STANDARDS FOR LIBRARY SERVICES IN HEALTH CARE INSTITUTIONS. pdf

1: Department Divisions | Health & Senior Services

Statement of the principles of administration essential to good library service in all types of health care institutions. Discussed under management of library services, health science library, and patients' library.

Data are viewed in an integrated manner while the organization progressively builds a truly integrated, comprehensive clinical information system at the back end. The administrative simplification provisions of the Health Insurance Portability and Accountability Act HIPAA originally mandated the implementation of a unique health identifier for individuals. However, Congress withheld funding of the implementation pending adequate federal privacy protection. Now that the HIPAA privacy rules have been implemented nationwide, means to link patient data across organizations should be revisited. In the meantime, pragmatic approaches to linking patient data have been emerging within the provider community. One approach used by many health care systems is the enterprise master patient index, which essentially creates a local unique patient identifier for persons cared for within a single health care system. Since most health care is local, and relationships among patients, physicians, and specific hospitals are ongoing, this approach has served as a viable interim solution; however, it is costly to maintain, does not address the issue of data coming from other systems of care, and requires the development of matching algorithims to solve such problems as patients with similar names. Because no algorithm is perfect, a small percentage of attempted matches will result in errors that can be recognized and reconciled only through human intervention. All medical data are retained by the health care organizations behind secure firewalls. Initially, authentication was accomplished through established hospital procedures. A three-key approach to authentication is in the process of being implemented: Achieving a New Standard for Care. The National Academies Press. Patients voluntarily opt into the program to allow their physicians access to past diagnoses, laboratory results, medications, allergies, and immunizations Carper, Sensitive medical data e. The committee believes that the careful examination and development of innovative methods for patient data linkage should be undertaken against a background of changing technology, illness patterns, and consumer attitudes. In particular, changing demographics have resulted in the growth of chronic care conditions that involve multiple providers and data sources, making it more difficult to maintain and integrate relevant patient information. Consumers will be more involved in their self-care and disease management and will require the capability to utilize a personal health record and engage in electronic communication with their provider s. Likewise, as they continue to become more savvy in accessing and understanding health information on the Internet, the demand for tools to incorporate this information into their care protocols and personal health records will likely increase. With HIPAA security rules in place, it is also possible to create patient data linkages in a manner that empowers patients to permit access to some of their data while restricting access to other, more sensitive data e. Terminologies Standardized terminologies facilitate electronic data collection at the point of care; retrieval of relevant data, information, and knowledge i. To promote patient safety and enable quality management, standardized terminologies that represent the focus e. Significant efforts during the last quarter-century have resulted in the development of standardized terminologies for the core phenomena of clinical practice: Although standardized measures for health outcomes have been developed, the incorporation of such measures into standardized terminologies has lagged behind that of measures for problems and interventions. Additionally, standardized terms for patient goals i. Technical Criteria and Representation of Clinical Domains Standardized terminologies vary along many dimensions; most important is the primary purpose of the terminology, as well as the extent to which it is concept oriented and possesses the semantic structures that enable computer algorithmic processing Ingenerf, ; Rossi et al. To achieve the integrated approach to patient safety envisioned by the committee, the terminology must serve the purposes of decision support tools, the EHR, and knowledge resources Chute et al. Terminology efforts for the EHR have focused on how to represent the history, findings, diagnoses, management, and outcomes of patients in a way that can preserve clinical detail and identify characteristics

