Subject: A Review of 10 Electronic Medical Records Specifications
Posted by pamnewstalk1911@ on Tue, 05 May 2020 19:42:28 GMT
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For doctors and medical personal providing specialized medical care is all determined by documentation and detailed specifications. These are the top 10 we know about at the urrent time.

1. FHIR- Fast Interoperability Resources

Fast interoperability resources is a specification defining data format and features along with application programs for electronic health records designed with the aim to provide electronic health information and serve as a guide for new users. They make use of theoretical and conceptual frameworks to provide reliable, easy to access mechanism for exchanging information between medical health cares. FHIR has incorporated the traceability process for tracing their RIM and other important content models.

2. OpenEHR

OpenEHR is a health specification used to store and manage electronic medical records that are designed to provide a solution for health care for retrieving and sending information through health care providers. They make sure that information can be stored within the electronic medical records with no additional information and can be managed in a distribution form that can be accessed anywhere and anytime it is needed.

3. Open mHealth

Open mHealth is a leading electronic medical record specification designed with the aim to provide patient with a developed healthcare decision and help them share their health information with medical teams around the world. They also provide a worldwide health technology developer that allows digital health to be understood through a common definition access

4. SMART on FHIR

SMART on FHIR is a fast electron medical record developed with the aim to allow medical records to be written and sent through different health care systems all over the world. They create a digital network infrastructure to allow users to make use of substitutional medical applications using simple components and create a tool to monitor, store and retrieve information thereby creating an environment where application software cannot be replaced.

5. StandardHealthRecord

Standard Health Record is an open electronic medical health specification used to define a record format and to make a record more reliable than the current format. The standard health record of patient provides detailed information needed by the health caregiver to give proper health care to the patient and it may include the patient’s response, address, and specific information of the patient. They also focus on the needs of the patient which may include patients managing their own information.

The standard health record strongly encourages market creativity through their open-source approach by making use of large scale information for taking care of patient and community level to improve patient involvement which encourages public awareness and make sure that patient has the right information at the right time.

6. Continuity of Care Document

Continuity of Care Document is an electronic medical records specification designed to define patient health records, arrangements, exchange patient health information, and reduce the rate of medical errors. They use a detailed set of the template to give out information and to send information to clinical health care.

The patient report provided contains a collection of data documents, health care section that contains financial, demographics, and health care information. They gather information from health care professionals, environments, programs, and transfer it to different health care providers to promote the continuity of health treatment.

7. Continuity of Care Records

Continuity of Care Records is a standard specification electronic health summary of patient health developed with the aim to increase the quality of patient health, and reduce medical mistakes by making available up-to-date data of the patient to health caregivers. They provide records of patient's safety and transfer of patient from one health caregiver to another through the electronic health systems

8. HL7 version 2

HL7 version 2 is a standard electronic information specification exchange in a health care system and the most commonly used in healthcare standards in the world. It is designed to allow health information to be shared between networks and it helps to promote the standard of health care given to patient.

9. Standard Health Record Collaborative

Standard Health record collaborative provides high quality and standard medical information by identifying a common purpose of standard of clinical records. They gather and compile an accurate number of patient statistics and allow user to communicate from home to any health care system. They also help to improve communication, monitor medical errors, and lower the cost in large scale prevention strategies.

10. OHDSI OMOP Common Data Model

OHDSI OMOP Common Data Model is an electronic medical record specification designed to constantly encourage research and innovation to improve the quality of health care. They provide answers to critical questions in health and collect all information around the healthcare institution to provide a more standard data model.