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Chapter 4 SW

**Real-World Case 4.1**

# Real-World Case Discussion Questions

1. What is the role of the EHR task force?

The role of the task force is now to analyze current processes and develop a strategy that will develop uniform policies and streamline processes within software.

2. Who are the users of the EHR? What do these users need to be able to do in the EHR?

 There are several users of the EHR from patient registration personnel, clinical staff in separate departments, billing staff, medical staff and administrators. They each need to access the EHR in order to perform their individual jobs.

3. How does the legal health record apply to the EHR?

Most of the data stored in an EHR is considered the legal health record. Organizations use specific policies that dictate specifically which data is included in legal record. The data included in the legal record must be adherent to the requirements set forth by accreditation agencies regarding documentation collection, usage, approval, distribution and storage. There must also be policies regarding the appropriate handling of outside consultation documents and how they are integrated into the health record.

**Real-World Case 4.2**

# Real-World Case Discussion Questions

1. What should be considered when deciding whether or not to use the copy and paste functionality?

Patient safety should be the number one concern. The copy and paste function can be misused very easily as this example shows. Effective time management is alsways a concern with meical professionls because they seem to be seeing more patients each day with less time between patients. However when cutting and pasting, patient identification is not verified electronically and data can be easily placed in the wrong chart.

1. What controls might be put in place related to the copy and paste functionality?

The copy and paste function could be controlled by only allowing it to be used for specific data, allowing only specific users to have access to the function and incorporating come sort of finalization control that asks the user to verify patient identification before the pasted material can be saved to the record.

1. What alternatives to the copy and paste functionality are available?

Alternatively, an organization can develop forms within the EHR that can be attached to each other. This would allow users to ‘attach’ the information in its original form rather than cutting and pasting.

# Application Exercises

*Instructions:* Answer the following questions.

1. Identify the accrediting or certifying body that address each of the following types of healthcare settings (an internet search can be utilized for assistance).

|  |  |
| --- | --- |
| **Type of Healthcare Setting**  | **Accrediting and Certifying Organizations** |
| Acute care hospitals | JCAHO, HFAP, AOA, CIHQ, DNV GL HEALTHCARE, URAC |
| Ambulatory care or physician office settings | **AAAHC, AAAASF, JCAHO, THE COMPLIANCE TEAM, URAC** |
| Ambulatory surgery facilities | **AAAHC, AAAASF, JCAHO** |
| Long-term care facilities | **ACHC, CHAP, JCAHO** |
| Behavioral healthcare facilities | **JCAHO, CARF** |
| Obstetric or gynecologic care settings | **CABC, JCAHO** |
| Rehabilitation services organizations | **JCAHO, CARF** |

JCAHO Joint Commission on Accreditation of Healthcare Organizations

HFAP Healthcare Facilities Accreditation Program

URAC Utilization Review Accreditation Commission

AOA American Osteopathic Association

CIHQ Center for Improvement in Healthcare Quality

AAAHC Accreditation Association for Ambulatory Health Care

AAAASF American Association for Accreditation of Ambulatory Surgery Facilities

CHAP Community Health Accreditation Program

CARF Commission on Accreditation of Rehabilitation Facilities

CMS Centers for Medicare and Medicaid Services

CABC Commission for the Accreditation of Birth Centers

2. Identify the type of consent, authorization, or acknowledgement based upon the description provided:

|  |  |
| --- | --- |
| **Consent Type**  | **Consent Document Language** |
| **Patient Rights Acknowledgement** | The protections afforded to individuals who are undergoing medical procedures in hospitals or other healthcare facilities |
| **ExpresseI consent**  | The type of permission that is inferred when a patient voluntarily submits to treatment |
| **Informed consent** | The spoken or written permission granted by a patient to a healthcare provider that allows the provider to perform medical or surgical services |
| **Notice of privacy acknowledgement** | Healthcare providers must provide the patient an explanation as to how the healthcare provider will use or disclose the patient’s PHI, as well as how the healthcare provider will safeguard the PHI in its possession, as well as what rights can be exercised by the patient. |
| **Consent to Treat/Notice o prvacy practice acknowledgemetn** | The patient has given the physician or other healthcare provider permission to touch him or her. |
| **Authorization** | Required under the Privacy Rule for the use and disclosure of protected health information. Provides the healthcare provider the authority to use or disclose patient protected health information for a specific purpose. |
| **Property and Valuables list** | Patients acknowledge that the healthcare provider is not responsible for any loss or damage of the patient’s belongings, |
|  **Informed consent** | A legal term referring to a patient’s right to make his or her own treatment decisions based on the knowledge of the treatment to be administered or the procedure to be performed |

