Nicole Batchelder

MCO 110

Professor Carol Zack

09/23/2016 Chapter 4

1. Define the following KEY TERMS:

Accreditation- institutional or organizational periodical review that evaluates quality of work against predetermined criteria

Acknowledgements- a form that allows a resident to verify receipt of important information

Ambulatory-treatment provided on an outpatient basis

Ambulatory surgery center (ASC)- under Medicare, an independent surgical facility that has its own national identifier and provides services that do not require inpatient hospitalization

AAAASF- an organization that provides accreditation for ASCs

Ancillary services-tests or procedures such as labs and x-rays that a physician orders for a patient for treatment and/or diagnosis

Authentication- verification of the source from whom information is provided via signature, handwritten initials or electronic signature.

Authorization- permission or restrictions on how to share, obtain or retain protected health information

Autopsy report-documentation of a postmortem pathological exam

CAAs-the defined intervals in which a patient is assessed, reassessed or when there is a significant change in their condition

Care plan-ongoing documentation of a patient’s care, condition and needs in order to reach specific goals

CMS-center for Medicare and Medicaid Services-responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards as well as maintaining HCPCS code sets and Medicare Remittance Advice Remark code sets

CARF- Commission on Accreditation of Rehabilitation Facilities- accredits behavioral healthcare, aging services, child and youth services, and medical rehab programs based on standards of care outlined.

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

Consent to treatment- the patient’s (or legal guardian’s) agreement to be treated by the provider

Consultation report- consultation report is the findings of an the initial contact between patient and physician of which is not the patient’s primary or attending physician

Documentation standards-principles, codes, beliefs, guidelines, and regulations that guide health record documentation

Documents imaging- scanning documents into an electronic health system for later retrieval

Expressed consent-spoken or written permission a patient provides to a healthcare provider to allow the provider to perform medical or surgical treatment

EMTALA-a law enacted that prevents transferring, discharging, or refusal to treat patients in an emergency department based on the inability to pay

Hybrid record-a combination of electronic and written health records.

Joint Commission-an organization that accredits and certifies healthcare organizations and programs

Legal health record-documents that a provider may include in response to a legally permissible request for patient information

MDS-minimum data set- mandated standard assessment that SNF must use to collect patient information and plan of care.

PAI-patient assessment instrument-standardized tool to evaluate a patient’s condition prior to and after admission.

RAI-request for additional information

SOAP- subjective, objective assessment plan- method of documenting observations, assessments and plans.

Standing orders- orders the medical staff or physician for a specific diagnosis or procedure

Statute-a piece of legislation written and approved by state or federal legislature and then signed into law

Transfer record-a review of the patient’s stay along with current status, discharge, transfer orders, and additional instructions that accompanies the patient when they are transferred to another facility

Universal chart order-a system in which the patient’s health records is maintained in the same format

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

     a.  Compare and contrast the mandates.

From the information I found it seems the federal mandates sort of rule the state. The federal set the guidelines and the state implements them

      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?

Depending on the type of institution the requirements of what needs to be included in the EHR can vary. Also, the federal government has also provided and incentive to providers that have implemented an EHR if they meet the requirements of receiving the incentive.

     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 an EHR so that all needed clinical and administrative information can be stored in one central location without the use of many different systems. An EHR also allows tracking of the people accessing the record to comply better with HIPAA regulations.