CHAPTER 5

Healthcare Records
Pretest (True/False)

• The primary source of a patient’s medical history is the patient or a relative.
• Consent to treatment and informed consent are the same thing.
• The store-and-forward method of telemedicine makes scheduling difficult if the involved parties live in different time zones.
• The average length of stay (ALOS) in a particular hospital is an example of aggregate data.
• If a patient reviews her health record and wishes to make a correction, the original entry should be changed to reflect the correction.
Terms

- **Patient health record** has replaced **patient medical record** because it encompasses holistic view of patient care.
- **Acute care patient record** usually concerned with one stay or episode.
- **Outpatient medical record** usually limited to one group or clinic.
- **Data** means both computer information and information in health record.
Functions of Healthcare Record

• Serves as principal communication document among various providers who might care for patient at different times in different departments

• Provides basis for all billing and reimbursement

• Serves as legal document; relevant portions may become evidence in court of law
Functions of Healthcare Record (continued)

- Provides basis for improvements in healthcare delivery
- Provide information to public health departments, Homeland Security, law enforcement officials
- Provide information for research, drug testing, trends, treatments
Primary Records

- Gathered directly from patients and their providers and from devices and diagnostic tests
- Used for patient care and as legal documents
  - Examples: admission and discharge reports, nursing notes, physician examinations and notes, orders, test results, operative reports, pathology and radiology reports, administrative and demographic forms
Secondary Records

• Created after patient care by the analysis, summarization, or abstraction of information from primary records

• Used for reimbursement or insurance claims, research, government agencies, quality improvement
  – Examples: health insurance claims, master patient index (MPI), aggregate data ALOS reports
Health Record Contents

- Demographics
- Legal Documents
- Clinical Documents
- Public Health Records
- Plan of Care Document
Demographic Data

- Collected from patients upon initial registration
- Includes name, address, phone numbers, next of kin, emergency contact information
- Called **face sheet** in paper-based system
- Scanned or input from face sheet into electronic system, if used
Legal Documents

- HIPAA consent to use and disclose PHI
- Consent to treatment
- Medicare patient rights statement
- Assignment of benefits
- Informed consent
- Refusal of treatment
Legal Documents (continued)

- Advance directive (living will)
- Organ donor
- Personal property list
- Disclosure record
## Clinical Data

- Medical history
- Physical exam
  - Often called SOAP note (*on next slide*)
- Diagnostic and therapeutic orders and reports
- Diagnostic images
- Operative records
- Nursing notes
- Referral consults
- Case management
- Discharge summary
- Obstetrical records
- Pediatric records
- Problem list
- Medication list
SOAP Stands For:

- **Subjective**
  - Patient’s description of symptoms and chief complaint
- **Objective**
  - Findings of physical exam and diagnostic tests
- **Assessment**
  - Physician’s diagnosis
- **Plan**
  - Physician’s orders and plan of care for treatment
Other Health Record Contents

- Public Health Records
  - Birth – examination notes, measures of child’s size and condition, and document recording birth
  - Death – date and time, discharge summary, and autopsy (if needed)
  - Disease

- Plan of Care Document
  - Used in long-term facilities and home care agencies
Document Standards

- Data elements
- Data sets
- Policies and procedures
Document Standards: Data Elements

