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Essentials of

Health Information Management

Fifth Edition

Principles and Practices

Mary Jo Bowie
MS, BS, AAS, RHIA

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Essentials of Health Information Management: Principles and Practices, **Fifth Edition**
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Preface

Introduction

Managing health information, both in paper and electronic format, is an important function of allied health professionals (e.g., cancer registrars, coders, health information administrators and technicians, medical assistants, medical office administrators, medical transcriptionists). Accurate management of health information has become more exacting (e.g., due to changing federal regulations). Allied health professionals require thorough instruction in all aspects of health information management, including health care delivery systems, health information management professions, health care settings, and the patient record (acute, outpatient, and alternate care settings) including the electronic health record, content of the patient record (standards and regulations), numbering and filing systems, record storage and circulation, indexes, registers, health data collection, legal aspects, and coding and reimbursement. *Essentials of Health Information Management,* 5th Edition, provides the required information in a clear and comprehensive manner. Chapter content covers traditional record-keeping concepts covered in an introduction to health information management course, and concepts common to all types of health care facilities are included. Chapters also focus on differences associated with record-keeping practices in hospitals, ambulatory care facilities, and physicians' offices.

Objectives

The objectives of this text are to:

1. Introduce health information management concepts common to allied health professionals.
2. Describe characteristics of health care delivery and settings in the United States.
3. Delineate career opportunities for health information management professionals.
4. Describe types of patient records, including documentation issues associated with each.
5. Describe numbering and filing systems and record storage and circulation methods, including the electronic health record.
6. Explain indexes, registers, and health data collection.
7. Introduce legal aspects of health information management.
8. Provide an overview of coding and reimbursement issues.
9. Compare paper and electronic health record systems.

This text is designed to be used by college and vocational school programs to train allied health professionals (e.g., cancer registrars, coders, health information administrators and technicians, medical assistants, medical office administrators, medical transcriptionists). It can also be used as an in-service training tool for new health care facility personnel and independent billing services, or individually by health information specialists.

New to the Fifth Edition

This edition expands content on information systems, data management, data security, ethics, cultural diversity and cultural competence, and human resources.

- Chapter 1 has been revised to reduce content about prehistoric, ancient, medieval, and Renaissance medicine; this content can now be found in the Appendix. The chapter includes new content about telehealth and telemedicine.
- Chapter 2 includes new content about the development of the American Health Information Management Association (AHIMA) and its predecessor organizations. Content about Ethical Standards of Practice has been expanded, including specifics about the AHIMA Code of Ethics. Content has been added about cultural diversity, cultural competence, health care disparities, health equity, and Healthy People 2030.
- Chapter 3 has been updated to include new content on critical access hospital, additional information on general hospitals in rural settings, a comparison of rehabilitation hospitals to general hospitals, the benefits of ambulatory care versus inpatient care, updated information about cancer treatments in infusion centers, and expanded examples about skilled care. A new section has been added titled Health Information Management in Various Settings.
- Chapter 4 has been revised to include electronic addenda, differences between manual and electronic signatures, and record retention laws for federal prisons. Content has been expanded in the section Role of Health Information Department in relation to electronic record documentation.

- Chapter 5 contains a new section on the Use of Information Technologies. This includes a definition of interoperability and the use of information technology during COVID-19. New sections have also been added for Information Systems and Database Management Systems, which include information on database design, data mining, data dictionary, clinical data repository, data warehouses, data mart, data definition language, structured query language (SQL), and relational database.
- Chapter 6 now discusses the professional disclosure standard and the reasonable patient standard in protecting health information. Additional content has been added on the manner in which new forms and new data items are developed and the functional characteristics of documentation format.
- Chapter 7 includes new content on the the HIPAA security rule and disaster plans.
- Chapter 9 has been expanded to include new content on the role and responsibilities of a security officer, at-will employment, independent contractors, reasonable accommodations, unions, and federal employment laws.

Features of the Text

- Key terms and learning objectives at the beginning of each chapter help organize the material. They can be used as a self-test for checking comprehension and mastery of the chapter. Key terms are bold-faced throughout each chapter and defined in the glossary to help students master the technical vocabulary associated with health information management.
- Exercises are located after major topics to provide students with an opportunity to apply concepts and skills immediately.
- Numerous examples are provided in each chapter to illustrate health information management concepts.
- End-of-chapter Internet links, summaries, study checklists, and reviews reinforce learning and identify topics requiring further study.
- Questions created for exercises and reviews serve as a self-test of chapter content.

Instructor Resources

Additional instructor resources for this product are available online. Instructor assets include an Instructor's Manual, Solution and Answer Guide, MindTap Educator's Guide, Transition Guide, PowerPoint® slides, and a test bank powered by Cognero. Sign up or sign in at www.cengage.com to search for and access this product and its online resources.

MindTap

MindTap is a fully online, interactive learning experience built upon authoritative Cengage content. By combining readings, multimedia activities, and assessments into a singular learning path, MindTap elevates learning by providing real-world application to better engage students. Instructors customize the learning path by selecting Cengage resources and adding their own content via apps that integrate into the MindTap framework seamlessly with many learning management systems.

This MindTap includes:

- Apply It activities that mimic on-the-job skills such as filing, case abstracting, and release of information
- Case Studies with real-world scenarios that promote critical thinking and are accompanied by short answer questions
- Quizzes that provide additional auto-graded questions to test students on mastery of chapter learning objectives

Acknowledgments

From Mary Jo Bowie:

To my husband, Bill, who always supports and encourages me in all that I do. To my daughter, Sarah, and daughter and son-in-law, Bethannie and Jesse, may you all grow strong in your faith. To my grandchildren, Isabella, Jesse Jr., Adelyn, and Deklyn who Papa and I will spoil with the royalties from this book!!

To my parents for their support through all of my life.

To my dear friend, Michelle Green, your love for teaching will always be the driving force for each new edition of this book.

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Chapter 1

Health Care Delivery Systems

Chapter Outline

- Key Terms
- Objectives
- Introduction
- History of Medicine
- Health Care Delivery in the United States
- Continuum of Care
- Health Care Facility Ownership
- Health Care Facility Organization Structure and Operation
- Licensure, Regulation, and Accreditation
- Internet Links
- Summary
- Study Checklist
- Chapter Review

Key Terms

abstracting
accreditation
Accreditation Council for Graduate Medical Education (ACGME)
active
agenda
American Recovery and Reinvestment Act
associate
biometrics
board of directors
board of governors
board of trustees
bylaws
Centers for Medicare & Medicaid Services (CMS)
chief resident
Code of Federal Regulations (CFR)
coding
consulting
continuum of care
contract services
courtesy
Current Procedural Terminology (CPT®)
deemed status
deeming authority
Deficit Reduction Act of 2005
digital signature
disaster recovery plan
do not resuscitate (DNR)
electronic health record (EHR)
electronic signature
Emergency Medical Treatment and Labor Act (EMTALA)
encoder
Federal Register
for-profit
Genetic Information Nondiscrimination Act (GINA)
governing board
government-supported hospitals
groupers
HCPCS Level II (national) codes
Healthcare Integrity and Protection Data Bank (HIPDB)
Health Care Procedure Coding System (HCPCS)
health care proxy
Health Insurance Portability and Accountability Act (HIPAA)
Health Plan Employer Data and Information Set (HEDIS)
Hill-Burton Act
Hippocrates
Hippocratic Oath
honorary

hospital administration
hospital departments
hospitalists
Human Genome Project
incomplete record processing
intern
International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
intranet
licensure
living will
Medicaid (Title 19)
medical staff
medical transcription
Medicare (Title 18)
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
Medieval medicine
Merit-Based Incentive Payment System (MIPS)
Middle Ages
minutes
modern medicine
National Practitioner Data Bank (NPDB)
not-for-profit
ORYX® initiative
paleopathology
Patient Safety and Quality Improvement Act of 2005
Patient Self-Determination Act
Physician Quality Reporting Initiative (PQRI)
prehistoric medicine and ancient medicine
primary care
proprietary hospitals
public hospitals
public key cryptography
quality improvement organization (QIO)
quaternary care
record circulation
regulation
Renaissance medicine
resident
rules and regulations
secondary care
Shared Visions—New Pathways™
smart card
standards
State Children's Health Insurance Program (SCHIP)
state department of health
survey
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
teaching hospitals
telehealth
telemedicine
tertiary care
Title XXI of the Balanced Budget Act of 1997
triage
universal chart order
veterans
voluntary hospitals

Objectives

At the end of this chapter, you should be able to:

1. Define key terms related to health care delivery systems
2. Trace the historical development of the health care delivery system from early times to the present
3. List milestones in the progression of the health care delivery system in the United States
4. List programs and services offered as part of the continuum of care
5. Differentiate between for-profit and not-for-profit health care facility ownership
6. Interpret the authority and responsibility associated with a health care facility's organizational structure
7. Provide examples of the various health care providers across the continuum of care
8. Compare and contrast the different health care roles, including physicians, dentists, chiropractors, podiatrists, optometrists, physician assistants, nurses, and allied health professions
9. Differentiate among licensure, regulation, and accreditation

Introduction

Health care delivery in the United States has been greatly impacted by escalating costs, resulting in medical necessity requirements (to justify acute care hospitalizations), review of appropriateness of admissions, and requirements for administration of quality and effective treatments. Patients routinely undergo preadmission testing (PAT) on an outpatient basis instead of being admitted as a hospital inpatient, and the performance of outpatient testing and surgical procedures has increased due to health care technological advances (e.g., laparoscopic surgeries). Health care consumers are better educated and demand higher-quality, more cost-effective health care; thus, the focus is on primary and preventive care.

History of Medicine

Information about historical health care delivery practices comes primarily from the study of textual references, artistic illustrations, and the study of human remains (called **paleopathology**), which is probably the most reliable source because of less potential for written and artistic bias. While diagnoses and treatments associated with prehistoric and ancient medicine were mostly a product of ignorance and superstition, an occasional discovery actually worked. Health care delivery in the United States is based on beliefs about disease and health that evolved over past centuries.

Prehistoric medicine and ancient medicine (see Appendix, Prehistoric Medicine and Ancient Medicine section) were both characterized by the belief that illness was caused by the supernatural, an attempt to explain changes in body functions that were not understood (e.g., evil spirits were said to have invaded the body of the sick person).

Hippocrates (460–370 BC, a Greek physician known as the "father of medicine") was the first physician to consider medicine a science and art separate from the practice of religion. The **Hippocratic Oath** was adopted as an expression of early medical ethics and reflected high ideals.

