Chapter 6
Primary Care Patient Management and Health Information Technology

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EXECUTIVE SUMMARY

Electronic Health Records (EHR) are a system of Health Information Technology (HIT) components including clinical documentation, medication orders, laboratory and diagnostic study results, management, and evidence based clinical decision support. In this case, a patient’s care is compromised because of incomplete documentation of medical information and lack of integration among data collection systems. The patient has had over fifty years of medical care in a U.S. government health system followed by care in a private primary care setting. Effective implementation and utilization of EHRs in primary care settings, will positively affect patient safety and quality of care. Appropriate use of EHR provides challenges to clinicians, HIT developers, and healthcare administrators. Provision of quality patient care utilizing HIT is challenging to use and implement, but when patients receive healthcare from multiple sources, the challenge becomes even greater. The need for integrated EHR systems is evident in the geriatric population (Ash, et al., 2009), where the ability to provide data to new clinicians may be affected by cognitive decline in this population. Management of health and chronic conditions in the geriatric population requires an ongoing commitment to HIT implementation for safer and more effective care.
CASE DESCRIPTION

A 70-year old man with multiple chronic medical problems relocates to a new community and seeks medical care from a local primary care provider. As a retired military officer, he has previously received care in a government health care facility. He has recently retired to Florida with his wife and seeks care in the civilian sector due to its proximity to his new home. His primary health care needs are for diabetes and cardiac disease as well as communication with an ophthalmologist, and podiatrist. Monitoring for colon cancer is needed due to a positive family history.

Following the initiation of healthcare in the private sector, the patients’ medical records are requested. This patient is in need of care before the records become available and the clinician must rely on the patient to provide all necessary information about his medical history. The patient’s medical condition is stable initially and the primary care physician is able to help the patient keep all medical conditions under control. After the medical records are received, data obtained from them is incorporated in to the primary care office electronic medical record system.

After becoming an established patient in the primary care practice, one of the medical conditions becomes unstable, requiring the patient to be hospitalized at the local community hospital. During the hospitalization, the patient receives a medication, which had previously caused him to have an allergic response.

This medication caused the patient to have difficulty breathing resulting in the placement of an endotracheal tube to provide him with respiratory support. Monitoring needs of the endotracheal breathing tube required the patient to be cared for in the intensive care unit. This patient required care in the intensive care unit for two weeks.

When the inpatient medical records of this patient were reviewed, there was no visible documentation of an allergy in the hospital record. Clinicians at the hospital reported that a patient history was not obtained from this patient orally because medical records from the primary care provider office had been provided. Further medical record evaluation revealed that there was documentation of the allergy in the record from the previous health care system. The inability to obtain information from medical records in an efficient manner caused a medical error, which was preventable. Providing rapid access to medical information through integrated systems would support the provision of patient safety measures.

A well trained health IT champion for this small primary care practice would support the clinicians and office staff to use electronic health records for quality patient care by: providing and documenting routine health visits, ordering and monitoring lab work and diagnostic tests, implementing standing orders for cardiac and
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