Certified Professional in Healthcare Virtual Assistants

Medical Records Management

Accountable Care Organization (ACO) refers to a network of healthcare providers who come together to provide coordinated care to patients. The main goal of an ACO is to improve the quality of care while reducing costs. In the context of Medical Records Management, ACOs must ensure that patient records are accurate and up-to-date, and that all members of the care team have access to the information they need to provide high-quality care. Related terms include Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO).

Active Record refers to a patient's current medical record, which contains up-to-date information about the patient's health status, medical history, and treatment plans. In Medical Records Management, active records are continuously updated to reflect changes in the patient's condition, new diagnoses, and ongoing treatment. Related terms include Inactive Record and Archived Record.

Admission, Discharge, and Transfer (ADT) refers to the process of managing patient movement within a healthcare facility. ADT involves tracking patient admissions, discharges, and transfers, and ensuring that patient records are updated accordingly. In Medical Records Management, ADT is critical to ensuring that patient records are accurate and complete. Related terms include Patient Registration and Master Patient Index.

American Health Information Management Association (AHIMA) refers to a professional organization that supports the development and implementation of health information management practices. AHIMA provides guidance on Medical Records Management, including standards for coding, classification, and reimbursement. Related terms include American Medical Association (AMA) and Healthcare Financial Management Association (HFMA).

Audit Trail refers to a record of all changes made to a patient's medical record, including edits, deletions, and additions. In Medical Records Management, audit trails are used to track changes to patient records and ensure that integrity is maintained. Related terms include Data Security and Compliance.

Authorization refers to the process of obtaining permission from a patient to disclose their protected health information (PHI). In Medical Records Management, authorization is critical to ensuring that patient confidentiality is maintained. Related terms include Informed Consent and HIPAA.

Barcode Medication Administration (BCMA) refers to the use of barcodes to track medication administration. In Medical Records Management, BCMA is used to ensure that medications are administered correctly and that patient records are updated accordingly. Related terms include Electronic Medication Administration Record (eMAR) and Automated Dispensing Cabinet (ADC).

Centralized Registry refers to a database that stores patient information and medical records in a centralized location. In Medical Records Management, centralized registries are used to manage patient

records and ensure that access is controlled. Related terms include Decentralized Registry and Distributed Database.

Certified Professional in Healthcare Virtual Assistants (CPHVA) refers to a credential that recognizes individuals who have demonstrated expertise in healthcare virtual assistance. In Medical Records Management, CPHVA-certified individuals are trained to manage patient records and ensure that confidentiality is maintained. Related terms include Certified Professional in Healthcare Information and Management Systems (CPHIMS) and Certified Medical Administrative Assistant (CMAA).

Clinical Decision Support System (CDSS) refers to a computer-based system that provides healthcare professionals with clinical decision-making support. In Medical Records Management, CDSS is used to analyze patient data and identify potential health risks. Related terms include Electronic Health Record (EHR) and Health Information Exchange (HIE).

Compliance refers to the process of ensuring that healthcare organizations adhere to relevant laws, regulations, and standards. In Medical Records Management, compliance is critical to ensuring that patient confidentiality is maintained and that regulations are followed. Related terms include HIPAA and Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Computer-Assisted Coding (CAC) refers to the use of computer-based systems to assign medical codes. In Medical Records Management, CAC is used to improve the accuracy of medical coding and ensure that reimbursement is maximized. Related terms include Clinical Documentation Improvement (CDI) and Medical Transcription.

Data Analytics refers to the process of analyzing data to identify trends and patterns. In Medical Records Management, data analytics is used to improve patient outcomes and reduce costs. Related terms include Business Intelligence and Data Visualization.

Data Security refers to the process of protecting sensitive data from unauthorized access. In Medical Records Management, data security is critical to ensuring that patient confidentiality is maintained. Related terms include Data Encryption and Access Control.

Decentralized Registry refers to a database that stores patient information and medical records in a decentralized location. In Medical Records Management, decentralized registries are used to manage patient records and ensure that access is controlled. Related terms include Centralized Registry and Distributed Database.

