

Research on the Current Status and Challenges of Universalizing Electronic Health Records for Community Residents

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Abstract: This study aims to further examine the current status of establishing electronic health records (EHR) for community residents and identify the barriers to their use, as well as explore the practical challenges in promoting EHR services at the grassroots level. To use a case study on Nantai Street Community in Zhaotong City, Yunnan Province. We used case investigation, questionnaire surveys, and interviews to analyze the establishment of EHR among community residents and the issues associated with their universal application. The findings reveal the truth below. Grassroots communities face insufficient publicity regarding EHR. The level of information sharing and co-construction is relatively low. Respondents are deeply concerned about the security of their personal information. Files are lack of timeliness and accuracy in record updates. To address these challenges, we recommend enhancing the promotion of EHR, raising residents' awareness of health management, advancing the construction of county-level medical consortia, and improving the legal framework for safeguarding the information security of EHR.

Keywords: Community Governance; Electronic Health Records; Universalization Dilemma; Health Management

1. Introduction

Electronic Health Records (EHR), hereinafter referred to as EHR are electronic repositories that store an individual's health information throughout their entire life cycle and serve as critical tools for health management [1]. Western countries emphasize the application of EHR tools in constructing national health management services [2,3]. In China, the implementation of EHR policies integrates

three types of policy instruments: environmental, supply-side, and demand-side [4]. The *National Basic Public Service Standards (2021 Edition)* stipulates that a unified and standardized electronic health record should be established for permanent residents within the jurisdiction [5]. The *14th Five-Year Plan for the Informatization of National Health* further highlights that every resident should possess a dynamically managed electronic health record and a fully functional electronic health code by 2025, aiming to enhance digital service capabilities in the health sector [6]. The state continues to reinforce support for primary-level medical and health services, promoting the *Internet + Medical Health* service model and innovating the supply mechanisms for grassroots healthcare. In 2019, the Yunnan Provincial Government proposed that, adhering to the principles of convenience, security, and efficiency. Functions such as medical treatment, medical insurance settlement, and electronic health record queries should be integrated into a single-code system. Despite these efforts, challenges remain in achieving universal coverage of EHR services in grassroots health management. Studies have shown that the development of EHR systems varies significantly across regions in China [7], with urban areas generally performing better than rural areas, which face issues such as insufficient resources and outdated technology [8]. To address these challenges, the research team conducted field investigations in county-level communities to explore practical problems related to EHR implementation and propose optimization strategies.

2. Methodology

2.1 Data Sources

The study population consisted of residents from the Nantai Street Community in

Zhenxiong County, Zhaotong City, Yunnan Province. The research focused on the current status and usage barriers of electronic health records (EHR). A questionnaire survey was conducted among community residents, while interviews were carried out with staff from the Health Poverty Alleviation Office of the County Center for Disease Control and Prevention, medical personnel responsible for EHR establishment at the County People's Hospital and the County Traditional Chinese Medicine Hospital, as well as grassroots-level community managers.

2.2 Research Methods

Literature Review: Relevant policies and literature on EHR at both national and local levels were systematically reviewed using databases such as CNKI, and previous studies were collected for analysis.

Questionnaire Survey: A preliminary questionnaire was designed and distributed to a small sample for pre-testing to ensure its validity and reliability. After revisions based on feedback, the finalized questionnaire was distributed to respondents using stratified random sampling.

Interview Survey: An interview guide was developed in advance, and structured interviews were conducted with personnel involved in EHR establishment from the local public health management department, the county hospital, and the county traditional Chinese medicine hospital.

Data Analysis: Questionnaire data were exported into Excel tables and analyzed using SPSS 25.0 software. Statistical analyses were performed to examine significant correlations among variables and to explore potential relationships between them.

3. Results

3.1 Basic Information of Community Residents

According to the latest statistics released by the People's Government of Zhenxiong County, the Nantai Sub-district consists of nine communities, including Xizheng Street, Dongzheng Street, and Wenwei. The sub-district has a total of 29,631 registered households with a population of 82,212, among whom 5,643 are from ethnic minorities such as Yi, Miao, and Bai. In addition, there

are over 100,000 collective households and floating residents in the area.

