administration function only to realize that there are five steps to administer the medication. He or she will likely figure out how to work around the electronic method and administer the medication differently. This could cause the nurse to miss important information in the patient's chart.

Nurses are responsible for patient safety, yet hospitals often don't include nurses in strategic planning, information-systems selection, or goal development. This sets nurses up for failure. However, including nursing

Oops, we forgot nursing!



Don't worry—it's never too late to involve nursing in the EHR implementation process. If you started without nurses on board, invite them to the table anyway, suggests **Linda L.E. Reino**, chief information officer for Universal Health Services, Inc., in King of Prussia, PA.

To soothe ruffled feathers, explain that you and your team have accomplished a significant amount. But now that you understand where the project stands and where it needs to go, you can't do it well without the help of nursing.

Explain all of the benefits electronic charting will bring to nurses. Also ask the chief nursing officer to clarify any and all confusion about the documents that nurses use. This is helpful because you'll need to categorize, inventory, and bar code these forms so they scan and automatically file into the EHR.

If you approach nursing with a "tell us how we can help you" attitude, you'll be more likely to involve these influential players, no matter what stage of the game you're in, Reino says.

If nursing remains behind the scenes until implementation, be prepared to endorse a complete project review and make changes, additions, or deletions to the project as recommended by nursing. ■

when designing the system will help prevent a nurse from figuring a workaround, which will in turn make medication administration easier. As a result, nurses will use the EHR, which will improve patient care.

Show nursing the benefits

Simply because you include nursing in EHR development doesn't mean that the department will buy in to the process or take it seriously. To improve your chances of achieving buy-in, sit down with the nurses and explain what's in it for them, suggests **Linda L.E. Reino**, chief information officer for Universal Health

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Services, Inc., in King of Prussia, PA.

To do this, you must understand how the EHR will make care delivery easier for practicing nurses. For example, with an EHR, nurses won't have to call the HIM department to obtain medical records when they treat recurring patients. Instead, they can simply find the chart online.

Also, when a patient is admitted to the hospital from the emergency room (ER), both nurses and physicians can access the ER record online. Clinicians can also read previous information and access ancillary departments online.

Nurses are patient advocates and "will view process redesign from the perspective of protecting patients," Cato says. If you show them the benefits of an EHR, they will undoubtedly make it easier for the HIM department, Reino adds. "Sell it to them!" she says.

Bring nursing to the table

One of the best ways to sell the EHR system to nurses is to include them from the beginning, Cato says.

Ask the CNO to sit on the steering committee. This will ensure nursing participation at an active level and will likely help the project enjoy more success. "And when the CNO is involved, he or she will back you when you go sailing up to Three Main to tell the nurses that their forms aren't automatically filing because HIM didn't know they existed," Reino says.

In addition to the CNO, include nurse managers (there is usually at least one per unit) because they are stakeholders and need to express their concerns to ensure that the EHR reaches their specific practice.

To cover all nursing bases, create a team of nursing informaticists who represent various clinical backgrounds so the team has a broad view of clinical practice. Also consider assigning nurses with strong clinical backgrounds to work as subject experts on the project.

Cato recommends that you include subject-matter experts from each nursing discipline to work with the team as temporary representatives. Rotate the tempo-

rary members through 12-week cycles as the team addresses each particular specialty.

Embrace nursing enthusiasm

Having all of these people on your team will push the project forward, particularly because nurses are significant technology users and tend to embrace change more quickly than others, especially physicians, Cato says.

If you work with enthusiastic nurses who understand the value of informatics, physicians often have no choice but to accept the EHR and learn from nursing. In addition, the functionality that nurses will build into the system will make it easy for doctors to follow suit. ■



Upcoming events

Upcoming audioconferences:

Don't miss this EHR audioconference series, featuring expert speakers and **EHRB** editorial advisors **Darice Grzybowski, MA, RHIA, FAHIMA; Kelly McLendon, RHIA;** and **John Christiansen, JD.**

January 31—Electronic Health Records: How to head off compliance trouble

February 28—Electronic Health Records: How to choose a vendor

March 28—Electronic Health Records: How to negotiate a contract

For more information about these upcoming audioconferences, contact Associate Editor Andrea Dickey at 781/639-1872, Ext. 3856; call HCPro's Customer Service Department at 800/650-6787; or go to www.hcmarketplace.com.

