**Chapter 4**

**Health Record Content and Documentation**

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**Real-World Case 4.1**

When Anywhere Hospital began developing its EHR the EHR task force set out to develop an EHR that will serve as the organization’s legal health record. The unofficial goal of the EHR task force was to compile all available health information into a single system and provide the means to deliver the needed administrative and clinical data instantaneously to end users when needed. Large volume of information, overcrowded computer screens, and lack of uniform structure soon proved overwhelming for the system’s end users. Their feedback called for useful and needed health record information formatted in a usable structure.

In response to end-user frustration, the EHR task force took a hard look at the captured information and how that information was then presented to the end user. The task force considered the following questions:

● How is the health information captured, formatted, and structured into one system when pulling from many sources?

● How long is health information retained?

● What information is purged from the system and when is it purged?

● What health information is archived? Is there any information needed to be kept permanently?

● How much control should end users have over the information they are allowed to access?

# Real-World Case Discussion Questions

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

 To compile all available health information into a single system and provide the means to deliver the needed administrative and clinical data instantaneously when needed.

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

 The users of the EHR are the Physicians, nurses ,;insurance agencies, lawyers etc.

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

#  The legal health records can be paper-based, Hybrid or Electronic and can be applied by HIM professionals or the task force

**Real-World Case 4.2**

As an HIM professional within Anywhere Hospital’s HIM department, you have been asked to review physician documentation within the hospital’s new EHR system, implemented six months ago. Your goal of the review is to catch any documentation issues early and work with the appropriate hospital leadership to fix those issues.

As you review the documentation within your facility’s EHR, you notice that physicians are utilizing the copy and paste functionality available within the EHR system, allowing physicians to select health record documentation from one source or from one section of the EHR and replicate it in another source or another section of the record. You notice in one particular instance that the health record identifies a patient as a 65-year-old male (as identified during the registration process) but in the progress notes is described as a 25-year-old female who has given birth. Clearly, the physician utilized the copy and paste functionality inappropriately and copied health record information from a health record of a patient who was a 25-year-old female and pasted that information accidentally into a health record of a 65-year-old male.

You find this concerning because this could have patient safety concerns, as well as billing and claims issues and the use of this functionality could open the facility up to potential claims of fraud and abuse by the payer. You take this concern to your leadership and a multidisciplined group of hospital employees including HIM professionals, nurses, physicians, and billing and revenue cycle employees to discuss and fix the problem. There are mixed opinions about the copy and paste functionality. Some individuals feel this feature is a time-saver and a productivity booster while others believe it only opens the hospital up to additional CMS scrutiny.

As the HIM professional, you present the following questions to the group for consideration:

● What, if any, are the regulatory requirements or prohibitions to using such a feature within an EHR?

● Does the design of the facility’s EHR promote or detract from health record documentation quality and integrity?

● Are there any alternatives to this feature that will assist with documentation efficiency?

● How would the facility set forth organizational documentation standards related to this feature?

# Real-World Case Discussion Questions

1. What should be considered when deciding whether or not to use the copy and paste functionality? No two documentation of patients can be opened at the same time, or simultaneously. Goals and objectives need to be well thought out, put in writing n, and be measurable Workflow analysis, investigate any interface issues.

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

The copy and paste function should be taken out of the computers or the function should be cancelled. Determine the roles of the end use what the end use can do with it i.e. read only, edit, delete, etc. The end user drives what controls are in place in terms of what health record r other data can be accessed and y

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

# Functionality that will prompt the user that copy and paste has an error so the user should go back and read over his/her notes for correction. Macros or smart text.

# 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 | **Joint Commission, ~~AOA,~~ Medicare** |
| Ambulatory care or physician office settings | **~~NCQA~~, Medicare, AAAHC~~, AOA~~, Joint Commission** |
| Ambulatory surgery facilities | **~~AOA,~~ Joint Commission, Medicare, AAASF** |
| Long-term care facilities | **CARF, Joint Commission, Medicare** |
| Behavioral healthcare facilities | **~~AOA~~, CARF, joint Commission, Medicare** |
| Obstetric or gynecologic care settings | **American College of Obstetrics and Gynecology** |
| Rehabilitation services organizations | **~~AOA,~~ CARF, Joint Commission, Medicare** |

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

|  |  |
| --- | --- |
| **Consent Type**  | **Consent Document Language** |
| **Informed** **Consent****Patient rights**  | The protections afforded to individuals who are undergoing medical proceduresin hospitals or other healthcare facilities |
| **Implied****Consent** | The type of permission that is inferred when a patient voluntarily submits totreatment |
| **Expressed****Consent** | The spoken or written permission granted by a patient to a healthcare providerthat allows the provider to perform medical or surgical services |
| **Authoriza-****Tion Notice of Privacy** | 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. |
| **General Consent to** **Treatment** | The patient has given the physician or other healthcare provider permission to touch him or her. |
| **Notice of** **Privacy****Practice****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. –Ambulatory Surgery Record~~ **Informed Consent**

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

c. You authorize your physician or other qualified medical providers to perform medical treatment and services on your behalf. - ~~Consents records~~ General 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. ~~Anmbulatory Record~~ Notice of Privacy

e. A patient states that he has experienced difficulty swallowing for the last two weeks. – ~~Physician Office~~ Record Medical history

f. Neck: supple. Carotid pulses 2/7. Slight Jugular venous distention is noted. – ~~Ambulatory record~~ Physical Exam

g. 6-2-2014 Admit via internal medicine. Urinalysis, Cardiac diet. – Patient ~~Instruction and transfer Record~~ Physician Order

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. Consultation

i. Time: 0120 Temperature 36, Pulse 144, Respiration 46 – ~~Physician Office Reord~~ Vital Signs

j. PT: 17.6 H, INR: 1.9, PTT: 32.0 - ~~Patient Health Record~~ Laboratory report

 H=High

j. Exam Date: 12/8/15

Check in# 15

Exam# 42589 - ~~Physician office Record~~ Diagnostic report

PA and Lateral Chest: 12/8/15

Findings: The lungs are clear

k. Date: 6/8/15

Surgeon: Dr. Anyone

Assistant: None

Anesthetic: Spinal - ~~Ambulatory Surgery~~

Record Operative report

Complications: None

Operation: Right Carotid Endarterectomy

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

Final Diagnosis: Coronary Artery Disease - ~~Emergency Department Record~~

Discharge summary

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

Hygiene: Shower

Nutrition: 2/3 eaten - Ancillary – ~~Patient Health Record~~ Progress note

IV Pump: D/C

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

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

Health records:- Emergency Department Record, Ancillary departments , Ambulatory Surgery Record,

Ambulatory Record,, physician office record, rehabilitation record , long term care and behavioral records.

Healthcare settings are Acute Care, Long term care, behavioral, physician clinics, home health care, Hospice, etc.

In both Long term care and Rehabilitation, the patient identification data is needed in the records..

In all of the healthcare settings, registration is needed.

In all of the settings only Emergency Department Record wouild need the means of arrival.

**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