Electronic Health Record Standardization

- Performance of the Marshall and Rotterdam scales as predictors of mortality in children with severe traumatic brain injury
- The use of generative artificial intelligence-based dictation in a neurosurgical practice: a pilot study
- Clinical experience implanting a miniature externally powered vagus nerve stimulator
- Anesthetic and perioperative management of pregnant patients undergoing neurosurgery: a case series from a single center in Morocco (2017-2024)
- Suboptimal Immunisations in Children With a Ventriculoperitoneal Shunt-Can We Do Better?
- The Lithuanian Stroke Database: selection of national stroke care performance measures
- Standardization and accuracy of race and ethnicity data: Equity implications for medical AI
- General Practitioners' Perspectives on Barriers to Communication With Specialists in the Referral System: A Systematic Review and Meta-Synthesis

Definition: EHR standardization refers to the process of applying common structures, terminologies, and communication protocols to electronic health records to ensure consistency and interoperability across healthcare systems.

Key Elements:

- Terminologies: SNOMED CT, LOINC, ICD-10
- Data exchange formats: HL7 FHIR, CDA
- Data models: OMOP, openEHR
- Structured documentation: templates for notes, diagnostics, procedures

Goals:

1. Facilitate sharing of health data across institutions
2. Improve clinical decision-making and patient safety
3. Enable research, audits, and public health initiatives
4. Support AI and analytics by providing high-quality, structured data