1.0 INTRODUCTION

1.1 Purpose And Use of These Guidelines:

Over the past decade, the long term care (LTC) industry has had an increased need for complete and accurate clinical record documentation. Documentation-based survey initiatives, quality indicators, corporate compliance, reimbursement changes and litigation have all had an impact on the industry and the need for properly maintained clinical record systems. The LTC Health Information Practice and Documentation Guidelines were developed to provide a resource to health information professionals and healthcare organizations on the role of the health information practitioners, practice guidelines for establishing and maintaining health information systems, and documentation guidelines specific to long term care.

Federal regulations for nursing facilities and skilled nursing facilities require organizations to maintain their clinical records in accordance with accepted professional standards and practices and to employ or contract with professionals necessary to carry out the regulations.

Just as the LTC industry has seen changes, it is anticipated that these practice guidelines will also be reviewed, revised and updated to adapt to future changes in practice, systems, and regulations.

Note: These guidelines were developed to address federal regulations for LTC facilities. State regulations should be followed if they differ from the practice guidelines.

1.2 Transition From Medical Records To Health Information Management (HIM):

The terms health information and health information management are used throughout this document to represent the medical record and medical record department. In the early 1990’s the American Medical Record Association changed its name to the American Health Information Management Association to better reflect the role the medical record professional. The new terminology recognized the maintenance of clinical information in a variety of formats and the evolution of the role of a medical record director to one whose role is to manage health information beyond the medical record.

1.3 Definition of Long Term Care Facility:

The term long term care (LTC) facility is used throughout the guidelines to represent nursing facilities and skilled nursing facilities. The term resident was used rather than patient to provide consistency with the term used in the federal requirements for long term care facilities.

1.4 Acknowledgements

These guidelines have been developed and made available to health care organizations and health information management professionals through donations to the Foundation of Research and Education in Health Information Management (FORE) by six contributing organizations. In addition to AHIMA, special thanks to --
Beverly Enterprises
Extendicare Health Services
Genesis Health Ventures
Good Samaritan Society
Harborside Healthcare Corporation
HCR-ManorCare

These guidelines were developed by a taskforce comprised of health information management professionals and specialists with key areas of expertise. Their hard work, dedication, experience and insight were instrumental in creating the LTC Health Information Practice and Documentation Guidelines.
LTC Health Information Practice and Documentation Guidelines

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Special thanks to those who reviewed and commented on the LTC Health Information Practice and Documentation Guidelines. The comments received were invaluable in validating and improving the quality of this document.

1.5 Copyright And Use Of Report

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These guidelines were developed and made available free of charge via the Internet and AHIMA’s website for use by health care provider organizations and health information management professionals to provide assistance and direction in developing and maintaining health information systems that meet professional practice standards. The guidelines, samples, and examples can be used in development of facility/organization systems, policies and procedures without obtaining special copyright permission.

1.6 Reference to HIM Practice Standards

In section four of this report (Practice Guidelines For LTC Health Information And Record Systems) there are HIM Standards displayed in a box which relate to the section topic. These standards were obtained from the book Health Information Management Practice Standards: Tools for Assessing Your Organization published by AHIMA in 1998. Not all HIM standards published in this book were referenced in this report – only those relevant to LTC.

Example:

4.1.2 Assigning a Medical Record Number

HIM STANDARD:
- The healthcare organization has a policy that requires a separate, unique health record for each resident.
2.0 ROLE OF THE HEALTH INFORMATION STAFF IN LONG TERM CARE FACILITIES:

In order to maintain quality health information systems, proper staffing and allocation of resources is necessary. The following guidelines provide an outline on the recommended qualifications, responsibilities and functions that would be performed by four different types of positions – 1) a health information consultant, 2) a credentialed health information practitioner working in a facility, 3) a non-credentialed practitioner working in a facility, and 4) a health unit coordinator. As documentation and clinical record systems increase in complexity in response to changes in the industry, HIM professionals and staff provide valuable expertise and help to maintain health information systems that impact quality of care, regulatory, legal, compliance and financial issues.

2.1 JOB QUALIFICATIONS, RESPONSIBILITIES, AND FUNCTIONS OF HEALTH INFORMATION STAFF IN A LTC FACILITY:

2.1.1 Role Of The Credentialed Consultant:

Many long term care facilities have access to a Health Information Consultant to provide professional expertise on health information, documentation and medical record issues. Consultants are usually contracted independent of the organization to support non-credentialed staff or employed at the corporate level. Consultants may also serve as an additional resource to a HIM corporate consultant to assist with state-specific issues, assist with implementation of corporate policies, and procedures. Consultants may also be used for special projects, independent auditing/monitoring services, training, etc. even when a credentialed practitioner is employed by the facility.

**QUALIFICATIONS OF A CONSULTANT:**

The following qualifications are recommended for a consultant in long term care.

