**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? The role of the task force is to develop an EHR which will serve as the organization’s legal health record by compiling all available health information into one system for instantaneous delivery to clinical and administrative users. The task force needs to do a systems review and determine best practices for ideal results.

2. Who are the users of the EHR? What do these users need to be able to do in the EHR? The users are clinical providers and people working in an administrative capacity. Clinical providers need to be able to access relevant health information as well as enter health information. Administrative users need to access health information for records request, and verify patient information, and make changes to demographic info as needed.

3. How does the legal health record apply to the EHR? The legal health record is the health record that is assembled and presented on request. It must be ascertained that the EHR and the paper record do not have any discrepancies. It also must be determined what elements of the EHR are to be included in the legal health record. Like a paper record, it must be determined if the record is authorized to be released to the requesting party and if the record would be held admissible in court.

**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? An audit should be done of records accuracy in relation to copying and pasting. The above-referenced error is an egregious one, but there be other slight errors not overtly obvious without an in-depth audit. The audit or tracking can also be performed on current, on-going entries. Determining the error rate associated with copying and pasting would be integral to determining whether it should continue to be used.

2. What controls might be put in place related to the copy and paste functionality? If the function is in use, perhaps there is a way for the system to limit the copy and paste function so that it would only work within a single patient record. Another suggestion might be for the author of the copy and paste to have a date and time stamp with name entered every time the copy and paste is done. This information should be available behind the scenes, but perhaps it would help users to feel more accountable.

3. What alternatives to the copy and paste functionality are available? It could be forbidden outright and there could be a requirement to type original text. Utilizing drop-down menus could be a time saver, or autofill, or perhaps there could be an option to import information over from another segment of the electronic health record, as long as it is the patient number is the same.

**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, Medicare, ~~American Osteopathic Association~~ |
| Ambulatory care or physician office settings | Joint Commission, ~~American Osteopathic Association,~~ Accreditation Association for Ambulatory Health Care MEDICARE |
| Ambulatory surgery facilities | Joint Commission, ~~American Osteopathic Association, Accreditation Association for Ambulatory Health Care~~ CARF; MEDICARE |
| Long-term care facilities | Joint Commission, Medicare CARF |
| Behavioral healthcare facilities |  CARFJoint Commission, Medicare, ~~American Osteopathic Association~~, ~~Commission on Accreditation of Rehabilitation Facilities~~ |
| Obstetric or gynecologic care settings | American Congress of Obstetricians and Gynecologists |
| Rehabilitation services organizations | Joint Commission, Medicare, Commission on Accreditation of Rehabilitation Facilities |

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

|  |  |
| --- | --- |
| **Consent Type** | **Consent Document Language** |
| 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 |
| Notice of Privacy Practices | 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 | 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. |
| Properties 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. Consents, ~~authorizations, and acknowledgements~~

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

c. You authorize your physician or other qualified medical providers to perform medical treatment and services on your behalf. Consents, ~~authorizations, and acknowledgements~~

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

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

g. 6-2-2014 Admit via internal medicine. Urinalysis, Cardiac diet. Physician’s orders

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 reports

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

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

 H=High

 Laboratory Results

j. Exam Date: 12/8/15

Check in# 15

Exam# 42589

PA and Lateral Chest: 12/8/15

Findings: The lungs are clear

Reports of diagnostic and therapeutic procedures

k. Date: 6/8/15

Surgeon: Dr. Anyone

Assistant: None

Anesthetic: Spinal

Complications: None

Operation: Right Carotid Endarterectomy

Operative Report

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

Final Diagnosis: Coronary Artery Disease

~~Patient Instructions~~ DISCHARGE SUMMARY

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

Hygiene: Shower

Nutrition: 2/3 eaten

IV Pump: D/C

Progress Notes

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

 Newborn Record

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

 Hospital settings document comprehensive information about the patient during their stay, including patient history. Daily notes, procedures, and lab results are all tracked, as well as all consultations. Long-term care settings have similar records, often hybrid systems like hospitals, but they must include MDS information as required by CMS.

Ambulatory care settings keep information on patient visits, and different information is kept depending on the specialty. They may also have electronic or access by fax to records for other specialties for the patient.

**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 anddischarge 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