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HIT I – MCO 110 51 N

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**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 EHR task force is to develop an electronic health record that will serve as the organization’s legal health record. The 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. The task force may utilize documentation standards, security and privacy policies and procedures and feedback from the end-users to create a structured documentation system under a user-friendly platform that ensures continued quality patient care.

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

As discussed in chapter 3 of the textbook, the primary purposes of the health record are related to providing care to the patient. The electronic health record is a digital record of an individual’s health information that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization. Some of the EHR users may include:

* Patient care providers: Patient care providers include physicians, nurses, and other allied health professionals who rely on information from the health record in order to make decisions about the care provided to the patient and for documentation of care.
* Patient care managers and support staff: As care is documented in the health record, it becomes a key resource in their evaluation of the quality of care provided. The managers use the EHR to look for patterns and trends to recommend changes to the process to improve outcomes and efficiency of the care provided.
* Coding and billing staff: Documentation in the health record is the basis for reimbursement or payment for the care provided. The coding staff must read the EHR and assign the appropriate diagnosis and procedure codes. The billing staff obtains the codes from the coders and submits the bill to insurance.
* Government policy makers: The health record may be used to develop and evaluate current and future laws, regulations, and standards related to healthcare.
* Healthcare delivery organizations: Healthcare delivery organizations include hospitals, physician’s offices, and home health agencies use the electronic health record to provide care, submit claims for reimbursement, evaluate the quality of care provided.
* Accreditation organizations: Accreditation organizations frequently require review of the health record to determine compliance with documentation and patient care standards.

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

# Each healthcare organization must define what its legal health record contains. The role of the legal health record includes documentation to support decisions made in the course of treating a patient, support documentation for the revenue pursued by payers, as well as documentation used for legal testimony related to the patient’s disease process, injury, treatment, decisions related to the treatment, and the patient’s response to treatment. The legal health record for the EHR would typically include the same documents as a paper-health record; however, the issue with the EHR is what to do with records from a different healthcare provider or organization when those records are included in the patient’s electronic health record. In order for the EHR to be a legal health record and meet the requirements as such there are several concepts that need to be considered, including how documentation is actually created and signed off on by the healthcare providers; how the documentation is managed and preserved; how the documentation impacts and interacts with the revenue cycle functions of billing and claims submission; and how the documentation is displayed both electronically to the user as well as in hard copy form, should the data be printed.

**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 multi-disciplined 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?**

 The first and most important consideration should be: what is the legality surrounding the copy and paste function and what risk does it pose to the organization? With the understanding of time-saving capabilities by utilizing the copy and paste function, can the group discuss other alternatives to help save time with documentation. The decision needs to include multi-disciplinary input from all users of the EHR, but specifically the users who provide patient care and are most apt to utilize copy and paste.

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

Organizations policies and procedures should be created once documentation decisions are made regarding utilizing copy and paste. If the organization allows providers to continue using the function, chart audits could be utilized to review the documentation for copy and pasted information that may be inaccurate, outdated, redundant, false, or inconsistent. Also, the amount of free-text in the EHR should be limited to reduce the amount of manipulated data.

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

# Templates are one alternative to copy and pasting in the EHR. A template is a pattern used to capture data in a structured manner and specify the information to be collected. It helps the provider ensure key information is not forgotten and the data is captured in a specific order and format. Some of the other functions of the EHR that would help save time in documentation and maybe limit the free-text or need to copy and paste include: using selection boxes to allow the user to select a value from a predefined list, drop downs, and minimizing clicks or keystrokes.

# 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, DNV GL Healthcare** |
| Ambulatory care or physician office settings | **Joint Commission** |
| Ambulatory surgery facilities | **AAAHC, AAAASF, HFAP, Joint Commission** |
| Long-term care facilities | **Joint Commission, CARF** |
| Behavioral healthcare facilities | **Joint Commission, CARF** |
| Obstetric or gynecologic care settings | **Commission for the Accreditation of Birth Centers** |
| Rehabilitation services organizations | **CARF, AOA, Joint Commission** |

**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. |
| **Consent to treatment** | 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. Consents