3.1.1 Demographic and sociological characteristics of respondents

The study focused on the resident population of the Nantai Sub-district Community in Zhenxiong County, Zhaotong City. A total of 350 questionnaires were distributed to community residents, with 315 successfully recovered, resulting in a recovery rate of 90%. All 315 returned questionnaires were deemed valid, achieving an effective rate of 100%. Following data cleaning, the descriptive statistical analysis of the sample data is presented in **Table 1**.

As **Table 1** has shown. Among the 315 surveyed community residents, 55.87% were male and 44.13% were female, indicating a slightly higher proportion of males. The age distribution was categorized into three groups: Youth (under 18 years old, 14.60%), working-age adults (18–59 years old, 53.65%), and elderly (60 years and above, 31.75%). In terms of educational attainment, the overall level was relatively low, with 61.59% of respondents having completed only primary school or junior high school education. Those with high school, technical secondary school, or vocational school qualifications accounted for 14.92%, while those with junior college education represented 6.98%. Only a small fraction (less than one-fifth) held a bachelor's degree or higher. Regarding marital status, 32.06% were unmarried, 39.37% were married, 17.78% were divorced, and 9.84% were widowed, with the latter group predominantly consisting of elderly individuals or those who had lost their partners. The majority of respondents earned their living through self-employment, with an average monthly income ranging between 3,000 and 4,999 yuan. Notably, the number of workers and farmers was approximately equal to that of dependents (e.g., students), reflecting the current reality of labor outflow in the community. Furthermore, 13.65% of respondents were not permanent residents, suggesting potential mobility in accessing medical services. Among the respondents, 38.73% belonged to key groups requiring disease prevention measures, while the majority reported being in good health. Ownership of smart communication devices (e.g., mobile phones and smartwatches) was widespread, with 95.87% of respondents

possessing such devices. However, lacked access to these technologies due to approximately 4.13% of elderly respondents insufficient experience in using them.

Table 1. Statistical Table of Sociological Information of Respondents

Category name	frequency	percentage (%)	Category name	frequency	percentage (%)
sex			Key groups for disease prevention		
male	176	55.87%	yes	122	38.73%
female	139	44.13%	deny	193	61.27%
age			employment status		
Under 18	46	14.60%	Personnel of administrative organs and institutions	13	4.13%
Age 18-59	169	53.65%	Enterprise staff	42	13.33%
Age 60 and over	100	31.75%	student	90	28.57%
			other	170	53.97%
education			marital status		
Primary school and below	67	21.27%	unmarried	101	32.06%
junior middle school	127	40.32%	married	124	39.37%
High school/vocational school	47	14.92%	dissociaton	56	17.78%
junior college	22	6.98%	bereft of one's spouse	31	9.84%
Bachelor degree or above	52	16.51%	other	3	0.95%
average monthly earnings			major income source		
Under ¥1000	46	14.60%	be engaged in agriculture	26	8.25%
¥1000-2999	42	13.33%	Wages and salaries (employees)	64	20.32%
¥3000-4999	99	31.43%	Income from self-employed business	125	39.68%
¥5000-7999	68	21.59%	state subsidies	7	2.22%
More than ¥8000	17	5.40%	Other	93	29.52%
Other	43	13.65%			
Permanent residents of the area			Smart device availability		
yes	272	86.35%	yes	302	95.87%
deny	43	13.65%	deny	13	4.13%

3.1.2 Community residents' medical services and medical treatment behaviors

The **Table 2** statistical results indicate that approximately one-third of the respondents are in good physical and mental health and rarely seek medical care, while only a small proportion of residents frequently visit healthcare facilities. Most respondents reside within 1–5 kilometers of the nearest medical institution, suggesting that the accessibility of

medical resources generally meets the basic healthcare needs of the community. Traditional methods of seeking medical care, such as in-person registration and seeking assistance from healthcare professionals, remain highly preferred among residents. With regard to past medical records, community residents predominantly rely on reviewing previous paper-based reports or consulting healthcare staff in person at the hospital.