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Selection strategies

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Finish off the selection process with free help

Once you narrow down your selection list, hop on the information superhighway for more guidance. We recommend the following associations:

- **The AHRQ National Resource Center** (www.healthbit.abrq.gov/home/index.html)—The Agency for Healthcare Research and Quality offers tools, resources, conference information, evidence reports, testimony, and research results to help you learn more about HIT.
- **American Medical Informatics Association** (www.amia.org)—This organization is directly involved in the development, implementation, and use of information technology (IT) in medicine.
- **Bridges to Excellence** (www.bridgestoexcellence.org)—This not-for-profit organization promotes HIT through measurement, reporting, rewards, and education.
- **The Center for Health Information Technology** (www.centerforhit.org)—The American Academy of Family Physicians hosts this site, which is dedicated to increasing the availability and use of low-cost, standards-based IT among family physicians.
- **Office of the National Coordinator for Health Information Technology** (www.os.dhhs.gov/healthbit/rfi.html)—Also known as ONCHIT, this organization provides leadership for the development and nationwide implementation of an interoperable HIT infrastructure.
- **Workgroup for Electronic Data Interchange** (www.wedi.org)—This organization works toward improving the quality of healthcare through effective and efficient information exchange and management. ■

these new functions may change those processes.

Prioritize each function in order of importance so you don't lose sight of exactly what you want when you evaluate vendors. Always refer to your ordered list and create specific criteria you can use when closely examining different systems' features. For a detailed checklist, see the sample on pp. 6–7.

2. Be clear and up-front about your needs. Outline your needs as specifically as possible with the vendor. For example, surgeons have different needs from primary care physicians, so it's important that you invest in a system that's right for you.

Ask vendors whether you can add specific EHR components to your existing systems and scheduling software. You may either need to purchase an entirely new EHR solution or find a vendor that can integrate your programs. If you can move forward with the add-on approach, assess the risk-benefit ratio and have realistic expectations about the pitfalls. Don't be a vendor's guinea pig.

Illustration by Dave Harbaugh



"I want you to write a comprehensive service level agreement and describe special objective obligations for the vendor. When you're finished, get a second opinion from the bloggers."

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3. Evaluate vendor operation. Once you identify the vendor solutions that meet your needs (i.e., the vendors that fulfill the criteria mentioned above) evaluate how the vendor operates. Obtain the answers to the following questions:

- How long has the vendor been in business (five years is the minimum; 10 years is better)?
- Is the company publicly held? If so, be sure the trend is positive.
- What is the vendor planning in terms of new releases? When will those components be available?
- What does the vendor spend on research and development? What is the company's vision for the future?
- Is the product Health Level Seven (HL7) compliant? By knowing this, you can ensure that you will be able to interface with practice management systems at physicians' offices and other hospital systems.
- Will you be able to retrieve and export data to a new system if you decide to change vendors in the future? How?

4. Analyze cost. You won't find an EHR boxed up nicely with a price tag attached. Cost includes several elements that you must understand from the beginning. Make a list and compare the following:


- Hardware
- Software
- Installation
- Training
- Technical support
- Upgrades

5. Do your homework. Research industry standards. Even though the HL7 draft standard for trial use (DSTU) won't be officially accredited by the American National Standards Institute until July, HL7 introduced significant changes to its original draft in 2005 that can help guide you through EHR selection. HL7 created conformance criteria—a completely new addition to the DSTU—for each function that an EHR should ideally perform.

The conformance criteria show both providers and vendors what a system needs to execute to comply with each function in the standard, says **Donald Mon, PhD**, vice president of practice leadership at the American Health Information Management Association and cofacilitator for the direct-care section of the EHR standard for HL7. For more information about the HL7 DSTU, see "HL7 updates draft standards to include conformance criteria" in the November 2005 **EHRB**.

Once you check out the HL7 conformance criteria, seek out other hospitals or practices that have purchased and use the system you are considering. Ask your potential vendor for a complete list of clients so you can determine with whom you would like to speak. Often vendors will direct you toward their most satisfied customer.

