

Data Sharing Needed to Increase Quality and Decrease Costs

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Immunizations are primary prevention. We all learned that in medical school. The first regularly recommended immunizations were against early 20th century killers like diphtheria, pertussis, and tetanus. They were successful for a variety of reasons, not the least of which was that universal immunization was a public health campaign that worked. Photos from the 1930s in the heart of the Depression show lines of kids presenting their arms for the shot or squirming away from the needles. During my clinical lifetime, we have seen the disappearance of polio, measles, rubella, *H influenzae* meningitis, and significant decreases in other communicable diseases. Younger doctors—those under 50—almost forget why we immunize patients against many diseases, since in many cases it is the consequences of those diseases rather than the diseases themselves that are the rationale for immunization. They not only have never seen the disease, but they have not seen the consequences.

Having a record of immunizations is crucial for both individual health and “herd immunity” and we see how cracks in universal immunizations have led to outbreaks of pertussis, measles and other, now rare infections. When we all carried around little folded paper records of immunizations that had been received from a number of sources, the portability was great and it led to real communication between public health clinics and practices. Now with the onset of electronic data collection, we have new challenges. Patients don’t carry their own records; they rely on their doctors and the data systems to do that. But those data systems contain human flaws that require both fixes to the technical process and assurance that

the human beings entering data into systems are doing it correctly. Mistakes lead to either under- or over-immunization. The latter creates unnecessary costs, while the former creates gaps that could lead to serious health consequences.

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While electronic health records (EHRs) offer the opportunity to improve population management for chronic disease,¹ they are not convincingly better on day-to-day quality.² However, accurate universal reporting of immunization records may be the only current system of sharing electronic health information that works. If immunizations can be shared across platforms, why can’t other medical information equally crucial to health? Until that happens, maybe we all should carry with us little books with our health records and medications should we wander outside of our insurance network.

Which leads us to the article in this issue of the *WMJ* by Schauer and colleagues comparing 2 methods of collecting immunization records—batched and real time.³ As one might suspect, the winner is real time, when data is entered at the time of the visit and leads to an

increase in documentation and completeness. While the evidence for increased quality is conclusive, the authors leave readers with a sobering thought: as more practices adopt electronic record systems, the statewide system of immunization recording and medical practices’ elec-

tronic systems must talk with each other or the whole process falls apart.

The Wisconsin Pharmacy Quality Collaborative is a program of the Pharmacy Society of Wisconsin that received an Innovation Award from Centers for Medicare & Medicaid Services to improve medication management for the people of Wisconsin. The special article in this issue of the *WMJ* describes the project and its goals and makes the case—if one still needs to be made—that pharmacists will play a crucial role in improving quality and decreasing costs of care through collaboration with patients and physicians.⁴ Having expressed skepticism about the potential for EHRs to address quality and cost, I have no doubt that getting pharmacists more engaged with patient care can only add value to a system of medication management. And data from electronic health records are essential to

the process. Keeping accurate medication lists will let pharmacists help us manage potential drug interactions, polypharmacy,⁵ and chronic diseases.⁶ The Collaborative needs physician involvement and commitment to make it work for everyone.

Lundin and her colleagues report on a large case series of enucleations resulting from trauma and found that young men were overwhelmingly the victims, assault was the primary cause, and the chief method of assault was guns.⁷ Other countries have far less trauma from guns as the reason for posttraumatic enucleation. Perhaps the most prescient article from a series during the Lebanese civil war recommended, "Wearing special glasses and imposing an international arms embargo are recommended to decrease ocular injuries and blinding consequences in potential future wars."⁸

The movement of diseases around the world can be human-borne, vector-borne, or both. In a review of another tick-borne disease in the upper Midwest, Schotthoefer and her col-

leagues from Marshfield clinic⁹ do a fine job of explaining the story of the spread of anaplasmosis, describing its presentation and outlining recommendations for treatment. Just in time for summer!

Our case reports in this issue highlight a frightening case of a man who almost died from an intercostal artery rupture, which is not a source one thinks of for a hemothorax without obvious trauma,¹⁰ and a case of a very nasty scalp condition that, when successfully diagnosed and treated, will save the patient a lifetime of suffering.¹¹

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