Chapter 4 HIM Key terms

1. Define the following KEY TERMS:

**Accreditation**—voluntary process of institutional or organizational review in which a quasi-independent body created for this purpose periodically evaluates the quality of the entity’s work against pre-established written criteria

**Acknowledgements**—are documents that the patient or patient’s authorized personal rep sign confirming the receipt of important and applicable info.

**Ambulatory**—treatment is provided on an outpatient basis

**Ambulatory surgery center (ASC)—**ambulatory facilities that perform surgery must have h&p prior. Outpatient surgery

**AAAASF**—American association for accreditation of Ambulatory Surgery Facilities, ambulatory surgery centers, occupational therapy and rural health clinics fall under this umbrella

**Ancillary services**—tests and procedures sometimes ordered by physician and these services assist the physician with diagnosing treating the patient. Indirect roll in patient care

**Authentication**—process of identifying the source of health record entries by attaching a hand written signature, the author’s initials or electronic signature.

**Authorization**—is a document that is required under the HIPAA for the use and disclosure of protected health info.

**Autopsy report**—a description of the examination of a patient’s body after he or she has died

**CAAs**—are area assessments, patient assessed and reassessed at defined intervals and whenever there is a significant change in his or her condition

**Care plan**-- means of communicating and organizing the actions of a constantly changing nursing staff. As the patient's needs are attended to, the updated **plan** is passed on to the nursing staff at shift change and during nursing rounds. **Care plans** help teach documentation.

**CMS**—Centers for Medicare and Medicaid Services is the federal agency within the US Dept of Health and Human Service’s.

**CARF**—commission on accreditation of rehabilitation facilities. Requires facility to maintain single case record for any patient it admits.

**Conditions for Coverage**—ensure patient care quality, safety, and improvement of clinical outcomes. Standards applied to facilities that choose to participate in federal government reimbursement programs such as Medicare and Medicaid

**Consent to treatment**—means the patient gives the physician or healthcare provider permission to touch them

Consultation report

**Documentation standards**—describe those principles, codes, beliefs guidelines and regulations that guide health record documentation

**Documents imaging**—is the process by which paper based documentation is captures, digitized, stored and made available for retrieval by the end user

**Expressed consent**—consent given by the patient by either his or her words or in writing

**EMTALA**—Emergency medical treatment and active labor act. Any patient going to er must be evaluated by their standards to determine if emergency situation exists.

**Hybrid record**—Both paper and electronic record

**Joint Commission**—industry leader in the area of healthcare provider organization accreditation. Also provides its member organizations with education and compliance outreach services

**Legal health record**—role includes documentation to support decisions made in the course of treating a patient, support documentation for the revenue pursued by payers, as well as documentation used for legal testimony related to the patient’s disease process, injury, treatment, decisions related to the treatment and the patient’s response to the treatment.

**MDS**—minimum data set is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

**PAI**—patient assessment instrument patient’s condition, services, diagnosis and medical condition a payment level is determined for the ip rehab stay.

**RAI**—resident assessment instrument based on the minimum data set for long term care. Framework includes mds triggers, utilization guidelines and care assessments.

**SOAP**—subjective, objective assessment, plan method used to construct physician progress notes and the acronym is a technique physicians use to remember what elements of documentation must be include within a progress note

**Standing orders**—orders the medical staff or an individual physician established as routine care for a specific diagnosis or procedure.

**Statute**—piece of legislation written and approved by a state or federal legislature and then signed into law by the state’s governor, or president of the United States.

**Transfer record**—PATIENT IS BEING TRANSFERRED FROM THE ACUTE SETTING TO ANOTHER HEALTHCARE ORGANIZATION ALSO CALLED A referral form

**Universal chart order**—health record post patient discharge is kept in reverse chronological order; this is called universal chart order

2. Internet activity: obtain state and federal regulatory documentation mandates as they relate to electronic health records.

     a.  Compare and contrast the mandates. State of Maine is adopting the electronic health record incentive program which was created by the clinical health act. The program pays 100% federally funded incentives to eligible professions and hospitals for adopting, implementing, upgrading and demonstrating meaningful use of certified her technology. There is no federal law which mandates a specific retention of health records. These are governed by state law. State of Maine has no retention law but hospital records are covered by DHHS and has a general rule of 7 years. Individual access to medical records are pre-empted by HIPAA. The federal guidelines are 30 days. This means a “reasonable” time. Federal has a meaningful use mandate that all providers have to be part of for Medicare payments.

      b. Identify state and federal level mandates the contradict and are in harmony with one another. The American Recovery and Reinvestment act lead to the meaningful use mandate. This mandate had to be implemented to maintain existing Medicaid and Medicare reimbursement levels. The things to be achieved are to improve quality safety, efficiency and reduce health disparities, engage patients and their family, improve care coordination, and maintain privacy and security.  There are state incentives to implement this mandate



 3. a.  What influence do state and federal law and accrediting and licensing bodies have on the type of electronic health record system technology that is adopted by a healthcare provider organization? The transition to the Electronic Health record has to consider the mandates on a state and federal level. Retention of records are left to the states and the accrediting process can affect how the records are compiled, the authentication process and maintenance of the records.

     b.  What should healthcare providers consider putting into place to protect health record data to ensure that the health record integrity remains intact as well as the health record data is available so that he patient can be treated? The customizable documentation templates assist with documentation but if the user is careless, could lead to inaccurate documentation. Records must be reviewed prior to sending the records to ensure accurate information is reported. Copying and pasting should be avoided as information that shouldn’t be reported or is inaccurate could be pasted over including signatures that weren’t made by the dr. Voice dictation shouldn’t be used without a validation process in place. Patient identification is priority. A photograph, making sure the information is correct, finger print and other types of safe guards should be in place. There should be an audit team in place to check and double check the accuracy of the records and the completeness and who is looking at them.

4.1

1. D. to ensure what is documented in the health record is complete and accurately reflects the treatment provided to the patient

2. A. the medical bylaws of the healthcare provider organization

3. A. asses the legal environment

4. B. medical history

4.2

1. b. all categories of healthcare records

2. True

3. true

4. false it can complete an action that wasn’t verified

5. False All entries in the health record should be permanent

4.3

1. C. administrative data

2. A. Ambulatory Record

3. A. Behavioral health records

4. C. hospital operative records

5. A. CARF

6. b. Emergency care

7. D. Long term care

8. A. Chief complaint

9. a. consultation

10. a. expressed consent

11. c. care plans

12. a. operative report

13. b. pediatric

14. true

15. true

16. true

4.4

1. b. problem orientated health record

2. b. documentation imaging technology

3. b. problem oriented health record

4. c. it is known as the her

4.5

1. b. objective

2. false

3. false

4. false

5. true