- Credentialed as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT). *Note: A RHIA (previously a RRA) holds a 4 year bachelor degree. A RHIT (previously an ART) typically has a 2 year associate degree or technical training.*
- Experience in long term care preferably as a Director or Coordinator of Health Information Services.
- Knowledge of regulations, survey process, accreditation standards and professional standards of practice pertaining to SNF/NF.
- Understanding of payment systems for SNF/NF including Medicare and Medicaid.
- Knowledge and application of ICD-9-CM coding in long term care.
- Understanding of HCPCS and CPT coding systems.
- Knowledge of documentation and legal issues pertaining to health information.
- Knowledge of quality assurance and ability to apply a quality improvement process to problem solving.
- Superior presentation skills, both oral and written.
- Solid clinical understanding of anatomy, physiology, pathophysiology and clinical/nursing process.
- Ability to teach using a variety of methods.
- Computer skills and understanding of information systems used on long term care with the ability to assist a facility move toward an electronic medical record.
- Supervisory and management skills and experience.
- Organizational skills.
Personal attributes of a qualified consultant should include:

- Ability to perform critical thinking, analysis, and problem solving.
- Leadership abilities preferred with an understanding of how to function within a team.
- Flexibility, creativity, and adaptability in dealing with problems and facility/corporate staff.
- Good communication skills with the ability to provide constructive information while being sensitive to the customer’s needs.

REPORING:

The Health Information Consultant should report to the Administrator or Executive Director of the organization to assure that he/she is aware of findings and recommendations that affect the facility operation and risk factors. The Administrator may choose to delegate direct reporting during a visit to another staff member such as the Director of Nursing Services or the Coordinator of Health Information Services.

COMMON FUNCTIONS PERFORMED BY A HEALTH INFORMATION CONSULTANT:

A consultant should be able to perform and train on all of the functions of a Health Information Coordinator as well as many of the functions of the Health Unit Coordinator. The following functions are unique to the role of a consultant.

- Ability to provide assistance and function as a key resource for the development, transition, and maintenance of an electronic medical record.
- Assist with implementation and function as a key resource on the Health Insurance Portability and Accountability Act (HIPAA) including information system security issues and privacy.
- Provide expertise on compliance issues and the integration of clinical documentation and coding with the billing process.
- Develop, implement and monitor health information department policy and procedures and job descriptions. Make recommendations or assist with implementation of corporate policies.
- Provide training and orientation to health information personnel on functions of the department and facility staff on documentation.
- Develop and maintain health information systems and processes that meet regulatory requirements (both state and federal), professional practice standards, legal standards, and management/corporate policy.
- Establish a process for systematically reviewing documentation on an ongoing basis for both quality and quantity of documentation.
- Ability to complete documentation/medical record audits and monitoring with an ability to assess the quality of documentation.
- Ability to recommend corrective actions for findings on medical record audits/monitoring.
- Initiate clinical record systems and indexes.
- Assist with forms development and forms analysis/flow.
- Support compliance process of facility/organization.
- Support quality assurance/quality improvement process of the facility/organization.
- Train staff on quality assurance/quality improvement process related to health information management and appropriate methods for the collection of data.
- Provide resources to the facility on health information, documentation, regulations, standards of practice, etc.
- Develop consultation reports in a timely manner. Communicate findings and recommendations effectively to facility administration and interdisciplinary team members.
- Maintain good communication with facility staff and interdisciplinary team members. Empower facility staff to work independently.
2.1.2  ROLE OF THE CREDENTIALED PRACTITIONER WORKING IN A LONG TERM CARE FACILITY

QUALIFICATIONS OF A CREDENTIALED PRACTITIONER:

A growing trend in the industry is to hire credentialed practitioners to manage the health information department in a facility. Facilities who hire a credentialed practitioner often forego contracting with a consultant or they will utilize a consultant for independent audit and training services. The following list provides the recommended qualifications for a credentialed practitioner working in long term care. If you are hiring a practitioner new to long term care, additional training specific to long term care regulations and documentation will be needed.

- Credentialed as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT). Note: A RHIA (previously a RRA) holds a 4 year bachelor degree. A RHIT (previously an ART) typically has a 2 year associate degree or technical training.
- Experience in long term care preferred.
- Knowledge of regulations, survey process, accreditation standards and professional standards of practice related to long term care.
- Understanding of payment systems including Medicare and Medicaid.
- Knowledge and application of ICD-9-CM coding appropriate for LTC.
- Understanding of HCPCS and CPT coding systems.
- Knowledge of documentation and legal issues pertaining to health information.
- Supervisory and management skills and experience preferred.
- Basic understanding of the budget and monitoring process.
- Planning and organizational skills.

Personal attributes of a credentialed health information practitioner should include:

- Leadership abilities preferred with an understanding of how to function within a team.
- Ability to provide instruction or guidance and communicate effectively.
- Ability to perform critical thinking, analysis, and problem solving.
- Flexibility, creativity, and adaptability in dealing with problems and staff.
- Good customer service and telephone skills.

REPORTING:

It is recommended that this position report directly to the Administrator or Executive Director in a facility. There are a number of reasons why reporting to the Administrator is important for this position. First, the medical record is a multidisciplinary record. Overall decisions made about the record, use of data and analysis should not be influenced by one discipline over another. Second and most important, full disclosure of audit and quality monitoring findings should be reported to the facility administrator and the quality assurance committee. Many of the functions, data gathering and analysis directly influence administrative and clinical management of the facility.

