Guidelines For Medical Record And Clinical Documentation

The definitive reference source on the management of health records, this book provides the basic guidelines on content and structure, analysis, assessment, and improvement of information critical to every health care organization. The author has updated her well-received book beyond hospitals, incorporating the latest and most successful practices - most notably, the computerization of record operations and systems and of the record itself.

Published in conjunction with the American Health Information Management Association (AHIMA), Medical Records and the Law is the ideal text for programs in HIM as well as a valuable reference for health and legal professionals. The Fourth Edition features an expanded discussion of state laws affecting the use and disclosure of health information and the substantial changes brought about by HIPAA and the growth of electronic health record systems. It also discusses the highly complex interplay of federal and state laws as well as the challenging area of how patient information may be used in connection with medical research involving human subjects.

In the last few years, the protection of computerised medical records, and of other personal health information, has become the subject of both technical research and political dispute in a number of countries. In Britain, the issue arose initially as an argument between the British Me dical Association and the Department of Health over whether encryption should be used in a new medical network. In Germany, the focus was the issue to all patients of a smartcard to hold insurance details and facilitate payment; while in the USA, the debate has been whether federal law should preempt state re gulation of computerised medical records, and if so, what technical and legal protection should be afforded the patient. Whatever the origin and evolution of this debate in specific countries, it has become clear that policy and technical matters are closely intertwined. What does 'computer security' mean in the medical context? What are we trying to do? What are the threats that we are trying to forestall? What costs might reasonably be incurred? To what extent is the existing technology - largely developed to meet military and banking requirements - of use? And perhaps hardest of all, what is the right balance between technical and legal controls? As the debate spread, it became clear that there was little serious contact between the people who could state the requirements - clinical professionals, medical ethicists and patients - and the people who could explore how to meet

The role of ICMCC with regards to patient-related ICT has become obvious with the start of the Record Access Portal. The goal of this publication is to come forward with a recommendation to the WHO on Record Access. This recommendation will therefore be one of the leading issues of the Round Table on the Responsibility Shift from Doctor to Patient. The subjects discussed in this publication are: HER and Record Access; Digital Homecare; Behavioral compunetics; The Paradigm Change Challenge towards Personal Health. This last subject has been handled by Prof. Dr. Bernd Blobel from the eHealth Competence Center (University of Regensburg Medical Center, Germany) jointly with the European Federation for Medical Informatics (EFMI) Working Groups “Electronic Health Records (EHR)” and “Security, Safety and Ethics (SSE)”.

Medical and Care Compunetics 5 accompanies the fifth annual ICMCC Event,

which is one of the leading information platforms for medical and care ICT. The focal point of this publication lies on compunetics, the social, societal and ethical aspects of medical and care ICT. This book contains a variety of debatable subjects. Among national and regional projects, issues discussed are aspects of electronic health records and European projects. There is also a discussion of knowledge management, which is lead by Arthur Krukowski and Andy Marsh; other issues that are considered are behavioral compunetics, empowerment and there is also a discussion of personal health paradigm challenging citizens and patients lead by Prof. Dr. Bernd Blobel from the eHealth Competence Center jointly with the European Federation for Medical Informatics, Working Groups ‘Electronic Health Records’ and ‘Security, Safety and Ethics’.

Hospital information systems (HIS) have become integral tools in the management of a hospital's medical and administrative information. With illustrated case studies, this book emphasizes clinical information systems (CIS) and their use in the direct management of the patient. Topics include the medical record, security, resource amangement, and imopaging integration.

The quality of coding is an important factor in determining the financial health of a practice. When problems occur they must be solved quickly. But before they can be solved, they must be found. Medical Record Chart Analyzer includes medical record documentation with a systematic guide to the medical record review process for the physician's or outpatient office. Learning objectives are included at the beginning of most chapters to overview chapter content and help measure progress. Medical chart review and coding tips are located throughout the book. The application exercises allow the reader to master each topic one chapter at a time. Also included is a final examination to test documentation and auditing skills. By the end of the book, the reader will be able to conduct reviews independently. Authored by Deborah J. Grider, CPC, CPC-H, CCS-P, CCP, an experienced professional in the fields of reimbursement, procedural and diagnostic coding, medical practice management and compliance. Readers can earn up to 10 CEU credits from AAPC.

