Learn EHR Basics

What Are Electronic Health Records (EHRs)?

An electronic health record (EHR) is a digital version of a patient’s paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider’s office and can be inclusive of a broader view of a patient’s care.

EHRs are real-time, patient-centered records. They make information available instantly, "whenever and wherever it is needed". And they bring together in one place everything about a patient's health. EHRs can:

- Contain information about a patient's medical history, diagnoses, medications, immunization dates, allergies, radiology images, and lab and test results
- Offer access to evidence-based tools that providers can use in making decisions about a patient's care
- Automate and streamline providers' workflow
- Increase organization and accuracy of patient information
- Support key market changes in payer requirements and consumer expectations

One of the key features of an EHR is that health information can be created and managed by authorized providers in a digital format capable of being shared with other providers across more than one health care organization. EHRs are built to share information with other health care providers and organizations – such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities, and school and workplace clinics – so they contain information from all clinicians involved in a patient’s care.
**Why Adopt EHRs?: Better Information Means Better Health Care**

Providers who use EHRs report tangible improvements in their ability to make better decisions with more comprehensive information. EHR adoption can give health care providers:

- **Accurate and complete information about a patient's health.** This enables providers to give the best possible care, whether during a routine office visit or in a medical emergency, by providing the information they need to evaluate a patient's current condition in the context of the patient's health history and other treatments.

- **The ability to quickly provide care.** In a crisis, EHRs provide instant access to information about a patient's medical history, allergies, and medications. This can enable providers to make decisions sooner, instead of waiting for information from test results.

- **The ability to better coordinate the care they give.** This is especially important if a patient has a serious or chronic medical condition, such as diabetes.

- A way to share information with patients and their family caregivers. This means patients and their families can more fully take part in decisions about their health care.

- **The main goal of health IT is to improve the quality and safety of patient care.** The promise of fully realized EHRs is having a single record that includes all of a patient's health information: a record that is up to date, complete, and accurate. This puts providers in a better position to work with their patients to make good decisions.

EHRs can also flag potentially dangerous drug interactions (to help prescribing doctors explore alternatives before a problem occurs), verify medications and dosages (to ensure that pharmacists dispense the right drug), and reduce the need for potentially risky tests and procedures.

**The Government and Health IT**

The Federal government does not dictate what system doctors or hospitals should use or even whether to use a health IT system at all. However, the government is
involved because health IT supports cost-effective ways to improve the quality of care. The government’s role in health IT includes:

- encouraging adoption,
- supporting information privacy,
- supporting research on the appropriate use of health IT; and
- using health IT systems in government-operated hospitals.

**The Government and Health IT: Encouraging Use, Protecting Privacy, Supporting Research**

Research shows EHRs can save lives and save money. That’s why Congress passed a law called the Health Information Technology for Economic and Clinical Health (HITECH) Act, giving hospitals and doctors together an estimated $20 billion to support their installing and using EHRs. Simply installing these systems is not enough to improve healthcare, any more than putting exercise equipment in your basement is enough to prove that you’re working out every day. Hospitals and doctors must demonstrate they are using EHR systems to actually improve care in specific ways that follow the strict guidelines established by the Office of the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology also promotes the use of health IT in a way that improves care.

**Protecting Privacy**

You have clearly defined rights when it comes to protecting your health information, and these rights extend to electronic health information.

If you believe your health privacy has been violated, the U.S. Department of Health and Human Services (HHS) has a division, the Office for Civil Rights, to educate consumers about their privacy rights and enforce the rules.

For a more detailed discussion of your privacy rights, visit the [Protecting Your Privacy & Security](http://HealthIT.gov) page on HealthIT.gov.
Supporting Research

The **Agency for Healthcare Research and Quality (AHRQ)** is an agency within HHS that supports research to improve the quality of care for all Americans. AHRQ and other agencies fund research to inform doctors and hospitals how to use health IT in a way that works best for them and their patients. AHRQ’s National Resource Center for Health IT shares research findings, best practices, lessons learned, and funding opportunities.

**Government Agencies Leading the Way: Using Health IT**

The **Veterans Health Administration**, a division of the Department of Veterans Affairs (VA) that oversees the health care needs of our nation’s veterans, is the largest medical system in the United States. It is also one of the most technologically advanced, offering both an EHR and a PHR to its millions of users. Doctors throughout the VA use its EHR, known as **VistA** (Veterans Health Information Systems and Technology Architecture). VistA tracks information on the millions of veterans who receive care through the VA and features an e-prescribing component.

The VA’s personal health record (PHR), **My HealtheVet**, (pronounced “My Healthy Vet”) is based on the core belief that informed patients can make better health choices. The PHR is free to veterans and available 24/7, wherever there is Internet access. VA patients who register on My HealtheVet and complete a one-time, in-person authentication process can get wellness reminders, view appointments, and participate in messaging with their health care team.

The My HealtheVet PHR is being expanded with the Blue Button Initiative, which allows veterans and Medicare beneficiaries to download personal health information. Blue Button lets users get a copy of their own health information so they can better understand and track their health. If they choose, they also can also share it with their doctors or other people they trust. Other government agencies and private companies have started to use Blue Button, too.

**Indian Health Service (IHS)** also maintains an EHR for IHS, Tribal, and Urban (I/T/U) Indian health care facilities. This EHR, called the **Resource and Patient Management System (RPMS)**, gives many of its facilities access to decades of personal health information and epidemiological data on local populations.
NASA has adopted an EHR system to better manage the health and safety of astronauts and other employees using the agency's occupational health clinics.

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