COMMON FUNCTIONS PERFORMED BY A CREDENTIALED HEALTH INFORMATION PRACTITIONER:

The following functions are recommended for a credentialed health information practitioner and represent the core functions for health information. Facility size, admission and discharge rates, department staffing and other non-HIM responsibilities assigned to the position should all be considered when developing the final job description for a facility. In a facility that also employs health unit coordinators, some of the functions outlined may be managed by this position but performed by the health unit coordinator.
Supervisory/Management Functions:
• Maintain current policy and procedures and job descriptions for the health information department.
• Manage human resource functions for the department including interviewing, hiring, staff scheduling, performance evaluation, disciplinary actions, and termination.
• Supervise health information staff to assure staff competency and performance.
• Provide guidance, motivation and support to health information staff.
• Monitor department budget as directed.
• Serve as the Privacy Officer under HIPAA and may serve as the Security Officer depending on expertise and facility need.

Quality Monitoring and Quality Assurance Functions:
• Participate in the facility quality assurance committee and process. Optional: Coordinate the facility quality assurance program.
• Maintain a qualitative and quantitative audit/quality monitoring process. Collect and report data from audit findings to QA committee. Report, monitor and follow-up on problems/concerns. Maintain routine audit and monitoring systems (admission, MDS, concurrent, acute problem, discharge) and focus audits on problem areas, QA concerns, Quality Indicator and survey issues.

Health Information Management Functions:
• Maintain security of health information systems and medical records. Assure physical protection is in place to prevent loss, destruction and unauthorized use of both manual and electronic records. For example, assure safeguards are in place such as record sign-out systems, assignment of computer passwords/log-ons, and systems for securing file cabinets and file rooms where overflow and discharge records are stored. Assure systems are in place to maintain confidentiality of both manual and electronic health information.
• Manage the release of information functions for the facility including review and processing of all requests for information.
• Maintain facility policies and standards of practice to assure release of information requests are appropriate and meet legal standards.
• Maintain a forms management system for development, review, and reproduction of facility forms. Maintain a master forms manual.
• Maintain systems for filing, retention and destruction of overflow/thinned records and discharge records.
• Develop systems for retention and destruction of medical records stored in an electronic format.
• Complete facility statistical reports such as monthly facility statistics, daily census, and licensure reports as applicable.
• Participate in meetings and committees such as daily stand-up, administrative/department head, quality assurance/quality improvement, and Medicare documentation review.
• Provide inservice education as applicable on health information issues.
• Provide orientation to new employees on topics such as the medical record organization and content, record completion, confidentiality, documentation standards and error correction procedures.
• Support and assist in carrying out corporate compliance initiatives as assigned by administrator.
• Manage the credentialing process for physicians and other professional staff when applicable. Optional: Review MDS validation reports and take appropriate actions to ensure errors are corrected. Retrieve quality indicator reports from HCFA and review findings.

Computerization/Automation:
• Understand all aspects of clinical computer system.
• Participate in decisions related to the computer system including systems selection, planning, and future expansion.
• Provide resources for training on computer system and use of clinical applications.
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- Monitor security of the system such as assuring audit trails and password security are in place. Monitor audit trails and follow up with possible breaches in confidentiality/security.
- Assure ICD-9-CM database utilizes the current version.
- Assure systems are in place to maintain up to date resident-specific information in the clinical information system.
- Complete data entry functions as applicable.
- Optional: Maintain the care plan and MDS schedule and transmit MDS information.

Oversight Records Management Functions:
The following list outlines the records management functions that are the responsibility of the health information department on admission, during the resident’s stay, and upon discharge. Depending on the facility size and department staffing some or all of these functions may be completed by other department staff such as a health unit coordinator.

Admission:
- Complete the appropriate information in the census register.
- Complete and file as applicable the master patient index information (computerized or manual).
- Initiate the inpatient medical record and inhouse overflow file, prepare labels, etc.
- Complete admission checklists and admission audits.
- Complete coding and indexing of admission diagnoses.

During the resident’s stay:
- Conduct concurrent audits/quality monitoring at regular scheduled intervals.
- Code diagnoses at regularly scheduled intervals.
- Thin inhouse records in accordance with the written policy and procedure and file in chart order for discharge in the inhouse overflow file.
- Contact physicians or departments as appropriate when signatures or information is needed before records can be completed.
- Maintain a monitoring system to assure telephone orders and other information is signed or completed by the physician as needed.
- File all incoming clinical information in the inhouse records on a daily basis.
- Monitor timeliness of physician visits on a monthly basis.

