Electronic Health Record (EHR)

Submitted by

Course

Date

**Electronic Health Record (EHR) In Practical Setting**

The system of concepts related to the Electronic Medical Record in the article is extremely important for building a reasonable, efficient system of maintaining Electronic Medical Records at all levels. So, at the level of the Electronic Medical Record in a particular medical organization there will be the greatest variety and the widest range of specific solutions implemented within the framework of specific medical information systems (EHR). Moreover, in our opinion, a specific EHR should be substantially adapted to a specific customer in accordance with the needs of the medical organization, with the technology of its work and, most importantly, with the level of the organization’s readiness to introduce information technologies. Implementation of the EHR - not one-off event, but a long (sometimes -long-term process of transition of health facilities from paper-based methods of medical documentation to electronic ones. As in most medical institutions, EHRs have several basic formalized types:

1. electronic medical record of an ambulatory patient
2. electronic medical record of a dental patient
3. medical card of the physiotherapy department (including forms for visits to the exercise therapy room)
4. electronic medical record of inpatient (including day hospital)
5. electronic card of pregnancy management
6. electronic medical history of childbirth

**Attaching files to medical records**

In the function of any MFD, the ability to attach files to a medical document can be added. The files and the medical documents themselves can be saved both in the information database (including on the database servers ) and in the file system volumes on the 1C: Enterprise server. The way the files are stored is set by the system administrator. For files that are images, the application allows you to use the inclusion of images in a medical document. For standard procedure of making HER, it is important to have a good system. Few questions needed to ask from vendor when implementing this IT system like;

1. How modern is the system?
2. How easy to use because different people and department need to use it ?
3. What the benefits of particular system over other available choices?
4. How much data can be stored in it?
5. What about back up ,if any incident happens?

When using an application solution in conjunction with medical equipment that supports the DICOM standard , it is possible to attach to medical documents clinical quality images obtained from PACS, viewing stations or medical equipment. (Ajami & Bagheri-Tadi, 2013). Currently, statements from the highest tribunes are heard that in the very near future the process of introducing medical information systems will go at full speed, recording to a doctor will be easily accessible via the Internet, and medical records will be kept exclusively in electronic form. At the same time, it is taken for granted that the indicated tasks will be solved if the appropriate funds are allocated, an appropriate IT infrastructure is created in each health care facility , computers and office equipment are purchased, and appropriate software is developed and implemented.

However, the best technological solutions will not be demanded if the majority of potential users will remain practically unprepared for working with new technologies or, even worse, will not understand, and what this will give directly to the end user. The problem is not only to organize training and the "elimination of computer illiteracy." In the end, as experience shows, even people of very old age, if they have a desire, after a few weeks, work with any information systems quite tolerably. (McGowan, Cusack & Poon, 2016). The problem is that a significant number of health workers have no desire to use even the most wonderful and modern means of automation or how and in what way these tools will help the health workers themselves, and some even resist the introduction of new technologies. As part of the application solutions included demonstration MDP for several medical services. SMDs can be developed by 1C partners at the implementation stage in medical organizations, IT staff of medical organizations, as well as independent developers as part of individual software products. (Pizziferri, Kittler, Volk, Honour, Gupta, Wang & Bates, 2015).

**HIM**

HIM experts are supporters for the individual's right to secluded, safe and confidential health information. Employed in numerous health care backgrounds, HIM support clinical research by the facility of health care data, administration of complex information systems and work with key stakeholders by means of health data to progress the health of all citizens. “The HIM specialist organizes work with other authorities in the field and beyond, that provides an excellent prospect to progress collaboration skills.” (Zandieh, Yoon-Flannery,Kuperman, Langsam,Hyman, & Kaushal, 2014). “there are hallenges to EHR implementation in electronic-versus paper-based office practices. Medical encoding includes the correct medical code setting for appropriate repayments by insurers and financiers such as Medicare and Medicaid. It also means confirming all health records as well as correct diagnosis according to the procedures describe. There are several sets of codes used by coders, and they must have the latest resources like some of the codes that change each year. “(Zandieh, Yoon-Flannery, Langsam, Hyman, & Kaushal, 2014).

**Director of nursing**

An EHR is a medical record that is edited in real time and is patient-oriented. Information from it is available instantly, whenever and wherever. EHR features including storing information about the patient's history, his diagnoses, medications taken, vaccinations, the presence of allergies; X-rays, laboratory data and test results. Providing access to tools for working with evidence that can be used in making decisions regarding the provision of medical care to the patient. Improved communication between doctors by giving each side full access to the patient’s medical history instead of a one-time review of the current admission. Contributing to a more thorough assessment and quicker accurate diagnosis by doctors. Improved organization and accuracy of patient information that will help nurses to diagnose and suggest care plan. It helps nurses in provision of vital, vital information to emergency personnel.

One of the main characteristics of an EHR is the ability to create it, manage it, and advise all authorized medical personnel and staff at different medical institutions at the same time. A huge number of health information management offers physicians with data regarding their patients treated as required. It too contains checking compliance records with national, federal and private insurance plans. Later , any submission failures should be forwarded to physicians and other physicians to allow them to improve their documents.

**Hospital management system**

The hospital electronic medical record system is an important symbol of the modernization of hospital information management. At present, the hospital HIS system based on fee management is gradually developing to the hospital information system cantered on patient information, and the hospital electronic medical record management system is a concentrated expression of patient information. How to use the patient information of the hospital management system to establish a hospital electronic medical record Software system are increasingly being valued by managers.

 General hospital patient basic information and medical records, expenses and other data are implemented in the hospital management system, so in order to obtain patient-related information in time when establishing the hospital electronic medical record management system, it can be extracted through the interface of the hospital HIS system and the hospital electronic medical record system. Such as the patient's basic information on hospitalization, cost and expense data, patient long-term (temporary) medical advice. Patient information may be demanded for numerous reasons such as insurance purpose or continuity of care. It is the responsibility of medical office to release timely information upon obtaining the permission of the patient or their lawful representative. Issue of information facilities include;

1. Get valid permission to issue protected health information
2. Excellence of medical records for copying
3. Give in to electronic health records
4. Observe requests and monitor reply time accuracy

Conclusion

The electronic document management in the organization of health care allows to fill out and save in the patient's history in electronic form such forms as prescription extracts, referrals for various examinations, certificates for obtaining vouchers, formalized extracts from an outpatient medical record and some others. The fundamental part of the electronic medical card is the module of the examination of the doctor - “Electronic Patient Reception”. It is based on working with templates. Each doctor, depending on the specialty, receives his own set of templates (primary and secondary examination of the patient), as well as viewing the patient’s history, test results, written prescriptions and comments of other doctors for the correct choice of patient treatment strategy.

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