

Which Sharing System is Safer? Paper or Electronic?

Would you rather have your medical information sent electronically or by mail? Which is more secure?

Let's look at the mail system. To mail information, you have to identify the right person's chart. This is not easy sometimes because at times you do not have enough demographics, names have changed, and birthdates are wrong or not provided at all. Next, a clerk gets the record, opens the chart, pulls out the parts that are needed, makes copies, puts it in an envelope. Then it goes into the mail, two to four days later it gets where it is going.

When the mail arrives where it is supposed to go, the mail clerk opens it, puts it into a mailbox, where it may sit for a day, then someone reads it. Then it has to go into another record. All the time, these records are exposed to prying eyes, to being misplaced, stacked underneath other records, and parts of the record may become detached and lost. And anyone opening the data can see all the data, even if they only need one part of it.

Now let's look at an electronic record. The patient's identification is automatically right because the system requires more demographics than paper requests often provide and has a very sophisticated way of identifying if the person matches the record. Nobody sees the data except the person requesting the data. There are no clerical people, charts to be lost, papers to be detached, delays, mail people, and no electronic records sits open on a desk somewhere. And there is no two to four day delay. The person reading the data is known because the computer tracks who is online. And because of levels of security, the person can only read the part of the data they are approved to see, rather than the entire record.

For anyone to read the data, they have to be approved and provided a password and ID, which is changed from time to time. Every record they see is noted by the computer and can be audited. Each person approved has a security level, so they can only see the amount of data that they need. For instance, a physician can see more information than a clerk.

In the system we are building, no data is directly taken from any provider system. Only the data the provider wants to have shared is available. The provider bundles all the patients data electronically according to what they are planning to send. Only then is that data sent to a central computer where it is locked into a "virtual vault" where only that provider's data is stored. When the data is requested it is sent, seen, and there is no second record made and stored from that request. After the data is gathered and used, it basically disappears back to the data section it came from.

For additional security, the data can only be sent to a registered computer, so nobody can access the system from anywhere else. The data is encrypted. That means it is extremely scrambled and can only be read by someone with the right descrambler.

Hopefully, it is clear that electronic records are much more secure than paper records. We have noted in earlier articles that electronic records are safer, faster, more accurate, save money, save time, and generally, as a result, provide better healthcare for the patients we serve.

Next Time-Can we help change the average health of the average person with our electronic exchange?