that enable improved risk adjustment, the development of common guidelines, aggregate outcome analyses, and shared decision support rules. While a number of diverse terminologies are required for clinical care, patient safety, and other aspects of biomedicine, a central group of terminologies can serve as the backbone of clinical information systems. A number of technical criteria must be met for terminologies to function in a way Page Share Cite Suggested Citation: The most basic criteria for a controlled medical vocabulary are identified by Cimino ; they include domain completeness, nonredundancy, synonymy, nonambiguity, multiple classification, consistency of views, and explicit relationships. In , the ANSI Health Informatics Standards Board went a step further and created a detailed framework of informatics criteria for the development and evolution of terminologies with high functionality Chute et al. The National Committee on Vital and Health Statistics NCVHS used these informatics criteria to evaluate and select a core set of well-integrated, nonredundant clinical terminologies that will serve as the national standard for medical terminology for the EHR Sujansky, Table Minimization of overlap in domain representation was another important criterion for selection of the NCVHS core terminology group. The CHI initiative is also evaluating the terminologies in this regard, as well as assessing their ability to meet the extensive data representation requirements for the common clinical domains that cut across the three dimensions of the NHII i. Issues related to data collection, sharing, and reuse are being addressed during the evaluations, as well as identification of the overlap and gaps in clinical representation. Table provides an overview of the cross-cutting domains identified by CHI to date. The terminologies determined by CHI to best represent requirements of the clinical domain areas, after consultation with NCVHS, will be accepted for federal governmentâ€”wide implementation. Additional areas within the clinical domains, including those relevant to patient safety, will be added as the process proceeds. CHI is working rapidly and expects to make recommendations on terminologies to represent many, if not all, of the domain areas identified in Table by late The first round of terminology evaluations includes laboratory results content, medications, demographics, immunizations, and interventions and procedures. Initially, CHI identified many of the domain areas that support the corresponding domains needed for patient safety reporting systems; however, the list is not comprehensive, and there will likely be a need to expand or extend the domains. For example, in the domain area for medications, CHI identifies clinical drugs, warnings, allergic reactions, and adverse drug events ADEs as primary areas for clinical representation. For patient safety, representation is also needed for subcategories, such as nutritional supplements and alternative medicines. Expansion of the domain areas for comprehensive clinical and patient safety data is a subject for additional work.

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2: List of NFPA Codes and Standards

Standards for Library Services in Health Care Institutions, [Prepared by the Hospital Library Standards Committee Association of the Hospital and Institution Libraries, American Library Association.] American Library Association, Chicago, IL.

Much of this circulation should be controlled. A better environment also contributes to better staff morale and patient care. Increased use of natural light , natural materials, and textures Use of artwork Attention to proportions, color, scale, and detail Bright, open, generously-scaled public spaces Homelike and intimate scale in patient rooms, day rooms, consultation rooms, and offices Compatibility of exterior design with its physical surroundings In addition to the general safety concerns of all buildings, hospitals have several particular security concerns: Protection of hospital property and assets, including drugs Protection of patients, including incapacitated patients, and staff Safe control of violent or unstable patients Vulnerability to damage from terrorism because of proximity to high-vulnerability targets, or because they may be highly visible public buildings with an important role in the public health system. Sustainability Hospitals are large public buildings that have a significant impact on the environment and economy of the surrounding community. They are heavy users of energy and water and produce large amounts of waste. Because hospitals place such demands on community resources they are natural candidates for sustainable design. These regulations put emphasis on acoustic and visual privacy, and may affect location and layout of workstations that handle medical records and other patient information, paper and electronic, as well as patient accommodations. This might require computer alcoves and data ports in corridors outside patient bedrooms. For more information, see WBDG Integrate Technological Tools Need to balance increasing attention to building security with openness to patients and visitors Emergence of palliative care as a specialty in many major medical centers A growing interest in more holistic, patient-centered treatment and environments such as promoted by Planetree. This might include providing mini-medical libraries and computer terminals so patients can research their conditions and treatments, and locating kitchens and dining areas on inpatient units so family members can prepare food for patients and families to eat together. Relevant Codes and Standards Hospitals are among the most regulated of all building types. However, federal facilities on federal property generally need not comply with state and local codes, but follow federal regulations. To be licensed by the state, design must comply with the individual state licensing regulations. Since hospitals treat patients who are reimbursed under Medicare, they must also meet federal standards, and to be accredited, they must meet standards of The Joint Commission. The Americans with Disabilities Act ADA applies to all public facilities and greatly affects the building design with its general and specific accessibility requirements. The technical requirements do not differ greatly from the ADA requirements. Federal agencies that build and operate hospitals have developed detailed standards for the programming, design, and construction of their facilities. Many of these standards are applicable to the design of non-governmental facilities as well. Federal Mandates and Criteria.

