Homework Week 4-Anita Hakala

**1. Define the following KEY TERMS:**

**Accreditation** is 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 per-established written criteria.

**Acknowledgements** are documents that the patient or the patient’s authorized personal representative sign, confirming the receipt of important and applicable information.

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

**Ambulatory surgery center (ASC)** is an ambulatory facility that performs surgery.

**AAAASF** is the American Association for Accreditation of Ambulatory Surgery Facilities who has requires for service.

**Ancillary services** are services provided by ancillary departs that assist the physician in carrying out order to assist with diagnosing and patient care. Also includes other professional healthcare services.

**Authentication** is the process of identifying the source of health record entries by attaching a handwritten signature.

**Authorization** is a document required under the Privacy Rule of HIPAA for the use and disclosure of protected health information (PHI).

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

**CAAs** are care area assessments which is a piece in the assessment data process for MDS processing.

**Care plan** is the specific goals in the treatment of an individual patient, amended as their 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** is the Centers for Medicare and Medicaid Services who oversee the operational oversight of Medicare with state government.

**CARF** is the Commission on Accreditation of Rehabilitation Facilities. It is an international independent, nonprofit accreditor of health and human services that develops customer focused standards for area such as behavioral healthcare, aging services, child and youth services, and medical rehabilitation programs.

**Conditions for Coverage** (CFC’c) are standards applied to facilities that choose to participate in federal government reimbursement programs.

**Consent to treatment** is a document signed by the patient or the patient’s legal representative giving the physician and other health care providers permission to touch them. It often contains an agreement for payment.

**Consultation report** documentation of the clinical opinion of a physician other than the primary are or attending physician.

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

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

**Expressed consent** is a consent given by the patient verbally or in writing.

**EMTALA** is the Emergency Medical Treatment and Active Labor Act that assures assessment in the emergency room to determine if an emergency condition exists; if it does then the patient must be stabilized before transfer or discharge.

**Hybrid record** a combination of paper and electronic health records.

**Joint Commission** is an independent, not-for-profit organization; an industry leader in the area of healthcare provider organization accreditation. It also provides education and outreach services.

**Legal health record** is defined by the health organization itself. It contains documents and data elements that a healthcare provider may include in response to legally permissible requests for patient information.

**MDS** is a minimum data set, the care plan format for long term care facilities.

**PAI** is a Patient Assessment Instrument that is completed shortly after admission and upon discharge.

**RAI** is the Resident Assessment Instrument, a care plan format for Skilled Nursing Facilities.

**SOAP** (subjective, objective, assessment, plan) is the method used to construct a physician progress note.

**Standing orders** are orders the medical staff or an individual physician establish a routine care for a specific diagnosis or procedure.

**Statute** is a piece of legislation written and approved by a state or federal legislature and the signed into law by the state’s Governor, or President of the United States.

**Transfer record** is a brief description of the patient’s acute stay along with current status, discharge and transfer orders, and any additional instructions sent to the receiving facility on transfer.

**Universal chart order is** 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 American Recovery and Reinvestment Act, all public and private healthcare providers and other eligible professionals (EP) were required to adopt and demonstrate “meaningful use” of electronic medical records (EMR) by January 1, 2014 in order to maintain their existing Medicaid and Medicare reimbursement levels.

“Meaningful use” of electronic health records (EHR), as defined by HealthIT.gov, consists of using digital medical and health records to achieve the following:

* 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

The American Recovery and Reinvestment Act also included financial incentives for healthcare providers who prove meaningful use of electronic health records (EHR). EHR is not only a more comprehensive patient history than electronic medical records (EMR), the latter of which contains a patient’s medical history from just one practice, but was also the end-goal of the federal mandate.

Penalties were also issued to those healthcare organizations that were non-compliant. For example, EP’s who didn’t implement [EMR/EHR](http://www.usfhealthonline.com/resources/key-concepts/ehr-vs-emr/) systems and demonstrate their meaningful use by 2015 experienced a 1% reduction in Medicare reimbursements.

**Meaningful Use Regulations**

The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the "meaningful use" of certified EHR technology. To receive an EHR incentive payment, providers have to show that they are “meaningfully using” their certified EHR technology by meeting certain measurement thresholds that range from recording patient information as structured data to exchanging summary care records. CMS has established these thresholds for eligible professionals, eligible hospitals, and critical access hospitals.

The Medicare and Medicaid EHR Incentive Programs include three stages with increasing requirements for participation. All providers begin participating by meeting the Stage 1 requirements for a 90-day period in their first year of meaningful use and a full year in their second year of meaningful use. After meeting the Stage 1 requirements, providers will then have to meet Stage 2 requirements for two full years. CMS has recently published a proposed rule for Stage 3 of meaningful use which focuses on the advanced use of EHR technology to promote health information exchange and improved outcomes for patients.

Eligible professionals participate in the program on the calendar years, while eligible hospitals and CAHs participate according to the Federal fiscal year. The Stage 3 proposed rule proposes to change the EHR reporting period so that all providers would report under a full calendar year timeline.

I could not find that Maine regulations address medical records separately. It appears that the regulations of medical information documentation and privacy are incorporated into the licensing of the facility by the state, where some states have separate laws regarding medical records.

Excellent research.

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

They both require meaningful use of the EHR.

Medicare and Medicaid has taken a three step approach with increasing incentives or decreasing payments based on how soon the organization completes the transition.

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 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 biggest influences are access to current patient care information to provide continuity of care, payment incentives, maintaining reimbursement levels and penalties.

**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?** Standards for documentation and using the EHR; policies and procedures related to HIPPA, ROI, a system that meets all state and federal requirements while being developed to meet end user needs to provide safe, quality, cost-effective health care across the continuum..