- Define specific units of information that may consist of several fields
- Used for both paper and electronic records
- Improve interoperability
- Provide common elements for system-wide reports
- Defined by NCVHS (National Committee on Vital Health Statistics)
<table>
<thead>
<tr>
<th>Core Data Elements Recommended by NCVHS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personal/unique identifier</td>
<td>21. Attending physician identification (inpatient)</td>
</tr>
<tr>
<td>2. Data of birth</td>
<td>22. Operating clinician identification</td>
</tr>
<tr>
<td>3. Gender</td>
<td>23. Health-care practitioner specialty</td>
</tr>
<tr>
<td>5. Residence</td>
<td>25. Primary diagnosis (inpatient)</td>
</tr>
<tr>
<td>6. Marital status</td>
<td>26. Other diagnosis (inpatient)</td>
</tr>
<tr>
<td>7. Living/residential arrangement</td>
<td>27. Qualifier for other diagnosis (inpatient)</td>
</tr>
<tr>
<td>8. Self-reported health status</td>
<td>28. Patient’s stated reason for visit or chief complaint (outpatient)</td>
</tr>
<tr>
<td>9. Functional status</td>
<td>29. Diagnosis chiefly responsible for services provided (outpatient)</td>
</tr>
<tr>
<td>10. Years of schooling</td>
<td>30. Other diagnosis (outpatient)</td>
</tr>
<tr>
<td>12. Current or most recent occupation and industry</td>
<td>32. Birth weight of newborn</td>
</tr>
<tr>
<td>13. Type of encounter</td>
<td>33. Principle procedure (inpatient)</td>
</tr>
<tr>
<td>14. Admission date (inpatient)</td>
<td>34. Other procedures (inpatient)</td>
</tr>
<tr>
<td>15. Discharge date (inpatient)</td>
<td>35. Dates of procedures (inpatient)</td>
</tr>
<tr>
<td>16. Date of encounter (outpatient and physician service)</td>
<td>36. Procedures and services (outpatient)</td>
</tr>
<tr>
<td>17. Facility identification</td>
<td>37. Medications prescribed</td>
</tr>
<tr>
<td>18. Type of facility/place of encounter</td>
<td>38. Disposition of patient (inpatient)</td>
</tr>
<tr>
<td>19. Health-care practitioner identification (outpatient)</td>
<td>39. Disposition (outpatient)</td>
</tr>
<tr>
<td>20. Provider location or address of encounter (outpatient)</td>
<td>40. Patient’s expected sources of payment</td>
</tr>
<tr>
<td></td>
<td>41. Injury related to employment</td>
</tr>
<tr>
<td></td>
<td>42. Total billed charges</td>
</tr>
</tbody>
</table>

**Figure 5-8** Core data elements recommended by NCVHS
• Collection of data elements determined to be minimum necessary for particular purpose
• Usually represent minimum list of data elements that must be collected (standard healthcare data sets)
<table>
<thead>
<tr>
<th>UACDS</th>
<th>UHDDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniform Ambulatory Care Data Set</td>
<td>Uniform Hospital Discharge Data Set</td>
</tr>
<tr>
<td>Patient identification</td>
<td>Patient identification</td>
</tr>
<tr>
<td>Residence</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Sex</td>
</tr>
<tr>
<td>Sex</td>
<td>Race and ethnic background</td>
</tr>
<tr>
<td>Race and ethnic background</td>
<td>Residence</td>
</tr>
<tr>
<td>Living arrangement and marital status</td>
<td>Health care facility identification number</td>
</tr>
<tr>
<td>Provider identification</td>
<td>Admission Date</td>
</tr>
<tr>
<td>Provider Location or address</td>
<td>Discharge Date</td>
</tr>
<tr>
<td>Provider Profession</td>
<td>Attending Physician Identification number</td>
</tr>
<tr>
<td></td>
<td>Surgeon identification number</td>
</tr>
<tr>
<td>Date, place, and address of encounter</td>
<td></td>
</tr>
<tr>
<td>Patient’s reason for encounter</td>
<td></td>
</tr>
<tr>
<td>Problem, diagnosis, or assessment</td>
<td>Principal diagnosis</td>
</tr>
<tr>
<td></td>
<td>Other Diagnoses</td>
</tr>
<tr>
<td>Services</td>
<td>Date and Principal procedure</td>
</tr>
<tr>
<td></td>
<td>Other Procedures and dates</td>
</tr>
<tr>
<td>Disposition</td>
<td>Disposition of the patient at discharge</td>
</tr>
<tr>
<td>Expected sources of payment</td>
<td>Expected sources of payment</td>
</tr>
<tr>
<td></td>
<td>Total charges</td>
</tr>
</tbody>
</table>