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3: Data Standards, Data Quality, and Interoperability (update)

*Standards for Library Services in Health Care Institutions [Association of Hospital and Institution Libraries] on www.enganchecubano.com *FREE* shipping on qualifying offers.*

Technical standards are essential to improving healthcare. Standards also enable aggregation of information from disparate sources and sophisticated reviews of such information to glean knowledge that can inform clinical decisions. Since the mids, a number of organizations have formed to develop such standards. Often these standards developing organizations SDOs form because of a perception that a new requirement is not met by an existing organization. The unfortunate result is a multitude of SDOs, which risks generating industry confusion over standards adoption rather than enhancing interoperability among disparate communities. The multiplication of organizations happens naturally enough. Over the subsequent years, its scope widens to meet the needs of its domain. Globally, similar SDOs are created to meet national and regional requirements. There has been limited collaboration to date. However, collaboration in the generation of harmonized standards from the very onset of development can be mutually beneficial, complementary, and valuable to the entire industry. Recognizing common interests, the two organizations agreed to share resources and build upon common interests. Joint work groups serve as forums in which members of both organizations harmonize standards and work together on common products. The Value of Collaboration Collaboration can save the standards developing community resources and improve the quality of the standards they develop. Most of the healthcare and informatics community feel that standards developing efforts have been unnecessarily delayed and often are achieved with disappointing results. There are many gaps in the set of needed standards. One challenge is limited resources. Most standards development organizations only meet face-to-face a few times each year. Clearly, volunteer time is a precious commodity, and staff contributions to the production and support of standards generation varies. The need to expand scope to address the gaps and to produce standards more efficiently requires an increase in paid staff, which cannot be achieved without an increase in revenue. In existing models, these funds have been almost exclusively generated from membership dues and educational fees. Simple management of an SDO also requires increasing resources. Unfortunately, resources are limited, as funding, staff, and volunteers are stressed. This is invariably exaggerated with SDOs competing for those funds. However, there is significant value to working together. This is true not only from the point of view of resource management and increased efficiencies, but also by ensuring harmonized and noncompetitive standards. Collaboration also leads to greater consistency in the standards produced. A global common information model and a common data model invariably increase consistency across standards. Reuse of models and tools provides a direct benefit for the organization and the end user. Consistent and compatible standards are a consequence of common models. Collaboration also leads to the development and sharing of common tool sets. This is particularly true in those circumstances in which standard development is based upon common models and a common methodology. Most SDOs in the US have a different standards development approach based upon the origins and focus of the organization. For example, the National Council for Prescription Drug Programs includes principally individuals from the prescription drug reimbursement domain. CDISC is largely comprised of biopharmaceutical and academic clinical researchers and technology and service providers for clinical research. HL7 is represented by government agencies, health IT vendors, and care providers. The standards organization X12 is almost exclusively limited to payers focused on claims reimbursement. As a consequence, a natural duplication or overlap of requirements and desired uses for standards evolved. At times, standards developed by each entity became more duplicative and ultimately more disparate and competitive. When SDOs collaborate in the production of standards, the end user always profits from the shared expertise across these often artificial boundaries. Benefits to End Users Ultimately, SDO collaboration results in the creation of a single standard for a single specific purpose, thereby reducing or eliminating competing and often unnecessarily duplicative standards. For the developer or end

