Guidelines For Medical Record And Clinical Umentation

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Conditions of Participation for Hospitals - United States. Social Security Administration 1966

Knowledge Representation for Health-Care - David Riano Ramos 2012-01-16
This book constitutes the refereed proceedings of the Third International KR4HC 2011 workshop held in conjunction with the 13th Conference on Artificial Intelligence in medicine, AIME 2011, in Bled, Slovenia, in July 2011. The 11 extended papers presented together with 1 invited paper were carefully reviewed and selected from 22 submissions. The papers cover topics like health care knowledge sharing; health process; clinical practice guidelines; and patient records, ontologies, medical costs, and clinical trials.

Steps Toward a Universal Patient Medical Record - Michael McGuire 2004
This book describes how an automated patient medical record could be built that could evolve into a universal patient record. Such a universal patient record would change medical care from a focus on short-term care to one oriented to long-term, preventive-care. It would remove patient care from being the province of the single physician to that of the responsibility of many different healthcare providers, possibly located anywhere in the world.

Electronic Medical Records - Jerome H. Carter 2001
Clinical Infomation Systems are increasingly important in Medical Practice. This work is a two-part book detailing the importance, selection and implementation of information systems in the health care setting. Volume One discusses the technical, organizational, clinical and administrative issues pertaining to EMR implementation. Highlighted topics include: infrastructure of the electronic patient records for administrators and clinicians, understanding processes and outcomes, and preparing for an EMR. The second workbook is filled with sample charts and questions, guiding the reader through the actual EMR implementation process.

Registries for Evaluating Patient Outcomes - Agency for Healthcare Research and Quality/AHRQ 2014-04-01
This User’s Guide is intended to support the design, implementation,

analysis, interpretation, and quality evaluation of registries created to increase understanding of patient outcomes. For the purposes of this guide, a patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes. A registry database is a file (or files) derived from the registry. Although registries can serve many purposes, this guide focuses on registries created for one or more of the following purposes: to describe the natural history of disease, to determine clinical effectiveness or cost-effectiveness of health care products and services, to measure or monitor safety and harm, and/or to measure quality of care. Registries are classified according to how their populations are defined. For example, product registries include patients who have been exposed to biopharmaceutical products or medical devices. Health services registries consist of patients who have had a common procedure, clinical encounter, or hospitalization. Disease or condition registries are defined by patients having the same diagnosis, such as cystic fibrosis or heart failure. The User’s Guide was created by researchers affiliated with AHRQ’s Effective Health Care Program, particularly those who participated in AHRQ’s DEcIDE (Developing Evidence to Inform Decisions About Effectiveness) program. Chapters were subject to multiple internal and external independent reviews.

Effective Documentation for Physical Therapy Professionals - Eric Shamus 2003-09-22

A comprehensive textbook for the documentation course required in all Physical Therapy programs. The textbook incorporates current American Physical Therapy Association (APTA) terminology and covers every aspect o documentation including reimbursement and billing, coding, legal issues, PT and PTA communication, as well as utilization review and quality assurance. An accompanying pocket book provides a handy, portable quick-reference guide to the materials. Includes sample documentation content, forms, cases, exercises, questions, flowsheets, and checklists

Electronic Health Records and Medical Big Data - Sharona Hoffman 2016-12-07

This book helps readers gain an in-depth understanding of electronic health record (EHR) systems, medical big data, and the regulations that govern them. It analyzes both the shortcomings and benefits of EHR systems, exploring the law's response to the creation of these systems, highlighting gaps in the current legal framework, and developing detailed recommendations for regulatory, policy, and technological improvements. Electronic Health Records and Medical Big Data addresses not only privacy and security concerns but also other important challenges, such as those related to data quality and data analysis. In addition, the author formulates a large body of recommendations to improve the technology's safety, security, and efficacy for both clinical and secondary (such as research) uses of medical data.