Table 2. Statistics on Medical Services and Medical Treatment Choices of Respondents

Category name	frequency	percentage (%)	Category name	frequency	percentage (%)
Number of visit medical per month			The nearest medical facility arrange		
<1st	108	34.29%	h<1km	49	15.56%
1-3 times	87	27.62%	1km≤h<3km	98	31.11%
4-6 times	100	31.75%	3km≤h<5km	125	39.68%
7-9 times	15	4.76%	5km≤h<10km	34	10.79%
More than 10 times	5	1.59%	h≥10km	9	2.86%
Methods for querying medical records			Common way of seeing a doctor		
Paper report form	245	77.78%	Queue up for registration	219	69.52%
Medical consultation mini program	128	40.63%	Make an appointment	183	58.1%

			online		
Consult the medical staff at the hospital	211	66.98%	Seek medical help	205	65.08%
other	9	2.86%	other	14	4.44%

3.2 Current Understanding of Electronic Health Records among Community Residents

This study designed the questionnaire content from the demand-side perspective to examine the current level of understanding regarding EHR among community residents. Currently, Yunnan Province offers convenient EHR services to residents via the WeChat official account *Yunnan Province Residents' Electronic Health Card* [9]. This platform allows residents to access health information, including outpatient visits, inpatient stays, physical examination results, and medication prescriptions from the past year, thereby enhancing their ability to seek medical care efficiently and conveniently.

3.2.1 Univariate analysis of respondents' understanding of EHR

Taking whether to establish EHR as the dependent variable and the factors with $P < 0.5$ in the univariate analysis (Table 3) as the independent variables, a multivariate analysis

was conducted using the binary Logistic regression model (Table 4). The independent variables included: gender, whether being a local permanent resident, and whether belonging to the key population for disease prevention.

3.2.2 Distribution of reasons why respondents are not familiar with electronic health records
Based on the above tables, there are some findings. The primary obstacle to the promotion and application of the EHR system currently is the insufficient awareness of EHR among residents [10]. Among the respondents, 143 individuals reported not understanding electronic health records, with reasons primarily categorized into four groups: limited flexibility in accessing the Internet, insufficient publicity and explanation, infrequent visits to designated medical institutions for treatment, and other reasons. As shown in Table 4, the top two influencing factors are limited flexibility in accessing the Internet and insufficient publicity and explanation.

Table 3. Current Status of Community Residents' Understanding of Electronic Health Records
[n (%)]

variable	Number of respondents	Do you know about HER (%)?		2x	P price
		understand	do not understand		
sex					
man	176	105(59.7)	71(40.3)	4.113	0.043
woman	139	67(48.2)	72(51.8)		
age					
Under 18	46	37(80.4)	9(19.6)	22.535	<0.001
Age 18-59	169	96(56.8)	73(43.2)		
Over 60 years old (including 60)	100	39(39.0)	61(61.0)		
degree of education					
Primary school and below	67	26(38.8)	41(61.2)	17.792	0.001
junior middle school	127	69(54.3)	58(45.7)		
High school / technical secondary school	47	37(78.7)	10(21.3)		
junior college	22	12(54.5)	10(45.5)		
Bachelor degree or above	52	28(53.8)	24(46.2)		
marital status					
unmarried	101	67(66.3)	34(33.7)	11.395	0.022
married	124	60(48.4)	64(51.6)		
dissociaton	56	32(57.1)	24(42.9)		
bereft of one's spouse	31	12(38.7)	19(61.3)		
other	3	1(33.3)	2(66.7)		
employment status					
Personnel of administrative organs and institutions	13	10(76.9)	3(23.1)	25.451	<0.001
Enterprise staff	42	31(73.8)	11(26.2)		
student	90	60(66.7)	30(33.3)		
other	170	71(41.8)	99(58.2)		

source of income					
be engaged in agriculture	26	7(26.9)	19(73.1)	24.366	<0.001
Wages and salaries (employees)	64	43(67.2)	21(32.8)		
Income from self-employed business	125	63(50.4)	62(49.6)		
state subsidies	7	0(0.0)	7(100)		
Other (family support)	93	59(63.4)	34(36.6)		
How well you know smart devices				59.841	<0.001
Very skilled, easy to operate	59	42(71.2)	17(28.8)		
Familiar and easy to operate	128	93(72.7)	35(27.3)		
Understand less, operate slowly	94	31(33.0)	63(67.0)		
Not used often, consult others	34	6(17.6)	28(82.4)		
Whether they belong to the key population for disease prevention				4.990	0.025
yes	122	57(46.7)	65(53.3)		
deny	193	115(59.6)	78(40.4)		

