**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-** 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, record keeping, and financial and accounting systems; has its sole purpose the provision of services in connection with surgical procedures that do not require inpatient hospitalization; and meets the condition and requirements set forth in the Medicare Conditions of Participation.

**AAAASF**- American Association for Accreditation of Ambulatory Surgery Facilities; 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; Services such as radiology, laboratory, or physical therapy.

**Authentication**- Process of identifying the source of health record entries by attaching a handwritten signature, the author’s initials, or and electronic signature.

**Authorization-** A covered entity may not use or disclose protected health information without and authorization that is valid under section 164.508

**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**- 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 primary source for ongoing documentation of the resident’s care, condition, and needs.

**CMS-** Centers for Medicaid and Medicare Services; DHHS is responsible for Medicaid and Medicare. Is responsible for the oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards.

**CARF**- Commission on Accreditation of Rehabilitation Facilities; international, independent, nonprofit accreditor of health and human services that develops customer-focused standards for areas such as behavioral healthcare, aging services, child/youth services, and medical rehab programs.

**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 or 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**- Practice of electronically scanning written or printed paper documents into an optical or electronic system for later retrieval.

**Expressed consent**- 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 records; health record that includes both paper and electronic elements.

**Joint Commission**- Independent, not for profit organization that accredits and certifies more than 20,000 healthcare organizations and programs in the United States.

**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; federally mandated standard assessment form that Medicare and Medicaid certified nursing facilities must use to collect demographic and clinical data on nursing home residents.

**PAI**- Patient Assessment Instrument; 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 each progress note contains documentation relative to subjective/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**- Legislation written and approved by a states or federal legislature and then signed into law by state’s governor or president.

**Transfer record**- 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**- 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.

Federal

[www.medicalrecords.com/physicians/meaningful-use-government-incentives-information](http://www.medicalrecords.com/physicians/meaningful-use-government-incentives-information)

State of Maine

([www.medicalrecords.com/maine-regional-extension-center-healthinfonet-emr-incentives](http://www.medicalrecords.com/maine-regional-extension-center-healthinfonet-emr-incentives))

 a. Compare and contrast the mandates.

As part of the American Recovery and Reinvestment Act, as of January 1st 2014 all public and private healthcare providers including EP were required to adopt and demonstrate meaningful use of EHR:

Improve quality, safety, efficiency, and reduce health disparities

Engage patients and family

Improve care coordination, and population and public health

Maintain privacy and security of patient health information

For Maine’s mandates they were update in 2016 to follow their incentive program. All providers are required to attest to a single set of objectives and measures. This replaces the core and menu objectives structure of previous stages.

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

I could not actually find any mandates that contradict each other as I had a hard time finding much information at all besides information on the incentive programs. I am very sure Maine based their mandates of the federal mandates if I cannot find any papers or newsletters on the subject.

 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 a base for accreditation/licensing organizations can build upon. They create and refine EHR to best suit the patient and provider. Accreditation and licensing agencies are the fine tooth comb that ever healthcare organization uses to ensure adaptability.

 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 should consider a nationally centralized EHR system, that can be sectioned per state. By that, I mean one system with 50 subdivisions, so if the system is hacked each state has its own security steps to access patient information. This would make it so much easier for providers to get access to patient’s records even if it is their first visit to their office. The only part not yet conjured is a security that cannot be breached by hackers or misusers.