Electronic Health Records Will Transform Practice

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This is *JOP*'s first thematic issue addressing electronic health records (EHRs). It is long overdue. Guest Editors Peter Paul Yu and Robert S. Miller have guided a successful effort, recruiting authors to address key topics in the field and to provide data pertinent to oncology.

Three articles in this issue establish the legislative and regulatory underpinning related to the topic. Robert Miller and Jeffrey Kan review the certification of EHRs and the process of qualifying for federal incentive monies for implementing EHRs, respectively.

Much emphasis is due Peter Yu's manuscript concerning meaningful use (MU). MU is a specific term of art and law, coined in the federal legislation known as the "stimulus" act, that is, the American Recovery and Reinvestment Act of 2009 (ARRA). This sweeping federal legislation includes sections collectively known as HITECH (Health Information Technology for Economic and Clinical Health). This legislation provides funding for practices and health care institutions that implement EHRs and requires that these systems be used in a meaningful manner, hence, the necessity of rules defining meaningful use.

The rules demand a lot from vendors in terms of building products that can capture and share information. (Dr Miller's article concerning certification elucidates this.) However, the rules' burden falls heaviest on practitioners, as we must document and certify that we use the capabilities provided by the products. Implementation of MU regulations is proceeding in stages. Stage one is in place, and comments are being gathered concerning stage 2 and stage 3 regulations. Each stage increases the requirements for vendors to provide more functionality and for providers to use it, all toward broad goals that will redefine the clinical enterprise.

In these times, when discussions of health care reform focus on the Affordable Care Act (ACA) signed into law in March 2010, the impact of meaningful use is less appreciated by practitioners. Arguably, ARRA, through MU regulations driving EHR technology into every practice, will reform the day-to-day provision of care more extensively than the reimbursement and payment reforms of the ACA. History underlines this potential when one considers that medicine has always been transformed by technological advance. My father practiced in an era that saw the introduction of antibiotics. Many of us (being of age!) have seen medicine change with the development of digital imaging such as computed tomography and magnetic resonance imaging. EHRs will effect even greater changes in that their use will force structural changes in how we deliver care. They will change how we obtain and process information, how we collab-

orate with colleagues, and how our patients engage us. New tools will demand new skills, reforming the care we deliver.

Brockstein and his colleagues from NorthShore University Health System in Illinois contribute two articles. In one, a Web-exclusive article, they describe their experience in implementing an EHR over a 5-year period. Readers will be challenged by the impact that EHR has on the culture of practice but can take solace in this report of successful implementation. Their other article provides data regarding quality and patient safety improvements realized with the implementation of EHRs. Beckjord et al use two robust surveys to assess the attitudes of patients with cancer concerning electronic exchange of health data. Interesting in their data is the finding that attitudes supporting exchange of health care data are more positive among patients with cancer compared with the general public, and that both groups value security highly. Patients realize, in an acute way, the role of information in the effective coordination of their care. Notably, care coordination and privacy are key tenets of meaningful use.

Baer's submission is not oncology specific yet is very pertinent. MU criteria mandate that patients have access to their data electronically. Secure messaging and patient portals will be mechanisms to meet these requirements while guarding patient privacy. Baer provides data indicating that implementation of an effective, secure electronic messaging system was associated with a decrease in office visits and a measurable increase in outcome quality.

Two additional Web-exclusive articles are available to readers. Warner et al tantalize with a report of technology being able to pull out structured information from free-text oncologic histories to create pertinent summaries. And Busby et al outline the need for a formal process in preparing standardized regimen order sets and keeping them updated.

Elsewhere within this issue, the reader will find additional articles regarding EHRs, as well as manuscripts touching on a variety of topics germane to practice. The editors seek feedback and suggestions concerning *JOP*. Please submit comments to jopeditorsdesk@asco.org. We hope you enjoy this special issue of *JOP*.

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