

Introduction to interchange data between various emr systems



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Introduction

This paper explores how health care service providers can leverage health information to attain quality care, improved care effects, decrease operational costs and accomplish better service return in psychiatric rehabilitation center. Government and business policy amendments have induced a literal healthcare information outburst (Gantry Group, 2007).

Particularly, this paper focuses on the electronic medical record modality of communication within the health care system. Information management can be a healthcare provider's nightmare as well as opportunity. Healthcare practitioners are obliged to manage the increasing information load to satisfy governmental fulfillment and manage increasing operational losses that arises due to increased records and reporting obligations (Gunter & Terry, 2005).

Definition

The EMR refers to an application setting dealing with clinical information repository, clinical record applications, pharmacy, computerized provider order entry, order entry, limited medical terms, and clinical judgment support. Such background sustains the patient's EMR throughout the inpatient as well as the outpatient context, and is employed by healthcare professionals to record, evaluate and organize health care practice in a Care Delivery Organization (CDO). The information in the EMR is the official proof of the patient's experience in the CDO and is a legal property of the CDO (Gunter & Terry, 2005). The Electronic Medical Records (EMR) is a lawful

document proof developed in hospitals and ambulatory settings that serves as the source of information for Electronic Health Record (EHR).

The EHR signifies the prospect to easily disseminate health information within the stakeholders and to afford patients information through the various forms of care undertaken by such persons. In this context the stakeholders refers to patients, healthcare practitioners, employers, and insurers involving the government (Gunter & Terry, 2005).

Application

Few health care institutions use EMR interventions that can successfully lower medical mistakes or boost the quality and success of patient care. The Clinical Transformation Staging Model was designed by HIMSS Analytics to evaluate the level of the clinical EMR application in healthcare delivery institutions. This model depicts that hospitals in the United States have a big task in the future to accomplish the HER vision conceived in Washington, D. C.

and in the 200+ neo-CHIN Regional Health Information Organization (RHIO) strategies in many states of development throughout United States (Garets & Davis, 2006). Transferring patients' record custody from paperwork and tangible filing systems to computers provides improved efficiency for patients, their providers and the health disbursement system.

Benefits versus limitation of EMR

Improved availability and portability of EMR may increase the ease with which they can be obtained and used by unlawful people relative to their

paper health records counterparts. This conviction is reflected by the rising security demands for EMR incorporated in the Health Information and Accessibility Act and by latest rise in allegation in confidential records incidents by EMR consumers.

Security concerns add to the opposition expressed for their extensive adoption. Handwritten health records can be linked to dismal legibility, which can encourage medical mistakes (Institute of Medicine, 1999). Printed forms, requirements for penmanship, the standardization of acronyms were previously encouraged to sustain credibility of paper medical records. On the other hand, digital recording promotes the universality of data entry, acronyms and jargon, as well as forms. Digitalization of datasheets enables the obtaining of information for epidemiology and clinical test 10/11.

Conversely, EMRs can be constantly updated based on particular legal guidelines. The capacity to interchange data between various EMR systems promotes the synchronization of healthcare practice in non-associated healthcare institutions. Also, information from an electronic data system may be applied secretly for statistical presentation regarding matters including quality improvement, public health infectious disease study.

Confidentiality concern An important issue emerging from the application of EMRs is that of sustainable confidentiality of personal information managed electronically. During hospitalization, an estimated 150 persons can access a at least a portion of a patient's medical record, while approximately above 600, 000 persons including care providers, financiers, plus other associates dealing with billing of records can access the clients Electronic Medical

Records to some extent. In the U. S.

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, this category of data is known as protected Health Information (PHI) and its organization is guided by the Health Insurance Portability and Accountability Act (HIPAA) including various local legislations (US Code of Federal Regulations, 2005). While in the European Union (EU), various European Parliament and Council Directives safeguards the synthesis and flow of private information to facilitate health care delivery (European Parliament and Council, 1995).

Contrast with paper based records

Paper documentations remain the precedence method of documenting patient's information in majority of the hospitals and healthcare facilities in the United States. This precedence over the EMRs is attributed to the simplicity of records entry and low cost associated with the paper based documentation. Nevertheless, as easy as they seem for the physician to enter medical facts on incident of care, they need sufficient storage capacity relative to digital data.

In the United States, majority of the states advocates that physical records be maintained for at least seven years. The fiscal aspect of paper-based storage device such as magnetic film and paper, in terms of unit data, distinguish from those of computerized storage media. When paper based data are preserved in various locations, gathering them to a single point for appraisal by health care practitioners is intricate and consumes a lot of time, while the process is simplified in electronic records.

Conclusion

Although, electronic medical data storage is costly, it facilitates quick access of records saves a lot of time. Thus, in the long run the cost for installation of EMRs system can be reimbursed, because saving time translates to saving money. Hospitals should adapt the EMRs modality of communication in order to improve care delivery.

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