Health Data in the Information Age - Institute of Medicine 1994-01-01

Regional health care databases are being established around the country with the goal of providing timely and useful information to policymakers, physicians, and patients. But their emergence is raising important and

sometimes controversial questions about the collection, quality, and appropriate use of health care data. Based on experience with databases now in operation and in development, Health Data in the Information Age provides a clear set of guidelines and principles for exploiting the potential benefits of aggregated health dataâ€"without jeopardizing confidentiality. A panel of experts identifies characteristics of emerging health database organizations (HDOs). The committee explores how HDOs can maintain the quality of their data, what policies and practices they should adopt, how they can prepare for linkages with computer-based patient records, and how diverse groups from researchers to health care administrators might use aggregated data. Health Data in the Information Age offers frank analysis and guidelines that will be invaluable to anyone interested in the operation of health care databases.

Clinical Documentation Reference Guide - First Edition - AAPC 2020-03-12

It's not the quantity of clinical documentation that matters—it's the quality. Is your clinical documentation improvement (CDI) program identifying your outliers? Does your documentation capture the level of ICD-10 coding specificity required to achieve optimal reimbursement? Are you clear on how to fix your coding and documentation shortfalls? Providing the most complete and accurate coding of diagnoses and site-specific procedures will vastly improve your practice’s bottom line. Get the help you need with the Clinical Documentation Reference Guide. This start-to-finish CDI primer covers medical necessity, joint/shared visits, incident-to billing, preventative care visits, the global surgical package, complications and comorbidities, and CDI for EMRs. Learn the all-important steps to ensure your records capture what your physicians perform during each encounter. Benefit from methods to effectively communicate CDI concerns and protocols to your providers. Leverage the practical and effective guidance in AAPC’s Clinical Documentation Reference Guide to triumph over your toughest documentation challenges. Prevent documentation deficiencies and keep your claims on track for optimal reimbursement: Understand the legal aspects of documentation Anticipate and avoid documentation trouble spots Keep compliance issues at bay Learn proactive measures to eliminate documentation problems Work the coding mantra—specificity, specificity, specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR templates—and the pitfalls of auto-populate features Master documentation in the EMR with guidelines and tips Conquer CDI time-based coding for E/M The Clinical Documentation Reference Guide is approved for use during the CDEO® certification exam.

ICD-10-CM Official Guidelines for Coding and Reporting - FY 2021 (October 1, 2020 - September 30, 2021) - Department Of Health And Human Services 2020-09-06

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the

classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Clinical Information Systems - Rudi Van de Velde 2006-04-06

Hospital information systems (HIS) have become integral tools in the management of a hospital's medical and administrative information. With illustrated case studies, this book emphasizes clinical information systems (CIS) and their use in the direct management of the patient. Topics include the medical record, security, resource amangement, and imopaging integration.

Nursing Documentation - Jennifer Richmond 1997-01-01

"If these are your concerns... I'll never get time to finish my nursing notes! Is it legal? Can I use white-out? Can't they make a better form than this? How can I record this family set-up quickly? Weren't computers made for clerks, not nurses? There has to be something wrong with documenting for funding. How do you record the pain level of someone who has a dementing illness? Who walks down critical pathways? What happens if a home health record gets lost? How can I document my client's spiritual concerns realistically? Will managed care affect what I write? Is there a culturally appropriate way to document? What is charting by exception? How did nurses document before NANDA?... then this book is for you." - Back cover.

Medical Records and the Law - William H. Roach 2003

Health Administration

Medical Record Abstraction Form and Guidelines for Assessing the Appropriateness of Hysterectomy - Marjorie J. Sherwood 1993

This report documents the medical record abstraction form and guidelines for appropriateness of hysterectomy used in the HMO Quality of Care Consortium study of this procedure. The abstraction form was designed to follow the format of a medical record so that abstraction would be both accurate and efficient. For each item or group of items, the section of the medical record that was to serve as the source of data was specified. In addition, items derived from a particular portion of the medical record were grouped. To standardize the abstraction process, a detailed set of guidelines was prepared to accompany the abstraction form. The guidelines define medical terms, specify data sources from the medical record, and provide important medical synonyms. A separate form was developed for use by the physician overreader who was responsible for reviewing the data collected on the abstraction form by the HMO

abstractor and reviewed by the nurse supervisor at RAND in order to make necessary clinical judgments. As with the medical records abstraction guidelines, the physician overreader guidelines provide item by item instructions for making the required clinical judgments.

