The Objective is to understand the documentation standards and describe how medical staff bylaws, accreditation entities, and state and federal regulations influence the documentation practice standards of healthcare provider organization. You will define the legal health record and how it has changed as health care providers have more widely adopted electronic health record (EHR) technologies. You will identify and describe the documentation content of health records within different healthcare settings and you will understand the difference among consents, authorizations, and acknowledgments.

1. Define the following KEY TERMS:

Accreditation- A voluntary process of instructional 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. A determination by an accrediting body that an eligible organization, complies with applicable standards

Acknowledgements- A form that provides a mechanism for the resident to recognize receipt of important information

Ambulatory- Treatment provided on an outpatient basis

Ambulatory surgery center (ASC)- outpatient surgery facility under Medicare that its license allows for Medicare participation

AAAASF- American Association for accreditation of Ambulatory Surgery Facility- An organization that provides an accreditation program to ensure the quality and safety of medical and surgical care provided in ambulatory surgery facilities.

Ancillary services- Tests and procedures ordered by a physician to provide info for use in patient diagnosis or treatment like radiology, laboratory or physical therapy

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

Authorization- As amended by HITECH, except as otherwise specified, a covered entity may not use or disclose protected health info without an authorization that is valid under section 164.508. When a covered entity obtains or receives a valid authorization for its us or disclosure of protected health info.

Autopsy report- Written document of the finding from a postmortem pathological exam

CAAs- Care Area Assessments- The patient is assessed and reassessed at defined intervals as well as whenever there is a significant change in his or her condition.

Care plan- The specific goals in the treatment of an individual patient, amended as the patient’s condition requires and the assessment of the outcomes of care; serves as the primary source of ongoing documentation of the resident’s care, condition and needs.

CMS- Centers for Medicare and Medicaid Service: The department of health and human services agency responsible for Medicare and parts of Medicaid.

CARF-Commission on Accreditation of Rehabilitation Facilities: An internal, independent nonprofit accreditor of health and human services that develops customer focused standards for areas such as behavioral healthcare, aging services, child and youth services medical rehab programs and accredits such programs on a basis of standards

Conditions for Coverage- Standards applied to facilities that choose to participate in federal government reimbursement programs such as Medicare and Medicaid

Consent to Treatment-Legal permission given by the patient or rep to a healthcare provider that allows the provider to administer care and treatment or to perform surgery or other medical procedures

Consultation report- Documentation of the clinical opinion of a physician other than the primary or attending physician

Documentation standards- Within the context of healthcare, describe those principles, codes, beliefs, guidelines and regulations that guide health record documentation

Documents imaging- The practice of electronically scanning written or printed paper documents into an optical or electronic system for later retrieval of the document or parts of the document if parts have been indexed. The process by which paper based documentation is captured, digitized, stored, and made available for retrieval by the end user.

Expressed consent- The spoken or written permission granted by a patient to a Healthcare provider that allows the provider to perform medical or surgical services

EMTALA- Emergency Medical Treatment and Active Labor Act- 1986 law enacted as part of the Consolidated Omnibus Reconciliation Act largely to combat “patient dumping”—The transferring, discharging, or refusal to treat indigent emergency department patients because of their inability to pay.

Hybrid record- A combination of paper and electronic health record

Joint Commission: An independent, not for profit organization, Accredits and certifies more than 20000 healthcare organizations and programs in the US. JC is recognized nationwide as a symbol of quality that reflects an organizations commitment to meeting certain performance standards

Legal health record-: Documents and data elements that a healthcare provider may include in response to legally permissible requests for patient info.

MDS- Minimal Data Set for Long Term Care- A federally mandated standard assessment form that Medicare and Medicaid Nursing facilities must use to collect demographic and clinical data on nursing home residents; includes, screening, clinical and functional status elements.

PAI: Patient Assessment instrument: A standardized tool used to evaluate the patient’s condition after admission to and at discharge from the healthcare facility

RAI: Residential Assessment Instrument: In skilled nursing facilities the care plan is based on a format required by federal regulations.

SOAP: Subjective Objective, Assessment, Plan

Standing orders: orders the medical staff or an individual physician has established as routine care for a specific diagnosis or procedure

Statute of limitations: A Specific time frame allowed by a statute or law for bringing litigation

Transfer record: A review of the patient’s Acute stay along with current status, discharge and transfer orders, and any additional instructions that accompanies the patient when he or she is transferred to another facility

Universal chart order: A system in which the health record is maintained in the same format while the patient is in the facility and after discharge.

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

     a.  Compare and contrast the mandates.

The Federal Government has begun to require Medical Facilities to use the EHR as of 2014. If the establishment chooses or does not switch to the EHR, and you wish to be part of Medicare/Medicaid, there is a 1% deduction rate increase in 2015 and 2% in 2016 and so forth. There are incentives to switch to the EHR. For example, physicians can receive up to 44 thousand dollars in Medicare incentive payments beginning in 2011. They must be able to demonstrate meaningful use. Meaningful use is: measured in stages. Stage 1. The physicians are to prove that they meet 14 to 15 core requirements. Then they should choose 5 more from 10 other options.

Most states have created a deadline to switch over to the EHR. Some states are willing to pull the license to practice if you don’t switch while others, like Maryland, don’t have an EHR mandate. Minnesota, MA, have no funding for the switch to the Electronic record.

      b. Identify state and federal level mandates the contradict and are in harmony with one another.

The federal government is providing incentives to switch to the EHR. Physicians who are part of Medicare and Medicaid will receive up to 44,000. However, in some states, Ma for example, don’t have an incentive other than physicians may lose their license if they have not implemented an EHR by 2015. Minnesota, is requiring all physicians to prescribe electronically by 2011.

 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 state and federal law as well as accrediting and licensing bodies have some influence on healthcare organizations. The federal government is providing incentives and stages/goals within a specific timeframe to ensure they receive the money perk. Some states, like MA will potentially move physicians license if they don’t comply. The licensing bodies have also educated the physicians about the improvement of Quality of Care for their patients.

     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?

Healthcare providers are trying to keep their health records protected by creating standards to follow. Some standards should be that the only individuals authorized are allowed to enter the document. Health record entries should be documented at the time the service is rendered. Authors of the entries should be clearly identified. Errors must be signed. The time and date of each entry must be documented. A great way to ensure the patient is protected is to have a log that tracks who, why, when and why anyone is viewing the document. They patient should also be clearly identified, Name, DOB, address, etc.