Electronic Medical Records (EMRs) come with the promise of centralized information. Key to reaping benefits while avoiding obstacles and delays are involvement before, during, and after EMR implementation.

A key selling point of an EMR is one log in to legibly read and review a patient’s encounter including transfer records, EMS patient care records (PCR), nursing and physician notes, radiology reports, etc. Accurate, efficient abstraction requires easy access to all state and nationally-mandated data.

The first obstacle in getting to the data is security to access the entire chart. To prevent HIPAA violations EMRs can be sectioned and secured so that, rightly so, a healthcare employee can only see areas that pertain to his or her job. A registrar, however, needs access to the entire chart to abstract all required data fields. Working with your EMR security team for clearance and training for EMR access is vital.

Smooth transitioning from paper to electronic begins with identifying abstraction requirements and data location within the EMR. Reports may be offered as an option but can be unreliable if the data is inconsistently documented or incomplete. Reports must also be built (which the end user may not be permitted to do), tested and maintained. Realizing this complexity, we identified the more accurate, efficient way to abstract data was directly from emergency department (ED) timelines, flow sheets and progress notes and not rely on reports. This potentially requires higher/different security.

Because EMRs are designed with multiple screens for documentation, education for ED and inpatient nurses and physicians is still key to assure consistent, complete charting. Unlike paper charts that easily displayed incomplete information, EMR documentation can be closed out still missing data. Key to avoiding/reducing this pitfall is early identification and communication of missing and inconsistent data. Registry staff should develop reports to check documentation compliance. Meet regularly with identified physician and nursing EMR super users and create standardized check lists and how-to guides to display in key locations.

To further facilitate abstraction, minimize scanned paper documentation delays by working with IT and nursing departments to scan records into the system while the patient is still in house. Work with ambulance providers to directly download electronic PCRs. You may also consider building an interface for data to import into your registry. Key to this, as with the reports, is mapping and validation of the data. Note that these interfaces can come at a cost from the EMR or registry vendor.

Minimizing or avoiding these obstacles requires meeting with staff and EMR development teams early and often to discuss where and how key data elements are documented and how best to access the data needed. Meet with those who assign security levels to assure that all areas of the record needed for abstraction of state and nationally-mandated data are available to your registrars. If possible, gain access to a test system prior to implementation to assess that everything works. Planning, communication, training, and ongoing education are key for complete and compliant registry data.