MEDITECH’s Electronic Health Record (EHR) is the longitudinal clinical record that captures and shares real-time patient information across the care continuum, including the acute, practice, ED, continuing care, and home care settings. Our centralized EHR is the single source for current and lifetime patient information, which is available for simultaneous viewing by care team members directly from their respective Expanse roles-based solution.

Access Real-Time Patient Records

Our EHR gives your care providers immediate access to real-time critical information to support informed decision-making throughout the entire continuum of care. Information collected in the patient’s record includes, but is not limited to:

- Vital signs and I&O data.
- Medications, including a direct link to the Medical Administration Record.
- Lab results, including Blood Bank, Pathology, and Microbiology.
- Reports and patient notes, including diagnostic imaging with links to PACS images.
- Patient care activity (assessments, outcomes, plans of care).
- Patient history and administrative information.
- All order history (including ambulatory, emergency, and acute settings).

Ensure Security of Patient Records

The EHR protects the security and confidentiality of patient information by establishing roles-based access and restrictions. For example:

- User access can be restricted based on patient and/or location.
- Confidential patient and VIP flags may be used to prevent users from accessing the records of patients located within confidential locations or who have been assigned a confidential status.
- Users may be restricted to viewing only those patients located within a designated nursing unit or assigned to a specified physician.

Review Patient Information Quickly

From the EHR, care providers can access summaries of their patients’ current activity, as well as snapshots of their complete visit history. Providers can easily drill down into each visit to view detailed information, such as test results and vital signs. Information available to be included on the centralized Summary Panel includes, but is not limited to:

- Current and ongoing problems.
- Allergies and adverse reactions.
- Medication history.
- Pharmacy information and location.
- Health maintenance.
- Legal, demographic, and referral data.
- Growth charts.
- Substance use.
- Current and past procedures.
- Diagnosis and codes.

The centralized Summary Panel also gives physicians instant access to all patient information in a widget-based format. The included widgets and screen layout can be tailored to create a specialty-specific mode of treatment depending on individual physician preference. See an example screenshot below:

Organize Data Using Flowsheets

Flexible flowsheets are designed to group patient data into clinically meaningful displays where clinicians can compare all facets of data, making it easy to trend and interpret information. Flowsheets provide detailed spreadsheets, which contain a wide range of patient information, such as test results and medications, that reflect common evaluations and may normally be viewed on separate panels. For example, a single flowsheet can include Respiratory, Neurological, I&O, and Diagnostic Report information.

Trend with Current and Historical Patient Information

Providers can review complete visit histories throughout the healthcare continuum. Users can select the visit(s) for which they want to see patient information, or they can request a compilation of data from all visits. This data includes medical histories, test results, abstracts, and demographics. In addition, providers can select a subset of data and use it to:

- Graph current and historical clinical results over time.
- Search for associated online clinical content, such as evidence-based medicine.
- Streamline documentation by saving and incorporating this data into patient notes and reports.
Exchange Information in Real-Time Between Care Settings

To support interoperability with other vendor systems, MEDITECH also offer a Continuity of Care Document (CCD-A) exchange suite for querying and pulling in External Medical Summaries (XMS) of past patient visits from other vendor systems. These XMS documents are accessible from the EHR and include such information as:

- Allergies.
- Current medications.
- Problem lists.
- Advanced directives.
- Immunizations.
- Visit history.
- Discharge summaries.

Benefit from System-Wide Integration

The EHR provides a central clinical repository for housing real-time patient information captured throughout the system. It can be accessed, viewed, and edited by all authorized staff. In turn, information updated in the EHR is pushed out to other applications in real-time through roles-based desktops and status boards to help deliver timely and coordinated care.

From their respective applications, care providers can intuitively navigate a patient's clinical record, minimizing clicks to retrieve detailed patient information. Real-time patient data is accessible during the entire documentation process to view a patient's progress. Seamless integration with CPOE, Pharmacy, and Bedside Verification also closes the medication management loop, effectively circumventing medication errors when reconciling, ordering, filling, and administering medications.

For more information, contact a MEDITECH Marketing Consultant.