Discharge:
- Update discharge information on master patient index (manual or electronic).
- Record appropriate discharge information in the census register.
- Initiate the discharge record control log to monitor discharge record processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours of discharge or death of a resident.
- Assemble record from the nursing station and the overflow file in established discharge order.
- Analyze the record for deficiencies using the discharge record audit/checklist.
- Follow up and monitor discharge record deficiencies including monitoring/mail information to the physician for completion as applicable.
- Maintain discharge record control log.
- File discharge record in incomplete clinical record file until complete and then file the discharge record in the complete file.
- Code and index final diagnoses using the ICD-9-CM code books.
2.1.3 ROLE OF THE NON-CREDENTIALED PRACTITIONER WORKING IN A LONG TERM CARE FACILITY

QUALIFICATIONS OF A NON-CREDENTIALED PRACTITIONER:
The qualifications and skills vary widely for a non-credentialed practitioner coordinating the health information functions in a facility. The basic functions of the health information department warrant the following minimum qualifications for an entry-level practitioner:

Minimum Entry Level:
- High school graduate or equivalent.
- Knowledge of medical terminology.
- Basic computer and typing/data entry skills.
- General office skills including filing, organizing, etc.
- Oral and written communication skills.
- Good customer service and telephone skills.
- Ability to work within a team.
- Empathy for the elderly.

Recommended Additional Qualifications:
- Long term care or healthcare experience preferably as a Coordinator of Health Information in another facility. Training as a Medical Records Secretary or equivalent.
- Experience with ICD-9-CM coding.
- Knowledge of documentation and legal issues.
- Knowledge of regulations, accreditation standards, and professional standards of practice for health information in long term care.
- Understanding of payment systems in long term care.
- Ability to provide instruction or guidance and communicate effectively.
- Supervisory and management skills depending on size of the department.
- Knowledge of the budget process.
- Interest in maintaining professional development and continuing education on health information issues.

REPORTING:

It is recommended that this position reports to the Administrator or Executive Director, however, this may vary depending on the skills and expertise of the individual. If the department is responsible for audit and quality management functions and/or supervises a department reporting to the administrator is imperative.

COMMON FUNCTIONS PERFORMED BY A NON-CREDENTIALED HEALTH INFORMATION PRACTITIONER:

The functions of this position are a subset of those functions outlined in the Credentialed Health Information Practitioner based on training, past experience, and skill level. At a minimum when hiring this position, the non-credentialed practitioner should be able to complete the following functions. The functions in the credentialed health information practitioner list could be completed by this position (depending on skill and experience) under the direction of a credentialed consultant.

Supervisory/Management Functions:
- Maintain current policy and procedures and job descriptions for the health information department.
- Monitor department budget as directed.
Quality Monitoring and Quality Assurance Functions:
- Participate in the facility quality assurance committee and process. Optional: Coordinate the facility quality assurance program.
- Maintain a quantitative audit/quality monitoring process and qualitative. Collect and report data from audit findings to QA committee. Maintain routine audits (admission, MDS, concurrent, acute problem, discharge) and focus audits on problem areas, QA concerns, Quality Indicator and survey issues.

Health Information Management Functions:
- Maintain security of health information systems and medical records. Assure physical protection is in place to prevent loss, destruction and unauthorized use of both manual and electronic records. For example, assure safeguards are in place such as sign-out systems, assignment of computer passwords/log-ons, and systems for securing file cabinets and file rooms where overflow and discharge records are stored.
- Assure systems are in place to maintain confidentiality of both manual and electronic health information.
- Manage the release of information functions for the facility including review and processing of all requests for information. Maintain facility policies and standards of practice to assure release of information requests are appropriate and meet legal standards.
- Maintain a forms management system for development, review, and reproduction of facility forms. Maintain a master forms manual.
- Maintain systems for filing, retention and destruction of overflow records and discharge records.
- Develop systems for retention and destruction of medical records stored in an electronic format under the direction of a consultant.
- Complete facility statistical reports such as monthly facility statistics, daily census, licensure reports as applicable.
- Participate in meetings and committees such as daily stand-up, administrative/department head, quality assurance/quality improvement, Medicare documentation review.
- Support and assist with carrying out corporate compliance initiatives as assigned by administrator.
- Manage the credentialing process for physicians and other professional staff when applicable.

Computerization/Automation:
- Understand all aspects of clinical computer system.
- Provide input into decisions related to the computer system including system selection, planning, and future expansion.
- Monitor security of the system such as assuring audit trails and password security are in place. Monitor audit trails and follow-up with possible breaches in confidentiality/security.
- Assure ICD-9-CM database utilizes the current version.
- Assure systems are in place to maintain up to date resident-specific information in the clinical information system.
- Complete data entry functions as applicable.
- Optional: Maintain the care plan and MDS schedule and transmit MDS information.

Records Management Functions:

Admission:
- Complete the appropriate information in the census register.
- Complete and file as applicable the master patient index information (computerized or manual).
- Initiate the inpatient medical record and inhouse overflow file, prepare labels, etc.
- Complete admission checklists and admission audits.
- Complete coding and indexing of admission diagnoses.
During the resident’s stay:

- Conduct concurrent audits/quality monitoring at regular scheduled intervals.
- Code diagnoses at regular scheduled intervals.
- Thin inhouse records in accordance with the written policy and procedure and file in chart order for discharge in the inhouse overflow file.
- Contact physicians or departments as needed when signatures or information is needed before records can be completed.
- Maintain a monitoring system to assure telephone orders and other information is signed or completed by the physician as needed.
- File all incoming clinical information in the inhouse records on a daily basis.
- Monitor timeliness of physician visits on a monthly basis.

