Berlinda to a pediatrician. this would call

Business, Management

BerlindaDzakpasu HIM Departmental Provision of AccurateInformation to Outside Requestors Health Information Management (HIM) isthe acquisition and protection of digital and traditional medical information usedto provide patient care.

Healthinformation is the information gathered from a patient's medicalhistory. There are signs and symptoms, diagnoses, procedures done, and outcomesfrom checkups. It is important that HIM departments provide accurateinformation to outside requestors as this could lead to patient safety, savingof financial resources and the expedience of the healthcare process.

Information can be requested orshared with other healthcare providers, insurance companies and governmentalagencies. It is common practice to transfer of patients from general practitionersto specialists with more expertise in certain fields. Proper, well updatedmedical records are of significant importance to effectively communicate betweenhealthcare professionals. A child with abnormal electrocardiogramwould be referred by the general practitioner to a pediatrician. This wouldcall for the exchange of information between two agencies. The practicingpediatrician would need access to the medical history as well as previousmedical images. Thus, both the primary health record and the patient healthrecord would be made available to the pediatrician.

The pediatrician would usehis or her expertise and the data provided by the HIM department of the generalpractitioner to further evaluate and treat the child. Secondary patient recordscan then be sent out for payment purposes

to the insurance company covering thecost of treatment. Any inaccuracy in information can be fatal. Poor record keeping as well asinaccuracies may have devastating consequences to a patient and all concernedin the care of a patient. Thus, the paramount importance of providing accurateinformation to outside requesters. How the Integration of EHR Systems CanImprove Patient Safety and Care An Electronic Health Record (EHR) isa computerized version of the paper records of a patient. It is a digitalversion of the medical history of a patient.

The integration of EHR systems hasnumerous benefits to a clinical setting. EHR Systems offer many institutionsand physicians opportunities to improve the quality of patient care delivery aswell as patient safety. Authorized providers and staff frommultiple health care facilities can create, manage and consult on a single EHR.

A single EHR compiles information about a patient’s history. This informationcomposes of current and past doctors, emergency facilities, school andworkplace clinics, pharmacies, laboratories, and medical imaging facilities. The aggregation of information reduces the adverse effects of informationasymmetry. EHRs are beneficial.

First of all, with EHRs, providers can easily make diagnosis. EHRs provide reliable access toa patient’s complete health information. This aids in the reduction of errorsand the repetition of tests.

Thus, they improve patient safety. An EHR automaticallychecks for problems associated with medication and allergies whenever a newmedication is

prescribed. The clinician is alerted to any potential conflictsif there is any before the information is transferred to a pharmacy.

Information recorded inan EHR tells a clinician in the emergency department about apatient’s life-threatening allergy and other pre-existing conditions. Eventhough a patient might be unconscious, the emergency staff can adjust careappropriately. Additionally, EHRs aid clinicians to quickly and systematicallyidentify and correct operational complications. Compared to a paper-basedsetting, identifying such complications is more difficult and may take years tomake corrections. Moreover, EHRs improve public healthoutcomes.

They can be used to benefit groups of patients with similar conditions. Data can be pooled and groups of patients with similar conditions canidentified. Healthcare providers with health information about a population ofpatients they cater for can look to improve and serve the needs of patients whosuffer from a specific condition, are eligible for specific preventive measuresand are currently taking specific medications. Systematized Nomenclature of Medicine (SNOMED)is a coding language that allows providers and electronic medical records tocommunicate in a common language. This increases the patient care qualityacross many different provider specialties as it improves patient data analysisaccuracy.

The use of a coding language that standardizes medical terminology fromone healthcare provider to another, simplifies the query and resultingreport. It allows users to be confident in their definition of a diagnosiswithout fear of missing anything life threatening.