1. Define the following KEY TERMS:

Accreditation-a voluntary process of instutional 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) =an outpatient surgery center that has its own national identifier.

AAAASF-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.

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

Authorization-as amended by HITECHexcept as otherwise specified, a covered entity may not use or disclose protected health information without an authorization that is valid under section 164.508.

Autopsy report-written documentation of the findings from a postmortem pathological examination.

CAAs-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.

CMS-the department of health and human services agency responsible for Medicare and parts of Medicaid.

CARF-an international independent nonprofit accreditor of health and human services that develops customer-focused standards for areas such a 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 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 principals, 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.

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-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.

Hybrid record-a combination of paper and electronic records.

Joint Commission-an independent nonprofit organization that accredits and certifies more than 20,000 healthcare organizations and programs in the United States which 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-a federally mandated standard assessment form that Medicare and Medicaid certified nursing facilities must use to collect demographic and clinical data on nursing homes residents. Includes screening, clinical, and functional status elements

PAI-a standardized tool used to evaluate the patient’s behalf and helps get any information or services needed.

RAI-in skilled nursing facilities the care plan is based on a format required by federal regulations.

SOAP-documentation method that refers to how each progress note contains documentation relative to subjective observations, objective observations, and assessments ad plans.

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

Statute

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 mandates are similar both are requiring health care professionals to implement the EHR system by 2015 or the risk penalities. The penalities in Massachuttes was more strict however because the physicican risked losing his license. In the federal the health care angies risk losing reimbursements for medicade and medicare payments

      b. Identify state and federal level mandates the contradict and are in harmony with one another. They are in harmony with each other but the federal is raising the penalty from 1 % to 5 % if the EHR is not implemented.

 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? Either they implement one or risk either losing their licenes or reimbursement for care.

     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?Have cross-trained staff that can handle intake and documentation, Document encounters in real-time, but be cognizant of time and detail, Route documents appropriately and delegate effectively

this was very hard and the internet activity I had a hard time searching for the answers but I did my best ☺ .