Health Administration

Revised and updated to include the latest trends and applications in electronic health records, this fifth edition of Electronic Health Records: A Practical Guide for Professionals and Organizations offers step-by-step guidelines for developing and implementing EHR strategies for healthcare organizations. New to This Edition: 2013 Update Addresses the expanded interaction among HIM professionals and system users, IT professionals, vendors, patients and their family, and others. Additions and updates include: Meaningful use (MU) definitions, objectives, standards, and measures Digital appendix on meaningful use stages ONC EHR certification programs Vision for health reform and enhanced HIPAA administrative simplification requirements under ACA Workflow, thoughtflow, and process management Strategies for managing e-discovery and the legal health record in an EHR environment Tools for cost-

benefit analysis and benefits realization for EHR Update on hospital resources for core EHR components, medical device integration, and beyond Update on physician practice resources Final Rule update on ARRA/HITECH privacy and security guidelines Update on risk analysis and medical identity theft Practical uses of SNOMED-encoded data Expanded coverage on HIE, PHRs, and consumer empowerment New chapter on specialty-specific EHRs New and expanded downloadable resources Instructor access to online EHR simulation modules

Doctors need hospitals and hospitals need doctors. Then why do they continue to communicate their needs to each other so badly? Why all the animosity, conflict, and mistrust? In The Physician's Survival Guide for the Hospital, Dr. Samuel H. Steinberg, an experienced hospital administrator, solves this problem by revealing the information needed for each of these groups to be successful in the hospital environment. Practice administrators will learn skills and information to help them improve their job performance and enhance their standing with their colleagues. Hospital administrators will learn what physicians need to take care of their patients. Physicians, those just starting their practice as well as the more seasoned, will learn the best and most efficient ways to get their hospital work accomplished. They will also become skilled at managing their hospital practice, thus making it a more enjoyable and rewarding experience. Step-by-step, The Physician's Survival Guide for the Hospital takes you through all of the issues of the physician-hospital practice in order to generate better teamwork, avoid common pitfalls and mistakes, and provide a road map to make the hospital a better place for patients and staff.

In an effort to contain health care costs, Medicare initiated a prospective payment system based on diagnosis-related groups (DRGs) in 1983. In 1985, RAND began a study to determine the effect of DRG-based prospective payment on quality of care for hospitalized Medicare patients. Six diseases (congestive heart failure, acute myocardial infarction, hip fracture, pneumonia, cerebrovascular accident, and depression) were selected for study in each of five states (California, Florida, Indiana, Pennsylvania, and Texas). This Note documents the medical record abstraction form and guidelines used to collect data from the medical records of patients hospitalized with pneumonia.

This volume in the CHC series is an overview of the critical information structures and standards required to build multifunctional electronic medical records (EMR). Description and critique of present clinical coding systems is emphasized, followed by the development of ideal design criteria required for a practical classification environment to support the electronic capture, presentation, and analyses of patient observations, findings, and events. The relationship of medical knowledge representation to patient data classification is examined, in the context of integrating clinical decision support systems and contextually appropriate guidelines into EMR systems. The role of messaging and content standards for the EMR is considered, covering the existing standards today, and

those under active development that are likely to influence system implementation and functionality in the near future.

Electronic Medical RecordsA Practical Guide for Primary CareHumana Press

In an effort to contain health care costs, Medicare initiated a prospective payment system based on diagnosis-related groups (DRGs) in 1983. In 1985, RAND began a study to determine the effect of DRG-based prospective payment on quality of care for hospitalized Medicare patients. Six diseases (congestive heart failure, acute myocardial infarction, hip fracture, pneumonia, cerebrovascular accident, and depression) were selected for study in each of five states (California, Florida, Indiana, Pennsylvania, and Texas). This Note documents the medical record abstraction form and guidelines used to collect data from the medical records of patients hospitalized with acute myocardial infarction.

Physician adoption of electronic medical records (EMRs) has become a national priority. It is said that EMRs have the potential to greatly improve patient care, to provide the data needed for more effective population management and quality assurance of both an individual practice's patients and well as patients of large health care systems, and the potential to create efficiencies that allow physicians to provide this improved care at a far lower cost than at present. There is currently a strong U.S. government push for physicians to adopt EMR technology, with the Obama administration emphasizing the use of EMRs as an important part of the future of health care and urging widespread adoption of this technology by 2014. This timely book for the primary care community offers a concise and easy to read guide for implementing an EMR system. Organized in six sections, this invaluable title details the general state of the EMR landscape, covering the government's incentive program, promises and pitfalls of EMR technology, issues related to standardization and the range of EMR vendors from which a provider can choose. Importantly, chapter two provides a detailed and highly instructional account of the experiences that a range of primary care providers have had in implementing EMR systems. Chapter three discusses how to effectively choose an EMR system, while chapters four and five cover all of the vital pre-implementation and implementation issues in establishing an EMR system in the primary care environment. Finally, chapter six discusses how to optimize and maintain a new EMR system to achieve the full cost savings desired. Concise, direct, but above all honest in recognizing the challenges in choosing and implementing an electronic health record in primary care, Electronic Medical Records: A Practical Guide for Primary Care has been written with the busy primary care physician in mind.