Medieval medicine (see Appendix, Medieval Medicine section) developed during the **Middle Ages**, which were characterized by a lack of education except among nobility and the most wealthy. The most significant medical development was the construction of hospitals to care for the sick (e.g., for bubonic plague). Often managed by monks and nuns, the care of patients was based on charity rather than on scientific principles.

Renaissance medicine (see Appendix, Renaissance Medicine section), mostly associated with Europe, was characterized by a renewed interest in the arts, sciences, and philosophy. This was the beginning of modern medicine, based on education instead of spiritual beliefs.

Society had an impact on **modern medicine**. Many discoveries paved the way for new understanding of the disease process and treatments. Review Table 1-1 and note the discoveries that helped to accomplish this. In addition, choosing health care as a profession became more acceptable, hospitals were reformed, and the training of physicians and nurses improved.

Table 1-1 Discoveries Impacting Medicine

- William Harvey proved the continuous circulation of the blood within a contained system; and Aselli discovered lymphatic vessels through experiments on animals, leading to a theory attributing cancer to lymph abnormalities. Lymphatic drainage became the key factor in developing more extensive surgical removal of cancer.
- Dutch amateur scientist Anton van Leeuwenhoek began using a microscope to study organisms invisible to the naked eye (now called microorganisms, microbes, or germs). Leeuwenhoek discovered certain microbes that later became known as bacteria.
- English physician Edward Jenner discovered a safe method of making people immune to smallpox; this was the first officially recorded vaccination. The success of the experiment initiated the science of immunology—the prevention of disease by building up resistance to it.
- Louis Pasteur and Robert Koch firmly established the microbial, or germ, theory of disease. Pasteur proved that microbes are living organisms, that certain kinds of microbes cause disease, and that killing certain microbes stops the spread of specific diseases.
- German physician Koch invented a method for determining which bacteria cause particular diseases. This method enabled him to identify the germ that causes anthrax—the first germ definitely linked to a particular disease.
- By the end of the 1800s, researchers had discovered the kinds of bacteria and other microbes responsible for such infectious diseases as cholera, diphtheria, dysentery, gonorrhea, leprosy, malaria, plague pneumonia, tetanus, and tuberculosis.
- In the 1840s, Americans Crawford Long and William T. G. Morton independently discovered that ether gas could safely be used to put patients to sleep during surgery. With an effective anesthetic, physicians could perform operations never before possible.
- The scientific study of disease, called pathology, developed during the 1800s. German physician and scientist Rudolf Virchow believed the only way to understand the nature of disease was by close examination of the affected body cells. The development of much improved microscopes in the early 1800s made his studies possible.

(Continues)

Table 1-1 Discoveries Impacting Medicine *(continued)*

- Before the mid-1800s, hospitals paid little attention to cleanliness and surgeons operated in street clothes. Pasteur's early work on bacteria convinced an English surgeon named Joseph Lister that germs caused the death of many surgical patients. In 1865, Lister began using carbolic acid, a powerful disinfectant, to sterilize surgical wounds. But this method was later replaced by a more efficient technique known as aseptic surgery. This technique involved keeping germs away from surgical wounds in the first place instead of trying to kill germs already there. Surgeons began to wash thoroughly before an operation and to wear surgical gowns, rubber gloves, and masks. Steam was also introduced for physical sterilization (e.g., surgical instruments).
- The discovery of x-rays by the German physicist Wilhelm Roentgen in 1895 enabled doctors to "see" inside the human body to diagnose illnesses and injuries. The discovery of radium by the French physicists Pierre and Marie Curie in 1898 provided a powerful weapon against cancer.
- About 1910, German physician and chemist Paul Ehrlich introduced chemotherapy, which involved searching for chemicals to destroy the microbes responsible for particular diseases.
- In 1928, the English bacteriologist Sir Alexander Fleming discovered the germ-killing power of a mold called Penicillium. In the early 1940s, a group of English scientists headed by Howard Florey isolated penicillin, a product of this mold. Penicillin thus became the first antibiotic.
- In 1935, German doctor Gerhard Domagk discovered the ability of sulfa drugs to cure infections in animals, which led to the development of sulfa drugs to treat diseases in humans.
- From 1940 through 1961, laboratory studies of prothrombin time, electrolytes, blood gases, and creatine phosphokinase (CPK) were introduced.
- In 1955, the Salk polio vaccine was licensed.
- During the 1960s and 1970s, the World Health Organization (WHO) conducted a vaccination program that virtually eliminated smallpox from the world.
- In 1966, the International Smallpox Eradication program was established. Led by the U.S. Public Health Service, worldwide eradication of smallpox was accomplished in 1977.
- In the 1970s, improvements in cardiac bypass and joint replacement surgery were made, and computed tomography and whole-body scanners were first used. Magnetic resonance imaging (MRI) was introduced in the 1980s.
- In 1981, Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus III (HIV) were identified. In 1984, the Public Health Service and French scientists identified the Human Immunodeficiency Virus. The National Organ Transplantation Act was signed into law. In 1985, the blood test used to detect HIV was licensed. By June 1990, 139,765 people in the United States had HIV/AIDS, with a 60 percent mortality rate. Also in 1990, the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act began to provide support for communities to help people with AIDS.
- In 1990, the **Human Genome Project** was established. This was a nationally coordinated effort to characterize all human genetic material by determining the complete sequence of the DNA in the human genome. In 2000, human genome sequencing was published.
- In 1994, National Institutes of Health (NIH)-supported scientists discovered the genes responsible for many cases of hereditary colon cancer, inherited breast cancer, and the most common type of kidney cancer.
- In 2006, the Food and Drug Administration (FDA) approved the first vaccine for human papilloma virus (HPV). The vaccine is delivered in three injections over six months and protects against four strains of the virus that can lead to genital warts and cervical cancer.
- Over the past decade, minimally invasive or robotic surgeries have expanded from gall bladder and gynecologic surgeries to include surgeries on the heart, intestinal organs, and cancer surgeries. The advantages of laparoscopic surgery over traditional "open" surgeries are smaller incisions, shorter recovery time and hospital stay, less scarring, and reduced blood loss.
- Over the last five years many diagnostic tests have been studied and developed to detect diseases. For example the National Institute on Aging presented a study in 2016 at the Society for Neuroscience. This study used a blood test to determine the amount of a single protein, IRS-1 (Internal Revenue Service-1), which was found to be defective in people with Alzheimer's disease. The study concluded that individuals with Alzheimer's disease had increased amounts of the inactive form of IRS-1 and decreased amounts of the active form of IRD-s than adults without the disease. Testing for IRS-1 can help to potentially diagnose the disease before symptoms appear.

Health Care Delivery in the United States

The development of health care delivery in the United States (Table 1-2) began with crude folk remedies used by settlers who had to cope with epidemics, life-threatening weather, nutritional disorders, and starvation. Advances in health care delivery closely followed the changes in England and Europe, and hospitals were established in larger cities (e.g., Philadelphia, New York City, and Boston). As the population of the United States increased, there was a corresponding need for health care facilities and trained personnel.

Because the increased number of schools and hospitals did not ensure quality, standards were later developed for hospitals and for the training of medical personnel.

In 1910 Abraham Flexner prepared a report entitled *Medical Education in The United States and Canada,* also known as the Flexner Report. This report was the catalyst for the health care standardization

Table 1-2 Development of Health Care Delivery in the United States

Year	Event
1751	The Pennsylvania Hospital founded by Benjamin Franklin and built in 1751 is the first U.S. hospital.
1765	Surgeon John Morgan organized a medical faculty at the University of Pennsylvania, thereby creating the United States' first medical school. It was based on a curriculum that combined instruction in the arts and the classics with practical knowledge necessary to make a living.
1798	The first Marine Hospital was funded to care for sailors. It was originally part of the Department of the Treasury because 20 cents per month was collected from seamen; later it became part of the Department of the Navy.
1847	The American Medical Association (AMA) was founded at the Academy of Natural Sciences in Philadelphia to elevate the standard of medical education in the United States. The AMA was reorganized in 1901 as a national organization of state and local associations, and membership increased from 8,000 physicians (1900) to 70,000 (1910), representing almost one-half of U.S. physicians. Partly as a result of the AMA's efforts, the first state licensing boards were set up in the late 1800s.
1862	President Lincoln appointed chemist Charles M. Wetherill to serve in the new Department of Agriculture, which became the Bureau of Chemistry, a forerunner to the Food and Drug Administration (FDA).
1872	The officers and employees of the Kansas Pacific Railroad in Denver, Colorado, started the Clara Hospital Association. Each contributed 50 cents per month toward its support.
1887	The federal government opened a one-room laboratory on Staten Island to conduct disease research, the forerunner to the National Institutes of Health (NIH).
1895	The National Medical Association (NMA) was created to represent Black physicians and health professionals in the United States.
1897	Osteopathic physicians founded the American Osteopathic Association (AOA) and adopted a "whole-person" approach to providing health care. The Doctor of Osteopathy (DO) particularly focuses on the musculoskeletal system, which reflects and influences conditions associated with other body systems.
1898	The Association of Hospital Superintendents was founded to facilitate discussion among hospital administrators, and in 1906 its name was officially changed to the American Hospital Association (AHA). The AHA currently represents almost 5,000 hospitals and health care networks to advance the health of individuals and communities and to lead, represent, and serve health care provider organizations that are accountable to the community and committed to health improvement.

movement. In Table 1-3 review the date entries for 1910 to 1918 for specific events that occurred.

During the 1920s to 1940s hospitals become obsolete due to the Great Depression and World War II. To modernize hospitals the Hill-Burton Act was passed. Refer to Table 1-3, date entry of 1946, for detailed information about the Hill-Burton Act.

Health care delivery in the twentieth century and beyond is characterized by an emphasis on rising costs, the need for insurance, and the role of government in the payment for services. See Chapter 10 for extensive coverage of the U.S. health care reimbursement system.

