

Information about the Electronic Medical Record (EMR)

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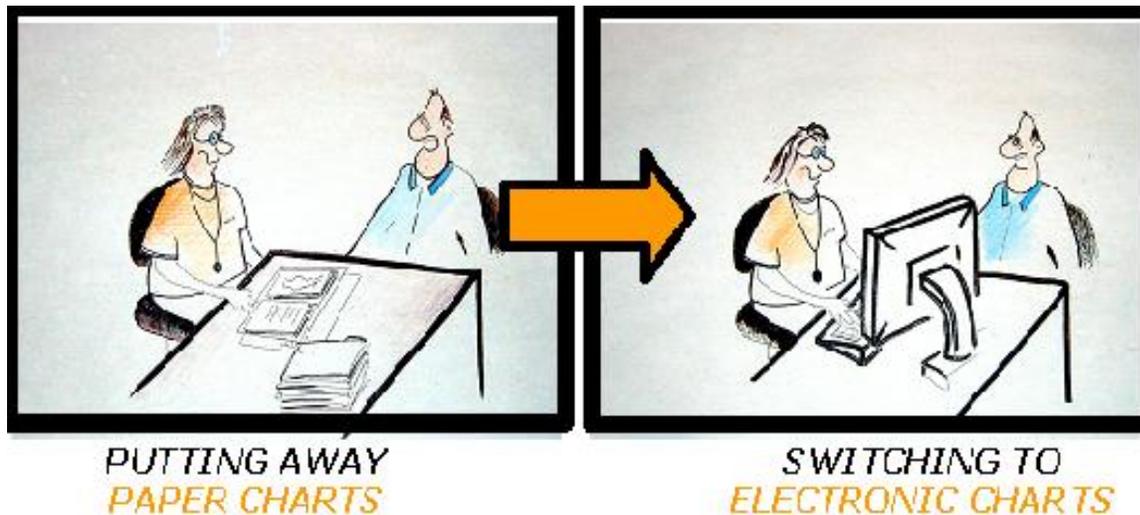
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Information about the Electronic Medical Record (EMR)



Motivation:

For the past several years, physicians and staff have been “going paperless” and this change includes electronic medical records. Thanks to the Health Transition Fund, a federal grant through Vancouver Coastal Health, Mid-Main will be implementing electronic medical records (EMRs). It is our hope that by introducing electronic medical records instead of paper charts, we will be able to better coordinate and improve health care service to you.

What is an Electronic Medical Record (EMR)?

An Electronic Medical Record (EMR) is a way of storing patient information on a computer. Electronic medical records have similar structure to the paper-charts, and these contain all the information that is relevant for the treatment and nursing of a patient. The electronic medical record includes both clinical information, such as diagnoses, allergies, and medicines, and demographic information, such as personal information, for non-clinical use—an example of such information is the patients’ health number.

The records **contain information** that is used for **different purposes**:

- ✚ Administrative tasks:
 - Registering patients
 - Scheduling appointments.
- ✚ Clinical practices (diagnostic and therapeutic decisions):
 - Computerized prescriptions
 - Lab tests
 - Diagnostic measures
 - Progress notes from different healthcare providers.
- ✚ Research practices.

Why use an EMR?

- ✚ Electronic Medical Records (EMRs) are expected to allow significant improvements to the way people work at Mid-Main. Replacing paper-charts with the EMR will radically **enhance the way information is gathered, stored, distributed, and used**. Expectations include:
 - Increased availability and accessibility of the whole record at any time from any computer: The time wasted searching for lost charts is completely eliminated since it is continuously available in the electronic format. In other words, all appropriate staff members can access information anywhere at anytime.
 - Decrease in the time spent on “paper-work”: Putting charts, undoing them, copying them, and putting them back together requires both physical resources and time. Some offices also use outside copy services. Using the EMR allows staff members to just click and print whenever records are requested (easy to update and print information).
 - Enhancement of the clinical time: Since less time is spent searching for particular information, more time is available for giving care.
 - New opportunities are being opened when staff members can quickly retrieve the most updated information. This in turn is expected to increase consistency and decrease or eliminate duplication of information.
 - Increase access to the same information at the same time from anywhere: Paper records can only be used by one person at the time. So for instance, if a pharmacy calls while the chart is being used, or waiting to be filed, the person taking the call cannot access the information in the timeliest, most efficient manner.
 - Improved structure and organization of information in the medical record.
 - Illuminations of handwriting misrecognition.
 - Digital documentation has a better quality than papers, and it is a safer medium for saving information. It maintains confidentiality and automatically allows multiple levels of security to patient records.
- ✚ The electronic medical record **opens up new opportunities** when it **allows sharing and exchanging information** among various healthcare practitioners. The ultimate goal is to allow the doctors to connect directly with other doctors, pharmacies, laboratory and radiology facilities, etc. This way, doctors will have the information they need to make the best decisions, and patients will benefit from better outcomes.
 - Increase collaboration between various professions
 - Allow comprehensive documentation to other medical professionals.
 - Improve and measure outcomes and compare clinical and administrative process.
 - Workflow efficiency: Today, a majority of the activities are still conducted by phone, fax or mail, including payments, treatment referrals and approvals, prescriptions and test results. Most of the activities can be conducted electronically (through e-mail or other communication channels) → this way, the time spent handling (communication) activities as leaving messages and waiting to hear back, or waiting to look up for information, is significantly reduced. Hence, the information flow and workflow documentation are improved, and healthcare providers can spend their time productively.

- Improve clinical decision-making process. Electronic medical records can for example prompt automatically reminders regarding abnormal results, allergies to medications, or any other information that the doctors should be aware of.
 - Improve patient management & compliance with current treatment guideline → EMR is also a management tool that will be able to improve the timeliness and quality of care. It can for example notify doctors of new medications, dosages, etc.
 - Improve patient safety by reducing treatment errors.
 - Increase efficiency, coordination and planning, and consequently → decrease waiting times for patients and costs.
- Opens up the possibility for participating in medical research studies.
- Opens up possibilities for patient education:
 - Appropriate printed instructions in the patient's language.
 - Allow patients to participate online with their chronic illness care, including keeping the patients apprised of their current medical condition.

Why invest in an EMR?

While for some people it might look like an astronomical amount of money is spent on electronic medical records, this investment would pay off quickly in terms of safety, quality and cost of care. As many as 24,000 Canadians die annually due to health errors. In addition, it was estimated that one of four X-ray and MRI tests are repeated because diagnostic results are misplaced or lost. Using electronic records will, to a large extent eliminate these problems.

The information that is provided here is related to the study that we conducted about the patients' perspective. We would therefore like to **thank** the patients that participated in this study and took the time to talk to Nina (whom is our PhD student studying health communications). Your answer had been a valuable and helpful contribution for us. If you have any questions or thoughts that you want to share with Nina, please leave her a note in the suggestions box.

Thank you for your support.
-- Mid-Main Community Health Clinic --