

Bloomington Hospital gets grant to expand data exchange

Hospital wants to improve health information system

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Bloomington Hospital wants to enhance and expand its Southern Indiana health information exchange, which links medical providers in four counties — enabling medical providers and hospitals to share patient information and records in electronic form.

That's why hospital officials are grateful for \$167,000 in federal funds for the Bloomington Hospital Foundation to bolster the exchange. It's not federal stimulus money, but money U.S. Rep. Baron Hill inserted into an omnibus appropriations bill — a type of bill legislators use to secure money for specific projects. The funds, which will come from the U.S. Department of Health and Human Services, should arrive in the next few months.

"We need accurate medical information that will follow the patient wherever the patient goes — to the hospital, the pharmacy, a nursing home or a doctor's office," said Dr. Todd Rowland, the hospital's director of medical informatics.

Rowland said since the hospital created the health information exchange in 2007, 200 physicians in 30 practices have each month electronically exchanged 130,000 pieces of patient information.

Rowland said health care professionals can electronically share medical histories and diagnostic and lab test results; and to do "e-prescribing," a process in which doctors can use a computer or hand-held device to create legible prescriptions and send them electronically to a pharmacist.

"E-prescribing is faster and reduces errors because it's more readable," Rowland said. "It also checks to make sure the prescribed drugs will not produce any adverse drug interactions."

Rowland said the health information exchange provides doctors who don't have electronic medical records with clinical messaging — a secure e-mail system medical providers can use to instantly share lab test results and other patient information.

Rowland said many people wrongly assume doctors always have access to a patient's medical records at the point of care — such as the emergency department, intensive care unit or a physician's office.

"Physicians and nurses make a great effort to do their best, but often function with incomplete information concerning patients' medical history and the list of medications they're allergic to," he said.