user, this collaboration removes the artificial decision of which standard to choose and implement. In the final analysis, the industry benefits and the motivation to more rapidly adopt and implement appropriate standards becomes much greater. Both vendors and users are able to plan a path for both adoption and deployment of these common standards. SDOs working together in meaningful and complementary ways will benefit a number of different communities and stakeholders. For example, in a large technology company, standards enable faster development and more rapid time to market. This almost always achieves lower cost structures. Deploying standardized interfaces rather than customized ones in a vendor solution results in a software solution that also will be more scalable. For regulatory authorities, standards improve reviews, enabling the use of standard tools for viewing data. Within academic research institutions, sharing of research information is being encouraged through governmental funding agencies. These grants encourage improvement in the way biomedical research is conducted and promote the engagement of communities in clinical research. The most effective means of exchanging research data is through the use of common standards. Standards harmonization that enables the secure flow of clinical information from electronic health records can benefit clinical research studies, safety reporting, and other use cases. For example, technical standards can ensure that a subset of appropriately de-identified data can be aggregated at an academic center or study sponsor site to assess the effectiveness or safety of a therapy. Standards for regulated clinical research such as the CDISC Operational Data Model are accompanied by an audit trail, allowing clinical study monitors or regulatory authorities or auditors to trace the data they receive in support of a marketing application back to its origin to ensure accuracy and integrity of the information they are reviewing before approving a new product. Barriers to Collaboration The barriers to collaboration are many. Most SDOs depend on volunteers, who often may have a limited view of the broad impact of standards development, either nationally or internationally. In addition, all SDOs take direction from their stakeholders, whether it be government, directorates, or customers. These stakeholders perceive value in very different ways, which places very competitive forces on overarching development strategy. In addition, every SDO is motivated to produce key standards that are implemented widely. That drive for survival is perhaps the most important barrier to collaboration. In simple terms, an SDO can be driven by a fear of becoming irrelevant. Most groups are willing to address the issues of cooperation and collaboration, but turning that willingness into action is a consistent challenge. At the most simplistic level, the proposition of a merger may only mean that the more dominant SDO would be willing to oversee the dissolution of its competitor and the adoption of its own long-term strategy, leadership, rules, and governance. Most frequently this leads an SDO to reject initiatives that appear to be less relevant. Inclusion of nonhuman animal subjects is one such barrier that often leads to contentious opposition to collaboration. Finally, a significant, often critical barrier is the difference in governance models, including policies for balloting and for publishing standards. In scope, one organization may support draft standards for trial use, while another does not provide for this option. Questions about leadership, work process, and joint work structures may be difficult to resolve. The treatment of intellectual property, particularly when shared, may become contentious. Even access to the shared standard, particularly if it is freely given to the public domain by one organization, may play havoc with the business model of the other. Other standards are self-proclaimed but use formal processes for creating and balloting standards. In addition to the SDOs, each country may have a national standards body e. The figure here illustrates this complicated arrangement, showing just a portion of the organizations currently involved in standards development, primarily in the US. The council currently includes five organizations committed to the global harmonization of standards related to healthcare informatics and research. A sample of other terminology-related standards and their organizations appears underneath. The rest of the figure is devoted to the US realm. The Department of Health and Human Services HHS has connection to many of the organizations as a user and facilitator of standards development in varying degrees. SCO and the Joint Initiative Council are now embarking on projects that will harmonize competing or overlapping standards within the US and internationally; for example, the identification of medical products. Examples of Productive Collaboration The value of collaboration almost always outweighs the barriers,

