Jay Kaplan Course:BCS 300 #90124 Due Date 9/16/2014

Assignment: Case Study: “A New Look at Medical Records”

Chapter 1, Pages 33, 34, 35. Answer 5 Questions: 1-14 to 1-18 on page 35

**Question: 1-14 - Identify and describe the problem in this case.**

The problem in this case is the inefficient medical record keeping that is currently happening in the United States. This inefficiency has been targeted as a potential $80 billion a year savings, a mere 13% of the $2.8 trillion spent on health care each year. The United States government has mandated all providers to transition from paper based medical records to an Electronic Medical Records (EMR) system. If a health care provider does not transition to an EMR system, the result will be fines, penalties, and reduced Medicaid and Medicare payments. The costs of implementing an EMR system is between $30,000 and $50,000 per doctor. While large practices, nursing homes, hospitals, and nonprofits are able to absorb the cost, there are many small offices that are not able to afford this type of financial impact. The cost of implementing an EMR system, or even loss of revenue due to fines and penalties, is too great for a small practice.

**Question: 1-15 - What people, organization, and technology factors are responsible for the difficulties in building electronic medical record systems? Explain your answer.**

The government has created and set forth a number of short and long term goals for all health care providers in the United States. These goals require all providers to be able to send 40% of their prescriptions electronically and have the ability to exchange and report data to a centralized network. These requirements cost on average $30,000 to $50,000 per doctor, a large financial burden to a number of small practices.

Smaller size physicians’ practices that don’t have a large staff to handle the paperwork would endure many hours of upgrading from paper records and converting them into electronic records. Most of these offices have not spent any time making preparations towards an EMR system. Therefore, the conversion process from paper records to electronic records will take long hours of manually keying in the information, as well as coding in all the diagnostic and procedure codes required by the new government mandates. As the current trend moves away from traditional face time between doctor and patient, doctors are now sitting at a terminal in an examination room and keying in what the patient is saying. This creates a new paradigm for the doctor-patient relationship.

The implementation of many EMR systems creates a large obstacle to the long term goals of creating a centralized and seamless network of electronic medical records: how are all of these different systems going to communicate with each other? There are many companies available that are offering different types of EMR systems, but there are no set standards for organizing and exchanging the data through a centralized process.

There are also issues with security in having personal and private information available digitally over a cloud-based network. The medical industry has laws in place to protect an individual's privacy called HIPAA laws. It’s unclear who would be responsible in any event of a security breach, misuse, or theft of a patient’s information.

**Question: 1-16 - What is the business, political, and social impact of not digitizing medical records (for individual physicians, hospitals, insurers, patients, and the U.S. government)?**

Doctors would be impacted financially by not qualifying for stimulus funds. The doctors would also be imposed fines and penalties by the U.S. government. Patients might choose other doctors as their primary care physician because the new doctor is able to access a patient's full medical records. This loss of patients would result in a loss of doctor fees for those offices who are not compliant with current health care laws.

Hospitals not connected to the broad health care exchange would not have any access to a patient's full medical record. This could cause a hospital to dispense the wrong medicine to a patient or, worse yet, not have a full understanding of a patient's allergies or drug interactions. In a system where a hospital is connected and has access to records, a simple scan on the medicine’s barcode before being given to a patient would alert the nurse not to do this. Without this technology, there is a greater risk of a hospital causing more harm than good to the local community.

Insurers who are unable to process claims quickly and efficiently could lose providers from their network because of extended payment delays compared to other insurers who are in the cloud and able to pay claims faster. Insurers who don’t adapt to the new EMR systems will have an older infrastructure that is bloated with human and financial capital spent on claims processing when those same funds could be better spent on an efficient EMR system, thereby saving an insurer those claim processing costs.

Patients whose medical records are not available to this centralized network of information would not have all of their medical history and information readily available during a doctor or hospital visit. This lack of information could be vital in preventing medical errors and even fraud. There are some people who feel this type of information should not be stored digitally due to security concerns and may want to have their information off a cloud-based network. This is a unique situation where a patient would need to find a doctor who does not participate, and may even have to pay the doctor directly because this type of practice may completely opt out of the entire EMR network.

The U.S. Government has imposed many different penalties and fines for providers who are non-compliant to the government’s short and long term goals of implementing a nationwide EMR network. Not enforcing everybody to comply with a nationwide EMR network would also hinder the growth of the current national health care system that was implemented in 2014. The savings of these EMR networks would help lower the costs to those national plans.

**Question: 1-17 - What are the business and social benefits of digitizing medical recordkeeping?**

The business benefits of digitizing record keeping would give providers access to stimulus money towards implementing and improving their electronic records. These improvements in record keeping would help reduce medical errors, improve claims processing, and help improve the overall quality of the care provided. With these three improvements, the industry can see as much as an $80 billion savings, a 13% reduction of the total health care market.

Providers would now be able to stay compliant with the new health care laws and prevent any fines and reduction in payments from the government. The insurance companies would reduce their overall claims processing costs because claims would be processed quickly and efficiently with all the correct diagnostic and procedure codes. The doctors and hospitals would now get paid faster and stay compliant with the new laws.

The social benefits would be that doctors would now have full access to their patients’ medical records and history. Patients would be able to go to any doctor or hospital and have all of their information pulled up at a moment’s notice. Patients can now go to a new doctor and not have to worry about having all their records from previous physicians faxed to the new doctor. As paper records become obsolete, offices will now have additional storage space that was once used for those paper records. Having an all-digital system would mean only having a closet filled with racks and servers to house the internal network, while the remaining storage space would be hosted electronically at the EMR provider’s network.

The U.S. Veterans Affairs system is a great example of the social benefits and how they can affect an entire network of patients. There are 1,400 VA facilities that switched to a digital record keeping system called VistA, which allows doctors and nurses to share a patient's history. A VistA record lists all of a patient's information such as height, weight, blood pressure, x-rays, lab results, list of medications, and reminders about upcoming appointments. This information becomes important when a nurse wants to dispense medicine, as she can now scan a barcode and not only make sure it’s the right medicine, but that there are no possible drug interactions or allergies. The VistA system also allows for all devices attached to a patient to upload the vitals into the system. All of these improvements have helped reduce hospital admissions by 25% and reduce the length of hospital stays by 20%, resulting in what some patients have labeled “effortless treatment.”

**Question: 1-18 - Are electronic medical record systems a good solution to the problem of rising health care costs in the United States? Explain your answer.**

Yes, as saving $80 billion a year is a great starting solution to an industry that has a lot of other problems to address. For example, the cost of prescription medicine from two pharmacies in the same town can vary dramatically. Even the cost of the same procedure at two hospitals in the same town can have large differences in cost.

There are a number of hurdles that the system needs to overcome in order to gain all the positive advantages. There is a current concern for the lack of interoperability that affects all EMR providers and the ability for all of a patient's records to be transparent in a cloud-based system. It’s unclear what would happen in the event of security hacks, misuse of record information, and who will be responsible. These EMR systems now make it easier to bill for services, but what will happen if doctors and hospitals begin to bill for services that were never received? EMR will not solve all the problems of the health care industry, but $80 billion is a great start.