Discharge:

- Update discharge information on master patient index (manual or electronic).
- Record appropriate discharge information in the census register.
- Initiate the discharge record control log to monitor discharge record processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours of discharge or death of a resident.
- Assemble record from the nursing station and the overflow file in established discharge order.
- Analyze the record for deficiencies using the discharge record audit/checklist.
- Follow up and monitor discharge record deficiencies including monitoring/mail information to the physician for completion as applicable. Maintain discharge record control log. File discharge record in incomplete clinical record file until complete and then file the discharge record in the complete file.
- Code and index final diagnoses using the ICD-9-CM code books.

2.1.4 ROLE OF THE HEALTH UNIT COORDINATOR (UNIT CLERK/SECRETARY, HEALTH INFORMATION ASSISTANT):

In addition to a health information manager, some facilities may choose to also hire a health unit coordinator(s) depending on facility size, number of admissions and discharges, or resident acuity level. Although this position is typically found at the nursing station, their functions primary revolve around the monitoring and completion of the record and station management. Since many of the health information functions are performed by the health unit coordinator position, it was critical to address this position under a health information model.

QUALIFICATIONS OF A HEALTH UNIT COORDINATOR:

Minimum Entry Level:

- High school graduate or equivalent.
- Knowledge of medical terminology.
- Basic computer and typing/data entry skills.
- General office skills including filing, organizing, scheduling and tracking.
- Oral and written communication skills.
- Good customer service and telephone skills/etiquette. Tact and warmth when dealing with family and residents.
- Ability to work within a team.
- Empathy for the elderly.

Recommended Additional Qualifications:

- Medical office secretary or health unit coordinator training/certificate (or other applicable course).
- Long term care or healthcare experience preferably as a Health Unit Coordinator.
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- Knowledge of documentation and legal issues.
- Knowledge of regulations, accreditation standards, and professional standards of practice for health information in long term care.
- Experience with transcribing physician orders with knowledge of medications and applicable terminology.

REPORTING:

It is recommended that the health unit coordinator position report to the Manager of Health Information Services to provide consistent application of health information policies throughout the facility. Because of the unique nature of a health unit coordinator, it is important that this position have an indirect reporting relationship with the nurse manager or supervisor for the nursing station.

COMMON FUNCTIONS PERFORMED BY A HEALTH UNIT COORDINATOR:

When this position is utilized in a facility, many of the record management functions are performed by the health unit coordinator along with additional functions unique to coordinating a nursing station. This position provides assistance to the nursing staff by moving non-nursing clerical functions away from nursing allowing them to spend more time with direct patient care. If a facility does not utilize a health unit coordinator position or incorporate their functions in another position, the nursing staff are completing many clerical functions keeping them away from delivery of direct patient care.

Records Management Functions:

When a health unit coordinator position is utilized by a facility, the following records management functions are performed by this position:

Admission:
- Initiate the inpatient medical record and inhouse overflow file, type labels, etc.
- Coordinate admission process.
- Optional: Transcribe admission orders after review by clinical staff with proper education and training.
- Complete admission checklists.

During the resident’s stay:
- Thin inhouse records in accordance with the written policy and procedure and file in chart order for discharge in the inhouse overflow file.
- Maintain the in-house chart appearance and organization.
- Maintain a monitoring system to assure telephone orders and other information is signed or returned by the physician and other professionals.
- File all incoming clinical information in the inhouse records on a daily basis.
- Monitor timeliness of physician visits on a monthly basis in conjunction with the Manager of Health Information Services. Pull charts for physician rounds and transcribe new orders if applicable.
- Track and schedule routine labs.
- Schedule resident appointments and arrange transportation.
- Transcribe vitals, input/output information, per system.
- Prepare paperwork for transfer or referrals.
- Optional: Transcribe physician orders once obtained from clinical staff. (Clinical staff to sign off on transcription).
- Optional: If data-entry is expected in this position for the MDS or care plan, additional time should be allocated.
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Discharge:
- Prepare paperwork for discharge.
- Assemble record from the nursing station and the overflow file in established discharge order.

Nursing Station-Specific Functions:
- Answer telephones at the nursing station.
- Maintain an organized nursing station.
- Stock forms and clerical supplies on the station.
- Maintain station lists.
- Maintain nursing assistant care cards/assignment records.
- Completes station filing of loose reports, policies, etc.

Other Functions:
*Additional hours should be allocated to this position if non-health information functions are shared with this position.*

2.1.5 EVOLVING ROLE OF HEALTH INFORMATION

As computerization continues to evolve, the role of the HIM practitioner will also change. Although some traditional functions in maintenance of a manual record may be eliminated, new issues will take their place. The HIM role will continue to be responsible for oversight of confidentiality, compliance, privacy and security management programs, ongoing auditing of the electronic medical record, and audit trails. HIM practitioners should be responsible for orientation and ongoing training of clinical staff on the information system, and overall administration of the information system. Even with a computerized record system, many of the routine HIM functions will still need to be carried out.

With the implementation of HIPAA, the HIM practitioner will see new roles as a privacy officer and possibly a security officer. Expertise on code sets will also be necessary for proper coding and reporting under the federal regulation. The HIM role in corporate compliance and billing should also evolve to assure that documentation supports services billed by the facility.