Table 4. Statistical Table of Selected Categories of Reasons

CLASS	RESPONSE FREQUENCY	POTENTIAL INFLUENCING FACTORS
CAN'T SURF THE INTERNET FLEXIBLY	98	Age, education level, proficiency in smart devices, etc.
LESS PUBLICITY AND EXPLANATION	92	Service provider publicity efforts, professional interpretation staff resources, etc.
DO NOT GO TO DESIGNATED INSTITUTIONS FOR MEDICAL TREATMENT	71	Physical health level, personal medical preference, distribution of medical resources, etc.
OTHER REASONS	9	—

3.2.3 Publicity and promotion within the community

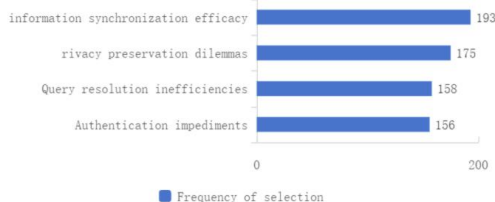


Figure 1. Chart of Community Residents' Awareness of Publicity

According to **Figure 1** upside, the majority of respondents (44.44%) perceive that there is little publicity regarding electronic health records within the community. The form of regular publicity is more prevalent, accounting for 36.83%. Only 2.54% of respondents believe that the community has vigorously promoted the use of electronic health records, while a notable 16.19% of residents report that

there is no publicity at all. These findings indicate that the relevant departments in the community have not adequately prioritized the promotion and popularization of electronic health records, highlighting the need for further improvement.

3.2.4 Binary logistic regression analysis of respondents' understanding

As shown in **Table 5** below. Taking whether one is familiar with EHR as the dependent variable, and the factors with $P < 0.5$ in the univariate analysis as the independent variables, a binary Logistic regression model was used for multivariate analysis. The independent variables included: gender, age, educational level, marital status, occupational status, source of income, proficiency in using intelligent devices, and whether one belongs to the key population for disease prevention.

Table 5. Estimation Results of Binary Logistic Model

factor	partial regression coefficient β	standard error SE	Waldx2 Value	P price	OR price	95%CI
Gender (Ref: male) woman	0.592	0.272	4.736	0.030*	1.807	1.061~3.078
Educational level (Referring to: primary school and below)	-1.160	0.503	5.322	0.021*	0.313	0.117~0.840
junior middle school	-1.465	0.438	11.203	0.001*	0.231	0.098~0.545
High school/vocational school	-1.699	0.508	11.184	0.001*	0.183	0.068~0.495
Bachelor degree or above						

Status of employment (reference: worker) Enterprise staff	-1.280	0.457	7.842	0.005*	0.681	0.113~0.681
Current level of mastery of smart devices (refer: not often used, consult others)	-2.683	0.627	18.323	<0.001 *	0.068	0.020~0.233
Very skilled, easy to operate Familiar and easy to operate	-2.516	0.525	23.002	<0.001 *	0.081	0.029~0.226

Note: * $P < 0.05$, the difference is statistically significant

3.3 Analysis of the Establishment of Electronic Health Records among Community Residents

3.3.1 Univariate analysis of the establishment status of electronic health records for interviewed residents

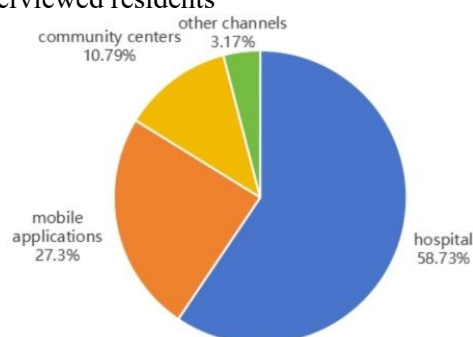


Figure 2. Approaches to Establishing Health Records for Community Residents

As Figure 2 is shown below. The hospital is

Table 6. Comparison of the Establishment Rates of Electronic Health Records among Community Residents [n (%)]

variable	frequency	Establishment of EHR		2x	P price
		build	Not established		
sex					
man	176	146(83.0)	30(17.0)	5.505	0.019
woman	139	100(71.9)	39(28.1)		
Whether they are permanent residents of the locality					
yes	272	219(80.5)	53(19.5)	6.818	0.009
deny	43	27(62.8)	16(37.2)		
Whether they belong to the key population for disease prevention					
yes	122	103(84.4)	19(15.6)	4.665	0.031
deny	193	143(74.1)	50(25.9)		