3. Identify the acute-care record component where the following information would be found.

a. I hereby acknowledge that Dr. Anyone has provided information about the procedure described above, about my rights as a patient, and he or she answered all questions to my satisfaction. Dr. Anyone has explained the risks and benefits of this procedure to me.

Informed consent

b. Patient name, date of birth, patient gender, next of kin information

Patient registration information

c. You authorize your physician or other qualified medical providers to perform medical treatment and services on your behalf.

 Consent to treat

d. I understand that I have a right to restrict the manner in which my protected health information is used and disclosed to carry out treatment, payment, or healthcare operations.

 Notice of Privacy Practices.

e. A patient states that he has experienced difficulty swallowing for the last two weeks.

 Medical history - Chief complaint

f. Neck: supple. Carotid pulses 2/7. Slight Jugular venous distention is noted.

 Physical examination – Review of systems

g. 6-2-2014 Admit via internal medicine. Urinalysis, Cardiac diet.

 Physician orders – Diagnostic/therapeutic

h. I have recommended to Mr. Patient that we proceed with CT scan of head to rule out bleed. Thank you for allowing me to participate in Mr. Patient’s care today.

 Care Plan

i. Time: 0120 Temperature 36, Pulse 144, Respiration 46

 Vital signs

j. PT: 17.6 H, INR: 1.9, PTT: 32.0

 H=High

 Diagnostic laboratory reports

j. Exam Date: 12/8/15

Check in# 15

Exam# 42589

PA and Lateral Chest: 12/8/15

Findings: The lungs are clear

Diagnostic radiology report

k. Date: 6/8/15

Surgeon: Dr. Anyone

Assistant: None

Anesthetic: Spinal

Complications: None

Operation: Right Carotid Endarterectomy

Surgical Procedure Report

l. Disposition: No lifting greater than 15 lbs. No driving for 6 weeks.

Final Diagnosis: Coronary Artery Disease

Discharge instructions

m. Activity: Up in chair 0700 6/19/15

Hygiene: Shower

Nutrition: 2/3 eaten

IV Pump: D/C

Progress note

n. 38 weeks gestation, Apgar’s 8/9, 6# 9.8 oz. good cry, to room with mom

 Newborn initial examination record

1. Compare and contrast the health records for the various healthcare settings.

Health records all contain the same basic information identifying the patient. Depending on the facility, other information is added to the record. Emergnecy departments add data referring to patient presentation (time and means of transport). Physician office records contain data that it more thorough an includes the patient’s medical history, family medical history and social history. Rehabilitation facilities EHR contains assessments reports, reports from outside physicians, therapeutic progress, goals and follow-up.

**Review Quiz**

*Instructions:* For each item, complete the statement correctly or choose the most appropriate answer.

1. Which of the following creates a chronological report of the patient’s condition and response to treatment during a hospital stay?

a. Physical examination

b. Progress notes

c. Physician order

d. Medical history

2. Which health record format is most commonly used by healthcare settings as they transition to electronic records?

 a. Integrated records

 b. Problem-oriented records

 c. Hybrid records

 d. Paper records

3. What is the end result of a review process that shows voluntary compliance with guidelines of an external, non-profit organization?

 a. Accreditation

 b. Certification

 c. Licensure

 d. Deemed status

4. Which part of a medical history documents the nature and duration of the symptoms that caused a patient to seek medical attention as stated in that patient’s own words?

a. Chief complaint

b. Social and personal history

c. Past medical history

d. Present illness

5. Which of the following is an example of administrative information?

 a. Admitting diagnosis

 b. Blood pressure records

 c. Medication records

 d. Patient’s address

6. The federal Conditions of Participation apply to which type of healthcare organization?

 a. Organizations that are accredited

 b. Organizations that provide acute care services

 c. Organizations that treat Medicare or Medicaid patients

 d. Organizations that are subject to the Health Insurance Portability and Accountability Act

