







The Electronic Health Record	
 Common acronyms for electronic records 	
for patient data	
– EHR	electronic health record (across the lifespan)
– CBMR	computer-based medical record
– CPR	computerized patient record
– EMR	electronic medical record
– EPR	electronic patient record
– PHR	personal health record
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Functions of the Health Record

• Document patient care

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- Provide communication among healthcare team members
- Establish financial and legal record
- Support research and continuous quality improvement
- Create repository of the clinical thought processes recording ideas and impressions over the period of care
- Archive (at a single point) all clinical data for long-term use

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Rights of Information

- Right information: accurate, free from error, and meaningful
- Right person: communicated to the person who should respond
- Right time: given to the decision-maker within a few minutes or hours
- Right place: accessible at the point of care
- **Right amount:** decisions can be made faster when appropriately-selective information is available

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Engage Patients and Families

- Patient eAccess on Request (Including Discharge Summary/ Instructions from hospital)
- Patient eAccess to Record (Patient Portal)
 Clinical Summaries each
- Clinical Summaries each Visit (Portal, email, CD, USB, paper)

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Summary of Objectives

The "Meaningful Use" Regulation for Electronic Health Records. *NEJM*, July 13th, 2010.

anthal D and Taverner R. The "meaningful use" regulation for electronic health records. N Engl J Med. July 13, Available from: http://healthcarereform.nejm.org/?p=3732&query=home

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