Keep accurate records. Share vital patient information. That’s our plan.

The Shared Health Clinical Health Record® (CHR) is a web-based, electronic health record that aggregates and presents encounter data, medications, lab results, immunizations, allergies, and vital signs to clinicians and other caregivers at the point of care. Because it is largely pre-populated, the CHR is one of the most accurate ways to obtain visibility into your patient’s clinical status. In addition, Shared Health ePrescribe® is an online application that allows authorized clinicians to write and submit end-to-end electronic prescriptions. Combined, the CHR and ePrescribe give a comprehensive, panoramic view of a patient’s medical history.

Easy setup. Secure access.

Since the CHR is a web-based system, the only equipment you need to begin using Shared Health is a PC with a high-speed Internet connection. Our Clinical Outreach Team will make sure everyone on your staff is registered with a unique user ID and password and trained to use our system.

Manage your workload better.

Shared Health isn’t just a record-keeping system. It makes your workflow more efficient. For example, you can cut down on routine paperwork by utilizing Shared Health ePrescribe®, track immunizations, allergies, and Early Periodic Screening & Diagnostic Testing (EPSDT).

And it’s free for you to use.

The Shared Health CHR gives you relevant information at the point of care, including:

- Medications
- Procedures
- Diagnoses
- Allergies
- Immunizations
- Laboratory Results
- Shared Health ePrescribe
- Well-child Screening (Early Periodic Screening & Diagnostic Testing)
The largest Health Information Exchange in Tennessee. And all of America.

Shared Health is currently used throughout Tennessee — connecting clinicians, patients, and pharmacies. Nearly 2 million Tennesseans are enrolled in Shared Health. This includes the entire TennCare population, BlueCross BlueShield of Tennessee (BCBST) employees, BCBST’s commercial group, and other self-insured employers. Our information exchange is compliant with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

Shared Health ePrescribe® —A way to manage prescriptions.

The Shared Health CHR solution also incorporates a free electronic prescribing tool. With Shared Health ePrescribe, the possibility of errors can be significantly reduced, and filling prescriptions becomes much easier for you and your patients. Plus, ePrescribe includes formulary information, which means you can choose the most effective medication at the lowest cost for your patients. Using Shared Health ePrescribe to send prescriptions electronically to pharmacies helps you be compliant with tamper-resistant script requirements.

It’s easy to integrate Shared Health into your practice.

Shared Health is the perfect complement to your office’s electronic patient record system. If you already have an electronic medical record, talk to your Shared Health representative about integrating Shared Health into your existing workflow.

Shared Health means better information, better care, and better business.

Depending on your health care setting, you’ll also see other specific benefits.

For office-based clinicians:
- Helps you better monitor your patients’ compliance once they leave your office, making it easy to check their adherence to medication dosing schedules, ordered tests, procedures, and specialist referrals.
- Reduces hassles for your patients by giving you supplemental immunization records, patient medication descriptions, and lab results.
- Improves your preventive care by giving you a better holistic view of your patients. Using information like that contained in a CHR during a well-child check-up detects at least one problem in 43% of patients.1

For health departments and rural health clinics:
- Improves collaboration with other medical facilities by connecting you with a larger network of information and medication history — increasing available patient information without increasing your paperwork.
- Enables better care and oversight for both first-time and returning patients.
- Gives authorized health care professionals immediate access to pertinent medical history, including medications and well-child exams.

For hospital-based clinicians:
- Reduces the potential for medical error.
- Provides pertinent medical history that will facilitate appropriate and efficient use of hospital resources.
- Enables clinicians to provide enhanced continuity of care by giving them an immediate snapshot of each patient’s medical and medication history.
- Helps reduce adverse drug events in the in-patient setting.