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 pre-established written criteria.

Acknowledgements – are documents that the patient or the patient’s authorized personal representative sign, confirming the receipt of information.

Ambulatory – means the treatment is provided on an outpatient basis.

Ambulatory surgery center (ASC) – ambulatory facilities that perform surgery.

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 – department that performs tests and procedures sometimes ordered by a physician. These services assist the physician with diagnosing and treating the patient.

Authentication – is the process of identifying the source of health record entries by attaching a handwritten signature, the author’s initials, or an electronic signature.

Authorization – is a document that is required under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPPAA).

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 – summary of the patient’s problems from the nurse or other professional’s perspective with a detailed plan for interventions.

CMS – Centers for Medicare and Medicaid Services – is the federal agency with the US Department of Health and Human Services. CMS oversees the Medicare program, plays a regulatory role in an organization’s medical staff makeup and the content of the medical staff bylaws.

CARF – commission on accreditation of rehabilitation facilities – requires a facility to maintain a single case record for any patient it admits.

Conditions for Coverage – standards applied to facilities that choose to participate in the federal government reimbursement programs such as Medicare and Medicaid.

Consent to treatment – means the patient gives the physician or other healthcare provider permission to touch them.

Consultation report – documents the clinical opinion of a physician other than the primary or attending physician.

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

Documents imaging – the process by which paper based documentation is captured, digitized, store, 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 ad Active Labor Act - - patient who presents to the ED must be examined to determine if an emergency condition exists, the patient must be stabilized before discharge or transfer.

Hybrid record – a combination of paper and electronic records.

Joint Commission – independent organization that accredits and certifies more than 20,000 healthcare organizations and programs in the US.

Legal health record – includes the contents of the paper health record in addition to diagnostic x-rays. Each organization must define what its legal health record contains.

MDS – Minimum Date Set (MDS) 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.

PAI - Patient Assessment Instrument – a standardized tool used to evaluate the patient’s condition after admission to and 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 – a method used to construct physician progress notes and the acronym is a technique physicians use to remember what elements of documentation must be included within the progress note.

Standing orders – are orders the medical staff or an individual physician 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 of the US.

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 American Recovery and Reinvestment Act, as of January 1st 2014 required all public and private healthcare providers to adopt and demonstrate meaningful use of EHR to do 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**

**If a provider didn’t acquire an electronic health record system before 2015, they were going to lose a small portion of your Medicare reimbursement.**

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

**The implementation of EHR provides financial incentives to those who show they are “meaningfully using” their certified EHR technology.  It seems on a state level the penalty could be greater than what was federally mandated such as in Massachusetts.**

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 and licensing organizations to build upon. They create and refine EHR to best suit the patient and provider. Accreditation and licensing agencies are the fine tooth comb that healthcare organizations use 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?

**A few of the safety measures that should be built in to electronic health record (EHR) systems to protect medical record s may include:**

1. **“Access control” tools like passwords and PIN numbers, to limit access to patient information to authorized individuals, like the patient's doctors or nurses.**
2. **"Encrypting" stored information. That means health information cannot be read or understood except by someone who can “decrypt” it, using a special “key” made available only to authorized individuals**