Table 1-3 Evolution of Health Care Delivery in the United States

Year	Event
1906	Congress passed the first Food and Drug Act, authorizing the government to monitor the purity of foods and the safety of medicines, now a responsibility of the FDA.
1910	The Carnegie Foundation for the Advancement of Teaching issued a report, *Medical Education in the United States and Canada*, which was prepared by U.S. educator Abraham Flexner. The *Flexner Report*, as it also came to be known, stated that only 1 of the 155 medical schools in the United States and Canada at that time provided an acceptable medical education. That school was the Johns Hopkins Medical School, founded in Baltimore in 1893.
1913	The American College of Surgeons (ACS) was founded to improve the quality of care for surgical patients by establishing standards for surgical education and practice. It adopted the "end-result system of hospital standardization" developed in 1910 by Ernest Codman, MD. Hospitals tracked patients long enough to determine whether treatment was effective; if treatment was ineffective, hospitals would attempt to determine how similar cases could be successfully treated in the future. *Note:* According to their website, the official abbreviation for the American College of Surgeons is ACS. Elsewhere, you might see the organization abbreviated as ACoS.
1917	The ACS developed the *Minimum Standard for Hospitals*, which was one page in length and contained five points.
1918	As part of its Hospital Standardization Program, the ACS performed on-site inspections of hospitals, with only 89 of 692 hospitals surveyed meeting requirements of the *Minimum Standard for Hospitals*. (The first standards manual, containing 18 pages, was printed in 1926; by 1950, the standard of care had improved with more than 3,200 hospitals achieving approval under the program.)
1926	General Motors established a group insurance plan contract with Metropolitan Life Insurance Company, which provided 180,000 employees with hospitalization and surgical benefits.
1929	The first Blue Cross plan was offered at Baylor University in Dallas, Texas, to guarantee schoolteachers 21 days of hospital care for $6 a year. Other groups of employees in Dallas soon joined the plan, and Blue Cross began offering private health insurance coverage for hospital care in dozens of states. *Note:* Blue Cross usually covers the cost of hospital care.
1935	Congress passed the Social Security Act (SSA), which did not include disability coverage or medical benefits. It did include unemployment insurance, old-age assistance, aid to dependent children, and grants to states to provide various forms of medical care.
1939	The first Blue Shield plan was offered in California (based on a concept initiated at the turn of the century in which employers paid monthly fees to groups of physicians who provided health care services to Pacific Northwest lumber and mining camps). *Note:* Blue Shield usually covers the cost of physicians' services.
1946	The Communicable Disease Center (CDC) was established. It is the forerunner of the Centers for Disease Control and Prevention (also abbreviated CDC).

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
1946 (*continued*)	The **Hill-Burton Act** (Hospital Survey and Construction Act) was passed and provided federal grants to modernize hospitals that had become obsolete due to lack of capital investment throughout the period of the Great Depression and World War II (1929 to 1945). In return for federal funds, facilities agreed to provide free or reduced-charge medical services to persons unable to pay. (The program has changed over time to address other types of infrastructure needs. It is managed by the Health Resources and Services Administration, located in the Department of Health and Human Services.)
1951	The Joint Commission on Accreditation of Hospitals (JCAH) was created as an independent, not-for-profit organization whose primary purpose is to provide voluntary accreditation. Its membership consisted of the American College of Physicians, the American Hospital Association, the American Medical Association, the Canadian Medical Association, and the American College of Surgeons. In 1987, the organization underwent a name change to become The Joint Commission on Accreditation of Healthcare Organizations, or JCAHO (pronounced jay' ko). In 2007, the organization underwent another name change, becoming The Joint Commission.
1952	The Hospital Standardization Program was transferred from the ACS to the JCAH (now The Joint Commission), which began accrediting hospitals in January of 1953 after publishing its *Standards for Hospital Accreditation*. (Hospitals were not charged for the accreditation process until 1964.)
1953	The Department of Health, Education, and Welfare (HEW) was created under President Eisenhower. (The cost of hospital care doubled in the 1950s.)
1961	The White House Conference on Aging was held, with many recommendations becoming law in the mid-1960s, including Medicare and Medicaid, Social Security reform, and the Older Americans Act that established the Administration on Aging and its counterpart, the State Units on Aging. The Community Health Services and Facilities Act of 1961 funded projects for testing and demonstrating new or improved services in nursing homes, home care services, and central information and referral centers, and provided additional personnel to serve the chronically ill and aged. It also funded the construction of nursing homes and the establishment of voluntary health planning agencies at local levels, resulting in community health centers to serve low-income regions.
1962	The Migrant Health Act was passed, providing medical and support services to migrant and seasonal farm workers and their families.
1964	The first *Surgeon General's Report on Smoking and Health* was released, becoming America's first widely publicized official recognition that cigarette smoking is a cause of cancer and other serious diseases.
1965	The Medicare and Medicaid programs were enacted as part of the Social Security Amendments of 1965 (SSA of 1965), making comprehensive health care available to millions of Americans. **Medicare (Title 18)** is for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD, which is a permanent kidney failure treated with dialysis or a transplant). **Medicaid (Title 19)** is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered for those who qualify for both Medicare and Medicaid. Provider-based utilization review was a condition of participation in Medicare, which helped assure medical necessity and quality of care. Amendments to the Dependents' Medical Care Act of 1956 created the *Civilian Health and Medical Program–Uniformed Services (CHAMPUS)*, which was designed as a benefit for dependents of personnel serving in the armed forces as well as uniformed branches of the Public Health Service and the National Oceanic and Atmospheric Administration. The program is now called *TRICARE*.

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
1965 (*continued*)	The JCAH was granted **deemed status** by Congress as part of the SSA of 1965, which means JCAH-accredited hospitals have met or exceeded Conditions of Participation to participate in the Medicare and Medicaid programs. The Centers for Medicare & Medicaid Services (CMS) develop regulations to improve quality and protect the health and safety of beneficiaries, entitled *Conditions of Participation (CoP)* and *Conditions for Coverage (CfC)*. Health care organizations must meet these regulations to receive reimbursement from (participate in) the Medicare and Medicaid programs.
1970s	Health care costs escalated, partially due to unexpectedly high Medicare expenditures, rapid economic inflation, expansion of hospital expenses and profits, and changes in medical care including greater use of technology, medications, and conservative approaches to treatment.
1970	The National Health Service Corps was created to improve the health of people who live in communities without access to primary health care (or primary care), which is the patient's entry to the health care system in most non-emergency situations and encompasses preventive care, health maintenance, identification and management of common conditions, and coordination of consultations and referrals.
1971	The National Cancer Act of 1971 was signed into law, which amended the Public Health Service Act to more effectively carry out the national effort against cancer. This was part of President Nixon's "War on Cancer" and centralized research at the NIH.
1972	Social Security Amendments of 1972 strengthened the utilization review process through formation of Professional Standards Review Organizations (PSROs)—independent peer review organizations that monitored the appropriateness, quality, and outcome of the services provided to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health Programs. (PSROs are now called Quality Improvement Organizations, or QIOs.) The federal Drug Abuse and Treatment Act of 1972 required that drug and alcohol abuse patient records be kept confidential and not subject to disclosure except as provided by law. This law applied to federally assisted alcohol or drug abuse programs that provide diagnosis, treatment, or referral for treatment of drug and/or alcohol abuse. *Note:* General medical care facilities are required to comply with the legislation *only* if they have an identified drug/alcohol abuse treatment unit or their personnel provide drug/alcohol diagnosis, treatment, or referral.
1973	The Veterans Healthcare Expansion Act of 1973 authorized Veterans Affairs (VA) to establish the *Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)* to provide health care benefits for dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service. The *Health Maintenance Organization Assistance Act of 1973* authorized federal grants and loans to private organizations that wished to develop *health maintenance organizations (HMOs)*, which are responsible for providing health care services to subscribers in a given geographic area for a fixed fee.
1974	The Privacy Act of 1974 was implemented to (1) protect the privacy of individuals identified in information systems maintained by federal government hospitals (e.g., military hospitals) and (2) provide access to records concerning themselves. *Note:* While this law has no effect on records maintained by non-federal hospitals, effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires *all* health plans, health care clearinghouses, and health care providers who conduct electronic financial/administrative transactions (e.g., electronic billing) to comply with national patient privacy standards, which contain safeguards to protect the security and confidentiality of patient information.

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
1977	The Health Care Financing Administration (HCFA), now called the Centers for Medicare & Medicaid Services (CMS), was created separately from the Social Security Administration to manage Medicare and Medicaid. The Utilization Review Act of 1977 was implemented to facilitate ongoing assessment and management of health care services, requiring hospitals to conduct continued-stay reviews to determine the medical necessity and appropriateness of Medicare and Medicaid inpatient hospitalizations. Fraud and abuse legislation was also introduced.
1979	The Department of Education Organization Act was signed into law, providing for a separate Department of Education. Health, Education, and Welfare (HEW) officially became the Department of Health and Human Services (HHS) on May 4, 1980.
1982	The Peer Review Improvement Act of 1982 replaced PSROs with Peer Review Organizations (PROs), which were statewide utilization and quality control peer review organizations. (In 1985, PROs incorporated a focused second-opinion program, which referred certain cases for diagnostic and treatment verification.) The **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** established the first Medicare prospective payment system, which was implemented in 1983. Diagnosis-related groups (DRGs) required acute care hospitals to be reimbursed at a predetermined rate according to discharge diagnosis (instead of a per diem rate, which compensated hospitals retrospectively based on charges incurred for the total inpatient length of stay, usually 80 percent of charges). *Note:* Additional prospective payment systems were implemented in subsequent years for other health care settings. See Table 10-4 in Chapter 10.
1984	HCFA (now called CMS) required providers to use the *HCFA-1500* (now called the *CMS-1500*) to submit Medicare claims. The HCFA Common Procedure Coding System (HCPCS) (now called Health Care Procedure Coding System) was created, which included CPT, Level II (national), and Level III (local) codes. Commercial payers also adopted HCPCS coding and use of the HCFA-1500 claim.
1985	The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 allowed former employees, retirees, spouses, domestic partners, and eligible dependent children who lose coverage due to certain qualifying events the right to temporary continuation of health coverage at group rates. Benefits can continue for 18 or 36 months, depending on the qualifying event, and premiums are calculated at 102 percent of the total premium rate, payable by the enrollee on a monthly basis directly to the carrier. It also allowed HCFA (now CMS) to deny reimbursement for substandard health care services provided to Medicare and Medicaid patients. The **Emergency Medical Treatment and Labor Act (EMTALA)** (antidumping statute) addressed the problem of hospitals' failure to screen, treat, or appropriately transfer patients (patient dumping) by establishing criteria for the discharge and transfer of Medicare and Medicaid patients.
1986	The Omnibus Budget Reconciliation Act of 1986 (OBRA of 1986) required PROs to report cases of substandard care to licensing and certification agencies. The federal Health Care Quality Improvement Act of 1986 established the **National Practitioner Data Bank (NPDB)**, which contains information about practitioners' credentials, including previous medical malpractice payment and adverse action history. State licensing boards, hospitals, and other health care facilities access the NPDB to identify and discipline practitioners who engage in unprofessional behavior.