2.2 HEALTH INFORMATION DEPARTMENT STAFFING

Staffing the health information department is based on five critical issues:
- The time requirements for functions under the responsibility of the health information department (see job positions and functions in Sections 2.1).
- Resident acuity and complexity.
- Census based on number of residents in the facility.
- Number of resident exchanges (admission, discharge, hospital transfer and hospital return).
- Availability of information technology.

3.0 HEALTH INFORMATION CONSULTANT SERVICES:

A health information consultant in long term care provides a facility or corporate office with professional expertise on health information, medical records, and documentation based on their education, skills and experience. At a time in the industry when quality of documentation for survey and litigation, coding, confidentiality and security are emerging as critical issues, the consultant is an invaluable resource for a facility. Consultants provide assistance with monitoring potential fraud and abuse issues, assistance with corporate compliance plans, and evaluation of documentation that supports the billing process.
By federal law, facilities are required to provide services that maintain the professional standards of practice. Many States have statutes that specifically require that facilities maintain the services of a consultant – check with your state to determine whether a consultant is mandated.

The section will assist in addressing expectations, performance standards, and utilization of a consultant. The information can be used both by a facility and a consultant to evaluate the quality of the services provided and make changes as necessary. This document is meant to provide a consistent set of expectations and deliverables to assure that both facilities and consultants have a common vision of role and services of a consultant. The specific types of functions and the role of a consultant are outlined in section 2.1.1.

A consultant is often contracted independently with a facility to provide professional expertise in coordination with a non-credentialed practitioner. However, many facilities utilize consultants to augment the services of a credentialed health information practitioner by providing independent audits and assessing the quality of documentation, the adherence to legal and regulatory documentation standards and billing support. In addition, many facilities utilize consultants for inservices and training programs.

### 3.1 FREQUENCY OF CONSULTANT VISITS:

The role and functions of a consultant should be tailored to the needs of each facility. This chart provides guidelines to align expectations with a recommended frequency for visits, but would not prevent a consultant and facility from mutually agreeing upon other functions during a visit. The frequency of consulting visits that a facility is looking for should directly correlate to responsibility and role of the consultant.

<table>
<thead>
<tr>
<th>Frequency of Visits</th>
<th>General expectations for the role of Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly or More Often</td>
<td>Oversight of HIM department to include health information system evaluation implementation, and monitoring, policy and procedures, assessment and monitoring of documentation; monitoring QI's, training and inservice training, input into facility QA Committee; assistance with billing and compliance issues, assistance with implementing new systems. The hours budgeted each month must provide the consultant with adequate time to complete the functions listed.</td>
</tr>
<tr>
<td>Quarterly or Semi-Monthly</td>
<td>Assess basic HIM functions and monitors status of key areas in the department – provide new information and spot checking, some troubleshooting of problems/issues with minimal follow-up; minimal audits – not proactive; minimal on-going monitoring; deals with problems identified by facility and HIM department; focus is on a few key areas with facility to follow-up; training or inservices as recommended by facility; Typically quarterly visits are full day visits regardless of size of facility.</td>
</tr>
<tr>
<td>Semiannually or Annually *Generally not recommended</td>
<td>Brief look at the general systems and department functions. No oversight or monitoring of department functions. Address issues identified by the facility. Minimal to no audits. If audits done they would be few in number to provide a snapshot but not representative of facility documentation practices with a comprehensive list of problem areas. Facility may request inservice or training based on problems that they have identified. Typically visits are full days regardless of size of facility.</td>
</tr>
<tr>
<td>Focus Review or PRN Visits</td>
<td>Functions performed specific to the need identified by the facility or per contract. Generally no oversight or monitoring of HIM functions.</td>
</tr>
</tbody>
</table>
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Recommended Number Of Visits:
The number of visits should be decided between the consultant and the facility, however, monthly visits are recommended to get the oversight of HIM systems including the department, documentation, quality indicators, coding/reimbursement and compliance. At a minimum it is recommended that facilities contract for no less than quarterly visits.

The factors that should be considered when deciding on a visit frequency including the bed size of the facility, availability of a corporate health information consultant, state regulations requiring specific HIM services, crisis situations or survey.quality indicator problems, staff turnover, and the performance or expertise of HIM staff.

Indicators for Increase in Consulting Visits:
There are times when an increase in consultation visits may be warranted. The following indicators provide a good rule of thumb to consider additional hours or warrant a focus review. The number of extra visits are variable based on the severity of the problems identified.

- Turnover in health information coordinator position requiring training of new staff. The number of additional visits will vary based on the past experience and performance of the new coordinator hired.
- Survey or quality indicator problems related to quality of care and documentation. Consultants can provide tailored documentation audits, inservices, and plans to assist in analyzing and correcting a problem.
- Reimbursement, coding or corporate compliance issues such as an increase in the number of denials by the fiscal intermediary. Focus audits can help to identify and correct a documentation problem.
- Program changes such as a change in licensure status, new accreditation status (JCAHO), or certification status (NF to SNF).
- Extraneous training needs based on findings from the facility.
- New major regulations or initiatives such as HIPAA, computerization initiatives, etc. that have an impact on health information systems, documentation or reimbursement.