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy!®, 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read,

bulleted format NEWdiscussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don’ts of charting – a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient’s health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter’s content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans “Nurse Joy” and “Jake” – expert insights on the nursing process and problem-solving That’s a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina.

This book describes how an automated patient medical record could be built that could evolve into a universal patient record. Such a universal patient record would change medical care from a focus on short-term care to one oriented to long-term, preventive-care. It would remove patient care from being the province of the single physician to that of the responsibility of many different healthcare providers, possibly located anywhere in the world.

This report documents the medical record abstraction form and guidelines for appropriateness of hysterectomy used in the HMO Quality of Care Consortium study of this procedure. The abstraction form was designed to follow the format of a medical record so that abstraction would be both accurate and efficient. For each item or group of items, the section of the medical record that was to serve as the source of data was specified. In addition, items derived from a particular portion of the medical record were grouped. To standardize the abstraction process, a detailed set of guidelines was prepared to accompany the abstraction form. The guidelines define medical terms, specify data sources from the medical record, and provide important medical synonyms. A separate form was developed for use by the physician overreader who was responsible for reviewing the data collected on the abstraction form by the HMO abstractor and reviewed by the nurse supervisor at RAND in order to make necessary clinical judgments. As with the medical records abstraction guidelines, the physician overreader guidelines provide item by item instructions for making the required clinical judgments.

Clinical Infomation Systems are increasingly important in Medical Practice. This work is a two-part book detailing the importance, selection and implementation of information systems in the health care setting. Volume One discusses the technical, organizational, clinical and administrative issues pertaining to EMR implementation. Highlighted topics include: infrastructure of the electronic patient records for administrators and clinicians, understanding processes and outcomes, and preparing for an EMR. The second workbook is filled with sample charts and questions, guiding the reader through the actual EMR implementation

process.

Medical records are the source of medical information. The keeping of medical records is crucial to the provision of quality medical care to patients. Deficient medical records can influence patient management and the continuity of medical care, which may result in inadequate health care (College of Physicians and Surgeons of British Columbia, 2014:1; Canadian Medical Association, 2012:3; Howarth & Gillespie, 2012:2; Pirkle et al., 2012:564; Wong & Bradley, 2009:4; Mann & Williams, 2003:329). Medical records are also medico-legal documents. They are used to defend doctors against legal action and also to inform expert medical opinions in the case of medico-legal litigation. Therefore, good medical record keeping is of paramount importance (Van den Heever & Lawrenson, 2015:3; Howarth & Gillespie, 2012:2; McQuoid-Mason & Dhai, 2011:85; Shamus & Stern, 2011:110). Accurate medical record keeping is also a requirement of section 27A of the ethical and professional rules of the Health Professions Council of South Africa (HPCSA), registered under the Health Professions Act (Act No. 56 of 1974) and promulgated in Government Gazette R717/2006. According to this act, the HPCSA has to provide doctors with guidance regarding ethical and professional conduct. The guidance is provided in the form of booklets. Booklet 9 provides guidance on medical record keeping. The Medical Protection Society (MPS) is the leading protection organisation for doctors. It protects and supports their professional interests. The MPS has also published guidelines regarding medical record keeping for its members to abide by in South Africa. This study compares the medical ethical guidance documents and relevant legislation in South Africa to ascertain the extent that the medical ethical guidance documents incorporate and repeat South African legislation regarding medical record keeping. The study also determines if the quality of medical record keeping influences the outcome of medico-legal cases in South Africa. Lastly, it determines, by a brief comparison of relevant South African legislation and medical ethical guidance documents with relevant Canadian law, guidelines and practices, if the different medical ethical guidance documents in South Africa regarding medical record keeping have value to the required extent. The study concludes that the courts in South Africa do not always consider the medical ethical commitment that doctors have in terms of the Health Professions Act i.e. to abide by the HPCSA's medical ethical guidance booklets. Therefore the quality of medical record keeping did not influence the outcome of the cases reviewed in this study. It is also concluded that the HPCSA needs to implement a system to ensure that doctors are trained on the topics covered in the HPCSA guidance booklets, and that such training is adequately monitored. The HPCSA further ought to provide supervision in the form of physical assessments of doctors' medical record keeping practices and patient practices. This will ensure that the HPCSA regulates professional and ethical conduct, as required by the Health Professions Act. The training and assessments by the HPCSA should form part of the licensing standards to be met by doctors to practise medicine in South Africa. This will limit, to a great extent, medical errors due to inadequate record keeping in order to enhance patient safety and quality medical care. It is further concluded that the references to and repetition of relevant legislation and the HPCSA guidelines should be removed from the MPS guidelines. The HPCSA guidance Booklet 9 should be updated with the guidelines pertaining to medical record keeping in South Africa currently contained only in the MPS guidelines. This will create a consolidated guideline under the HPCSA and the current MPS guidelines can then be discontinued.