**Figure 5-9** Comparison of elements in ambulatory care and hospital charge data sets.
Healthcare Data Set Examples

- Uniform Hospital Discharge Data Set (UHDDS)
- Uniform Ambulatory Care Data Set (UACDS)
- Uniform Clinical Data Set (UCDS)
- ORYX®
- Minimum Data Set (MDS)
- Resident Assessment Instrument (RAI)
- Outcome and Assessment Information Set (OASIS)
- National Cancer Data Base (NCDB)
- Data Elements for Emergency Department Systems (DEEDS)
- Health Plan Employer Data and Information System (HEDIS)
- Uniform Ambulatory Medical Care Minimum Data Set (UAMCMDS)
Document Standards: HIM Policies and Procedures

- Establish documentation requirements for health records
- Ensure uniformity of both content and format of health record
- Include policies related to making entries or corrections in healthcare records
Patient Record Ensures Continuity of Care

- Serves as vital communication tool among various care providers who serve the patient.
- Tracks clinical data as patient moves through different departments within an inpatient facility.
- Provides longitudinal account of patient’s previous visits and test results within outpatient facility where patient is seen less frequently.
Continuity of Care: RHIO (Regional Health Information Organization)

- Regional or local version of future National Health Information Network (NHIN)
- Allows different providers to share patient records
- Encourages the exchange of a patient’s health information across medical practices and facilities that are owned by different entities for the better well-being of the patient
- “Neutral organization that adheres to a defined governance structure which is composed of and facilitates collaboration among the stakeholders in a given medical trading area, community or region through secure electronic health information exchange to advance the effective and efficient delivery of healthcare for individuals and communities” (HIMSS)
Continuity of Care: RHIO Implementation Issues

- **Technical issues** related to interfacing with multiple, unrelated healthcare systems
- **Economic issues** related to who bears cost of networking, interface programming, and maintenance of translation and Master Patient Index (MPI) systems
- **Political issues** related to information sharing with competitors
- **Ownership issues**, such as who owns the data
Continuity of Care:  
Personal Health Record (PHR)

- Allows patient to create via neutral online entities
- Allows patient access and ability to update continuously
- Provides patient control over who may access
- Integrates with other electronic systems
- Requires patient to update, which may become burdensome
Telemedicine

• Uses communication technology to deliver medical care to a patient in another location
• Examples: phone call between two doctors, videoconference, examination, and surgical procedure

Telemedicine Video

• Real-time telemedicine
  – Requires presence of all parties at same time (conference calls, or remote, robotic or guided surgery)
  – Challenges: different time zones, state laws

• Store-and-forward telemedicine
  – Allows one party to send information that is saved and then reviewed (e.g. voice mail)
  – Challenges: delays when additional info. or tests needed; response needed
Other Telemedicine Examples

- **Teleradiology**
  - Transmission of diagnostic images from one location to another, usually to have images “read” by radiologist
  - [Teleradiology Video](#)

- **Telemonitoring**
  - Transmission of information from devices that allow doctors to study multiple measurements of vital signs or tests in course of patient’s normal daily activity
  - Stores the readings and transfer the data to the doctor’s system either by using a modem and phone line or by downloading from the device during a patient encounter
  - Examples: blood pressure monitors, glucose meters, Holter monitors
    - [Telemonitoring Video](#)
Figure 5-12  An IQholter™ worn by the patient gathers cardio data. (Courtesy of Midmark Diagnostics Group.)
E-visits

- Allows the patient to be treated by a clinician for non-urgent health problems without having to come into the office
- Conducted over the Internet
- Permits secure message transmission between patient and physician
- Creates documented medical record with symptom information that becomes part of patient’s chart
- May be handled by “doctor on-call”
- May be reimbursed as legitimate visit by Blue Cross/Blue Shield plans and other private insurance carriers

E-visits Video