Table 7. Regression Analysis of the Current Status of EHR Establishment

factor	partial regression coefficient β	standard error SE	Waldx2 Value	P price	OR price	95%CI
Whether they are permanent residents of the locality (Ref: Yes) deny	0.812	0.357	5.186	0.023*	2.253	1.129~4.534

Note: * $P < 0.05$, the difference is statistically significant

As Table 7 is shown upside. It can be seen from the binary logistic regression model that non-local permanent residents are less likely to

the most common and widespread channel for establishing residents' electronic health records.

3.3.2 Binary logistic regression analysis of factors influencing the establishment of electronic health records for respondents

With the establishment of an EHR as the dependent variable, and factors with $P < 0.5$ in the univariate analysis (Table 6) as independent variables, a multivariate analysis was performed using the binary logistic regression model (Table 7). The independent variables included: gender, residency status (whether they were permanent residents of the area), and membership in key groups for disease prevention. In this context, permanent residents within the jurisdiction are defined as individuals who have resided in the area for more than six months, including both registered residents and non-locals [11].

establish personal electronic health records compared to local permanent residents (OR = 2.253).

3.3.3 Analysis of the archiving status of the interviewed management department

On-site interviews revealed that the quality of the early-stage archives was generally low, with issues such as missing information and duplicate coding being prevalent. In recent years, since the transfer of management responsibilities to the county disease prevention and control center, operations have gradually become more standardized, and the quality of archiving has steadily improved. Nevertheless, numerous management challenges remain unresolved.

3.4 Analysis of Barriers to the Use of Electronic Health Record Services among Community Residents

This section examines the barriers that community residents face in using EHR services in their daily lives, focusing on the dimensions of record establishment and record utilization. Through statistical analysis of

Table 8. The Convenience of Establishing Electronic Health Records

class	frequency	percentage (%)	Effective percentage (%)	Cumulative percentage (%)
Very convenient	47	14.92	14.92	14.92
more convenient	178	56.51	56.51	56.51
Generally convenient	78	24.76	24.76	24.76
Not convenient	12	3.81	3.81	3.81
amount to	315	100.0	100.0	100.0

3.4.2 Analysis of obstacles in the use of electronic health records

(1) Perceived Helpfulness of Using Electronic Health Record Services. As shown in As **Table**

Table 9. Degree of Perceived Helpfulness of EHR Services among Community Residents

class	frequency	percentage (%)	Effective percentage (%)	Cumulative percentage (%)
Most of it was helpful	53	16.83	16.83	16.83
Generally helpful	167	53.01	53.01	53.01
Less help	87	27.62	27.62	27.62
No help	8	2.54	2.54	2.54
Total	315	100.0	100.0	100.0

(2) Challenges Faced by Respondents in Using Electronic Health Records. As illustrated in **Figure 4** as below. The most significant challenge respondents encounter when using EHR in their daily lives is the untimely and inaccurate updating of record content.

(3) Analysis of Factors Influencing Respondents' Frequency of Using Electronic Health Records. As illustrated in **Figure 5** below. The primary factors include concerns about personal information security, daily work and lifestyle circumstances, proficiency

survey results in these two areas, the specific circumstances are summarized and described.

3.4.1 Analysis of barriers in establishing records

(1) Prerequisite for Establishing Personal Electronic Health Records. As illustrated in As **Figure 3** is shown below. The primary barrier respondents encounter in establishing personal EHR is concerns regarding personal information security.

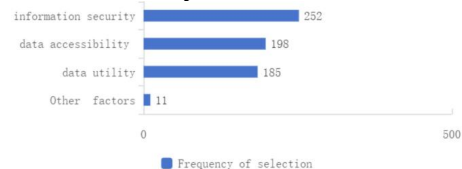


Figure 3. Premises and Guarantees for Establishing Electronic Health Records

(2) The convenience of the process of establishing electronic health records.

As **Table 8** is shown below. Most respondents felt that the process of establishing electronic health records was relatively convenient.