If you decide to visit a vendor's client, plan to visit during the work day. You'll want to see who uses the software that you might purchase and how well it works during peak hours. ■

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Sample vendor assessment checklist

Functionality/Usability

Company	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
How long have you been in business?						
When did you first develop this software?						
Where is your support located?						
How can we access support?						
What happens if your company goes out of business or is sold?						
Do you have experience with Medicare or third-party audits?						
How many versions and upgrades has your program been through?						
In case of system difficulty, how readily will a support person(s) be available once the system goes live?						
Have many systems have you sold? Installed?						
Health record management	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Can I look up a patient by different criteria (e.g., name, medical record number, Social Security number, etc.)?						
Does the system provide a summary view of a patient's health status?						
Does the system handle clinical documents (e.g., x-rays, reports)?						
Does the system allow me to maintain patient lists (e.g., allergies, medication, etc.)?						
Does the system organize patient information similar to the way paper charts do?						
Charting and health data	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Is data entry available via						
• text?						
• voice?						
• mouse?						
• tablet?						
• scan?						
• wireless connection?						
Can the user						
• easily build/customize off-the-shelf templates?						
• access previous labs/progress notes from a patient's electronic chart while entering data?						
• edit and addend clinical documentation?						
Can the system accommodate (and potentially improve) my workflow?						
Does the system						
• alert me about unfinished portions of clinical documentation?						
• bypass the alert, if necessary?						
• allow me to multitask (create tasks/order labs) while charting?						
• allow forwarding of patient information to staff, other physicians, etc., via e-mail, electronics faxing, messaging, etc.?						
• ensure that only authorized clinicians can sign clinical documentation?						
Decision support	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Does the system						
• use clinical information from all parts of the chart to provide decision support?						
• provide alerts for						
- drug-dose checking?						
- allergy checking?						
- drug-interaction checking?						
- drug-lab checking?						
- drug-condition checking?						
• generate reminders (preventive services)?						
Can the system alert the user of overdue tasks and urgent lab results?						
How disruptive are the alerts?						
Can the user override the alert?						
Can the user customize alerts?						
Can the user access medical literature, clinical guidelines, etc.?						
Lab and results management	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Can the user complete a lab order with a few clicks?						
Can the system send and receive lab orders electronically to/from laboratories, hospitals, etc., in my local market?						
Does the system notify me of abnormal lab results and provide normal ranges?						
Can the system show me trending of results over time?						
Can the user create/customize off-the-shelf order sets?						
Prescriptions	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Can the user						
• complete a prescription with a few clicks?						
• look up valuable medication information?						
• accurately check for drug interactions (drug-drug, drug-allergy, drug-food)?						
How accurate is the system in identifying drug-condition warnings (e.g., pregnancy)?						
Can the system						
• manage multidrug formularies?						

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Sample vendor assessment checklist (cont.)

Prescriptions (cont.)	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
<ul style="list-style-type: none"> send electronic prescriptions to pharmacies in the local market? 						
Reporting and population health management	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Can I query the system to identify patients who have a particular condition, are on a certain medication, etc. (assuming good data-entry for all patients)?						
Does the system track patients for follow up or send reminders?						
Can I create ad-hoc reports or am I limited to using off-the-shelf reports?						
Can I customize ad-hoc reports?						
Does the reporting module recognize "and/or" queries together?						
Electronic communication and connectivity	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Can I <ul style="list-style-type: none"> Access and manage various tasks (e.g., sign progress notes/review labs) with a few clicks? task or message someone else in the practice? manage tasks and messages from a computer other than my own? 						
Can the system generate consult letters/records to send/share with consultants?						
Can the system interface with the financial, appointment, and dictation software?						
Any other outside sources of clinical data?						
Accessibility	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Does the system allow <ul style="list-style-type: none"> more than one user to access an individual record? access from more than one location or office? 						
Can the end user access data by date or problem?						
Can the end user only search for text?						
Does the system provide Web access for patients?						
Implementation	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
What is the <ul style="list-style-type: none"> length of implementation? process for managing problems during implementation? knowledge and skill-set of the implementation staff? 						
How many days does the implementation staff spend on site?						
Can the vendor accommodate modification requests?						
Training	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
For how many hours does the vendor provide training?						
Which types of training methods does the vendor provide (e.g., classroom, on-site, or train-the-trainer)?						
What is the knowledge and skill set of the trainers?						
Does the vendor provide quality training materials?						
Cost	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
What is the approximate cost of <ul style="list-style-type: none"> software licenses? interfaces? ongoing maintenance? upgrades? 						
How does the vendor issue the necessary licenses (i.e., concurrent user versus per practitioner)?						
How often will support services/personnel be available once your facility goes live?						
Roughly how much should the system cost?						
Can you offer an application service provider (ASP) option, purchase option, or monthly subscription option?						
Administrative processes	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
Can the system perform online real time eligibility verification with copays and deductibles?						
Can the system print advance beneficiary notices for nonallowable procedures?						
Does CPT/ICD-9 scrub occur when coding the visit at the point of service?						
Does it provide status on claims?						
Can you drill down an item on a patient's ledger to read insurance activity/denial information?						
Does it provide electronic posting from payers?						
Can the system schedule resources/rooms/physicians at the same time?						
Can the system rotate schedules for multiple physicians?						
Miscellaneous	Priority	Vendor A	Vendor B	Vendor C	Vendor D	Vendor E
What are the hardware requirements?						
Do you handle antivirus and antispyware programming and support?						
Can I start as ASP and move to an in-house server?						
Are secure online backups available?						