Digital Signature refers to an electronic signature that authenticates the identity of a healthcare professional. In Medical Records Management, digital signatures are used to verify the authenticity of medical records and ensure that integrity is maintained. Related terms include Electronic Signature and Public Key Infrastructure (PKI).

Disaster Recovery refers to the process of recovering lost or damaged data in the event of a disaster. In Medical Records Management, disaster recovery is critical to ensuring that patient care is not disrupted. Related terms include Business Continuity and Data Backup.

Distributed Database refers to a database that stores patient information and medical records in multiple locations. In Medical Records Management, distributed databases are used to manage patient records and ensure that access is controlled. Related terms include Centralized Registry and Decentralized Registry.

Electronic Health Record (EHR) refers to a digital version of a patient's medical record. In Medical Records Management, EHRs are used to store and manage patient information, and to improve the quality of care. Related terms include Personal Health Record (PHR) and Electronic Medical Record (EMR).

Electronic Prescribing (e-Prescribing) refers to the use of electronic systems to prescribe medications. In Medical Records Management, e-prescribing is used to improve the safety and efficiency of medication prescribing. Related terms include Electronic Medication Administration Record (eMAR) and Automated Dispensing Cabinet (ADC).

Health Information Exchange (HIE) refers to the process of sharing health information between healthcare providers. In Medical Records Management, HIE is used to improve the quality of care and reduce costs. Related terms include Health Information Network (HIN) and Regional Health Information Organization (RHIO).

Health Insurance Portability and Accountability Act (HIPAA) refers to a federal law that regulates the use and disclosure of protected health information (PHI). In Medical Records Management, HIPAA is critical to ensuring that patient confidentiality is maintained. Related terms include Health Information Technology for Economic and Clinical Health (HITECH) and Patient Protection and Affordable Care Act (PPACA).

Hybrid Record refers to a combination of paper and electronic medical records. In Medical Records Management, hybrid records are used to manage patient information and ensure that access is controlled. Related terms include Paper Record and Electronic Record.

Inactive Record refers to a patient's inactive medical record, which contains historical information about the patient's health status, medical history, and treatment plans. In Medical Records Management, inactive records are stored securely and retained for a specified period of time. Related terms include Active Record and Archived Record.

Indexed File refers to a system of organizing and storing medical records using indexes and codes. In Medical Records Management, indexed files are used to manage patient records and ensure that access is controlled. Related terms include Alphabetical File and Numerical File.

Information Governance refers to the process of managing information across an organization. In Medical Records Management, information governance is critical to ensuring that patient confidentiality is maintained and that regulations are followed.

Interoperability refers to the ability of different systems to communicate and exchange information. In Medical Records Management, interoperability is critical to ensuring that patient care is coordinated and that information is shared effectively. Related terms include Health Information Exchange (HIE) and Electronic Health Record (EHR).

Master Patient Index (MPI) refers to a database that stores patient information and medical records in a centralized location. In Medical Records Management, MPI is used to manage patient records and ensure that access is controlled. Related terms include Enterprise Master Patient Index (EMPI) and Patient Registry.

Medical Transcription refers to the process of converting dictated recordings into written text. In Medical Records Management, medical transcription is used to create accurate and complete medical records. Related terms include Speech Recognition and Clinical Documentation Improvement (CDI).

National Provider Identifier (NPI) refers to a unique identifier assigned to healthcare providers. In Medical Records Management, NPI is used to identify healthcare providers and ensure that claims are processed correctly. Related terms include Medicare Identifier and Medicaid Identifier.

Offsite Storage refers to the process of storing medical records in a secure location outside of a healthcare facility. In Medical Records Management, offsite storage is used to protect patient records from loss or damage. Related terms include Onsite Storage and Cloud Storage.

Onsite Storage refers to the process of storing medical records in a secure location within a healthcare facility. In Medical Records Management, onsite storage is used to manage patient records and ensure that access is controlled. Related terms include Offsite Storage and Cloud Storage.

