1. Define the following KEY TERMS:

Accreditation – voluntary process of institutional or organized 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) – 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 – Tests and procedures ordered by a physician to provide information for use in patient diagnosis or treatment. Professional healthcare services such as radiology, laboratory, or physical therapy.

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 – a document that is required under the Privacy Rule of the Health Insurance Portability and Accountability Act for the use and disclosure of protected health information

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 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; serves as the primary source for ongoing documentation of the resident’s care, condition, and needs.

CMS – Centers for Medicare and Medicaid Services – the federal agency within the US Department of Health and Human Services.

CARF – Commission on Accreditation of Rehabilitation Facilities – requires a facility to maintain a single case record for any patient it admits. Many rehabilitation facilities are accredited through CARF

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

Consent to treatment – Legal permission given by a patient’s 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 principles, codes, beliefs, guidelines, and regulations that guide health record documentation

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

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 - Emergency Medical Treatment and Labor Act - requires any hospital that accepts payments from Medicare to provide care to any patient who arrives in its emergency department for treatment, regardless of the patient's citizenship, legal status in the United States or ability to pay for the services.

Hybrid record – a combination of paper and electronic records, a health record that includes both paper and electronic elements

Joint Commission – industry leader in the area of healthcare provider organizations accreditation, Continuous improvement in terms of its survey processes and the updating of its criteria and standards to better reflect industry changes in clinical and operational practices and understanding.

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– 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 at discharge from.

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 observations, objective observations, assessments, and plans

Standing orders – orders the medical staff or an individual physician has established as routine care for 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

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.

HIPAA privacy rule gives individuals to access their health information. Organizations must meet obligations as well as protect the confidentiality of patient records by ensuring they are released to or accessed by authorized individuals only. The privacy and security of patient health information is a priority for patients and their families, health care providers and professionals, and the government. Health care providers that handle health information to have policies and security to protect the patient’s health information whether it is stored on paper or electronically.

CMS is known for its operational oversight of the Medicare program and in collaboration with state governments. CMS will focus on advanced use of certified EHR technology to support health information exchange advanced quality measurement and maximizing clinical effectiveness and efficiencies.

1. Compare and contrast the mandates.

They both use the EHR to support health information and the patient’s information is private. The HIPAA is more about security and privacy where CMS publishes a final rule that specifies criteria that eligible professionals, hospitals, and critical access hospitals meet in order to participate in the Medicare and Medicaid HER Incentive Program.

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

CMS and The Joint Commission both mandate the content of bylaws. State laws may affect the ability of individuals to access their health information in a number of ways. HIPAA allows patient’s access to their health information. In a number of area’s the HIPAA Privacy Rule is silent or postponed by state law. State law continues to have an important role in these areas and has the potential to either ease or make difficult for patient’s ability to access their health information electronically.

 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?

Healthcare provider organizations seek accreditation so the organization gets the opportunity to achieve its ability and see what operational improvements can make from the findings of the accreditation organization. Specific programs and services of the healthcare organization must be accredited in order to participate in the Medicare and Medicaid programs. The medical staff bylaws provide overall quality of care and treatment provided to patients by the physicians.

1. 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?

To make certain the patients data is collected accurately and consistently the health care organizations need to train all levels of staff. This can include incorporating the usefulness of these data for detecting and addressing health care needs into the training of health professionals, administrative staff, and hospitals.