The Computer-Based Patient Record - Committee on Improving the Patient Record 1997-10-28

Most industries have plunged into data automation, but health care organizations have lagged in moving patients' medical records from paper to computers. In its first edition, this book presented a blueprint for introducing the computer-based patient record (CPR). The revised edition adds new information to the original book. One section describes recent developments, including the creation of a computer-based patient record institute. An international chapter highlights what is new in this still-emerging technology. An expert committee explores the potential of machine-readable CPRs to improve diagnostic and care decisions, provide a database for policymaking, and much more, addressing these key questions: Who uses patient records? What technology is available and what further research is necessary to meet users' needs? What should government, medical organizations, and others do to make the transition to CPRs? The volume also explores such issues as privacy and confidentiality, costs, the need for training, legal barriers to CPRs, and other key topics.

ICD-9-CM Official Guidelines for Coding and Reporting - 1991

The Book of Style for Medical Transcription - Lea M. Sims 2008-01-01

Telepsychiatry and Health Technologies - Peter Yellowlees 2018-01-22

The only current book on the topic, Telepsychiatry and Health Technologies: A Guide for Mental Health Professionals is a practical, comprehensive, and evidence-based guide to patient-centered clinical care delivered in whole or in part by technological devices and applications. Not a technology-centered "health informatics" book, but rather one that describes basic technological concerns and emphasizes clinical issues and workflows, it is designed for psychiatrists, psychologists, and other mental health clinicians who seek to learn the modes, models, and methods of telepsychiatry. More than 30 practitioners of telepsychiatry across the core mental health disciplines were involved in development of the text, contributing knowledge and clinical examples. Rich with case studies and hands-on guidance, the book introduces strategies, then clearly illustrates how to put them into practice. The editors believe that psychiatry increasingly will focus on the treatment of populations, and that technology offers the best hope of doing so efficiently and effectively.Careful thought went into the book's conception and design, resulting in a marriage of structure and content that meets the needs of today's clinicians: The editors employed a unique process of manuscript development, first outlining each chapter in its entirety, then assigning sections to contributors selected for their specific clinical experience and therapeutic expertise. The result is a text that flows logically and creates synergy across chapters without duplication. The book provides "how-to" guidance on setting up a new telepsychiatry practice or integrating technologies into a

current practice, covering critically important topics such as data collection, security, and electronic health records. Technologies addressed include telephony, smartphones, apps, e-mail, secure texting, and videoconferencing, all of which are increasingly being used in the assessment and treatment of patients with psychiatric disorders. More than 30 case examples of patients or programs are included, illustrating the range of clinical techniques that can be used and the types of patient that can be treated using available technologies -- whether in person, online, or in a hybrid form of care combining both modalities. Every chapter concludes with a summary of major learning objectives or findings covered. Telepsychiatry and Health Technologies: A Guide for Mental Health Professionals is destined to become a core resource in the training of mental health professionals from all disciplines, as well as an indispensable reference for those already integrating new technologies into their practices.
The Belmont report - United States. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978

The Electronic Health Record for the Physician's Office - Julie Pepper 2017-02-15
Get hands-on practice with entering data into the Electronic Health Record! The Electronic Health Record for the Physician's Office, 2nd Edition uses online simulations to walk you through each EHR task. Clear, step-by-step guidelines simplify the exercises in each simulation, so you learn all the EHR skills required of a medical office professional. This edition adds in-depth review and preparation for the Certified Electronic Health Records Specialist (CEHRS) examination. Written by Medical Assisting educator Julie Pepper, this how-to manual helps you master the administrative, clinical, and billing/coding skills you need to gain certification and succeed on the job.
Complete Guide to Documentation - Lippincott Williams & Wilkins 2008
Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards, and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards, and documenting outcomes and interventions for key nursing diagnoses.
Ending Medicine’s Chronic Dysfunction - Lawrence L. Weed 2021-03-25
This book describes an overlooked solution to a long-standing problem in health care. The problem is an informational supply chain that is unnecessarily dependent on the minds of doctors for assembling patient data and medical knowledge in clinical decision making. That supply chain function is more than the human mind can deliver. Yet, dependence on the mind is built into the traditional role of doctors, who are educated and licensed to rely heavily on personal knowledge and judgment. The culture of medicine has long been

