1. Define the following KEY TERMS:

Accreditation – A 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 preestablished written criteria.

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) – Under Medicare, an outpatient surgical facility that has its own national identifier; is a separate entity with respect to its licensure, accreditation, governance, professional supervision, administrative functions, clinical services, recordkeeping, and financial and accounting systems; has as its sole purpose the provision of services in connection with surgical procedures that do not require inpatient hospitalization; and meets the conditions and requirements set forth in the Medicare Conditions of Participation.

AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities. 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 information for use in patient diagnosis or treatment. Professional healthcare services such as radiology, laboratory, or physical therapy.

Authentication – The process of identifying the source of health record entries by attaching a handwritten signature, the author’s initials, or an electronic signature. Proof of authorship that ensures, as much as possible, that log-ins and messages from a user originate from an authorized source. As amended by HITECH, means the corroboration that a person is the one claimed.

Authorization – As amended by HITECH, except as otherwise specified, a covered entity may not use or disclose protected health information without an authorization that is valid under section 164.508. When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with the authorization (45 CFR 164.508 2013).

Autopsy report – Written documentation of the findings from a postmortem pathological examination.

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 for ongoing documentation of the resident’s care, condition, and needs.

CMS – Centers for Medicare and Medicaid Services. The Department of Health and Human Services agency responsible for Medicare and parts of Medicaid. Historically, CMS has maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs.

CARF – Commission on Accreditation of Rehabilitation Facilities. An international, 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, and medical rehabilitation programs and accredits such programs on the basis of its 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 a patient or a patient’s legal representative 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. A 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 (Public Law 99-272 1986)

Hybrid record – A combination of paper and electronic records; a health record that includes both paper and electronic elements.

Joint Commission – An independent, not-for-profit organization, the Joint Commission accredits and certifies more than 20,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s 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 information.

MDS – Minimum Data Set for Long-Term Care. A federally mandated standard assessment form that Medicare- and Medicaid-certified 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 – Resident Assessment Instrument. In skilled nursing facilities, the care plan is based on a format required by federal regulations.

SOAP – Subjective, objective, assessment plan. Documentation method that refers to how much each progress note contains documentation relative to subjective observations, objective observations, assessments, and plans.

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

Statute – A piece of legislation written and approved by a state or federal legislature and then signed into law by the state’s governor or the president.

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.

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

 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? State and federal laws create statutes and regulations that organizations must follow in order to comply with the regulations. Accrediting and licensing bodies provide standards of quality for the organization to follow.

     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? Their own documentation standards that equal or surpass the standards, statutes and regulations put in place by the laws and accrediting standards.