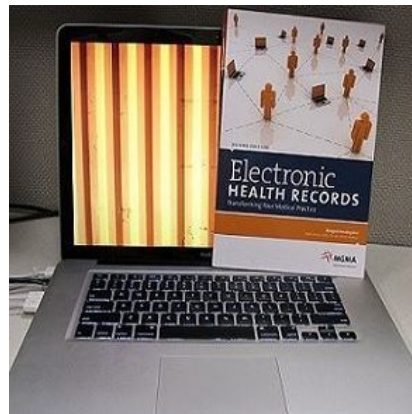




EHR: Ways to Improve Care for Patients with Chronic Conditions



Limitations in the design and use of electronic health records for both clinicians and patients have prevented optimum use of EHR systems to improve chronic disease care and research. Now experts have identified strategies for using EHRs to improve care for patients with chronic kidney disease. The guidance, published in the *Clinical Journal of the American Society of Nephrology (CJASN)*, could help clinicians and hospitals better manage individual patients with chronic conditions and identify groups of patients most likely to benefit from different treatment strategies.

The experts cite several reasons that make chronic kidney disease (CKD) an ideal model for identifying and evaluating methods for more effectively designing and using EHRs to allow clinicians to better care for patients with chronic conditions.

"CKD is common and its care is suboptimal, allowing significant room to show improvement as EHRs are optimised, and because CKD is defined by objective data, the disease is an ideal example of a condition that can be easily identified by information commonly found in EHRs," says Uptal Patel, MD, Duke University School of Medicine. Dr. Patel is chair of the National Kidney Disease Education Program's Health Information Technology Working Group, which developed the guidelines for using EHRs to improve care for patients with CKD.

"CKD care also requires collaboration between diverse professionals across numerous healthcare settings, which could be facilitated by EHRs," Dr. Patel explains. "Furthermore, CKD often heralds increased risk for hospitalisations, cardiovascular events, and all-cause mortality, so EHR-based improvements in CKD management may in turn improve care for these related conditions."

Dr. Patel and the other members of the Working Group have outlined specific design features and goals for incorporating CKD-related data into EHRs. A key recommendation is documenting CKD-related data (such as laboratory results and information related to risk factors and medical complications) into EHRs using standard code systems and units. For example, systolic and diastolic blood pressure should be stored in separate fields, rather than in a single field separated by a slash.

In addition, the group recommends storing CKD-related data in formats that can be easily accessed by patients and clinicians. EHRs could also be used to develop CKD registries so that clinicians can manage panels of patients and coordinate care with other specialties.

Implementation of these strategies will hinge on EHR interoperability across multiple healthcare settings. The goal of the Working Group is to enable and support the widespread interoperability of data related to kidney

health among healthcare software applications to optimise CKD detection and management.

Source: [American Society of Nephrology](#)

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