3.2 PERFORMANCE EXPECTATIONS FOR A CONSULTANT

- PROFESSIONALISM: Possess knowledge and understanding of current issues affecting long term care facilities. Possess good communication skills with the ability to establish rapport and motivate staff through positive interaction.
- CONSULTATION REPORT: A type written, professional report is delivered in a timely manner after the consultation visit unless other arrangements are made with the facility. A process should be in place to follow up on past recommendations. See section 3.3.2 on the content of a consultation report for more details.
- INITIAL EVALUATION: When first contracting with a facility, a consultant should complete a comprehensive evaluation. It is preferred that the consultant have an evaluation checklist such as one published in the Health Information Management Standards of Practice published by AHIMA.
- WORK PLAN: A work plan should be developed for the facility which identifies the areas to be evaluated, when they were evaluated, and when follow-up should occur. It is recommended that a work plan be developed for a calendar year. Developing a work plan can help in managing the expectations of the facility with the number of hours contracted. Set clear expectations with regard to hours available. Clarify facility goals and crosscheck against budgeted hours.
- ENTRANCE CONFERENCE: An entrance conference should be conducted with facility staff to discuss and communicate the work plan for the day. The plan for the day should be agreed upon mutually by the facility and consultant. The consultant should adjust his or her work plan to accommodate facility needs.
- EXIT CONFERENCE: An exit conference should be held with the appropriate staff (such as administration and other staff administration would like to have present). It may not always be
appropriate to have an exit conference with all staff mentioned depending on the sensitivity of the information to be discussed.

- **SCHEDULING VISITS:** Consultation visits should be scheduled in advance during the working hours of the health information coordinator and administration.

- **PROFESSIONALISM:** Consultants should be professional in dress and attitude.

- **CONTRACT HOURS:** Meet assigned contract hours unless a change in the schedule is mutually agreed upon.

- **MAINTENANCE OF A CONTRACT:** A written contract should be signed by both the consultant and the facility. The contract should include the number of hours or visit schedule agreed upon, the scope of services to be provided, the hourly rates and expenses to be charged by the consultant. The contract should contain language that protects the confidentiality of the consultation reports from discovery (i.e., litigation purposes) by placing the report under the quality assurance program. As an example, the following statement could be used: *As part of the facility's Quality Assurance Program, [consultant name] has been retained to provide oversight of the facility health information systems, conduct audits, etc. [tailor role based on functions performed]. Any reports shall be part of the facility quality assurance documents and considered confidential.*

- **WORK WITH CORPORATE AND FACILITY POLICIES:** A consultant should be mindful of corporate policies related to HIM and assist the facility in adhering to those policies and procedures. If the consultant recommends changes in corporate policy/procedures and the facility concurs, a written report should be made to the corporate contact person with suggested alternatives and valid reasons.

- **EVALUATION OF CONSULTANT SERVICES:** On a routine basis (i.e., annually) the consultant and facility administrator should evaluate the consultant services. A formal mechanism such as a survey sent by the consultant or in a face to face meeting with the facility administrator or their designee can be conducted. (See the section 3.4 on Evaluating Consulting Services)

- **ABILITY TO ASSESS THE QUALITY OF DOCUMENTATION:** It is critical that a consultant have the ability to assess the quality of documentation across all disciplines. To do so, the consultant must understand the regulations, clinical standards, legal issues, reimbursement methods and have the ability to apply them to a variety of situations.

- **PROVIDE TELEPHONE CONSULTATION:** Because not all problems can wait until the next consultation visit, the consultant should provide telephone or e-mail consultation as situations arise. Telephone consultation time is equivalent to on-site consultation time. The facility should expect to pay for the time it takes to answer the questions that arise between consultation visits.

### 3.3 CONSULTATION REPORTS

Consultation reports should be provided after each visit to summarize the activities, findings and recommendations. There may be times when the consultant is working on an on-going project in which a written report after each visit is not necessary, but a summary is expected at the end of the project. The consultant and administrator/designee should decide on the expectations for a written report prior to the start of the project.

#### 3.3.1 Timeliness of Consultation Reports

Timely, complete and accurate consultant’s report are a valuable tool for follow-up and monitoring by a facility or corporation. The quality of a consulting service is equally dependent on the quality, content and timeliness of the written report provided after the consultation. A report is considered timely if it is provided to the facility within 7 to 10 working days after the consultation visit was conducted.

It is an advantage for the consultant and the facility to have a report or an abstract/draft report of activities, findings and recommendations prior to leaving the facility on the day of a visit. With the use of laptops or pre-printed reporting worksheets, a consultant should strive to provide some documentation on the day of the visit before leaving the facility.
3.3.2 Content of Consultation Reports

I. Demographics: Each consultation report should include the following basic information: Name and address of the facility, date of consultation visit, and consultants name, credentials and title.

II. Statement of Activities: It is suggested to start a report with a concise statement of the activities performed during the consultation visit. This can be in the form of a brief narrative summary, bulleted list or a pre-printed checklist form with activities identified. This summary will give the administrator a document that can be reviewed and summarized quickly.