in denial of this problem, even now that health information technology is increasingly used, and even as artificial intelligence (AI) tools are emerging. AI will play an important role, but it is not a solution. The solution instead begins with traditional software techniques designed to integrate novel functionality for clinical decision support and electronic health record (EHR) tools. That functionality implements high standards of care for managing health information. This book describes that functionality in some detail. This description is intended in part to be a starting point for developers in the open source software community, who have an opportunity to begin developing an integrated, cloud-based version of the tools described, working with interested clinicians, patients, and others. The tools grew out of work beginning more than six decades ago, when this book's lead author (deceased) originated problem lists and structured notes in medical records. The electronic tools he later developed led him to reconceive education and licensure for doctors and other health professionals, which are also part of the solution this book describes.

Information Management and Record of Care, Treatment, and Services - Jean S. Clark 2009-02

The new, fully updated Information Management and Record of Care, Seventh Edition, is a comprehensive guide to the most current Joint Commission standards, elements of performance for information management and record of care, and the survey process.

Improving Data Quality - Regional Office for the Western Pacific World Health Organization 2003-01-01

This publication provides a set of guidelines for health care workers, health information managers and administrators to help them focus on improving the timeliness, accuracy and reliability of health care data. They describe key activities and tasks to be considered when addressing the question of data quality in health care, regardless of the setting or size of organisations.

Clinical Practice Guidelines We Can Trust - Institute of Medicine 2011-06-16

Advances in medical, biomedical and health services research have reduced the level of uncertainty in clinical practice. Clinical practice guidelines (CPGs) complement this progress by establishing standards of care backed by strong scientific evidence. CPGs are statements that include recommendations intended to optimize patient care. These statements are informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options. Clinical Practice Guidelines We Can Trust examines the current state of clinical practice guidelines and how they can be improved to enhance healthcare quality and patient outcomes. Clinical practice guidelines now are ubiquitous in our healthcare system. The Guidelines International Network (GIN) database currently lists more than 3,700 guidelines from 39 countries. Developing guidelines presents a number of challenges including lack of transparent methodological practices, difficulty reconciling conflicting guidelines, and conflicts of interest. Clinical Practice Guidelines We Can Trust explores questions surrounding the quality of CPG development processes and the establishment of standards. It proposes eight standards for developing trustworthy clinical practice guidelines emphasizing transparency; management of conflict of interest ; systematic review--

guideline development intersection; establishing evidence foundations for and rating strength of guideline recommendations; articulation of recommendations; external review; and updating. Clinical Practice Guidelines We Can Trust shows how clinical practice guidelines can enhance clinician and patient decision-making by translating complex scientific research findings into recommendations for clinical practice that are relevant to the individual patient encounter, instead of implementing a one size fits all approach to patient care. This book contains information directly related to the work of the Agency for Healthcare Research and Quality (AHRQ), as well as various Congressional staff and policymakers. It is a vital resource for medical specialty societies, disease advocacy groups, health professionals, private and international organizations that develop or use clinical practice guidelines, consumers, clinicians, and payers.

Medical Record Abstraction Form and Guidelines for Assessing the Appropriateness of Hysterectomy - Marjorie J. Sherwood 1993

This report documents the medical record abstraction form and guidelines for appropriateness of hysterectomy used in the HMO Quality of Care Consortium study of this procedure. The abstraction form was designed to follow the format of a medical record so that abstraction would be both accurate and efficient. For each item or group of items, the section of the medical record that was to serve as the source of data was specified. In addition, items derived from a particular portion of the medical record were grouped. To standardize the abstraction process, a detailed set of guidelines was prepared to accompany the abstraction form. The guidelines define medical terms, specify data sources from the medical record, and provide important medical synonyms. A separate form was developed for use by the physician overreader who was responsible for reviewing the data collected on the abstraction form by the HMO abstractor and reviewed by the nurse supervisor at RAND in order to make necessary clinical judgments. As with the medical records abstraction guidelines, the physician overreader guidelines provide item by item instructions for making the required clinical judgments.