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
1987	The Nursing Home Reform Act (part of the Omnibus Budget Reconciliation Act of 1987) ensured that residents of nursing homes receive quality care, required the provision of certain services to each resident, and established a Residents' Bill of Rights. Nursing homes receive Medicaid and Medicare payments for long-term care of residents if they are certified by the state in which they reside to be in substantial compliance with the requirements of the Nursing Home Reform Act.
1988	The McKinney Act was signed into law, providing health care to individuals experiencing homelessness. *Clinical Laboratory Improvement Act* (*CLIA*) legislation established quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. The *Medicare Catastrophic Coverage Act* mandated the reporting of ICD-9-CM diagnosis codes on Medicare claims; in subsequent years, private third-party payers adopted similar requirements for claims submission. *Note:* ICD-10-CM replaces the reporting of all ICD-9-CM diagnosis codes, and ICD-10-PCS replaces the reporting of ICD-9-CM inpatient procedure codes. CPT and HCPCS Level II codes continue to be reported for all outpatient procedures and services. All coding systems are discussed in Chapter 10 of this textbook.
1989	OBRA of 1989 created the Agency for Health Care Policy and Research (now called the Agency for Healthcare Research and Quality, or AHRQ), which conducts health services research for the Department of Health and Human Services (HHS) and complements the biomedical research mission of the National Institutes of Health (NIH). AHRQ develops outcomes measures of the quality of health care services.
1990	OBRA of 1990 required PROs to report adverse actions to state medical boards and licensing agencies. The **Patient Self-Determination Act** required consumers to be provided with informed consent, information about their right to make advance health care decisions (called advance directives), and information about state laws that impact legal choices in making health care decisions. The following are examples of advance directives that will be discussed in Chapter 6. • Do Not Resuscitate (DNR) Order • Durable Power of Attorney for Health Care • Health Care Proxy • Living Will • Organ or Tissue Donation
1991	The Workgroup on Electronic Data Interchange (WEDI) was created to reduce health care administrative costs through implementation of the electronic data interchange (EDI), which uses national standards to transmit data for reimbursement purposes. (ASC X12, the national standard, refers to the "Accredited Standards Committee X12" that is comprised of North American government and industry members who create EDI draft standards for submission to the American National Standards Institute, or ANSI). WEDI helped ensure passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 and is a consultant to the Secretary of Health and Human Services for implementation of Administrative Simplification HIPAA legislation.
1993	The Vaccines for Children Program was established, providing free immunizations to all children in low-income families.
1995	The Social Security Administration became an independent agency on March 31, 1995.

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
1996	The **Health Insurance Portability and Accountability Act (HIPAA)** was passed. It mandates administrative simplification regulations that govern privacy, security, and electronic transactions standards for health care information. HIPAA also protects health insurance coverage for workers and their families when they change or lose their jobs. In addition, the **Healthcare Integrity and Protection Data Bank (HIPDB)** was created, which combats fraud and abuse in health insurance and health care delivery by alerting users to conduct a comprehensive review of a practitioner's, provider's, or supplier's past actions.
1997	The **State Children's Health Insurance Program (SCHIP)** (or **Title XXI of the Balanced Budget Act of 1997**) was established. It is a health insurance program for infants, children, and teens that covers health care services such as doctor visits, prescription medicines, and hospitalizations.
1999	The Ticket to Work and Work Incentives Improvement Act of 1999 was signed into law, making it possible for millions of Americans with disabilities to join the workforce without fear of losing their Medicaid and Medicare coverage. It also modernized the employment services system for people with disabilities. In addition, the initiative on combating bioterrorism was launched.
2000	The *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act* (BIPA) requires implementation of a $400-billion prescription drug benefit, improved Medicare Advantage (formerly called Medicare+Choice) benefits, faster Medicare appeals decisions, and more. *Consumer-driven health plans* (*CDHPs*) are introduced as a way to encourage individuals to locate the best health care at the lowest possible price with the goal of holding down health care costs.
2001	The **Centers for Medicare & Medicaid Services (CMS)** was created, replacing the Health Care Financing Administration (HCFA). In addition, HHS responded to the nation's first bioterrorism attack, which was the delivery of anthrax through the mail.
2002	CMS announced that peer review organizations (PROs) will be known as **quality improvement organizations (QIOs)**, and that they will continue to perform quality control and utilization review of health care furnished to Medicare beneficiaries. Under the direction of CMS, the network of 53 quality improvement organizations is comprised of private contractors that work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services and by investigating beneficiary complaints about quality of care.
2002	The *employer identification number* (*EIN*), assigned by the Internal Revenue Service (IRS), is adopted by DHHS as the National Employer Identification Standard for use in health care transactions.
2003	The **Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)** was implemented. This act: • Provides Medicare recipients with prescription drug savings and additional health care plan choices (other than traditional Medicare) • Modernizes Medicare by allowing private health plans to compete • Requires that Medicare Trustees analyze the combined fiscal status of the Medicare Trust Funds and warn Congress and the president when Medicare's general fund subsidy exceeds 45 percent The *Medicare Contracting Reform* (*MCR*) *initiative* was established to integrate the administration of Medicare Parts A and B fee-for-service benefits with new entities called Medicare administrative contractors (MACs). MACs replaced Medicare carriers, DMERCs, and fiscal intermediaries to improve and modernize the Medicare fee-for-service system and establish a competitive-bidding process for contracts.
2005	The **Deficit Reduction Act of 2005** created the Medicaid Integrity Program (MIP), which is a fraud and abuse detection program.

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
2005 (*continued*)	The **Patient Safety and Quality Improvement Act of 2005** amends Title IX of the Public Health Service Act to provide for improved patient safety and reduced incidence of events adversely affecting patient safety. It encourages the reporting of health care mistakes to patient safety organizations by making the reports confidential and shielding them from use in civil and criminal proceedings. The Standard Unique Health Identifier for Health Care Providers, or *National Provider Identifier* (*NPI*), is implemented.
2006	The Tax Relief and Health Care Act (TRHCA) of 2006 authorized implementation of a **Physician Quality Reporting Initiative (PQRI)**, which established a financial incentive for eligible professionals who participate in a *voluntary* quality reporting program.
2008	The **Genetic Information Nondiscrimination Act (GINA)** prohibits group health plans and health insurance companies from denying coverage to a healthy individual or charging higher premiums based solely on a genetic predisposition to development of a disease in the future. It also bars employers from using genetic information when making hiring, firing, job placement, and promotion decisions. CMS grants *deeming authority* to Det Norske Veritas Healthcare, Inc. (DNV) as a national accreditation program for hospitals seeking to participate in the Medicare program. (Hospitals can pursue accreditation through DNV in addition to or as an alternative to The Joint Commission accreditation.)
2009	The **American Recovery and Reinvestment Act** authorized an expenditure of $1.5 billion for grants for construction, renovation and equipment, and the acquisition of health information technology systems. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) (included in the American Recovery and Reinvestment Act of 2009) amended the Public Health Service Act to establish an Office of National Coordinator for Health Information Technology within HHS to improve health care quality, safety, and efficiency.
2010	The Patient Protection and Affordable Care Act (PPACA) focuses on private health insurance reform to provide better coverage for individuals with preexisting conditions, improve prescription drug coverage under Medicare, and extend the life of the Medicare Trust fund by at least 12 years. Its goal is to provide quality affordable health care for Americans, improve the role of public programs, improve the quality and efficiency of health care, and improve public health. PPACA also amended the time period for filing Medicare fee-for-service (FFS) claims to one calendar year after the date of service. The Health Care and Education Reconciliation Act (HCERA) amended the PPACA to implement health care reform initiatives such as increasing tax credits to buy health care insurance, eliminating special deals provided to senators, closing the Medicare "donut hole," delaying taxes on "Cadillac" health care plans until 2018, implementing revenue changes (e.g., 10 percent tax on indoor tanning services effective 2010), and so on. HCERA also modified higher-education assistance provisions such as implementing student loan reform.
2011	The Investing in Innovations (i2) Initiative is designed to spur innovations in health information technology (health IT) by promoting research and development to enhance competitiveness in the United States. Examples of health IT competition topics include applications that allow an individual to securely and effectively share health information with members of his or her social network; generate results for patients, caregivers, and/or clinicians by providing them with access to rigorous and relevant information that can support real needs and immediate decisions; allow individuals to connect during natural disasters and other periods of emergency; and facilitate the exchange of health information while allowing individuals to customize the privacy allowances for their personal health records.

(Continues)

Table 1-3 Evolution of Health Care Delivery in the United States *(continued)*

Year	Event
2015	The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a legislation signed into law on April 16, 2015. This act combines the previously established Centers for Medicare and Medicaid Service programs that included the Physician Quality Reporting System (PQRS), the meaningful use EHR Incentive Program, and the Value-Based Modifier Program (VBMP) into a program entitled **Merit-Based Incentive Payment System (MIPS)**. One of the purposes of MIPS is to change the manner in which Medicare rewards clinicians for value-based care. MIPS will calculate a single composite performance score for the provider based on quality, resource use, clinical practice improvement activities, and meaningful use of a certified EHR technology. This score will then be used to make adjustments to the provider's base rate for Medicare Part B payment.
2016	**Telehealth**, the use of telecommunication technology to provide and support the delivery of health-related services at a distance, greatly increased in use starting in 2016. Another term that is used is the term **Telemedicine**. The term Telemedicine typically has a more limited meaning than telehealth and describes clinical services that are provided remotely. Telemedicine remotely connects the patient to a provider. Initially, telemedicine was used to provide access to providers for patients who were located in remote areas and were not able to access health care. **Telesurgery** was/is used to allow a surgeon to operate a robot to perform surgical interventions to patients at remote locations. Telemedicine services were expanded during the COVID-19 pandemic thus allowing patients to have access to providers with no risk of transmitting or contacting COVID-19.

Exercise 1–1 History of Medicine and Health Care Delivery in the United States

Short Answer: Identify the significant act established in each year for the purpose listed.

1. 1946-provided federal grants to modernize hospitals. _____
2. 1982-established the first Medicare Prospective Payment System. _____
3. 1986-established the National Practitioner Data Bank. _____
4. 1996-mandated administrative simplification regulations that govern health care information. _____
5. 2003-provided Medicare recipients with prescription drug savings. _____
6. 2006-established financial incentives for healthcare professionals that participate in a voluntary quality reporting program. _____
7. 2009-authorized an expenditure of $1.5 billion for grants for projects including the acquisition of health information technology systems. _____
8. 2015-established the Merit-Based Incentive Payment System. _____

Continuum of Care

A complete range of programs and services is called a **continuum of care**, with the *type of health care* indicating the *health care services provided.* The Joint Commission defines the continuum of care as "matching an individual's ongoing needs with the appropriate level and type of medical, psychological, health or social care or service." The continuum of care contains three levels: primary, secondary, and tertiary.