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. Consents

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. Authorizations

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

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

 Physical Exam

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

 Physician 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 report

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

Vital signs in the physical exam

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

 H=High

j. Exam Date: 12/8/15 Radiology report

Check in# 15

Exam# 42589

PA and Lateral Chest: 12/8/15

Findings: The lungs are clear

k. Date: 6/8/15 Operative report

Surgeon: Dr. Anyone

Assistant: None

Anesthetic: Spinal

Complications: None

Operation: Right Carotid Endarterectomy

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

Final Diagnosis: Coronary Artery Disease Discharge summary

m. Activity: Up in chair 0700 6/19/15 Long-term care or progress notes

Hygiene: Shower

Nutrition: 2/3 eaten

IV Pump: D/C

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.**

* + **Medical and Surgical**: The medical and surgical health record is found in a variety of settings including inpatient care units, long-term care facilities, home health, surgical centers, and ambulatory care units. The medical and surgical health record contains documentation originating from physicians, nurses, diagnostic procedures, dietary, pharmacy, and social services. The categories of information found in the medical and surgical record include clinical data, medical history and physical, diagnostic and therapeutic orders and reports, progress notes, operative notes when applicable, consultation reports, discharge summary or transfer record, administrative data, registration information, consents, authorizations, and acknowledgments.
	+ **Obstetric:** Obstetric and gynecological health records are specialized services that require specific kinds of information in addition to other ambulatory care documents. This information includes: medical history to include history of abuse or neglect and sexual practices; Periodic laboratory testing, including Pap tests and mammography, cholesterol levels, and fecal blood tests; Additional laboratory testing needed for high-risk groups such as tuberculosis skin testing and testing for sexually transmitted diseases.
	+ **Newborn:** Within the hospital and acute-care setting, a newborn’s health record documentation is handled separately from the mother’s health record information. The newborn’s health record will contain an examination performed upon birth and an examination performed prior to discharge. Immediately after birth, the baby’s physical condition is evaluated which determines the baby’s APGAR score. APGAR stands for appearance and skin color, pulse and heart rate, grimace response and reflexes, activity and muscle tone, and respiratory and breathing rate. Each element is a score from 0 to 10, 10 being the best possible score. The newborn health record will also contain physician’s orders, nursing notes, and progress notes, the same as what is found within an adult health record.
	+ **Emergency Department:** The emergency department record is a health record generated when a patient visits an emergency department seeking treatment. Any patient who presents to an ED must be examined in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA) to determine if an emergency condition exists. EMTALA prohibits healthcare providers from refusing to treat patients or delaying treatment due to the patient not having insurance or inability to pay. The emergency department record must reflect certain elements in compliance with regulations governing emergency treatment. The ED record is sometimes incorporated within the inpatient health record and sometimes it is kept separately. The ED record has some similar elements to an ambulatory record, but also has specialized documentation elements which should include:
		- Patient demographics
		- Arrival time
		- Means of arrival (ambulance, car, private, etc)
		- Name of the person bringing the patient to the ED
		- Pertinent history of illness
		- Physical findings
		- Diagnostic tests
		- Treatment provided
		- Disposition of patient (whether the patient was admitted, transferred, or discharged)
		- Condition of patient upon discharge
		- Patient discharge instructions
		- Signatures of patient
	+ **Ambulatory:** Patients receiving ambulatory care are seen on an outpatient basis and do not require admission to the hospital. The ambulatory record is very similar to an inpatient hospital health record. Documentation in ambulatory care patient records typically include:
		- Registration forms including patient identification data
		- Problem lists
		- Medication lists
		- Patient history questionnaires
		- History and physicals
		- Progress notes
		- Results of consultations
		- Diagnostic test results
		- Miscellaneous flow sheets
		- Copies of records from other healthcare facilities
		- Correspondence
		- Consents to disclose information
		- Advance directives

Ambulatory care records include several elements unique to the ambulatory care setting, such as the problem list which describes any significant current and past illnesses and conditions as well as the procedures that patient has undergone. The problem list may include information on the patient’s previous surgeries, allergies, and drug sensitivities.

