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Opinion Article

Use of Health Care Databases in Various Aspects of Telemedicine

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DESCRIPTION

Medical records databases are derived from electronic clinical records kept by physician practices, typically general practitioners (i.e., primary care providers) while providing care. The general practitioner or office staff is also in charge of entering conditions diagnosed by outpatient specialist physicians and hospital admission information including hospital diagnoses. Specialist referral reports or hospital discharge summaries bring this information to the general practitioner's office.To assess data harmonization and quality across databases incidence rates of Upper Gastro Intestinal Bleeding (UGIB) and No Steroidal Anti-Inflammatory Drug (NSAID) utilization patterns were compared. The known association between NSAIDs and UGIB was used to demonstrate the system's sensitivity by comparing UGIB Incidence Rate Ratios (IRRs) during NSAID use to UGIB incidence rate ratios (IRRs) during all other person-time.

According to the Institute of Medicine health care quality is defined as increasing the likelihood of desired health outcomes through services. Consistent with current professional knowledge. It implies that quality measures can be based on either achieving health care outcomes or completing processes that experts agree have been shown by scientific evidence to improve outcomes. When the user needs to know how to improve quality when provider comparisons show equivalent outcomes but all providers should improve processes when measures are needed to evaluate health care that is intended to improve long-term outcomes or when the contribution of individual providers (especially providers with a small number of cases) needs to be defined process-based measures are especially appropriate. However many different process-based measures are needed to comprehensively assess quality and many process-based measures require detailed clinical data currently found only in medical records.

As a result the cost of abstracting records is a deterrent to process-based measurement. Large-scale process-based measures are becoming more feasible to the inclusion of required clinical data in large databases. The integration of existing inpatient and outpatient databases with pharmacy and laboratory databases is a critical step toward obtaining data that connects all patient admissions appointments, diagnostic procedures and prescriptions with diagnoses and test results. Other data useful for process-based measures such as clinical findings, patient preferences and medical and family history must still be obtained by abstracting data from records. Such information could be added to large databases in the future to create computerized medical records. Because clinical trials include small and selective groups of people knowledge of the safety profile of drugs or vaccines prior to marketing is limited. These systems are based on suspected adverse drug reactions reported to national authorities by a wide range of people including physicians and other healthcare practitioners, patients and even lawyers. However because SRSs rely on voluntary information the system is vulnerable to a variety of limitations including underreporting a lack of information on the user population and drug use patterns, and reporting bias due to excessive media attention or class lawsuits.

Pharmacoepidemiology is the study of medication use and side effects in populations. Large health-care databases are frequently used to answer pharmacoepidemiology research questions. It describes briefly the types of research questions that can be addressed using pharmacoepidemiology databases, provides some differences between medical records and administrative databases discusses factors to consider when selecting a database for a specific study and speculates on what the future holds. We restrict consideration to longitudinal databases that contain information on outpatient drugs and on medical encounters. Pharmacoepidemiologic and pharmacoeconomic analysis of health care databases has become an important source of evidence to support health care decision making and efficient health care organization management. However, decision makers frequently consider nonrandomized health care database studies to be more difficult than randomized trials because many design choices must be considered. This is regarded as a significant impediment to making decisions about the efficacy and safety of medical products. The visualization of design details will make database studies more reproducible, faster to review and easier to communicate to a diverse group of decision makers.

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