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## **The gold in the thread of Information from a Digital and Electronic Medical Record Environment**

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What should be the reasons for a move to scanned records. It is often simply a cost management strategy to improve paper flow, and record access. It should be part of a longer term strategy to move to a computable record that can be both accessible when needed, and able to provide automated clinical decision support at the point of care (eg clinical pathway automation).

The Digital Medical Record is really the first step towards the EHR as part of the continuum to accessible, computable health information.

What do we mean by health information in this context? We mean information that is accessible and usable from the point of capture at the patient's bedside through to national public health statistics.

This paper is not about the process of introduction of DMRs or their logical extension and eventual replacement by the electronic medical record, but what works and what delivers real benefits.

Look back at what we did and what did and didn't work.

Includes:

The things we thought we wanted, and the things that worked, the things we needed that we didn't realise we were going to want.

Requirements:

A reflective view of what we have learnt. The staff and workflow changes. The jobs and problems that have disappeared, and those new jobs or tasks that have emerged.

The need to replace the paper record as a workflow control mechanism.

The opportunities for data warehousing to provide solutions.

The CIO had the vision of a data warehouse that would gather information from existing hospital systems and make that information available to meet the needs of users, administrative, departmental, coding, clinical and others in a format suited to that need.

This resulted in the development of a data mining operation at the hospital which has a regular production of priceless nuggets and the capacity to drill to new levels and new payloads (diamonds (daily reports), gold (workload figures), sapphires (administrative monitoring) and the capacity to extend the mines capacity infinitely.

Any paper in this area must include discussion of relevant industry standards.

If the health informatics standards covering scanned records, EHR structure and interoperability that are available now were available then it would have been easier

and allowed us to make more informed decisions about our needs and priorities. We would have identified the scope of relevant current standards and been able to inform Standards Australia of required updates to those standards – leading to ongoing improvement and communication throughout the health information industry in Australia (using standards for ongoing process improvement).

**One of the things we didn't do and probably should have done is:**

- Consider requirements and methods of communication between computer systems (the need to integrate PRM, DMR, with EHR, CIS and ATD etc)
- Consider what standards could provide guidance. When Geelong started there were few standards that would have assisted, that is no longer the case. How do you find a standard?
- Requirements for Vendor standards compliance (their capacity to comply).