9 is shown below. Respondents believe that the establishment of personal electronic health records has an insignificant role in solving practical problems.

in operating smart devices, and the availability of smart device configurations.

(4) **Figure 6** presents the respondents' views on the service functions of electronic health records that require ongoing enhancement.

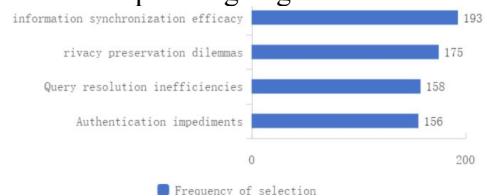


Figure 4. Difficulties and Problems Faced by Community Residents in Using Archives

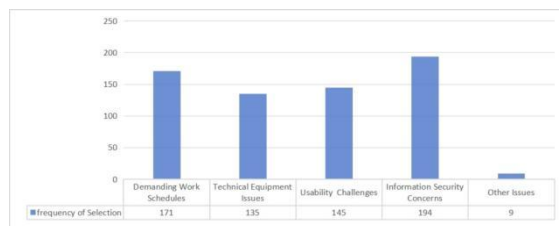


Figure 5. Statistical Chart of Factors Affecting the Frequency of Community Residents' Use of Archives



Figure 6. Statistical Chart of Factors Affecting the Frequency of Community Residents' Use of Archives

4. Discussion

4.1 Insufficient Publicity Efforts and Weak Resident Awareness of Health Management

To address the insufficient promotion of EHR in health services, it is crucial to deepen their application, particularly among groups with limited proficiency in electronic technology. Community-based smart device usage training programs should be implemented, focusing on assisting elderly individuals and residents with lower educational attainment in mastering EHR query skills. Multi-channel strategies, including online media platforms and offline health promotion activities, should be employed to enhance residents' understanding of personal health records and encourage greater utilization of EHR.

4.2 Imbalance in Institutional IT Infrastructure and Record Damage Issues

The local government must take a leading role in overcoming barriers such as inadequate communication, unclear division of responsibilities, and mutual shirking among medical institutions within county-level medical consortia. Clear definitions of each institution's core functions are essential to promote the development of an information-sharing network system. Strengthening the capacity of primary healthcare services will further facilitate seamless collaboration and reduce record damage risks.

4.3 Untimely Information Updates and

Concerns About Personal Information Leakage

In response to concerns about personal information protection, local authorities should ensure lawful collection and safeguarding of personal health data. In the era of big data, grassroots public health service departments should fully leverage the potential of EHR systems by simplifying user interfaces, enabling intelligent input features, and reducing operational complexity. By adopting advanced practices from other provinces, the system's information service gaps can be addressed, promoting timely updates and enhancing the accuracy, timeliness, and convenience of EHR collection and usage.

4.4 Service Deficiencies for Migrant Populations and Long-Term Accumulated Problems

Health management services for migrant populations remain inadequate. Regional departments should implement the registration at place of residence policy based on local conditions, providing convenient registration pathways for non-resident populations, especially migrants. Establishing an electronic health record platform tailored to their needs will improve accessibility. Simultaneously, efforts should focus on strengthening inter-provincial health information platform integration to ensure synchronized exchange of medical data for patients seeking care outside their home regions, minimizing duplicate registrations, information loss, or redundancy.

5. Summary and Outlook

Electronic health records (EHR), serving as a repository for residents' health information, are a critical tool for enhancing the efficiency and quality of primary community healthcare services. They play a pivotal role in improving healthcare service delivery, promoting residents' self-management of health, and fostering innovation in primary community healthcare. However, this study has certain limitations regarding data collection scope, research methodology, sample selection, and conclusions drawn. Future research could further validate and refine the findings of this study by broadening the data collection scope, employing more rigorous research methods, increasing sample representativeness, and

conducting in-depth analyses of the interplay between health behaviors and lifestyle factors.

Acknowledgments

This research was generously supported by the following projects: ① The reform of diversified and compound payment methods for medical insurance in Yunnan Province (42121003); ② The Innovative Experimental Program for Undergraduates of Kunming Medical University (2024CYD514).

We extend our deepest gratitude to the Review Expert Committee for their invaluable contributions as esteemed members of the academic community. Additionally, we sincerely thank the researchers of relevant literature for providing logical guidance and inspiration that significantly enriched this study.

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