Primary care services include preventive and acute care, are referred to as the *point of first contact,* and are provided by a general practitioner or other health professional (e.g., nurse practitioner) who has first contact with a patient seeking medical treatment, including general dental, ophthalmic, and pharmaceutical services. These services are usually provided in an office setting where the care is continuous (e.g., quarterly office visits for a chronic condition) and comprehensive (e.g., preventive and medical care). The primary care provider manages and coordinates the patient's care, including referring the patient to a consultant for a second opinion. Primary care services include the following:

- Annual physical examinations
- Early detection of disease
- Family planning
- Health education
- Immunizations
- Treatment of minor illnesses and injuries
- Vision and hearing screening

Secondary care services are provided by medical specialists or hospital staff members to a patient whose primary care was provided by a general practitioner who first diagnosed or treated the patient (the primary care provider refers the patient to the specialist).

> **Example** A family practitioner sees a patient with an unusual respiratory condition, provides primary care, and refers the patient to an internist who specializes in respiratory disorders; the internist then becomes the source of secondary care.

Note: In the United States, self-referral is often performed by patients seeking secondary care services (instead of being referred by a primary care provider). This is a very different practice from that performed in the United Kingdom and Canada, where all patients must first seek care from a primary care provider (e.g., emergency department physician, general practitioner) who decides whether to refer the patient to secondary or tertiary care providers. If a referral is not made by a primary care provider, the secondary care provider is not reimbursed by the nationally funded health care system.

Tertiary care services are provided by specialized hospitals equipped with diagnostic and treatment facilities not generally available at hospitals other than primary teaching hospitals or Level I, II, III, or IV trauma centers (Table 1-4). This level of service is also provided by doctors who are uniquely qualified to treat unusual disorders that do not respond to therapy that is generally available as secondary medical services. Stabilization services are provided by a tertiary care facility or a designated level IV trauma center when it is necessary to ensure, within reasonable medical probability, that no material deterioration of a patient's medical condition is likely to result from or occur during the transfer of the patient to a tertiary care facility.

The following facilities, procedures, and services are associated with tertiary care centers:

- Burn center treatment
- Cardiothoracic and vascular surgery

Table 1-4 Tertiary Care—Level I, II, III, and IV Trauma Centers

Criteria	Level I	Level II	Level III	Level IV
Also called a regional trauma center	X			
Provides the highest level of comprehensive care for severely injured adult and pediatric patients with complex, multi-system trauma	X			
Has the capability of providing total patient care for every aspect of injury from prevention through rehabilitation	X			
Emergency physician, general surgeon, anesthesiologist, and nursing and ancillary personnel who can initiate immediate surgery are in-house and available to the patient upon arrival at the emergency department	X			
Broad range of sub-specialists are on-call and promptly available to provide consultation or care	X	X		
Provides care for severely injured adult and pediatric patients with complex trauma	X	X		
Physicians are Advanced Trauma Life Support (ATLS) trained and experienced in caring for traumatically injured patients; nurses and ancillary staff are in-house and immediately available to initiate resuscitative measures	X	X	X	X
Board-certified general surgeon and anesthesiologist are on-call and available to the patient		X	X	

(Continues)

Table 1-4 Tertiary Care—Level I, II, III, and IV Trauma Centers *(continued)*

Criteria	Level I	Level II	Level III	Level IV
Comprehensive diagnostic capabilities and supportive equipment are available	X	X		
Provides initial evaluation and stabilization, including surgical intervention, of severely injured adult or pediatric patients			X	
Provides comprehensive inpatient services to those patients who can be maintained in a stable or improving condition without specialized care			X	
Critically injured patients who require specialty care are transferred to a higher-level trauma system hospital in accordance with preestablished criteria			X	X

- Inpatient care for AIDS patients
- Magnetic resonance imaging (MRI)
- Neonatology level III unit services
- Neurosurgery
- Organ transplant
- Pediatric surgery
- Positron emission tomography (PET)
- Radiation oncology
- Services provided to a person with a high-risk pregnancy
- Services provided to a person with cancer
- State-designated trauma centers
- Trauma surgery

Quaternary care is considered an extension of "tertiary care" and includes advanced levels of medicine that are highly specialized, not widely used (e.g., experimental medicine), and very costly. Quaternary care is typically provided by tertiary care centers.

Patients are seen at various levels of the continuum of level depending on the care that the patient needs. Review Figure 1-1 and note examples of the types of care.

Exercise 1–2 Continuum of Care

True/False: Indicate whether each statement is True (T) or False (F).

____ 1. Primary care services include patient immunizations and education.

____ 2. Secondary care services include a patient being seen by a specialist because of angina.

____ 3. Stabilization services are provided by a tertiary care facility to ensure that no material deterioration of a patient's medical condition occurs during the transfer to another facility.

____ 4. Tertiary care services include a patient's annual history and physical.

____ 5. The continuum of care contains two levels.

Primary Care	Secondary Care	Tertiary Care	Quaternary Care
A patient is seen by a primary care provider for an annual physical	A patient is seen by a urologist for continuous urinary tract infections	A patient is seen by a physician at a specialty hospital for the treatment of AIDS	A patient is seen by an oncologist at a Cancer Institute to treat stage 4 cancer and conduct research

Figure 1-1 Continuum of Care

Health Care Facility Ownership

Hospital ownership is either **for-profit** (privately owned and excess income is distributed to share-holders and owners) or **not-for-profit** (excess income is reinvested in the facility) and categorized according to:

- Government (not-for-profit)
- Proprietary (for-profit)
- Voluntary (not-for-profit)

Government-supported hospitals (or **public hospitals**), representing about 25 percent of all health care facilities in the United States, are not-for-profit, supported by local, regional, or federal taxes, and operated by local, state, or federal governments.

Example 1
The Department of Veterans Affairs (VA) manages health care benefits for **veterans** (individuals who have served in the U.S. military), who are eligible to receive care at VA Medical Centers (VAMCs) located throughout the United States. The VA also operates ambulatory care and community-based outpatient clinics, nursing homes, domiciliaries, and comprehensive home-care programs.

Example 2
The Department of Defense establishes military treatment facilities for active personnel and their dependents.

Example 3
States own and operate behavioral health care facilities.

Example 4
Municipalities (cities) own and operate hospitals.

Proprietary hospitals represent about 15 percent of all health facilities in the United States, and they are for-profit and owned by corporations (e.g., Humana), partnerships (e.g., physicians), or private foundations (e.g., Tarpon Springs Hospital Foundation, Inc., which does business as Helen Ellis Memorial Hospital in Tarpon Springs, Florida). Corporations often own a chain of hospitals located in several states, and they may own nursing homes and other types of health care facilities as well.

Voluntary hospitals represent about 60 percent of all health care facilities in the United States, and they are not-for-profit. These hospitals are operated by religious or other voluntary groups (e.g., Shriners).

Teaching hospitals can be government (not-for-profit), proprietary (for-profit), or voluntary (nonprofit), and they are affiliated with a medical school. They include 24-hour access to physician care and the latest therapies; in addition to treating patients, they are training sites for physicians and other health professionals. Many of the physicians in a teaching hospital are interns and residents who work under the supervision of senior staff physicians. Historically, the term **intern** was used to designate a physician in the first year of graduate medical education (GME), which ordinarily immediately follows completion of the four-year medical curriculum. Since 1975, the **Accreditation Council for Graduate Medical Education (ACGME)** has not used the term *intern*, referring to individuals in their first year of GME as residents (although they still complete an internship). A **resident** is a physician who has completed an internship and is engaged in a program of training designed to increase his or her knowledge of the clinical disciplines of medicine, surgery, or any of the other special fields that provide advanced training in preparation for the practice of a specialty. A **chief resident** is a physician who is in his or her final year of residency (e.g., surgery) or in the year after the residency has been completed (e.g., pediatrics); the chief resident plays a significant administrative or teaching role in guiding new residents.

Exercise 1–3 Health Care Facility Ownership

Fill-in-the-Blank: Enter the appropriate term(s) to complete each statement.

1. A hospital that is affiliated with a medical school is called a _____.
2. A physician who has completed an internship and is engaged in a program of training designed to increase his or her knowledge of the clinical disciplines to prepare for a practice of specialty is called a(n) _____.
3. A hospital that is privately owned and distributes excess income to shareholders and owners is _____.
4. Public hospitals represent about 25 percent of all health care facilities in the United States and are also known as _____.
5. A not-for-profit hospital run by a religious or volunteer organization is known as a _____ hospital.

Health Care Facility Organization Structure and Operation

Most health care facilities utilize a *top-down format* so that authority and responsibility flow downward through a chain of command (Figure 1-2). Members of the organization include the following:

- Governing board
- Administration
- Medical staff

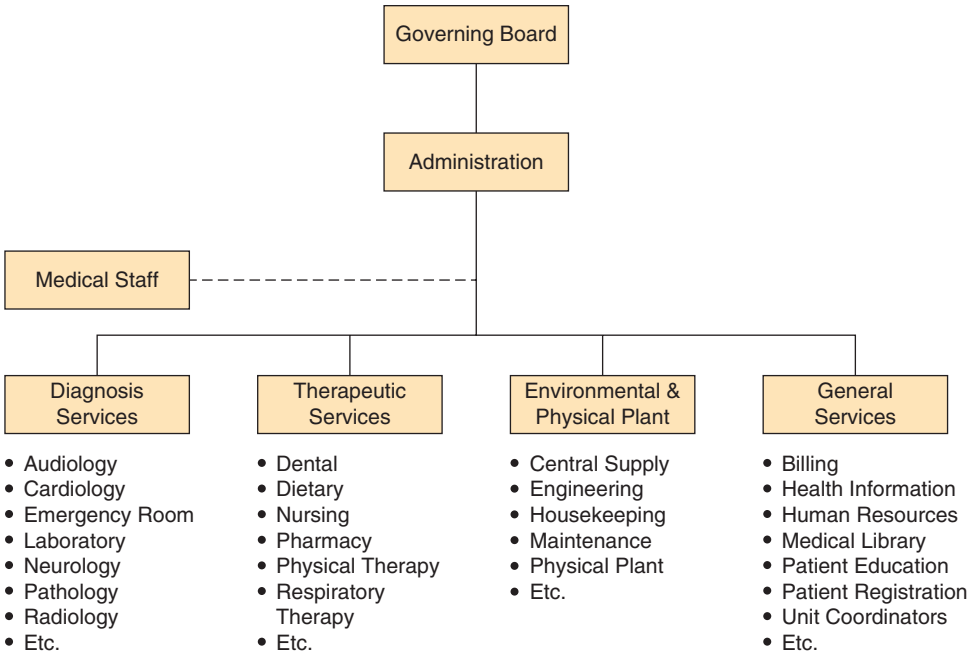

Figure 1-2 Hospital Organization Chart

- Departments, services, and committees
- Contracted services

Governing Board

The **governing board** (or **board of trustees**, **board of governors**, **board of directors**) serves without pay, and its membership is represented by professionals from the business community. It has ultimate legal authority and responsibility for the hospital's operation and is responsible for the quality of care administered to patients. The governing board is also responsible for:

