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New Research on Electronic Health Records

HealthIT.gov provides an excellent overview of EHR (Electronic Health Records) for providers and other health care professionals. This information is important, because research shows that the use of EHRs result in improved patient care and improved diagnostics and patient outcomes. EHRs are, in their simplest format, digital (computerized) versions of patients’ paper charts. But in a robust system, they are much more valuable to the patient.

Doctors Define Meaningful Use

A phrase you will hear often when you work with electronic health records is “meaningful use.” This concept is part of the standards and criteria developed in the health care field to encourage a smooth and productive transition to EHRs. This important concept refers to the use of certified EHR technologies by health care professionals in ways that measurably improve the quality of health care and bring efficiency to the processes. Examples include better engagement of patients and family, improving care coordination, improving safety, and reducing health costs.

Health Information Privacy and Security

At the forefront of the Electronic Health Records movement is the need for privacy and security. Electronic records, just like paper records, must always be private and secure. Health care organizations must provide access controls to make sure only authorized individuals can access health information. An audit function that can track who has accessed what pieces of health information must also be in place. And finally, patients must have access to Internet portals that enable them to see who has viewed their records and to check the accuracy of their records. Patients must be able to trust the systems.

Research Sources Aid in EHR Implementation

At HealthIT.gov, you can learn more about important research regarding Electronic Health Records. For example, the National Center for Cognitive Informatics and Decision Making in Healthcare provides strategic leadership in patient-centered cognitive support research. SHARPS (Strategic Health IT Advanced Research Projects on Security) is a research project that addresses many areas of EHR, including technology convergence, collaboration, and telemedicine. Readers of this newsletter will also learn from the research paper included with this mailing.

***Ensuring the privacy and security of health IT can help patients achieve their health goals. Everyone has a role in protecting and securing this important health information.***

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Electronic Health Records

There is often a discrepancy between what American physicians prescribe for their patients and how those patients actually follow their doctor’s orders. This is often translated into poor outpatient care and poor results to prescriptive care. In 1991, the Institute of Medicine called for better outpatient care through the use of electronic health records, which is commonly referred to by the acronym EHR.

Those clinical practices that have used electronic health records claim that since they have implemented outpatient EHR, there is easier communication with patients, better communications with other providers, better and faster access to medical records, and fewer pharmaceutical errors. However, most physicians have been slow to adapt the EHR policy. A 2004 study done by Jeffrey Linder, an internist and Assistant Professor of Medicine at Harvard Medical School, asked the question “Do EHRs make you a better doctor?” The study concluded that the evidence of improved outpatient care due to EHRs is lacking.

According to Linder’s data, he found “no quality difference between ambulatory care provided with and without EHRs.” Additionally, several recent studies have also failed to make a connection between the use of EHR and improved quality of care.

Linder claims that there are two principal reasons for the disappointing outcomes in the study. First, the National Ambulatory Medical Care Survey data that Linder and his team had available to use was outdated from a technological perspective. And second, the survey asked physicians whether they use EMR but not how they were using it if they had it. Says Linder, “If people are simply turning on a computer replacement for their old paper records, why would you even expect quality to improve?”

Linder insists that the data should not be interpreted that electronic health records are ineffective. On the contrary, high-tech medical records—or any high tech systems for that matter—are simply tools. The tools must be used, and they must be used correctly.

Further research is still needed to hone in on specific facts as to why more doctors are not using EHRs and why patients refuse to avail themselves of the technology. Patients do not always get the advice they need from external sources and they may get information that is wrong. On the other side, sometimes doctors do not know that a patient falls into a specific risk group. The use of EHRs can benefit both the patient and the clinician.

In conclusion, despite the possible benefits of adopting EHRs, many institutions are concerned about the increased costs associated with using these systems. Users also want to know whether the costs are in line when compared to the benefits of using EHRs instead of paper records, and whether this will actually result in better quality of outpatient care.

Works Cited