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Q&A: Versioning isn't the villain when you limit access

Q: What is a quick definition of versioning?

A: In the context of the EHR, versioning is the ability to capture and track serial changes in electronic documents, data, or reports.

Documents, data, and reports are not necessarily static within a dynamic EHR because they evolve as clinicians add, change, or remove information.

Q: Why is versioning important?

A: Logging changes to record information and matching them to clean, organized versions is important because when you are looking at the record, you can track any changes made. Without versions, there is no way to reconstruct which clinicians knew about which information at what point during a patient's course of care.

Versions create snapshots of the documents, data, or reports at a given time. This information is useful not only in legal proceedings, but also in any activity that requires tracking of the course of information growth during and after a patient's encounter.

Q: What problems can versioning cause?

A: Versioning can cause several problems, including

- the inability to maintain all versions of a document
- poor record organization
- administration trouble
- difficult retrieval of past versions

Consider restricting user access to past versions to make sure that clinicians use the most current data in patient care. However, keep in mind there are exceptions to this.

For example, when trending lab information over time, it may be helpful to use more than one version. However, exceptions typically involve various document or report changes that are not truly new versions, but rather additional data or reports.

Q: How can I prevent these problems? I've heard that using icons is a solution.

A: There are a couple of items you should consider when defining and specifying versioning requirements to prevent the above problems.

First, ensure that you can easily differentiate between the most current version and previous versions. Use a logical numbering scheme tied to a date or icons that change state (i.e., the icon looks different depending on which version it links to) according to the version specifics.

Second, create a system within your organization that requires users to gain permission to view old versions so old versions remain hidden from users who do not need to see them.

Q: How do you lead people to the most recent information?

A: Typically, the document you see when you open an application is the current version. To view older versions of the document, you should be able to navigate through the "view old version" application sequence. Icons and document, data, or report names or identifiers that reflect the current and past version numbers can be helpful.

Q: How do you indicate whether preliminary information was used for care?

A: This is typically a function of matching old versions with their dates and time stamps to audit logs that show who used which components of the EHR application and when they used the EHR. This points to a need for clear organization of not only the various versions but also the audit logs. Many times these logs are searchable—as they should be—which makes finding the appropriate data possible. ■

Editor's note: Kelly McLendon, RHIA, president of Titusville, FL-based consulting firm Information Evolution Management, answered these questions.

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Leavitt awards contracts to lay NHIN groundwork; states continue to take initiative

Department of Health and Human Services (HHS) Secretary Mike Leavitt in November 2005 awarded contracts totaling \$18.6 million to four HIT groups to develop prototypes for a nationwide health information network architecture.

The contracts will move the nation toward President Bush's goal of personal EHRs by creating a uniform architecture for healthcare information that can follow consumers throughout their lives.

Each group is a partnership between technology developers and healthcare providers in three local healthcare markets and will develop an architecture and a standards-based prototype network for secure information sharing among hospitals, laboratories, pharmacies, and physicians within the next year.

The four groups are led by

- Accenture
- Computer Sciences Corporation (CSC)
- International Business Machines (IBM)
- Northrop Grumman

HHS will release the architecture design for each network in the public domain to stimulate others to develop further innovative approaches to implementing HIT. The prototypes will test

- information-locator services
- patient authentication
- security protections
- specialized network functions
- the feasibility of large-scale deployment

This work will help the American Health Information Community, a new federal advisory committee chaired by Secretary Leavitt that is charged with providing input to HHS and the industry about how to make health records digital and interoperable. Go to www.hhs.gov/healthit for more information.