* + **Ambulatory Surgery:** Patients who have surgery in an ambulatory surgery center must still have a history and physical prior to surgery present within the health record, the same as patients having surgery in a hospital setting. The patient must also have signed the appropriate consent documentation prior to the procedure. Much like an inpatient health record containing a surgery component, an ambulatory surgery record must contain operative reports, diagnostic and therapeutic notes, consultations, and discharge notes at the conclusion of treatment. Ambulatory surgery centers also perform discharge follow-up phone calls, where a nurse will call the patient within 24 to 48 hours after discharge to check on the patient, assessing pain levels, and addressing any immediate or future needs the patient has or will have related to the treatment. This conversation must be documented in the health record.
	+ **Ancillary Departments:** Ancillary departments are considered departments that provide treatment and services that support the patient’s overall care plan. These services assist the physician with diagnosing and treating the patient. Ancillary departments also consist of departments that play an indirect role in patient care, these include pharmacy, nutrition, HIM, social services, and patient advocacy and relations. Many ancillary departmental services must be documented within the patient health record.
	+ **Physician Office:** Routine healthcare treatment commonly occurs within the physician office setting. In many instances, hospital-based records can be included within the physician office record if the hospital and physician office records are electronic and information can be exchanged from one system to another. The physician office record can be paper-based, electronic-based, or hybrid. The physician office record has similar documentation elements as ambulatory and inpatient care settings; the content of the physician office record consists of:
		- Medical history
		- Family history
		- Social history
		- Vital signs
		- Chief complaint
		- Progress notes
		- Allergies
		- Medication list
		- History of present illness
		- Review of systems
		- Assessment and diagnosis
		- Plan of treatment
	+ **Long-Term Care:** Long-term care is provided in a variety of facilities, including: skilled nursing facilities or units, subacute-care facilities, nursing facilities, and assisted-living facilities. Most SNFs and NFs are governed by both federal and state regulations. Assisted-living facilities are usually governed only by state regulations. The stay for a patient or resident in long-term care settings can be lengthy, health records are based on ongoing assessments and reassessments of the patient’s needs. An interdisciplinary team including the patient’s physician, nursing, nutritional services, social services, and physical therapy, develop a plan of care for each patient upon admission to the facility and the plan is updated regularly over the patient’s stay. The care plan format is called the resident assessment instrument (RAI) which is based on the Minimum Data Set (MDS) for Long-Term Care. The RAI is a critical component of the health record. In addition to development of the care plan, Medicare uses the form to determine reimbursement. The physician’s role is not as involved as in other care settings. The physician develops a plan of treatment and visits the resident in the facility on a 30- or 60-day schedule unless the resident’s condition requires more frequent visits. The physician reviews the plan of care and physician’s orders and makes changes as necessary. The following list identifies the most common components of long-term care records:
		- Registration forms including resident identification data
		- Personal property list, including furniture and electronics
		- History and physical and hospital records
		- Advance directives, bill of rights, and other legal records
		- Clinical assessments
		- RAI and care plan
		- Physician’s orders
		- Physician’s progress notes and consultations
		- Nursing notes
		- Rehabilitation therapy notes
		- Social services, nutritional services, and activities documentation
		- Medication and records or monitors, including administration of restraints
		- Laboratory, radiology, and special reports
		- Discharge or transfer documentation
	+ **Rehabilitation:** The documentation requirements for rehabilitation facilities vary because facilities range from comprehensive inpatient care to outpatient services or special programs. Inpatient rehabilitation hospitals and units within hospitals are reimbursed by Medicare under a prospective payment system. A patient assessment instrument (PAI) is completed shortly after admission and upon discharge. Based on the patient’s condition, services, diagnosis, and medical condition, a payment level is determined for the inpatient rehabilitation stay. The Commission on Accreditation of Rehabilitation Facilities (CARF) requires a facility to maintain a single case record for any patient admitted. The documentation standard for the health record includes the following:
		- Patient identification data
		- Pertinent history, including functional history
		- Diagnosis of disability and functional diagnosis
		- Rehabilitation problems, goals, and prognosis
		- Reports of assessment and program plans
		- Reports from referring services and service referrals
		- Reports from outside consultations and laboratory, radiology, orthotic, and prosthetic services
		- Designation of a manager for the patient’s program
		- Evidence of the patient’s or family’s participation in decision making
		- Evaluation reports from each service
		- Reports of staff conferences
		- Progress reports
		- Correspondence related to the patient
		- Release forms
		- Discharge summary
		- Follow-up reports
	+ **Behavioral Health:** Behavioral health records are more commonly referred to as mental health records and contain much of the same content as a non-behavioral health record such as history and physical, discharge summary, or physician’s orders. Behavioral health records contain a treatment plan that often includes family and caregiver input and information as well as assessments geared toward the transition to outpatient, non-acute treatment. CMS requires that social workers assess and document the family or home environment and community services that are compatible with the patient’s needs. The behavioral health record also contains a psychiatric evaluation that consists of a patient history, current mental status, and cognitive function.

**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