EMR shouldn't stand for 'empty medical record'

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AS THE MOMENTUM for purchasing and installing electronic health Records continues to grow, the number of health care institutions and physicians employing this technology for the first time grows as well. While most hospitals have information technology departments to select, install and operate this technology, many physician offices do not. All too often the task is delegated inappropriately or treated as an administrative chore by practicing physicians who are already too busy. And who can blame them? Physician practices are virtually under assault, with declining reimbursement, rising costs and increasing patient demands. Practitioners, particularly those in private practice, are desperate for something that will increase quality and productivity.

Jim Oakes

Unfortunately, many physicians are experiencing a kind of "buyer's remorse" when they install a stand-alone EMR. While the functionality is wonderful, much of the data that is so important to the functional richness of an EMR is still locked away in paper charts.

The surprising fact is that much of the information in a patient chart in a physician's office comes from external sources – lab results, consult reports, and so forth. The data needs to be integrated with the physician's practice EMR so that it supports the patient care workflow and results in a mainly paperless office. This external data is also needed for the analyzing and manipulating of this information that is critical to the functionality and usefulness of an EMR. A colleague has joked that without this externally provided information, the EMR is nothing but an "empty medical record," incapable of delivering the value promised.

Can't physicians solve the problem by tying their system to a hospital's EHR? Well, no. For one thing, many physicians don't have relationships with just one hospital, but with two or more (or in the case of many family practitioners, none). More important, however, is the fact that the hospital is not the only source of information that must be used to populate the physician office EMR. We recently participated in the development of a plan for a Health Information Exchange (HIE), and found that physician offices get external data from an average of five to nine sources, depending on the specialty. Some practices with EMRs resorted to having their staff take lab reports that had been mailed in and type the information into the EMR, while others scanned in the reports.

Joan Duke

While many HIEs and Regional Health Information Organizations are floundering, some are delivering solid value to their members. Some are surviving and some are even thriving. We have observed that a common characteristic of these HIEs is that they have tried to take a simple problem – getting result information in the hands of the practitioner – and solve it, taking over a thankless business from hospital and referral labs. They are delivering real value to the recipients of the information. We observed that small physician practices frequently have as much as 1/2 an FTE involved in filing results and consults into charts. An HIE makes it possible for already automated practices to "plug in" to the exchange to receive externally developed information electronically.

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