Online Lecture

on

Electronic Health Records

Course Code: MPH 5153 (Lecture – 4)

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Definition

- An **electronic health record** (**EHR**) is digital documentation of an individual's medical history that is maintained by health professionals and official agencies.
- An **electronic health record (EHR)** is an evolving concept defined as a systematic collection of electronic health information about individual patients or populations.

- An **electronic** health **record** (eHR) is a digital version of a **patient's** paper chart. EHRs are real-time, **patient**-centered **records** that make information available instantly and securely to authorized users.

What is an EMR? EHR? PHR?

- **Electronic Medical Record**
  - is the digital version of the paper chart, located at the clinic or hospital where you receive care
- **Electronic Health Record**
  - is a broader data set written by the entire care team; designed to follow the patient across different care settings
- **Personal Health Record**
  - is like an EHR but entirely entered and managed by the patient

What is in an electronic record?

- Past History & Problems
- Medications you take
- Allergies you have
- Clinical notes
- Vital signs
- Scanned documents
- Results and Images

Before EHR

After EHR

Is it time for a change?

Why should this office implement Electronic Medical Records?

- Financial Incentives
- Time Saver
- Charting Benefits
- Increases Availability of Information
- Accuracy

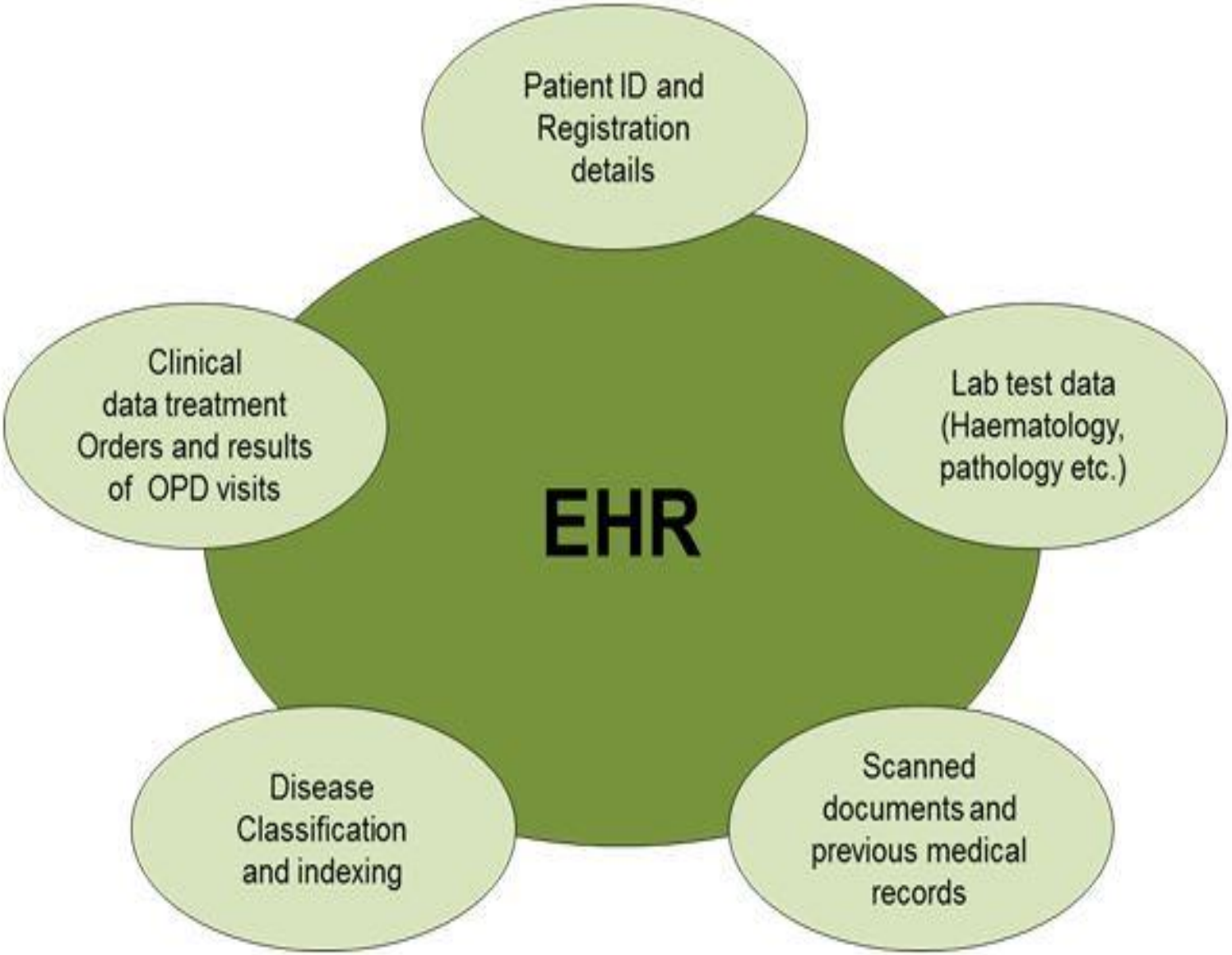

Figure 1; *Source: Electronic Health Records: Manual for Developing Countries by WHO.*

Medical Records – Objectives

- Review patient care, appropriate take clinical decisions & develop treatment plans
- Provides an archival and legally acceptable record
- Provides material for researchers
- Act as a source of information for heath administrators

Medical Records – Objectives

- Enables for hospital auditing
- Be stored in such a way that it is available when required
- Be subject to access controls to protect patient privacy, to avoid un-authorized/misuse

Medical Records

- The safe and cost-effective practice of medicine is becoming increasingly complex, and relies more and more on knowledge of the results of recent research into causes, manifestations, diagnosis and effective treatment of illness.

Convenience for Providers

- Quick access to patient records
- Legible, complete documentation that facilitates accurate coding and billing
- Safer, more reliable prescribing

Convenience for Patients

- Reduced need to fill out the same forms at each office visit
- Convenience of e-prescriptions electronically sent to pharmacy
- Patient portals with online interaction for providers
- Allowing easier access to follow-up care with specialists

Electronic Medical Records

- Availability, transfer and retrieval
- Linkage
- Storage
- Data Views
- Abstraction & Reporting
- Data Quality and Standards
- Decision Support

Obstacles – Electronic Medical Records

- Technology Investment
- Adoption by the user
- Modification of existing practices
- Understanding of legal and ethical issues
- Holistic view of the service to the patient

Who Uses an EHR?

Hospital

Nursing Home

Your Home

Surgery Center

Doctor's Office