- Hospital organization, management, control and operation, and for appointing the medical staff
- Abiding by the hospital's written constitution and bylaws, which clearly outline its organization, duties, responsibilities, and relationships with other members of the hospital team
- Conducting regular meetings (usually monthly) with minutes of meetings documented
- Hiring a competent administrator and delegating to that person the authority and responsibility for carrying out hospital policies
- Ensuring that competent, well-qualified personnel are employed in adequate numbers to carry out the functions of the hospital
- Providing a mechanism for assisting employees in addressing physical and mental health problems
- Maintaining standards of professional work in the hospital and requiring that the medical staff function competently

Administration

The **hospital administration** serves as liaison between the medical staff and governing board and is responsible for developing a strategic plan for supporting the mission and goals of the organization. In addition to the hospital administrator (Chief Executive Officer, or CEO), the following positions, which report to the CEO, may exist in the hospital organization:

- Chief Financial Officer (CFO), responsible for financial operations (e.g., accounting, billing, payroll)
- Chief Information Officer (CIO), responsible for information resources management (e.g., financial, administrative, and clinical)
- Chief Operating Officer (COO), responsible for overseeing specific departments (e.g., ancillary services)

Medical Staff

The **medical staff** consists of licensed physicians and other licensed providers as permitted by law (e.g., nurse practitioners and physician assistants) who are granted clinical privileges. The governing board delegates authority and responsibility to maintain proper standards

of medical care and to provide well-defined patient care services to the medical staff. Licensed physicians include Doctors of Osteopathy (DO), Medical Doctors (MD), Doctors of Podiatric Medicine (DPM), and Doctors of Dental Surgery (DDS). The medical staff is organized into clinical departments according to medical specialty (Table 1-5), with a chairperson appointed to each department, and members serve on medical staff committees (Table 1-6) and hospital committees (Table 1-7). The types of medical specialties that a hospital has vary depending on the size of the facility.

Note: **Hospitalists** are physicians who work in the hospital setting and treat patients who are receiving hospital-based care. They may or may not be considered hospital employees depending on the business arrangements that they make with the hospital.

The medical staff appointment procedure is performed every two years and follows these steps:

1. Physician completes application for clinical privileges
2. Medical staff coordinator conducts preliminary evaluation, verifying the applicant's:
   - Education (medical school)
   - Physical health status
   - Experience (internship and/or residency)
   - Request for medical staff category
   - References as to ethical character
   - Liability history (malpractice)
   - State licensure
   - Office of Professional Conduct report
   - Drug Enforcement Agency (DEA) license

Table 1-5 Medical Specialties

Medical Specialty	Description
Allergy & Immunology	Evaluation and treatment of immune system disorders (e.g., asthma, anaphylaxis, eczema, rhinitis, adverse reactions to drugs/foods/insect stings)
Anesthesiology	Assessment of patient risks for undergoing surgery, management of pain relief, monitoring of patients during and after surgery (postanesthesia recovery), and resuscitative care of patients with cardiac or respiratory emergencies (assessment of need for artificial ventilation)
Colon & Rectal Surgery	Diagnosis and medical/surgical treatment of diseases in the intestinal tract, colon, rectum, anal canal, perianal region, and related organs and tissues (e.g., liver, urinary, and female reproductive system)
Dermatology	Diagnosis and treatment of skin disorders (e.g., contact dermatitis, benign and malignant lesions or growths) and cosmetic disorders of the skin (e.g., scars)
Family Practice	Management of an individual's or family's total health care, including geriatrics, gynecology, internal medicine, obstetrics, pediatrics, and psychiatry, with an emphasis on preventive and primary care
General Surgery	Management of conditions for which general surgery is warranted (e.g., appendectomy, tonsillectomy, hernia repair), including diagnosis and preoperative, intraoperative, and postoperative care to surgical patients
Gynecology	Diagnosis and treatment (including preventive management) of female reproductive and urinary system disorders
Internal Medicine	Management of common and complex illnesses of patients of all ages (e.g., cancer, infections, diseases of blood, digestive, heart, joints, kidneys, respiratory, and vascular systems). Primary care internal medicine includes disease prevention, mental health, substance abuse, and wellness. Subspecialties include: • Adolescent medicine • Cardiovascular medicine • Critical care medicine

(Continues)

Table 1-5 Medical Specialties *(continued)*

Medical Specialty	Description
	• Electrophysiology • Endocrinology • Gastroenterology • Geriatrics • Hematology • Immunology • Infectious disease • Nephrology • Oncology • Pulmonary medicine • Rheumatology • Sports medicine
Medical Genetics	Diagnosis and treatment of patients with genetically linked diseases
Neurology	Diagnosis and treatment of disorders of the nervous system
Obstetrics	Management of pregnancy, from prenatal to puerperium
Ophthalmology	Diagnosis and treatment of eye disorders
Orthopedics	Diagnosis and treatment of musculoskeletal disease and injury
Otorhinolaryngology	Diagnosis and treatment of ear, nose, and throat diseases
Plastic & Reconstructive Surgery	Surgery for the purpose of reconstructing, repairing, or restoring body structures
Psychiatry	Diagnosis and treatment of behavioral health diseases
Radiology	Diagnosis of diseases and injuries using radiologic methods (e.g., electromagnetic radiation, x-ray, radionuclides, and ultrasound). Treatment of diseases (e.g., cancer) using radiant energy (e.g., radiation oncologist)
Thoracic Surgery	Surgical management of disease within the chest (coronary artery disease, lung cancer)
Urology	Diagnosis and treatment of disorders of the genitourinary system and the adrenal gland

Table 1-6 Medical Staff Committees

Medical Staff Committee	Description
Credentials Committee	Reviews and verifies medical staff application data
Ethics Committee	Meets as needed in order to discuss ethical problems
Executive Committee	Acts on reports and recommendations from medical staff committees
Joint Conference Committee	Serves as liaison between governing body and administration

Table 1-7 Hospital Committees

Committee	Description and Functions
Disaster Control	Responsible for establishing a disaster plan, a requirement of state licensure and compliance with The Joint Commission standards. The committee assesses the facility's capability of responding to a disaster, including potential problem areas and other concerns. Membership includes representation from every department in the facility. (A **disaster recovery plan** ensures an appropriate response to internal and external disasters (e.g., explosion) that may affect hospital staff, patients, visitors, and the community. The plan identifies responsibilities of individuals and departments during the management of a disaster situation.)
Drug Utilization Review (or Pharmacy and Therapeutics)	Responsible for maintaining the formulary (updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health), performing drug use evaluation, and developing policies and procedures regarding medications in all clinical areas
Education	An interdisciplinary committee that determines facility-wide education and training needs (e.g., disaster preparedness, new regulations, patient safety) and facilitates scheduling of in-service training for staff
Finance	Responsible for establishing guidelines and protocols for the management of funds within the facility
Forms	Reviews proposals for new patient record forms to ensure consistency with facility standards, reduces the number of patient record forms (wherever possible), consolidates patient information, enhances quality of documentation, and complies with regulatory agencies. Membership usually includes health information department management staff who meet with individuals submitting proposals.
Health Information	Responsible for ongoing review of patient records for timely completion and quality of documentation *Note:* In facilities where the information management department combines information technology services and health information management, an "information management team" meets to resolve issues related to (1) the impact of regulations (e.g., HIPAA) and information technology (e.g., electronic health record) on health care delivery; (2) problems regarding patient record documentation, including forms design; and (3) interdisciplinary record review (performed by separate teams comprising staff members and managers from all disciplines). Team membership usually includes the facility's CEO, CFO, director of patient care services, director of information management, quality/risk manager, and medical director.
Infection Control	Involved in prevention and correction of hospital-originated infections (nosocomial infections)
Quality Management	Concerned with quality of care provided to the patient
Risk Management	Responsible for coordinating and monitoring risk management activities, analyzing trends of incidents, and establishing priorities for dealing with high-risk areas. The goal is to ensure patient safety
Tissue Review	Responsible for reviewing preoperative and pathologic diagnosis to determine the medical necessity for surgery
Transfusion	Responsible for reviewing blood transfusion records to determine proper utilization
Utilization Management	Concerned with appropriate use of resources in providing patient care

The medical staff coordinator also references the (1) National Practitioner Data Bank (NPDB), which contains reports on medical malpractice payments and adverse licensure actions, clinical privilege actions, and professional society membership actions and (2) Healthcare Integrity and Protection Data Bank (HIPDB), which serves to alert users about a comprehensive review of a practitioner's, provider's, or supplier's past actions.

3. Medical Staff Credentials Committee reviews and verifies application and submits recommendation to Executive Committee
4. Medical Staff Department Chairperson reviews application
5. Executive Committee reviews application and recommendations, votes, and makes recommendation to Medical Staff
6. Medical Staff votes on application at its monthly meeting
7. Governing Board votes on application (approves or rejects application)

Medical staff membership categories include:

- **Active** (delivers most hospital medical services, performs significant organizational and administrative medical staff duties)
- **Associate** (advancement to active category is being considered)
- **Consulting** (includes highly qualified practitioners available as consultants when needed)
- **Courtesy** (admits an occasional patient to the hospital)
- **Honorary** (includes former members who are honored with emeritus status and other outstanding practitioners whom the medical staff wish to honor)

The medical staff creates and votes on **bylaws** (rules that delineate medical staff responsibilities) and **rules and regulations** (procedures based on federal and state regulations, and accreditation standards, which clarify bylaws).

Note: Hospital medical staffs used to be categorized as open or closed. Hospitals that had an open medical staff allowed any physician in the community to admit and treat inpatients. Hospitals with a closed medical staff required physicians to undergo the previous credentialing process. Open medical staffs proved to be a danger to patients when it was determined that individuals who were not actual physicians were admitting and treating inpatients. Thus, hospitals adopted the closed medical staff model. Interestingly, mention is rarely made of open versus closed medical staff models in medical literature—this is probably due to the closed model having become the standard.

