The evolution of health care

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The Evolution of Health Care HCS/531 January 11, 2013 The Evolution of Health Care Through the years healthcare systems have evolved all over the nation, one could say that it has changed from being somewhat primitive to highly technological. Gone are the days when one would have to search for a patients chart for hours, for their up coming appointment with their primary care physician or specialist, in order to ensure continuity of care. Today with a few simple clicks a patient's information is readily accessible and care continues almost flawlessly. Electronic health records also called Electronic medical record is now being implemented in almost every hospital and medical care facility across the nation. It collects and stores patients Health information over a period of time in any care delivery setting. It includes vital information on the patient like, demographics, vital signs, progress notes, past medical and family history, Lab data, immunization a and radiology reports. With this type of information it allows authorized users immediate access and clearance to patient information in order to provide for knowledge and support and to enhance quality and safety of patient care. EHR has helped to reorganize the workflow of providers and it helps to generate a complete record of a clinic visit and provide the patient with a summary of their visit for the day. It focuses on the total Health of the patient by allowing physicians from different hospitals and other medical care facilities access to a patients chart at anytime that they are under their care. The sharing of this data results in a more open involvement and communication in patient care. It is believed that widespread adoption of The Electronic Health system will lead to major savings in health care costs, reduce errors and improve health. (Singh pg. 164) Many Practices are using

this method to save time, which works out to be cost effective, for their practice. Many have reported how the use of E-prescribing has saved them time. Also the Reporting of labs and increase in data confidentiality has great improved quality of care for physicians. Electronic medical records has impacted the quality of care through quicker and easier access to patient's medical information, through easier scheduling of appointments, through reduction of medical errors, and through refined billing. Before electronic medical records were created the patient's personal information was written on paper and kept in file folders placed in a file cabinet or on a shelf. When a patient enters the physician's office or other medical facility the records would need to be found amongst all of the other patient's records. Information could become lost, misfiled, or compromised. With the creation of electronic medical records the patient's personal and health care information is saved in the computer. When a patient arrives for an appointment the information is pulled up on the computer. This information can be shared with any physician or specialist through the internet. As patient's visit the physician there is always a bill needing to be paid. Before electronic medical records were created billing was completed by hand and mailed out to the patients. The billing specialist would have to find the ICD-9 billing codes, calculate the prices, and create the bill manually. The bill would then be mailed out to the patient. After the creation of electronic medical records the ICD-9 codes are placed into the computer. The bill is automatically completed which is sent to the patient through an email. This action reduces overhead costs for the health care facility. After the patient visits the health care physician for a situation the patient usually needs a

follow-up visit or an appointment to a specialist. Making an appointment with the same physician would require the receptionist to look through the desk calendar and create another appointment. However, if the appointment is with a different physician such as a specialist the receptionist would need to contact the specialist over the phone to make an appointment. The patient would need a complete copy of the medical records to carry to the appointment. With the technology of electronic medical records the receptionist can go to the specialist's site, make an appointment, and email the patient's medical records immediately. While medical staff writes information in a patient's chart errors can be easily created. A person's handwriting may be messy and unclear. There are medications which are similar in spelling and can create severe situations such as medication errors if the writing is not clear. With the technology of electronic medical records fewer errors can be made through the clarity of typed information. This also reduced the time spent writing notes in the records and more time caring for the patient. The implementation of an EHR system is no easy task. The conversion from a paper chart to an EHR system puts a great deal of stress on the complex social systems that exists within health care institutions. It requires conceptualizing the medical record and medical communication, including organizational-level changes in workflow. Resistance to even minor changes is normal response, especially in complex environments, Resistance to even minor changes is a normal response, especially in complex environments, the need for EHR interoperability, along with the expense of EHR systems, is likely to drive fundamental changes in how medical records are stored. Centralized third-party medical record keeping, in the form of

data “ banks, " may supplant the current model of record keeping by individual practices. Centralized record keeping would enable health care workers, and patients themselves, to access medical records where and when needed. It would also, of course, require strong security measures. No discussion of EHRs can ignore the concerns of privacy, confidentiality, and security. Privacy is the ability of a patient to control the Ethical and Social Challenges of Electronic Health Information information about him or herself. Confidentiality is the commitment of another person or organization to the patient to control information about the patient. Security measures are safeguards against inadvertent or malicious breaches of confidentiality. Security measures also include protections against loss of information. It is generally accepted that privacy of medical data is an important right of the individual. Privacy may be viewed either as a utilitarian concept (i. e. patients will not honestly and completely discuss their medical problems without assurances of confidentiality) or as a right in and of itself. Privacy is also essential to the exercise of autonomy in medical decision making, just as a secret ballot is fundamental to the exercise of democracy. Maintaining privacy and confidentiality through appropriate security is one of the key challenges of EHRs. It has long been recognized for related uses of electronic media, such as an email . Aside from technical issues, there are a number of factors that contribute to the challenge. Determining the proper security measures for medical records must be done in the context of the goals for the records. Reference Electronic Medical Records. (n. d.). The impact of healthcare of electronic medical records. Retrieved from http://www. electronic-medicalrecords. com/the-impact-of-healthcare-of-electronic-

medical-records/ Benefits of EHR. Improving patient’s outcomes and Diagnostics with EHR. Retrieved From http://www. healthit. gov/providers-professionals/medical-practice-efficiencies-cost-savings Bell, B & Thornton K From promise to reality achieving the value of an EHR. hfm (Healthcare Financial Management); Feb2011, Vol. 65 Issue 2, p50 Anderson, J. G. and Ayden, C. E. (1994). “ Evaluating Medical Information Systems: Social Contexts and Ethical Challenges, in K. W. Goodman, Ed., Ethics, Computing and Medicine: Informatics and the Transformation of Health Care, Cambridge: Cambridge University Press, 57-74.