News for Immediate Release

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Governor's Office of Health Care Reform Receives $17 Million from Recovery Act for Health Information Technology Expansion

Harrisburg – The Governor's Office of Health Care Reform has received more than $17 million in federal Recovery Act funds to help develop a health information "superhighway" to connect health care practitioners, patients, facilities and pharmacies through a secure network giving them the ability to have a complete record of a patient's medical history.

"The transition to an electronic system of health records is another critical step in achieving the goals of Governor Rendell's comprehensive Prescription for Pennsylvania. The Pennsylvania Health Information Exchange, or PHIX, which is the name of our superhighway, will support patient-centered health care and improve access, quality and efficiency of care," said Ann Torregrossa, director of the Governor's Office of Health Care Reform.

Increased use of health IT will allow for better coordination and delivery of health care across Pennsylvania. An effective health information exchange will allow health care providers to see a patient's entire health care story, saving valuable resources and allowing them to focus on healthcare delivery.

Transitioning from paper to secure electronic health records allows for more accurate, complete and timely medical information to be available as patients are treated. It will add efficiency to the system, save on unnecessary and duplicative tests and improve outcomes.

The $17.1 million grant is part of a $750 million American Reinvestment and Recovery Act initiative to increase capacity and expand health information technology across the country.

GOHCR is finalizing a strategic plan to create PHIX. The funds will be spent over the next four years as PHIX is implemented across the state.

More information on PHIX is available at www.pahealthinfoexchange.com

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Editor's Note: The charts below illustrate how PHIX can improve health care.

Consider the following scenario: It's midnight Saturday and you have been involved in a car accident and are critically injured. The ambulance has taken you to a hospital that has never treated you before. As the emergency department staff begins treatment, the doctor has a few important questions about your medical history. What medications are you taking? Do you have any allergies? In your current medical condition you are unable to provide the answers and your medical records are several miles away where you are normally treated.

The following chart illustrates the differences in how your ER visit is handled with and without electronic health information exchange that will be supported by PHIX.

ER Visit *without* Electronic Health Records and Health Information Exchange	**ER Visit *with* Electronic Health Records and Health Information Exchange**
Physician knows nothing about your health history and tries to get it from your family members, if any are present.	Physician is able to access electronic health records, including: · medications that you are taking, · chronic conditions for which you are being treated, · primary care practitioner and specialists treating you, · history of recent hospital visits, · allergies and blood type, and · diagnostic tests and lab results.
Physician orders full battery of diagnostic tests to determine patient's condition.	Physician is able to view critical information from your electronic health record and determine what tests, if any, need to be run.
Hours and many dollars are spent evaluating the situation.	Hours and many dollars are saved evaluating situation.
Potential for medication errors.	Medications you take are known. This can avoid drugs that are contraindicated.
You take home discharge instructions; your primary care practice or specialist may request paper records which will arrive in days or weeks.	Report on treatment and care needed post-ER immediately available to primary care practice and/or specialists treating you.

Widespread adoption of electronic health records technology and use of PHIX will dramatically affect the way day-to-day business is conducted by primary care practitioners and specialists.

Primary Care Visit Before PHIX	Primary Care Visit After PHIX
Patient's record is thick file folder of paper.	Patient's record is totally computerized.
All information is hand-written into chart and may be illegible. (Patient provides new health history for nearly every medical appointment).	All information is entered in computer in examining room.
Practitioner asks about visits to specialists since last visit - nothing in file. Information on ER visits or hospitalizations may or may not be available to practitioner, lag time is common.	Practitioner has immediate access to summary info from visits to specialists, ER and hospital since last visit.
Practitioner orders lab tests, writes out script, gives to patient to take to lab.	Practitioner enters lab orders and electronically transmits to lab.
Practitioner tells patient to call back in several weeks for test results.	Practitioner gives patient secure Web site and password into system so patient can check lab results.
Patient is the source of information for medications being used.	Practitioner can see what medications have been prescribed by others in electronic health record.
Practitioner writes out script for medications, gives to patient to take to pharmacy.	Practitioner enters prescriptions and electronically transmits to pharmacy.
Practitioner must glean critical information about key health issues from thick health care paper records.	Practitioner alerted when preventive care is due, and when best practice requires intervention (test, lab work, etc.).

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