Hospital Departments, Services, and Committees

Quality patient care delivery requires the coordinated effort of hospital departments, contract services, and hospital committees. **Hospital departments** (Table 1-8) include those that provide direct patient care as well as ancillary (e.g., clinical laboratory) and support services (e.g., health information department). Hospitals contract with agencies and outside organizations to provide certain services, including health information management functions. It should be noted that hospital committees (Table 1-7) are multidisciplinary, and composition consists of representation from hospital departments and the medical staff.

Effective Committee Meetings

Hospital committees are central to a facility's activities and provide a forum during which decisions are made that impact the entire organization. Each committee must work as a team and be well structured and organized. Effective committee meetings are chaired by a person who is responsible for overseeing the committee and establishing an agenda for each meeting. Committee members must actively participate and be prepared to accept their roles and responsibilities during each meeting. The structure of a committee meeting can be formal or informal, and the purpose of the meeting will determine the structure.

> **Example** Meetings conducted by the executive committee of the medical staff meeting will be formal, but a temporary committee that meets to plan the annual holiday party will be informal.

Prior to any meeting, the chairperson establishes an **agenda**, which is a listing of all items of business to be discussed. The chairperson and secretary are largely responsible for preparing the final meeting agenda, with the secretary responsible for circulating the agenda along with other documents to committee members prior to the meeting so members have time to review the items. It is common practice to arrange an agenda according to the following headings:

- Review of minutes of the previous meeting
- Old business (matters arising from the previous meeting)
- Member reports
- New business (items for decision, arranged in order of importance)
- Items for information or correspondence

Table 1-8 Hospital Departments

Department	Description
Admitting (Patient Registration)	• Registers emergency patients, inpatients, and outpatients • Obtains patient signature for consent to general medical treatment and release of information for insurance purposes • Provides patients with *advance directive* materials (e.g., living will, health care proxy, and do not resuscitate, or DNR) based on state regulations. Each state has different regulations that govern living wills, health care proxies and DNR orders. A **health care proxy** is a legal document in which the patient chooses another person to make treatment decisions in the event the patient becomes incapable of making these decisions. A **living will** contains the patient's instructions about the use of life-sustaining treatment. A **do not resuscitate (DNR)** order is documented in the patient's medical record by the physician. It instructs medical and nursing staff to not try to revive the patient if breathing or heartbeat stops.
Biomedical Engineering	• Maintains all clinical equipment used at the facility
Business Office (Finance Office)	• Accounting (prepares annual operating and capital budgets, and conducts annual facility audit) • Accounts payable (processes invoices for purchased services and products) • Patient accounts (processes patient bills and insurance claims) • Payroll (prepares and edits payroll)
Case Management (Discharge Planning)	• Initiates discharge planning process upon inpatient admission • Generates a discharge planning worksheet, which is used as an assessment tool to identify patients who may require post-hospital services on discharge • Discusses discharge plans with patients and their families on admission and during the hospital stay • Prepares a discharge plan to help determine home needs, assists in planning for needed medical equipment, helps in choosing a facility for care if the patient is unable to return home, and facilitates discharge to home or transfer to another facility
Central Sterilizing Service	• Processes the sterilization of surgical instruments and supplies
Chaplain	• Meets spiritual and religious needs of patients and families
Clinical Laboratory	• Conducts diagnostic tests ordered by physicians on samples of body fluids, body tissues, and body wastes • Information obtained from tests helps physicians diagnose illness, monitor treatment, and check general health. Results from tests are reported to physicians, who interpret them and explain them to patients • Directed by a pathologist, a physician employed by the hospital who has special training in clinical and laboratory sciences. Staffed by medical technologists, medical technicians, and assistants
Community Relations (Public Relations)	• Communicates special events, media concerns, and hospital publications to the public
Compliance	• Facility-wide program that monitors standards of conduct, offers educational programs, implements sanctions for noncompliance, and maintains a confidential integrity hotline to report concerns about possible legal and ethical violations
Durable Medical Equipment	• Provides patients with medical equipment to facilitate continuity of quality care from hospital to home, some facilities use a contracted service or refer patients to outside vendors to obtain equipment

(Continues)

Table 1-8 Hospital Departments *(continued)*

Department	Description
Electroneurodiagnostic Testing	• Provides electroneurodiagnostic testing to patients with neurological diseases, including routine electroencephalogram (EEG), sleep deprived EEG, auditory evoked potential, visual evoked potential, and somatic sensory potential
Emergency Department	• Provides crisis care 24 hours per day after **triage** (organized method of identifying and treating patients according to urgency of care required)
Employee Assistance Program (EAP)	• Provides professional guidance to employees and family members when personal or work-related problems become difficult to manage
Employee Health Services	• Coordinates and monitors health-related activities for employees (employment screening physical, drug testing)
Environmental Services	• Provides general housekeeping services for the hospital, cleaning and disinfecting all patient and non-patient areas of the hospital • Disposes of regular and medical waste • Distributes linens throughout the facility • Provides general housekeeping services required for health safety and patient care
Health Information Management Services (Medical Records)	• Maintains complete inpatient, outpatient surgery, and emergency records in a confidential manner. Releases information only with patient's written authorization or with a court order • Transcribes medical dictation and edits voice recognition produced documents. Assembles, analyzes, and abstracts paper patient records. Assigns standardized codes to diagnoses and procedures, which are used for statistical reports, strategic planning, mandatory reporting to state agencies, and insurance processing • Files, retrieves, and tracks paper patient records to assist physicians and nursing staff in providing patient care. Coordinates electronic health record processes. Retrieves, stores, and processes cancer case data
Hospice Care	• Provides services to patients and families using an interdisciplinary team approach that includes the attending physician, nurses, social service counselors, home health aides, volunteers, and so on
Human Resources	• Conducts an orientation program to acclimate new employees to their work environment • Manages the employee benefit program (vacation time, health insurance) • Advertises employment opportunities and screens prospective employees
Information Systems	• Manages information resources and provides computing services to facility and medical staff
Legal Services	• Reviews policies (e.g., patient e-signature, web portal identification) and other documents (e.g., articulation agreements with college health information management academic programs) for hospital departments
Medical Education	• Coordinates the internship and residency programs
Medical Library	• Contains health care books, journals, and audio-visual materials, as well as Internet access to health care information • Is linked to public, private, and medical libraries nationwide through mail, phone, fax, and computer • Provides library services and resources to hospital and medical staff (and to patients when coordinated through nursing and medical staff)

(Continues)

Table 1-8 Hospital Departments *(continued)*

Department	Description
Medical Staff	• Serves as liaison between the medical staff members and administration • Verifies physician credentials • Coordinates continuing medical education programs • Records minutes at committee meetings and physician functions
Nursing	• Provides 24-hour patient care to inpatients, outpatients, and emergency department patients
Nutrition and Food Service	• Manages production and service of meals for patients, staff, and visitors • Registered dietitians provide nutrition care for inpatients and clients in ambulatory settings
Occupational Therapy	• Serves patients who have experienced loss of function resulting from injury or disease
Operating Room Suite	• Includes operating rooms with scrub areas, equipment and instrument storage, dressing rooms, and recovery rooms
Patient Advocacy	• Serves as a representative for patients who issue recommendations or concern about the hospital to uphold care, ethics, moral, and operational standards
Patient Education	• Helps patients make informed decisions to better manage health care needs
Performance Improvement (PI)	• Facilitates desired outcomes by monitoring and evaluating the quality and appropriateness of patient care, measuring both process and outcome and conducting trend analyses, pursuing opportunities to improve patient care, ensuring high-quality care, and developing standards for monitoring quality of care • Six Sigma is a tool that was introduced to streamline processes and improve the quality of health care delivery. It involves a rigorous data-driven, decision-making process and uses a systematic five-phase, problem-solving process abbreviated as DMAIC (Define, Measure, Analyze, Improve, and Control) • Performance improvement in health care has evolved since its inception in the 1970s, and although the following are often used interchangeably with PI, each has a unique definition: ◦ *Quality Assurance (QA)*: reviewing problems on a retrospective basis by performing medical audits, quality review studies, or focus review studies, which involved reviewing patient records according to preestablished criteria; the problem with QA was that it assumed that a certain level of error was normal (and therefore acceptable) ◦ *Continuous Quality Improvement (CQI)*: replaced QA in the 1980s to provide an ongoing, proactive, data-driven *process* to assess ways to improve patient care; CQI is a tool that can be used to respond to identified problems, prevent problems, and improve upon the *status quo.* (Quality improvement [QI] has its origin in engineering, statistics, and management, and investigates the steps to be performed to make sure correct procedures are followed. PI has its origins in the behavioral sciences.) ◦ *Total Quality Management (TQM)*: a management *philosophy* that emphasizes a commitment to excellence throughout the organization; implemented in combination with CQI ◦ *Quality Management (QM)*: ensures patient access to quality health care by coordinating physician credentialing, clinical assessment activities, and utilization management functions; performance improvement is one aspect of QM

(Continues)

Table 1-8 Hospital Departments *(continued)*

Department	Description
Pharmacy	• Supplies all medications administered to patients during hospitalizations • Pharmacists review physician medication orders, maintain and review individual patient medication profiles, and provide drug information to health care team members • Directed by a registered pharmacist who ensures safe and effective drug therapy in accordance with physicians' orders
Physical Therapy	• Uses physical agents of exercise, massage, and other modalities
Plant Operations and Maintenance	• Repairs and maintains non-medical equipment • Maintains building and grounds, and heating and cooling systems
Preadmission Testing (PAT)	• Patients visit PAT prior to elective admission (inpatient or outpatient surgery) to register with Admitting, undergo preoperative nursing assessment, and receive preanesthesia evaluation by an anesthesiologist • Phlebotomists draw blood samples for preoperative testing • Electrocardiograms and chest x-rays are performed if ordered • PAT results are documented in the patient's records and are available to the patient care team prior to the patient's admission
Purchasing	• Procures equipment, products, and services • Rents and leases equipment • Issues documents (e.g., purchase orders) that commit facility funds for future purchase of products and services
Radiation Oncology	• Provides radiation therapy for cancer patients, including: ◦ Clinical scoring of late effects (measures the amount of toxic radiation received) ◦ Radiation dosimetry (develops dose delivery mechanisms that minimize treatment of non-target tissue while optimizing tumor control)
Radiology	• Provides image-guided procedures for inpatients and outpatients, including: ◦ Computerized tomography (CT scan) in which the source of x-ray beams rotates around the patient, the beams are detected by sensors, and information from sensors is computer processed and displayed as an image on a video screen ◦ Magnetic resonance imaging (MRI), which uses a large magnet that surrounds the patient, along with radio frequencies and a computer, to produce images ◦ Mammography, a method for detecting early-stage breast abnormalities ◦ Nuclear medicine, which uses very small amounts of radioactive materials or radiopharmaceuticals to study organ function and structure and to treat disease (radiopharmaceuticals are substances that are attracted to specific organs, bones, or tissues) ◦ Positron emission tomography (PET), which measures radioactive tracers (e.g., radioactive glucose) injected into the body ◦ Radiography (x-rays), which detect disease or injury in the body when an image (x-ray film) is produced as the result of passing a small amount of radiation through the body to expose sensitive film on the other side ◦ Ultrasonography, which uses high-frequency sound waves to study parts of the body, including the heart and vessels, to generate an image of the area being studied • Directed by a radiologist, a physician employed by the hospital who has specialized training in radiology. Staffed by registered x-ray technicians. *Note:* Patients who undergo a radiological procedure (x-ray, CT scan, mammogram, etc.) receive bills from both the facility and the radiologist (interpretation)