regardless of the seeming significance they seem to impose. The leadership of the respective standards development organizations and associated groups must coalesce to define fruitful collaboration and to minimize or completely overcome the multiple barriers, either real or imagined. If it cannot collaborate appropriately and productively, the health data standards industry risks increasing irrelevance and could ultimately fail to meet the real-world needs of its stakeholders. HL7 was formed in March At that time the ASTM group E31 was focused on a standard to transfer laboratory data from commercial laboratories to healthcare facilities. The individuals who founded HL7 were interested in creating a larger scope of activity that would address all data interchanges required to support the functionality of hospital information systems. As a consequence, HL7 created a standard that overlapped with the E31 efforts. Eventually, this redundancy had to be resolved. HL7, from its beginning, has been an open organization, welcoming any group to join to create standards that were within its scope. In some cases, HL7 expanded its scope to accommodate new activities when circumstances demanded it. CDISC was founded to fill an identified need for data interchange standards within the clinical research domain. In an initial CDISC volunteer group began working with the US Food and Drug Administration, biopharmaceutical companies, academic research organizations, and other clinical research stakeholders including technology and service providers and academic research institutes to develop clinical research standards. CDISC immediately became a growing and productive organization. The collaboration has not always been easy or straightforward, but it has been productive. Since the earliest efforts to establish common benefits, both organizations have sought to complement rather than dominate the relationship. Very early in the process there was a recognized need to leverage the unique skill sets that the respective membership offered. An initial attempt to harmonize these was unsuccessful. In exploring what failed in greater depth, the two organizations identified a number of solutions. These resulted in a recommendation by an HL7 expert, which led to the development of a clinical research domain analysis model. Equally important was that the collaboration process also served to ensure harmonization among the various CDISC content standards. This standard facilitates the electronic transport of clinical research laboratory data in bulk from central laboratories to research sponsors based upon a CDISC standard content format.

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4: Hospital | WBDG Whole Building Design Guide

The Leading Practices Library is a knowledge sharing hub of innovative practices that have been identified through a rigorous evaluation process. It is available to the public, policy makers and organizations who are seeking ways to improve the quality of health services for all.

By leveraging the use of XML, the HL7 Reference Information Models RIMs , and coded vocabularies, the CDA makes documents both machine-readable so they are easily parsed and processed electronically and human-readable so they can be easily retrieved and used by the people who need them. Resource Source HL7 Standards: EHR Profiles These standards provide functional models and profiles that enable the constructs for management of electronic health records. The function list is described from a user perspective with the intent to enable consistent expression of system functionality. Through the creation of functional profiles, this model enables a standardized description and common understanding of functions sought or available in a given setting i. The scope has been limited to those knowledge bases that can be represented as a set of discrete modules. By leveraging the use of XML, HL7 Reference Information Models RIMs , and coded vocabularies, the CDA makes documents both machine-readable so they are easily parsed and processed electronically and human-readable so they can be easily retrieved and used by the people who need them. HL7 HL7 Version 2. HL7 IEEE Point of Care Medical Device Communication A family of medical device communications standards which allows hospitals and other healthcare providers to achieve plug-and-play interoperability between medical instrumentation and computerized healthcare information systems, especially in a manner that is compatible with the acute care environment. Vocabulary, Terminology, and Classification Systems Systems that facilitate the organization, storage, and retrieval of healthcare data. Standards Development Organizations Private or government organizations involved in the development of healthcare informatics standards at a national or international level. ASTM European Committee for Standardization CEN CEN contributes to the objectives of the European Union and European Economic Area with voluntary technical standards that promote free trade, the safety of workers and consumers, interoperability of networks, environmental protection, exploitation of research and development programs, and public procurement. CEN Clinical and Laboratory Standards Institute CLSI A global nonprofit standards development organization that promotes the development and use of voluntary consensus standards and guidelines within the healthcare community. Its core business is the development of globally applicable voluntary consensus documents for healthcare testing. CLSI Clinical Data Interchange Standards Consortium CDISC CDISC is an open, multidisciplinary nonprofit organization that has established worldwide industry standards to support the electronic acquisition, exchange, submission and archiving of clinical trials data and metadata for medical and biopharmaceutical product development. As an ANSI-accredited organization, its primary function is to facilitate electronic communications by developing standards for information exchange among healthcare trading partners. HL7 Institute of Electrical and Electronic Engineers IEEE A national organization that develops standards for hospital system interface transactions, including links between critical care bedside instruments and clinical information systems. International Organization for Standardization ISO ISO is a nongovernmental organization and network of national standards institutes from countries. NISO standards address areas of retrieval, re-purposing, storage, metadata, and preservation. Founded in to improve the quality of medical records, AHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning. It oversees the creation, promulgation and use of thousands of norms and guidelines that directly affect businesses in nearly every sector. ANSI is also actively engaged in accrediting programs that assess conformance to standards including globally recognized cross-sector programs such as the ISO quality and ISO environmental management systems. ANSI Healthcare Information and Management Systems Society HIMSS A membership organization exclusively focused on providing global leadership for the optimal use of healthcare