Better EHR - Jiajie Zhang (Professor of biomedical informatics) 2014-10-01

Electronic Health Records (EHR) offer great potential to increase healthcare efficiency, improve patient safety, and reduce health costs. The adoption of EHRs among office-based physicians in the US has increased from 20% ten years ago to over 80% in 2014. Among acute care hospitals in US, the adoption rate today is approaching 100%. Finding relevant patient information in electronic health records' (EHRs) large datasets is difficult, especially when organized only by data type and time. Automated clinical summarization creates condition-specific displays, promising improved clinician efficiency. However, automated summarization requires new kinds of clinical knowledge (e.g., problem-medication relationships).

Nursing Documentation Made Incredibly Easy - Kate Stout 2018-06-05

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy!®, 5th Edition.

Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEWdiscussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don’ts of charting — a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient’s health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts — a quick summary of each chapter’s content Advice from the experts — seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans “Nurse Joy” and “Jake” — expert insights on the nursing process and problem-solving That’s a wrap! — a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina.

Medical Records Manual - Who Regional Office for the Western Pacific 2002-01-01

This manual is aimed at helping medical record workers in the development and management of medical records services of health care facilities in developing countries in an effective and efficient manner. It has not been designed as an introductory text to medical record management, but rather as an aid to medical record officers (MROs) and medical record clerks by describing appropriate systems for Medical Records Departments in developing countries. It covers manual procedures and may be used as an adjunct to computerized systems. It does not provide all of the options for medical record management, but it does provide one option in each area for the management of medical records in developing countries. A list the textbooks that provide detailed information on medical record management is also provided.

Medical Record Auditor - Deborah J. Grider 2011

"This book helps readers understand the principles of medical record

documentation and chart auditing. It introduces readers to principles of medical record documentation and how to conduct a medical record chart review in the physcian's or outpatient office"--Provided by publisher.

Clinical Practice Guidelines - Institute of Medicine 1990-02-01

The Alberta clinical practice guidelines program is supporting appropriate, effective and quality medical care in Alberta through promotion, development and implementation of evidence-based clinical practice guidelines.

A National Protocol for Sexual Assault Medical Forensic Examinations - 2004

The Physician Advisor's Guide to Clinical Documentation Improvement - Trey La Charite 2014-04-30

The Physician Advisor's Guide to Clinical Documentation Improvement Physician advisors are not just needed for case management anymore. ICD-10-CM/PCS and the changing landscape of healthcare reimbursement make their input invaluable in the realm of CDI and coding, too. This book will help your physician advisors quickly understand the vital role they play and how they can not only help improve healthcare reimbursement, but also reduce claims denials and improve the quality of care overall. This book will: * Provide job descriptions and sample roles and responsibilities for CDI physician advisors * Outline the importance of CDI efforts in specific relation to the needs and expectations of physicians * Highlight documentation improvement focus areas by Major Diagnostic Category * Review government initiatives and claims denial patterns, providing physician advisors concrete tools to sway physician documentation

Health Promotion and Disease Prevention in Clinical Practice - Steven H. Woolf 2008

Incorporating the latest guidelines from major organizations, including the U.S. Preventive Services Task Force, this book offers clinicians a complete overview of how to help patients adopt healthy behaviors and to deliver recommended screening tests and immunizations. Chapters provide practical guidance on counseling patients about exercise, nutrition, tobacco use, substance use, sexually transmitted infections, and depression and on gathering information from the patient, ordering evidence-based screening tests, designing a personalized health maintenance plan, facilitating behavior change, and the work-up of abnormal results from screening tests. This new edition includes updated chapters on practice redesign, the use of electronic medical records, and reimbursement; updated patient resource materials and instructions; and new authors with deep expertise on the topics. A companion Website (www.healthpromodisprev.com) features fully searchable text online.

