

Control Yourself

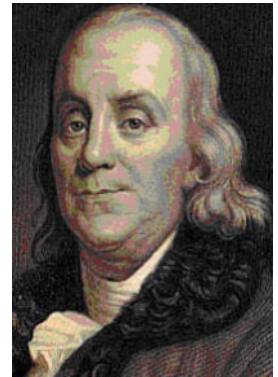
Greetings!

In 1752, Benjamin Franklin founded the Pennsylvania Hospital, a venerable institution that is still open for business. Conceived as a sanctuary of care for Philadelphia's poor and insane, America's oldest hospital is recognized as the birthplace of American psychiatry, surgery, the first national medical library, maternity ward, and the modern medical record.

Largely administrative, the first medical records listed the patient's name, address, admission and discharge dates, but with 18th century advances in medicine, and a new, humanistic concentration on the individual, it soon

became an essential tool in developing clinical data on each patient. No longer a narrow view of gross generalizations and philosophies, Medicine evolved into a science of direct observations applied to the distinct and singular patient.

Deliverance or death sentence, the availability and condition of your medical records are of paramount importance to your health.



"Life's Tragedy is that we get old too soon and wise too late." –Ben Franklin

Clean Bill of Health?

An old joke goes something like this: Doctors go to school to learn how to write illegibly, and Pharmacists go to school to learn how to read what Doctors write.

Long acknowledged with a wink and a nod, the illegible penmanship of Doctors kills more than 7000 Americans every year and injures more than 1.5 million (*National Institute of Medicine, 2006*); many of these incidents are attributable to incomprehensible or incomplete medical records and prescriptions.

Your medical record serves as the doctor's memory, representing your body's history and geography, "The definition of an adequate medical record is one which enables reconstruction of the events without reference to memory and contains only the information which clinician B will require when taking over the care of a patient from clinician A." (*Dr. Gerard Panting, Communications and Policy Director Medical Protection Society, O:\Lectures\2004\A&E Conference\Article.doc*)

Imagine yourself vacationing far from home and

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Save Your Own Life.

The popular wisdom of the day says that you should seize control of your own health record as a part of the self-education and empowerment movement afoot in the Internet age of healthcare.

Author Dr. Laura Nathanson, a pediatrician who lost her husband to a misdiagnosis, has published a book called, **What You Don't Know Can Kill You**, in which she gives detailed instructions for obtaining and organizing your medical records. "Think of your Medical Record as if it were a contract with your physicians," she says. "Your responsibility is to make sure there are no errors of fact, logic, procedure, or credentialing before you "sign off" on it." She goes on to advise the reader to, "Just clear away the medical terms and then look at the plain English structure. You can spot scary unanswered questions, "pretend" rather than real diagnoses, reports that are incomplete or ambiguous, and illogical thinking. You can make sure a student doctor's report has been carefully read and corrected, and that your specialists have the appropriate Board Certification to treat your particular condition."

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After reading the standard criteria for a medical record that follows, consider whether or not you would feel secure in making conclusions for your own or a loved one's welfare:

The Standard Medical Record Should Include:

IDENTIFICATION - Identification information should contain the following information on one single form:

1. Name.
2. Sex.
3. Date of birth or age.
4. Address.
5. Home phone number.
6. Place of employment and phone number.
7. Next-of-kin, or emergency contact, with phone number.
8. Marital Status

HISTORY AND PHYSICAL - History and physical is to be conducted for patients seen more than three (3) times. Refer to preventive health guidelines as to frequency and content to be included in exam.

1. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
 2. Social/psych/personal history should be documented. For patients 14 and older, social history shall include (for patients seen three or more times) a substance abuse query along with tobacco and alcohol usage.
 3. Family history is to be present in all members' charts, including children.
 4. Allergies/drug reactions should be prominently displayed in an easily accessible area. If patient has no known allergies this should also be noted.
 5. Current medications and pertinent past medications should be documented. And a current medication list is present.
 6. Height/Weight/Vital Signs should be documented.
 7. Immunization record should be present in all PCP's charts, and may be pertinent in specialist's charts.
- Age/sex specific preventive health screens should be followed. Follow preventive health guidelines for specific criteria.

OFFICE VISITS – All medical records will contain the following for patient office visits:

1. Date of visit.
 2. Chief complaint, including history of problem and pertinent medications.
 3. Physical exam findings.
 4. Pertinent Vital Signs/Weight.
 5. Documentation of Diagnosis consistent with findings.
 6. Documentation of Treatment Plan consistent with findings.
- There is no evidence that the patient is placed at inappro-

priate risk by a diagnosis or therapeutic problem.