information technology and management systems for the betterment of healthcare. Data Standards Initiatives and Resources Resource Source National e-Health Collaborative NeHC A federally chartered commission that provides input and recommendations to HHS on how to make health records digital and interoperable and ensure that the privacy and security of those records are protected in a smooth, market-led way. Its goal is to empower the healthcare and public health communities with health information technology standards to improve individual and community health. NIST National Resource for Global Standards A search engine that provides users with standards-related information from a wide range of developers, including organizations accredited by the American National Standards Institute ANSI , other US private sector standards bodies, government agencies, and international organizations. NSSN Office of the National Coordinator for Health Information Technology ONC ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The Office of the National Coordinator for Health Information Technology provides leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of healthcare and the ability of consumers to manage their care and safety. PHIN is a national initiative to implement a multi-organizational business and technical architecture for public health information systems. The NTTAA directs federal agencies with respect to their use of private sector standards and conformity assessment practices. The objective is for federal agencies to adopt private sector standards, wherever possible, in lieu of creating proprietary, non-consensus standards. There are three sublanguages currently available:

countries, 'hospital library' could signify either a biomedical/health sciences library or a patients' library, with the latter providing leisure reading collections or health information materials or both.

Adam Crumbliss, Chief Director The Division of Community and Public Health is responsible for supporting and operating more than programs and initiatives addressing public health issues such as communicable disease control, chronic disease management, genetic health conditions, cancer, pregnancy, vital statistics and health care access. The division also assures the continuity of essential public health services to all citizens of and visitors to the state of Missouri. Through partnerships with local public health departments, hospitals and other health care organizations, local government, first responder agencies, and other partners, the office works to assure systems are in place to protect the health of Missourians during a public health emergency. It provides leadership, training and technical assistance to those agencies, communities, not-for-profit organizations and other health-related key stakeholders regarding the development of processes that improve community-based public health systems. The Section for Community Health Services and Initiatives directs statewide programs that are designed to prevent and control chronic diseases for all Missourians and support the nutritional health of high-risk populations. The section provides leadership in assessment, planning and policy development and implementation of evidence-based approaches to prevent and control cancer and chronic diseases, the leading causes of death in Missouri. In addition, the section administers statewide programs that provide early screening and detection, and health and wellness interventions to reduce risk factors for chronic diseases e. In addition the Bureau of Special Health Care Needs SHCN provides statewide health care support services, including service coordination, for children and adults with disabilities, chronic illness, birth defects and adults who have sustained a traumatic brain injury State and federal funding supports SHCN services. The Section for Disease Prevention is the principal section involved in the investigation of the cause, origin, and method of transmission of communicable or infectious diseases. The Section for Environmental Public Health protects the health of all Missourians and visitors to the state by ensuring healthy food and environments and through the investigation and prevention of illnesses and medical conditions related to the environment. Efforts to assure a healthy environment include activities in food establishments, lodging establishments, childcare facilities and individual homes. Investigation and prevention of illness related to the environmental focus on those conditions associated with exposure to chemical, bacteriological and physical agents in our environment and in water we consume. The Section of Epidemiology for Public Health Practice promotes a better understanding of health problems and needs in Missouri and assists the division in many functions including initiation and maintenance of surveillance systems, data management and reporting; collection of birth and death information; coordination of specific grants; public information dissemination; and fiscal services. The section also issues certified copies of Missouri birth and death records. The Section for Healthy Families and Youth promotes optimal health through a series of programs that provide educational, nutritional and support services for women of childbearing age, pregnant women, infants, and children. This section is responsible for developing policy; planning systems of care; and designing, implementing and evaluating programs to meet the health care needs of families in the state of Missouri, including those with genetic disorders. The section is also responsible for the provision of educational and nutritional support to child care centers, schools, pregnant women, infants and children across the state. Division of Administration Tonya R. Services include budget administration; grant and contract administration; accounting and procurement functions; internal audit; maintenance of the inventory of physical assets; warehouse, delivery and mailroom services; and building lease management. The Section for Child Care Regulation is responsible for conducting state inspections and investigating complaints at licensed family child care homes, group child care homes, and child care centers. The section also conducts health and safety inspections at license-exempt child care facilities e. The Section for Long-Term Care Regulation is responsible