Patient Portal refers to a secure online platform that allows patients to access their medical records and communicate with healthcare providers. In Medical Records Management, patient portals are used to improve patient engagement and empower patients to take an active role in their care. Related terms include Personal Health Record (PHR) and Electronic Health Record (EHR).

Patient Registration refers to the process of collecting patient information and creating a medical record. In Medical Records Management, patient registration is critical to ensuring that patient care is coordinated and that information is shared effectively. Related terms include Admission, Discharge, and Transfer (ADT) and Master Patient Index (MPI).

Personal Health Record (PHR) refers to a digital version of a patient's medical record that is maintained by the patient. In Medical Records Management, PHRs are used to empower patients to take an active role in their care and to improve the quality of care. Related terms include Electronic Health Record (EHR) and Electronic Medical Record (EMR).

Practice Management System (PMS) refers to a computer-based system that manages the administrative and clinical functions of a healthcare practice. In Medical Records Management, PMS is used to manage patient records and ensure that access is controlled.

Protected Health Information (PHI) refers to individually identifiable health information that is protected by HIPAA. In Medical Records Management, PHI is critical to ensuring that patient confidentiality is maintained. Related terms include Health Insurance Portability and Accountability Act (HIPAA) and Electronic Protected Health Information (ePHI).

Record Retention refers to the process of storing and maintaining medical records for a specified period of

time. In Medical Records Management, record retention is critical to ensuring that patient care is coordinated and that information is shared effectively. Related terms include Record Storage and Record Destruction.

Release of Information (ROI) refers to the process of disclosing protected health information (PHI) to authorized individuals or organizations. In Medical Records Management, ROI is critical to ensuring that patient confidentiality is maintained.

Risk Management refers to the process of identifying and mitigating risks to patient safety and quality of care. In Medical Records Management, risk management is critical to ensuring that patient care is coordinated and that information is shared effectively. Related terms include Quality Improvement and Patient Safety.

Scanning and Indexing refers to the process of converting paper medical records into digital format and indexing them for easy retrieval. In Medical Records Management, scanning and indexing is used to improve the efficiency of medical records management and to reduce costs. Related terms include Electronic Document Management (EDM) and Electronic Content Management (ECM).

Security Clearance refers to the process of granting access to sensitive information based on an individual's role and responsibilities. In Medical Records Management, security clearance is critical to ensuring that patient confidentiality is maintained. Related terms include Data Security and Access Control.

Standard Operating Procedure (SOP) refers to a documented process that outlines the steps to be taken in a specific situation. In Medical Records Management, SOPs are used to ensure that medical records are managed consistently and that regulations are followed. Related terms include Policy and Procedure.

Systemized Nomenclature of Medicine (SNOMED) refers to a standardized system of terminology used to classify and code medical concepts. In Medical Records Management, SNOMED is used to improve the accuracy of medical coding and ensure that reimbursement is maximized. Related terms include International Classification of Diseases (ICD) and Current Procedural Terminology (CPT).

Telehealth refers to the use of telecommunications technology to deliver healthcare services remotely. In Medical Records Management, telehealth is used to improve the access to healthcare services and to reduce costs. Related terms include Telemedicine and Remote Monitoring.

Unique Identifier (UID) refers to a unique code assigned to a patient or healthcare provider. In Medical Records Management, UIDs are used to identify patients and healthcare providers and to ensure that medical records are accurate and complete. Related terms include National Provider Identifier (NPI) and Medicare Identifier.

Virtual Private Network (VPN) refers to a secure network that encrypts data and protects it from unauthorized access. In Medical Records Management, VPNs are used to protect patient confidentiality and to ensure that medical records are secure.

Workflow Management refers to the process of managing and optimizing business processes to improve

efficiency and productivity. In Medical Records Management, workflow management is used to streamline medical records management and to reduce costs. Related terms include Business Process Management (BPM) and Electronic Content Management (ECM).