Michigan adds another RHIO

Lansing, MI-based healthcare providers, educators, and

state officials announced plans in November to develop a RHIO to reduce costs and medical errors and allow officials to monitor health trends, *The State News* reports. The proposed project will cost \$3 million and stakeholders plan to complete the network within two years, *The Lansing State Journal* reports.

The proposed system would give community physicians secure access to patients' EHRs. Sparrow Hospital, Ingham Regional Medical Center, and Michigan State University each donated \$100,000 to create the exchange. The Michigan Department of Community Health matched the funding, but the project still needs an additional \$2.4 million, *The Lansing State Journal* reports. Committee members are gathering technology resources and working with a consultant from the Michiana Health Information Network, an RHIO in South Bend, IN, that has been operational for five years. Visit www.mbin.com for more information about the Michigan RHIO.

North Carolina to track outbreaks

North Carolina is implementing a new electronic health database that will use emergency room (ER) data to track illnesses and monitor for early signs of disease outbreaks, according to *The News & Observer*. Every 12 hours, ER staff will submit information about the symptoms they see in their patients.

The program, which will cost \$3.4 million over five years, will be up and running in all of the state's 24-hour ERs by spring, according to *The News & Observer*. Currently, 52 of the state's 113 hospitals use the reporting program. The system uses software from information technology firm MercuryMD, which also captures nonidentifying demographic information such as age, gender, and county.

CA docs offer PHRs

The California Association of Physician Groups (CAPG) has joined an initiative to bring Californians interactive personal health records (PHR) from their own doctors as part of the iHealthRecords service. The

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Regional Roundup

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CAPG has already begun using iHealth, noting that “the system quickly brings the patients into the e-health process and makes them active participants.”

iHealth services also enable the sharing of a patient's record with physicians, family members, and other appropriate caregivers in case of an emergency and includes automated education programs specific to the patient's conditions and medications, patient-physician secure e-mail, and same-day Food and Drug Administration medication warnings and recalls.

Medem, the patient-physician communication network founded by the American Medical Association and U.S. Medical Societies, provides the network for iHealth.

Gulf Coast rebuilds electronically

HHS is collaborating with the Southern Governors' Association and the Louisiana Department of Health and Human Services to plan and promote the use of EHRs in the hurricane-ravaged Gulf Coast. As hospitals and health centers rebuild, the partnership will help implement, disseminate, and support new records that will eventually connect with each other for an interoperable health information exchange, HHS reports.

The agreement with the governors' association will unite local and national resources and coordinate planning for digital health information programs. The state's department of health agreement will provide EHR support and develop a prototype for sharing health information. ■

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HIM department

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Not all e-signatures are created equal

The proposed HIPAA security rule originally included a standard for electronic signatures (e-signatures), but CMS later removed it from the final rule, even though healthcare organizations may already use e-signatures for electronic documentation that requires a signature (e.g., patient records, physician notes, and dictaphone transcriptions). Many pharmacies already use e-scribing—a form of e-signature—for prescriptions.

We will see an e-signature rule at some point, but probably later rather than sooner, says **Rebecca Herold**, information privacy, security, and compliance consultant, author, and instructor in Van Meter, IA. “But the real challenge right now is defining [e-signatures].”

The proposed security rule refers to the use of an e-signature as “the act of attaching a signature by electronic means” and states that the e-signature process involves

- authentication of the signer’s identity
- a signature process that follows system design and software instructions
- binding the signature to the document
- nonalterability after the signature has been affixed

to the document

There are several types of e-signatures, according to Herold, including

- a simple, electronic image of a person’s signature.
- a digital signature—a more complex, technology-specific electronic signature that uses a level of authentication to verify that the person sending the information actually owns the signature. This type of signature is similar to a public key infrastructure and uses the exchange of keys (i.e., digital certificates and encryption algorithms) for authentication.
- the “click here if you agree” section of online click-through forms.

It’s important not to confuse the different signatures because all e-signatures don’t necessarily have the same level of authentication, adds Englewood, CO-based information technology consultant **Edward B. Tinker, SSCP**.

“And it’s important to know that the person who owns the signature and not his or her assistant is the one sending you the information,” he says. ■

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