7. Patient education/discharge instructions. This may be in the form of literature given, instructions, consultations, etc.
8. Patient compliance/response to treatment. Unresolved problems from previous office visits are addressed in subsequent visits.
9. Next appointment/follow-up required. The recommendation is that documentation of the follow-up required should be in the form of phone calls, or return visits noted in weeks, months, or PRN.
10. Documentation of no-shows.
11. Documentation of Advanced Directive

DIAGNOSTIC/THERAPEUTIC/REFERRALS - All charts should contain the following for diagnostic studies, treatment plans, therapeutic services, ancillary services and referrals:

1. Diagnostic studies, i.e., labs, x-rays, EKG's ordered as appropriate and justified by documentation.
2. Diagnostic results are initialed and dated by the physician. Abnormal results should have documentation of follow-up to be taken.
3. Follow-up of abnormal study findings should be documented.
4. Consult/referral should have documentation of reason for referral(s).
5. Acknowledgment of referral(s) should be noted.
6. Follow up on consult referral recommendations should be present.
7. Copies of consultation referral reports should indicate receipt within 60 days of service.
8. Copies of hospital, ER and Urgent Care discharge summaries should be present within 60 days of service
9. Copies of home health nursing reports, specialty physician reports, and physical therapy are present within 60 days of service.

CHART FORMAT - Charts should be legible and aid in easy data retrieval. The following criteria should be present:

1. All entries legible.
2. All entries signed and dated.
3. Chart format should be designed to facilitate data retrieval and identifies past and ongoing problems.
4. Every page should have patient identification.
5. A problem list should be present which documents chronic or ongoing problems.

A daunting project for the layman, the things that can go wrong in a document as voluminous as your medical record are legion. Do you even remember the vaccinations you received as a child? Before 'just clearing away' the medical terms in your record, consider a consultation with a professional LifeSpan Care Manager to review your records and organize them into a coherent storyline that will carry you safely to your desired destination. ♥

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becoming sick enough to need medical attention. Without medical records, the caregivers attending to you have no way of knowing that the medication prescribed will interact badly – perhaps even fatally - with the medication you're already taking. With access to all of your medical data, clearly and concisely presented, the outcome of this encounter would be entirely different.

Imagine yourself on the eve of a lifesaving medical procedure, when a Hurricane Katrina caliber disaster takes place, sweeping all of your medical records away, and leaving the hospital staff without the essential information necessary to proceed with the surgery. Portable medical records stored in more than one location would dramatically alter the end of this story.

Finally, imagine that you suffer from later-stage diabetes, and so in addition to your primary care physician, you regularly consult with an endocrinologist, a nephrologist, an ophthalmologist, a podiatrist, a vascular surgeon and a neurologist. That's a huge paper trail, disseminated between seven different offices, and an presenting overwhelming administrative task to organize and coordinate. A LifeSpan GuardianKey™ USB flash drive with each of these physician's notes, histories, observations, records, prescriptions and prognoses would be both safer and more cost effective, ensuring fewer medical and medication errors, hospitalizations, and duplications of tests and procedures.

In 1928, the American College of Surgeons established the Association of Record Librarians of North America (ARLNA) to, "elevate the standards of clinical records in hospitals and other

medical institutions." In 1938, to keep up with increasingly data-driven decision-making in healthcare settings, the organization created standards and regulations that made their members medical record experts. Today, ARLNA has been rechristened the American Health Information Management Association (AHIMA) and they are on the cutting edge of the new age implementation of electronic medical records, as well as to the creation of a national health information network.

Broadly, AHIMA describes your medical record as a:

- Basis for planning your care and treatment
 - Means by which your doctors, nurses and others caring for you can talk to one another about your needs
 - Legal document describing the care you received
- Means by which you or your insurance company can verify that services billed were actually received

In a State of the Union Address in 2005, President Bush called for national standards that would enable medical information to be digitized, stored and shared electronically. "Within ten years, every American must have a personal electronic medical record," he said. A new position has even been created within the Department of Health and Human Services to coordinate government health-Information Technology initiatives. "The 21st century healthcare system is using a 19th century paper-work system. Modern technology has not caught up with a major aspect of healthcare, and we've got to change that," the President said.

2015 might as well be 3015 if you or a loved one are unwell. Be an early innovator and save your own life. ♥

Websites We Love

www.whoissick.org

Thinking that the wife had appendicitis, this site was founded by a couple who wasted hours in an out-of-town emergency room only to find that a flu virus had been ravaging their vacation destination for weeks. Plug in the zip code in question to find out the travel itineraries of colds, allergies, pink eye, or whatever ailment concerns you – then take two aspirin and call us in the morning!

health08.org

In November, a thinking person's fancy turns to politics. This website has everything you want to know about the healthcare platforms and issues for 2008. Operated by the Kaiser Family Foundation, you will find analysis of policy issues, regular public opinion surveys, daily news updates, video of speeches and debates from the campaign trail, and original interviews.

www.Ahima.org

The website of the American Health Information Management Association has a wealth of information about medical records and even lists LifeSpan Care Management as a resource!

For previous issues of this newsletter,
visit:

www.lifespancm.com/news.aspx

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