for conducting state inspections and federal surveys, and for investigating complaints regarding long-term care facilities. The section oversees the Pre-Admission Screening and Annual Resident Review PASARR process, provides construction plan review services to healthcare facilities regarding new construction and extensive remodeling projects and maintains the level one medication aide register, certified medication technician register and the federally mandated nurse assistant register. The division is responsible for the development and implementation of programs designed to protect seniors and adults with disabilities and for the administration of an integrated system of care for eligible adults that require long-term care. In coordination with the department director, the division director, deputy division director and financial office advise legislators, advocates, state agencies and other organizations and individuals regarding services and data available to support this function. The Section for Adult Protective and Community Services investigates reports of elder abuse, neglect and financial exploitation and provides crisis intervention and Adult Protective Services for eligible adults age 18 and over that are determined to be unable or unwilling to provide or access services needed to meet their daily needs. Additionally, the section provides oversight to Medicaid funded Home and Community Based Services that are authorized on behalf of adults choosing to receive long-term care in the home or community. The section administers programs designed to maximize independence and safety for adults who choose to remain independent in the community by accessing state and federal community-based programs. The Office of the Long-Term Care Ombudsman advocates for facility residents, has responsibility for complaint resolution on behalf of facility residents, educates and trains staff, consumers and community partners on issues related to long-term facility care, and manages over volunteer Ombudsman serving in facilities across the state. The Bureau of Senior Programs is responsible for oversight of programs authorized and funded through the Older Americans Act. The bureau is responsible for collaboration and coordination of programs within various state agencies and local communities as necessary to set policy and integrate state and federal goals for seniors within Missouri with emphasis on programs that enable seniors to maximize independence and safety in the community. Program implementation is administered by Area Agencies on Aging who are responsible for ensuring that federal funding is allocated in a manner that refl ects the needs of seniors within each of the ten planning and service areas.

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6: National Standards and Accreditation | Safety and Quality

Standards are found in practically every area of our daily lives, but why do we need them in health information and technology? Today's current healthcare landscape consists of a variety of care settings and stakeholders, which all leverage a number of different information systems in their delivery of care.