The CMS Hospital Conditions of Participation and Interpretive Guidelines - 2017-11-27

In addition to reprinting the PDF of the CMS CoPs and Interpretive Guidelines, we include key Survey and Certification memos that CMS has issued to announced changes to the emergency preparedness final rule, fire and smoke door annual testing requirements, survey team composition and investigation of complaints, infection control screenings, and legionella risk reduction.

Integration of Medical and Dental Care and Patient Data - Valerie Powell 2012-01-18

This book informs readers of the needs and rationale for the

integration of medical and dental care and information with an international perspective as to how and where medical and dental care separated into specific domains. It provide high level guidance on issues involved with care and data integration and how to achieve an integrated model of health care supported by integrated HIT. A patient typically expects that a visit to a dentist can usually be resolved immediately. This expectation places a premium on instant, accurate, thorough, and current information. The state-of-the-art of fully integrated (dental-medical) electronic health record (EHR) is covered and this is contrasted with the current state of dental-medical software. While dentists in the US Veterans Health Administration (VHA), the US Indian Health Service (IHS), or the US military, for example, have access to fully integrated health records, most US clinicians still gather information from separate sources via fax or phone calls. The authors provide an in-depth discussion of the role of informatics and information science in the articulation of medical and dental practices and clinical data with the focus on applied clinical informatics to improve quality of care, practice efficiency, coordination and continuity of care, communication between physicians and dentists and to provide a more comprehensive care for the patients. Lastly, the book examines advances in medical and dental research and how these may affect dentistry in the future. Most new advances in healthcare research are information-intensive.

Key Capabilities of an Electronic Health Record System - Institute of Medicine 2003-07-31

Commissioned by the Department of Health and Human Services, Key Capabilities of an Electronic Health Record System provides guidance on the most significant care delivery-related capabilities of electronic health record (EHR) systems. There is a great deal of interest in both the public and private sectors in encouraging all health care providers to migrate from paper-based health records to a system that stores health information electronically and employs computer-aided decision support systems. In part, this interest is due to a growing recognition that a stronger information technology infrastructure is integral to addressing national concerns such as the need to improve the safety and the quality of health care, rising health care costs, and matters of homeland security related to the health sector. Key Capabilities of an Electronic Health Record System provides a set of basic functionalities that an EHR system must employ to promote patient safety, including detailed patient data (e.g., diagnoses, allergies, laboratory results), as well as decision-support capabilities (e.g., the ability to alert providers to potential drug-drug interactions). The book examines care delivery functions, such as database management and the use of health care data standards to better advance the safety, quality, and efficiency of health care in the United States.

Health Informatics: Practical Guide Seventh Edition - William R. Hersh 2018

Health informatics is the discipline concerned with the management of healthcare data and information through the application of computers and other information technologies. The field focuses more on identifying and applying information in the healthcare field and less on the technology involved. Our goal is to stimulate and educate healthcare and

IT professionals and students about the key topics in this rapidly changing field. This seventh edition reflects the current knowledge in the topics listed below and provides learning objectives, key points, case studies and extensive references. Available as a paperback and eBook. Visit the textbook companion website at http://informaticseducation.org for more information.--Page 4 de la couverture.

Beyond the HIPAA Privacy Rule - Institute of Medicine 2009-03-24

In the realm of health care, privacy protections are needed to preserve patients' dignity and prevent possible harms. Ten years ago, to address these concerns as well as set guidelines for ethical health research, Congress called for a set of federal standards now known as the HIPAA Privacy Rule. In its 2009 report, Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research, the Institute of Medicine's Committee on Health Research and the Privacy of Health Information concludes that the HIPAA Privacy Rule does not protect privacy as well as it should, and that it impedes important health research.

Medical Decision Making - Harold C. Sox 2013-07-29

This book clearly demonstrates how to best make medical decisions while incorporating clinical practice guidelines and decision support systems for electronic medical record systems. New to this edition is how medical decision making ideas are being incorporated into clinical decision support systems in electronic medical records and also how they are being used to shape practice guidelines and policies.