Week 5 Assignment -

Electronic Health Record

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The electronic health record (EHR) can best be defined as a digital version of a patient’s medical chart. The key distinction between a traditional paper chart and an electronic chart is the fact that electronic health records are available in real-time, have a patient’s full medical history (at least logged up to that point), and are available at any facility (that has access to these EHR systems). The “patient demographics, progress notes, problems, medications, vital signs, past medical history immunizations, laboratory data, and radiology reports” (Burke, p. 25) that are contained in an EHR offer a level of automation and streamlining of processes that brings continued progress of healthcare to the next level. You can already begin to envision the potential for patient care and efficiency that electronic health records can offer, so let’s explore some further applications of electronic health records and how its components interact with one another.

Some of the main accomplishments and benefits, stated by HealthIT.gov, of using electronic health records are: improving patient care, increasing patient participation, improving care coordination, improving diagnostics and patient outcomes, and practicing efficiencies and cost savings. These benefits pretty much run the gamut of the healthcare field and the electronic health record has components that span the administrative, clinical, financial, and infrastructure aspects of the healthcare field. On the administrative side, the EHR allows for organized and timely application of care for the patient. By linking the data in an EHR to the rest of the networked devices and databases across the facility’s systems, the administration of healthcare is greatly sped up and made much more efficient. The coding and grouping used in medical database systems also applies to the electronic health record in that each category of information provided by a patient is entered into a form to become part of the record in a table of the database. This record then can be accessed and modified where needed (personal, medical, and insurance information), so the coded and grouped record itself really serves as the basis for integration with other components across the systems.

On the clinical side of things, the benefits of the electronic health record are probably most obviously seen. When patients are given any direct care, such as diagnosis, monitoring, or treatment, the information pertaining to the care can easily be transcribed into the electronic health record. This helps it to become a living and breathing (figuratively speaking) record that has all of the most up-to-date, accurate information possible regarding the patient. In addition, perhaps one of the most important features of an electronic health record is the communication lines that are established by its use; all clinicians involved in a patient’s care are able to access, use, and add to a patient’s EHR which really streamlines the ability to make quick, informed decisions about providing patient care.

As you can begin to see, the information contained in an electronic health record is highly accessible and is easily transposed across a vast network of healthcare facilities and systems. This means that the data is also transferrable to components of non-direct healthcare such as the financial aspects that make the delivery healthcare possible. This includes the accounting functions of healthcare which consist of insurance arrangements and claims. The record can potentially keep track of what type of insurance coverage a patient has or doesn’t have, and therefore can allow the facility to determine how to handle the claims of the account, which is an integral part of providing healthcare. Burke (p. 49) indicates that the fact that the record (and the accounting transaction) is electronic/computerized allows accounting to avoid being buried in paper and helps to keep all patient accounts accurate, up-to-date and well-organized.

A national focus is being placed on helping promote interoperability of all of these aspects of the healthcare field. Jamoom (2016) states that currently there are plans and funding to expand electronic health record systems via incentive payments made possible by the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 – the 2014 national percentage of office-based physicians who have a certified electronic health record system was over 74 percent. The electronic health record provides, and makes use of, an overall infrastructure of computerized medical devices and software that is currently revolutionizing the healthcare industry. The increased ability to be able to access and share vital information across all aspects of healthcare, and patient-care, are greatly improving the quality and efficiency of both. The electronic health record serves as a basis for much of this information sharing and allows the existing systems to interface in a way that previously was not achievable. It’s safe to say that this has been the decade of Health Information Technology, and at the root of this advancement in technology has been the electronic health record.

References

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