Large hospitals centers may include all the various subsidiary health care types that are often independent facilities. The old expression, "You never get a second chance to make a good first impression" applies to health care facilities. The facility conveys a message to patients, visitors, volunteers, vendors, and staff. The facility also communicates a torrent of clues about the organization and the medical care being provided there. The clues start at the approach to the facility, the drop-off area, the parking lots, and the street signs. Ideally, that message is one that conveys welcoming, caring, comfort, and compassion, commitment to patient well-being and safety , where stress is relieved, refuge is provided, respect is reciprocated, competence is symbolized, way-finding is facilitated, and families are accommodated. The facility also influences employee service attitudes and behaviors. Finishes, signage, and artwork must be carefully selected, well coordinated, and integrated. Thoughtful design can help ensure the proper first impression is created and sustained. VA Medical Center, Dallas, Texas The design of health care facilities is governed by many regulations and technical requirements. It is also affected by many less defined needs and pressures. The most pressing of these are workforce shortages, reimbursements, malpractice insurance, physician-hospital relations, capacity, care for the uninsured, patient safety, advances in technology, and patient satisfaction per a recent American College of Healthcare Executives survey of hospital CEOs. The entire health care system is under great pressure to reduce costs , and at the same time, be more responsive to "customers". The aging are the heaviest users of health care services, and the percentage of the aging in our population is increasing significantly. At the same time, rapid technological advances, often involving very sophisticated techniques and equipment, make more diagnostic and treatment procedures available. The consequent increase in health care costs is not easily accommodated. Designers find increasing focus on limiting both construction costs and the costs of their design services, while compressing construction schedules and still meeting the highest quality standards. As cost pressures increase, health care facilities find themselves in increasing competition for both patients and staff. Architecture is often recognized as an important tool in attracting and retaining the best doctors and nurses, the most successful HMOs and insurance plans, and the most patients. Consumer decisions are based on cost , accessibility , quality of service, and quality of medical care. An aesthetically pleasing facility is a key aspect of the perceived quality of care. Health care is a labor-intensive industry, and much of that labor is highly skilled and highly paid. Flexibility must be a basic feature of any new health care facility to keep it from rapid obsolescence in the face of changing needs and technologies. Health care facility needs are evolving rapidly, and the direction of that evolution is difficult to forecast with any certainty. New equipment technologies, new treatment methodologies, changes in diseases, and changes in the patient population base all impact the facilities that house them. Inpatient care is steadily being reduced while outpatient services are growing. There is increasing emphasis on special-care units and smaller satellite facilities rather than large, centralized facilities. In the past, communicable diseases were the major health problem, and sanitation or cleanliness was the main characteristic of a healing or therapeutic environment. Cleanliness remains extremely important, but there is increasing recognition of the value of a pleasant , easily-understood, and non-threatening environment for patient recovery. For example, the Planetree Hospital philosophy of "demystifying medicine" emphasizes such a physical environment as part of its approach. Good design in the health care setting starts by recognizing the basic functional needs, but does not end there-it must also meet the emotional needs of those who use such facilities at times of uncertainty, dependency, and stress. These regulations put emphasis on acoustic and visual privacy. While HIPAA does not regulate facilities design, its implications for healthcare facilities may affect location and layout of workstations that handle medical

records and other patient information, paper and electronic, as well as patient accommodations. There is a noticeable movement from hospital-based acute care to outpatient care, and toward a more holistic, preventative, and continuous care of health and wellness. Sustainability must be a consideration for the design of all health care facilities. Many sustainable design features can be incorporated into health care facility design, including daylighting, energy and water conservation, nontoxic materials and finishes, and sustainable operations and maintenance. The Energy Independence and Security Act of provides additional requirements for energy conservation. Emerging Issues There is an increasing emphasis on security , especially in large public facilities, and the need to balance this with the desired openness to patients and visitors. According to the Center for Health Design, "Evidence-Based Design is the process of basing decisions about the built environment on credible research to achieve the best possible outcomes. Evidence-based health-care architecture creates safe and therapeutic environments for patient care and encourages family involvement. It promotes efficient staff performance and is restorative for workers under stress. Among them are hospitals, nursing homes, outpatient facilities, psychiatric facilities, rehabilitation facilities, hospices, assisted living facilities, congregate housing, adult day care facilities, and various specialized outpatient facilities. The WBDG currently includes sections on the following four specific building types:

7: Health Care Facilities | WBDG Whole Building Design Guide

Ambulatory Health Care, Hospitals, Critical Access Hospitals, Behavioral Health Care, Laboratory, Nursing Care Center, Office-Based Surgery, Home Care, Advanced Disease-Specific Care Certification, Disease-Specific Care, Health Care Staffing Services, Long Term Care (Medicare/Medicaid), Palliative Care, Primary Care Medical Home.

8: Healthcare Standards Development: The Value of Nurturing Collaboration

Technical standards are essential to improving healthcare. For health IT to reduce medical errors and risk to patient safety, improve access to medical records, and support innovations in "individual-based" care, its tools must adhere to certain data interchange standards.

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