

Friday, January 21, 2005

System targets medical errors

Meeting to explore electronic records

By Elizabeth Lynch

Poughkeepsie Journal

With many local health care providers using electronic medical records, employers and health insurance companies will meet next week in an effort to streamline the process.

The result, experts agree, will be better and more efficient care for patients.

"Health plans and employers want doctors to use these systems because they know medical errors will be reduced and there will be a cost savings," said Dr. John Blair, president and chief executive officer director of the Taconic Health Information Network and Community.

The organization will host the meeting, which will include representatives from IBM, MVP and other companies and health plans in the region.

Wide access

A full electronic medical record will allow a physician to access patients' medical history, receive laboratory results, view X-ray reports, prescribe medications and much more.

St. Francis, Kingston and Benedictine hospitals and Vassar Brothers Medical Center participate, as do two labs -- LabCorp and Quest. Those participants feed information, such as the insurance coverage, results of blood tests, cholesterol tests, EKGs, admissions, discharges and other text reports into the system, where doctors can access it.

Electronic records will be particularly helpful in emergency rooms, where time is crucial and patients often are unable to provide basic medical history such as allergies. It also will assist doctors when they cover for each other and don't know the patient well.

"It will be a great tool," said Dr. J. Keith Festa, a private practice physician for 16 years who now is vice president of medical affairs at St. Francis Hospital in Poughkeepsie. "The most important part is the safety of the patients and the ability to access information."



Darryl Bautista/Journal
Glenn Grossman of Health Visions, right, and Dianne Koval of MedAllies explain the applications of the electronic health records system they and their team are putting in place for the region.

This spring, physicians will be able to send prescriptions to pharmacists electronically. And by July, the full electronic medical record system is expected to be available, Blair said.

Standard guidelines are goal

At present, health plans have varying guidelines they expect doctors to follow to keep patients healthy and minimize emergencies. One objective will be to streamline those guidelines, for the health plans to agree upon one and include them in the electronic medical record.

"This addresses very concisely, strategic health policy initiatives to improve patient safety through medical errors reduction," said IBM employee health adviser Christopher Nohrden said. The company, which self-insures, provides health insurance coverage for some 62,000 employees in the Hudson Valley region.

Some studies suggest as much as \$6 a month per patient can be saved by eliminating duplication and reducing errors.

Part of the cost-saving comes from ensuring patient illnesses are managed before emergencies develop.

"There's a general principle that if the right care is being provided at the right time and place, that's generally less expensive," said Dr. Jerry Salkowe, vice president of clinical quality improvement for MVP, which will be among the participants next week.

"Where we really need to be in terms of an electronic health record goes beyond taking current paper records and putting them into a computer," he said.

As part of the meeting, employers and health plans will decide what aspects of the system they will offer bonuses for to entice doctors to use it.

Doctors who are members of the Taconic group have free access to the basic portal and electronic prescribing. Non-members pay a monthly \$50 fee for each, or can join the group. There will be a \$500 monthly fee for access to the full electronic medical record, which will not be covered by the Taconic group.

The system will allow doctors, with a couple of clicks of a computer mouse, to find out which of their patients are in the hospital, to sign off on dictated notes, see lab reports and know if the results are in the normal range and view the text report of an X-ray.

They can even graph cholesterol levels for those with heart conditions or sugar levels for diabetics to see if the patient is doing a better job at managing their disease. And they can look for trends.

The information is available through a secure Internet connection.

Drug interactions checked

With the electronic prescription service, the system will check for interactions with other medications the patient is taking and may suggest a dosage, and will tell the patient what the co-pay for that medication will likely be. Because it's all done electronically, it will reduce such human errors as misreading a physician's handwriting.

After quality guidelines are agreed upon, the system also may help physicians manage patients with chronic illnesses, such as congestive heart disease, asthma and diabetes. For example, it might suggest a diabetic patient should be scheduled to have their glucose levels checked.

"It really allows the physician to focus on the evaluation of the patient," Salkowe said, "and spend less time chasing after various forms of the paper chart."

Elizabeth Lynch can be reached at llynch@poughkeepsiejournal.com