7. Which of the following materials is documented in an emergency care record?

 a. Minimum Data Set

 b. Time and means of the patient’s arrival

 c. Patient’s complete medical history

 d. APGAR

8. Which of the following statements is true of the process that should be followed in making corrections in paper-based health record entries?

 a. Addendum should be backdated

 b. The reason for the change should be noted

 c. The incorrect information should be obliterated

 d. The phrase late entry should be noted on the entry

9. Which of the following types of facilities is generally governed by long-term care documentation standards?

 a. Rehabilitation

 b. Subacute care

 c. Behavioral health

 d. Ambulatory surgical center

10. Which of the following includes names of the surgeon and assistants, date, duration, and description of the procedure and any specimens removed?

 a. Operative report

 b. Anesthesia report

 c. Pathology report

 d. Laboratory report

11. Which of the following is a function of the discharge summary?

 a. Providing information about the patient’s insurance coverage

 b. Ensuring the other healthcare providers know what to do next while the patient is hospitalized

 c. Providing information to support the activities of the medical staff review committee

 d. Documenting the patient’s health history in detail

12. A patient’s registration forms, personal property list, RAI/MDS and care plan and discharge or transfer documentation would be found most frequently in which type of health record?

a. Rehabilitative care

b. Ambulatory care

c. Behavioral health

d. Long-term care

13. Which group focuses on accreditation of rehabilitation programs and services?

a. HFAP

b. Joint Commission

c. AAAHC

d. CARF

14. Results of a urinalysis and all blood tests performed would be found in what part of a healthcare record?

 a. Autopsy report

 b. Laboratory findings

 c. Pathology report

 d. Surgical report

15. Which of the following is clinical data?

 a. Patient consent

 b. Physician orders

 c. Patient registration

 d. Name of insurance company

16. A healthcare provider organization, when defining its legal health record must \_\_\_\_\_\_\_\_\_\_\_.

a. Assess the legal environment, system limitations, and HIE agreements

b. Determine what other healthcare provider organizations are doing

c. Determine if a legal health record is needed

d. Only include the paper components of the health record

17. Documentation standards have become more detailed and have become focused on \_\_\_\_\_\_\_\_.

 a. EHR technology

 b. Licensure requirements

 c. Patient care quality

 d. Accreditation standards

 18 Written or spoken permission to proceed with care is classified as \_\_\_\_\_\_\_\_\_\_\_.

a. Expressed consent

b. Acknowledgment

c. Advance directive

d. Implied consent

19. The Joint Commission places emphasis on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Appropriate and standardized health record documentation

b. Electronic health record technologies used to support documentation

c. Clinical and operational practices related to the health record

d. Statutes at both the federal and state level

20. Which of the following electronic record technological capabilities would allow a paper-based x-ray report to be accessed?

a. Database management

b. Documents imaging

c. Text processing

d. Vocabulary standards

21. The Subjective, Objective, Assessment Plan (SOAP) came from the:

a. Source-oriented health record

b. Problem-oriented health record

c. Hybrid health record

d. Depends on facility policy

22. The overall goal of documentation standards is to \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Ensure physicians have access to the health record information they need to care for the patient

b. Ensure that the healthcare provider organization is reimbursed appropriately by payers

c. Ensure that the Centers for Medicare and Medicaid Services (CMS) do not find reason to fine the healthcare provider organization

d. Ensure what is documented in the health record is complete and accurately reflects the treatment provided to the patient

23. What standard does a hospital that participates in the Medicare and Medicaid programs have to comply with that hospitals who do not accept Medicare and Medicaid patients do not?

a. Medical bylaws of the healthcare provider organization

b. Conditions of Participation

c. Accreditation organization

d. Documentation standard

24. Which of the following is an example of an acknowledgement?

a. General consent to treat document

b. Notice of privacy practices

c. Consultation report

d. Patient instructions document

25. The management of health information is a fundamental component of which of the following?

a. The overall information governance model

b. The EHR workflows

c. The documentation standards

d. Cloud Computing