III. Summary of Findings, Recommendations, and Follow-up: Provide a written summary of key findings, recommendations and follow-up activities or direction necessary. It is not necessary to describe every activity performed during the visit, but to focus on the key findings in which there are recommendations and/or follow-up. The report should direct the facility and provide guidance on what the facility is to do -- an action plan format may work well for this section of the report. The report should be written in language that is understandable to the reader.

IV. Attachments or Appendixes: This section should include either a copy of the audit tools or a summary of the audit findings and any copies of resources provided such as forms, regulations, etc.

V. Report Footer: A statement such as the following should be included in the consultation report to protect the confidentiality of the consultation report and audit findings. As part of {facility name} Quality Assurance Program, {consultant name} has been retained to provide oversight of the facility health information systems, conduct audits, etc. {tailor role based on functions performed}. Any reports shall be part of the facility quality assurance documents and considered confidential.

If the facility or corporation requests a specific format or specific forms for the consultation report, their request should be accommodated if possible.

Note: When summarizing audits of patient records, the patient name should not be included in the report. The medical record number should be referenced.

3.3.3 Distribution of The Consultation Report

Upon initiation of the contract, the consultant and administrator should decide to whom the consultant’s reports should be sent. It is often necessary to send two copies of the report – one to the administration/director of nursing services and one to the health information coordinator.

If the corporate office requests copies of reports to assist in their monitoring of the HIM problem areas, a copy of the report should be sent to the appropriate corporate person.

3.3.4 Retention of Reports (Facility And Consultant)

As a general rule, facilities should retain the consultation reports for a minimum of 2 years unless state law or corporate policy specifies a different time frame. Consultants should retain a copy of their reports for a minimum of 7 years or the state-specific statute of limitations for business records.

3.4 EVALUATING CONSULTING SERVICES

To assure that the customer (the facility or corporation) is satisfied with the services provided, it is recommended that a consultant incorporate some type of formal evaluation for feedback from the client. Feedback is essential to maintaining, improving, and growing a consulting business. One possible method would be to send out a questionnaire on an annual basis evaluating the services that they are providing. If the consultant does not have a process, the facility administrator should implement an evaluation and discuss their comments with the consultant during a consultation visit.
Sample 1: Consulting Service Evaluation:

The following questionnaire provides a baseline for an evaluation of services.

1) In general, do you feel that the services provided by your consultant have been helpful?:
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

2) Are the reports you receive helpful?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

3) Are the reports you receive understandable?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

4) Are the reports you receive returned promptly?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

5) Do you feel that the frequency of on-site visits are made regularly and as needed according to contract?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

6) Do you feel there is good rapport and communications between the consultant and your staff?
   __ Yes __ No
   Comments:

7) Do you feel that the entrance and exit conference with each visit is:
   __ Beneficial __ Not Beneficial
   If not, why?
   Comments:

8) If asked, would you recommend this consultant to other long term care facilities?
   __ Yes __ No
   If not, please explain:
   Comments:

9) Do you feel that the consultant keeps you up to date with changes and brings new ideas to your facility?
   __ Yes     __ No
   Comments:

Recommendations for Improvement:

General Comments:
Sample 2: Consulting Service Evaluation:

Use the following scale to rate your health information consulting services in the past year.
Scoring: Excellent = 4   Good = 3   Fair = 2   Poor = 1 Not Applicable = N/A

(Circle the score. Please provide comments and suggestions if score is less than three.)

1. Provides quality training and direction to the health information designee.
   Score: 4  3  2  1  N/A
   Comments:

2. Assesses the quality of the health information designee’s job duties and makes recommendations.
   Score: 4  3  2  1  N/A
   Comments:

3. Keeps us informed of new regulations and provides updates.
   Score: 4  3  2  1  N/A
   Comments:

4. Provides “quality” inservices to meet our needs.
   Score: 4  3  2  1  N/A
   Comments:

5. Identifies and prioritizes problem areas for action (identifies our strengths and weaknesses).
   Score: 4  3  2  1  N/A
   Comments:

6. Written reports clearly identify problems.
   Score: 4  3  2  1  N/A
   Comments:

7. Written reports include realistic recommendations directed to solve identified problems.
   Score: 4  3  2  1  N/A
   Comments:

8. Consultant reports are timely.
   Score: 4  3  2  1  N/A
   Comments:

9. Follows up on prior reports.
   Score: 4  3  2  1  N/A
   Comments:

10. Assists during survey and with plan of correction if requested.
    Score: 4  3  2  1  N/A
    Comments:

11. Exits with Administrator/Director of Nursing Services.
    Score: 4  3  2  1  N/A
    Comments:

12. Health Information Department policy and procedure manual is rated as:
    Score: 4  3  2  1  N/A
    Comments:
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Comments:

13. I have a good rapport with my consultant.
   Score:  4   3   2   1   N/A
   Comments:

   Score:  4   3   2   1   N/A
   Comments:

15. Overall rating of medical records consulting services.
   Score:  4   3   2   1
   Comments:

General Comments, strengths and suggestions: