

AS RECORDS GO DIGITAL, HOW PHYSICIANS PRESERVE THE FULL STORY

The electronic medical record revolution is upon us

BY AMY FLETCHER

The United States is on the verge of a technological evolution—if not revolution—when it comes to health care. But the extent to which electronic medical records will improve patient care and tell patients' full stories depends in part on the type of systems providers implement and how they are used.



Prompted largely by sizable grants from the federal government and the reality of lower reimbursements in coming years if new standards aren't met, the health care industry is moving—albeit in some cases slowly—towards implementing electronic medical records. In the eyes of critics, the current way of recording and using clinical information is downright primitive, with important information stored in file folders and papers, with no way to analyze or search the information systematically.

Patient information is often divided among several doctors' offices and hospitals, with no office or facility having access to the full story. Even a patient's own doctor may have to thumb through a paper file to find, for example, whether a patient has recently had a tetanus shot. This manual and tedious process takes time and can lead to oversight and error. The use of paper records—or even electronic ones that aren't shared—can lead to physicians ordering the same tests, or prescribing the same or conflicting medication, as well as incomplete information about patients' medical histories. Duplication means unnecessary bills, and incomplete information leads to lower-quality care.

This kind of data isolation is often the norm in health care, and a far cry from the progress other industries have made in terms of using integrated networks to deliver powerful results. For example, for years ATM cards have been used worldwide, regardless of where customers or their bank accounts are located.

The federal government—and even certain parties in the healthcare sector itself—is hoping to change this. As for the government's part, it has developed an incentive program designed to offset the cost of implementing electronic health records. However, there are some strings attached. Providers must meet a "meaningful use" standard to receive the federal funding. That's because the goal is not merely to get technology in place and scan in existing health records, but to have useful

data points that are well organized and can be shared across secure networks. The thought is that information that is more useful, manageable, and accessible will help doctors and others make better decisions.

THE CHALLENGE

While excitement builds around a better way of collecting and sharing vital patient information, there are also concerns about what could be lost—namely tidbits of vital information that patients share with doctors and nurses that don't fit easily into an electronic medical record. And physicians and other providers are also concerned about identifying software and hardware that can talk to each other, meet the meaningful use standard, and aren't too expensive or difficult to master.

That's where Health Story, a nonprofit alliance of healthcare vendors, providers, and associations comes in. Over the last three years, Health Story members have pooled resources to produce common data standards for the flow of information between common types of healthcare documents and electronic health records. They've also developed scanners, software, and systems that accommodate the way that doctors, nurses, and others are used to working.



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In this period of transformation, it's important that certain parts of the patient record are not lost. Even existing medical records are gold mines of information, holding important and private data about patients, including their medical histories, medications, and lab results. Some of this data is relatively straightforward—height, age, weight, temperature, and codes associated with specific diagnoses and treatments—and easily correlates with fields in a database that might form an electronic medical record.

What is more difficult is capturing the more nuanced information that comes from patient observation and interaction, namely lifestyle factors and other events that provide valuable information but are generally described through long-hand narratives. This may include observations that surgeons make during a procedure that are later transcribed or written reports that are not easily transferred into the fields of a database. For example, there is no code to indicate that stress at home or work may be contributing to a heart condition, or that a hospital patient didn't sleep well because he or she got a bit tangled in an IV line.

Many providers are used to jotting down notes that are entered into a computer later. But merely putting this

information into a word processing file or scanning a paper document doesn't go far enough, especially when considering the new meaningful use standards. However, new technology allows even observations about how a patient slept to be recorded in a way that makes the information recognizable, usable, and universally available, even across different systems. And these systems can be used without extending providers' workdays or negatively impacting interactions with patients.

Any professional will tell you that in order to do his or her job well, they must have the proper tools. However, healthcare professionals have been operating far too long without always having the very tool they need most: the right information. Electronic health records, and the accompanying "smart" documents to go with them, provide instant access to a patient's full medical history. Having the right information in the right place at the right time is a prescription for success.

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