**Electronic Health Records** 

Increasing the **Quality of Care** 

An Electronic Health Record (EHR) is an electronic version of a patient's medical and treatment history. EHR systems go beyond standard clinical data, providing a broader view of a patient's care that can be used by multiple providers.



- EHRs provide information needed to evaluate a patient's current condition in the context of the patient's health history and other treatments. This helps providers give patients the best possible care.
- In a crisis, EHRs provide instant access to information about a patient's medical and treatment history, allergies, and medications. This allows providers to make informed decisions faster.
- EHRs make it easier for providers to coordinate the care they give. This is especially important if a patient has a serious or chronic medical condition, such as diabetes.
- EHRs make it easier for providers to share information with patients and their families so they can more fully take part in decisions about the patient's care.
- EHRs help reduce paperwork, eliminate duplicate tests, and facilitate accurate code assignment for billing.
- EHRs can flag potentially dangerous drug interactions, verify medications and dosages, and reduce the need for potentially risky tests and procedures.







- EHRs can improve health care delivery and provider services but they can also pose challenges with privacy and security, altering entry dates, cloning, upcoding, and the use of coding modifiers.
- Use the security features that exist to allow only appropriate or authorized entities to have access to certain information in the patient's medical and treatment history.
- Be sure the EHR system has the capability to identify changes to an original entry, such as addendums, corrections, deletions, and patient amendments.
- "Cloning" information in an EHR means cutting and pasting medical information from one date of service to another. Though cloning can be useful to document a patient's history on each page of an EHR, lacking appropriate documentation to support a billed service may result in recoupment of payments.
- Always enter patient information immediately at the point of care, so the patient's EHR is complete. This "real time" updating will improve the delivery of care and patient transitions from one service or provider to another.
- A "modifier" is an extension of an assigned code. Only use them to clarify the procedures and services performed; never use them to increase reimbursement.