(Continues)

Table 1-8 Hospital Departments *(continued)*

Department	Description
Recreation Therapy	• Restores, remediates, and rehabilitates patients to improve functioning and independence, as well as reduce or eliminate the effects of illness or disability
Rehabilitative Services	• *See* Occupational Therapy, Physical Therapy, and Speech and Language Pathology
Respiratory Therapy	• Supplies oxygen, breathing aids, prescribed inhalants, and other aids for patients with respiratory distress • Directed by a qualified therapist who follows physicians' orders
Respite Care	• Inpatient care provided to homebound hospice patients (AIDS, Alzheimer's, cancer) to provide primary caregivers with temporary relief from care
Risk Management	• Promotes delivery of quality health care and safety • Identifies and controls hazards and injuries, and protects the facility resources • Recipient of all incident reports • Risk manager works with the facility's insurance company and attorney when lawsuits are filed
Safety Management	• Provides patients, personnel, and visitors with a physical environment free of recognized hazards • Manages activities to reduce the risk of injuries
Social Services	• Assists patients and families in locating resources that are specific to their health care needs
Speech and Language Pathology	• Evaluates, diagnoses, plans, and provides therapy to patients with speech, language, and swallowing difficulties • Utilizes speech technologies to improve communication skills • Services are provided by licensed speech and language pathologists who are employed by (or may contract with) the hospital
Telemedicine	• Connects practitioners and patients through online consultation with specialists, live and interactive clinical and educational programs, and custom or Internet-based video streaming
Utilization Management	• Reviews and/or recommends admission for all levels of care. Monitors appropriate levels of care, assesses compliance with stated standards, and monitors utilization of patient care delivery resources • Works with case managers from insurance companies to determine whether an admission is appropriate and to agree on an appropriate length of stay • Follows Medicare conditions of participation with respect to admissions and transfers to lower levels of care
Volunteer	• Feeds and transports patients, delivers flowers and mail, staffs the gift shop, assists visitors at the information desk, and works as clerical and support staff

- Other business (deals with items unknown to the chairperson when agenda was created but which are too urgent to table until the next meeting)
- List of documents circulated prior to the meeting
- Date, time, and location of next meeting

To document items discussed during meetings, the secretary records **minutes**, which are concise, accurate records of actions taken and decisions made during the meeting. The minutes should not contain lengthy accounts of discussions, but should serve as a summary of items discussed. The following information should be included when preparing committee minutes:

- Date, place, and time of the meeting
- Members present
- Members absent
- Guests present
- Items discussed
- Actions taken
- Time meeting was adjourned
- Location, time, and date of next meeting
- Secretary's name and signature

Note: A committee member who is assigned a task or volunteers for an assignment should be clearly indicated by name and responsibility accepted.

At more formal meetings during which legal business transpires, the minutes should also include:

- Decisions made
- Action required to implement decision
- Who will act to carry out the decision
- Any deadlines associated with the decision
- Full text of motions and amendments
- Names of proposer and seconder for each motion
- Results of votes, as announced by chairperson

When taking minutes, the secretary should document key items and statements to record "who says what," keeping each item separate under the headings outlined in the agenda. When recording minutes, members should be referred to by their full name (not by initials or first names), and abbreviations should not be used. Minutes should be an objective and impartial recording of the facts of the meeting without any editorial comments or opinions. Minutes should be prepared as soon as possible after the meeting is concluded, and the chairperson or another committee member should review them. Notes taken during the meeting should be kept until the following meeting. After the minutes have been approved by the committee at the next meeting, the chairperson should sign them.

Note: Minutes of a hospital (or medical staff) committee document facility and patient care issues, are considered confidential and privileged, and are protected from discovery (e.g., *subpoena duces tecum*) except in a legal action brought by a quality-management committee (e.g., to revoke a physician's license) or a legal proceeding alleging malpractice.

Health Information Department

The health information department is responsible for allowing appropriate access to patient information in support of clinical practice, health services, and medical research, while at the same time maintaining confidentiality of patient and provider data. The management of health information is changing as the health information moves from a paper format to electronic formats. Regardless of the format, paper or electronic, the health information department is still tasked with the responsibility of managing the health information. The use of electronic technology to gather, store, and retrieve patient information varies greatly from organization to organization. Large facilities are more likely to use electronic technology to manage patient information while smaller facilities and provider offices use a combination of paper and electronic systems. Regardless of the system, paper or electronic, health information services are still performed. Health information services (Figure 1-3) include:

- Department administration
- Cancer registry
- Coding and abstracting
- Image processing
- Incomplete record processing
- Medical transcription
- Record circulation
- Release of information processing

Department Administration

Health information department administrative functions are directed by registered health information administrators (RHIAs) and registered health information technicians (RHITs). They include (1) developing, monitoring, and improving systems related to the establishment, maintenance, control, and dissemination of medical records and related patient information; (2) planning activities of subordinate managers and staff to ensure continuous quality operation; and (3) participating in a variety of committee, team, and work group activities that monitor, establish policies and procedures for, and enhance the quality of patient care, education, financial, and management practices.

Cancer Registry

Cancer registry functions are performed by individuals who are credentialed as certified tumor registrars (CTRs) and include using computerized registry software to conduct lifetime follow-up on each cancer patient; electronically transmit data to state and national agencies (e.g., Georgia Center for Cancer Statistics, ACS National Cancer Data Base) for use at local, regional, state, and national levels; and generate reports and information for requesting entities (e.g., physicians). Other responsibilities include coordinating the national survey process through the ACS Commission on Cancer, scheduling weekly cancer conferences (in which multidisciplinary staff examine and discuss unique cancer cases), arranging monthly or bimonthly cancer committee meetings (multidisciplinary committee that provides necessary leadership to maintain an effective cancer program), generating statistics and graphs for the cancer program annual report, and participating in state and national professional association activities.

Note: Depending on the size of the facility, cancer registry might also be a stand-alone department with its own manager. The need for employees that support a cancer registry has increased as well as the need for CTRs.

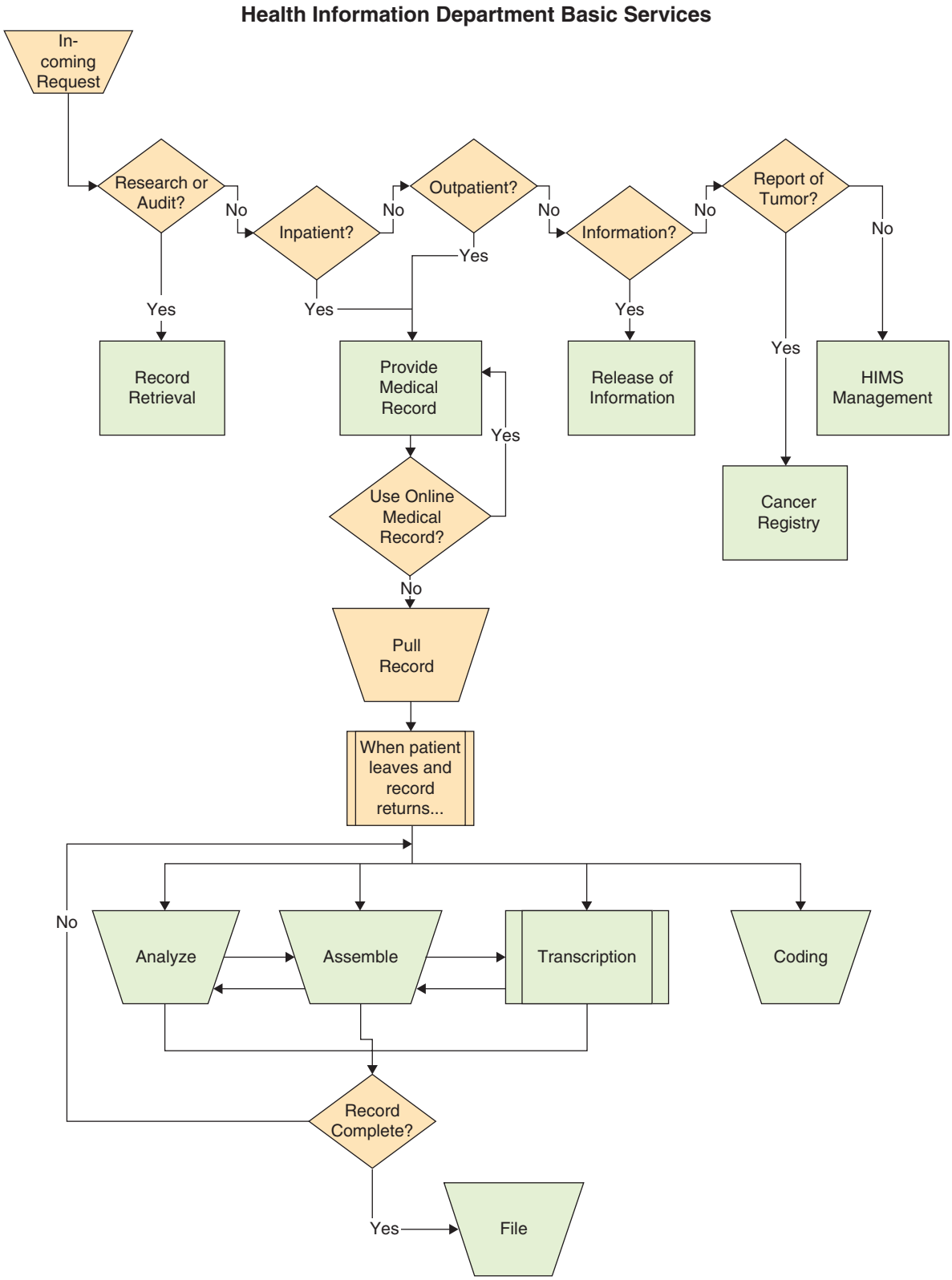

Figure 1-3 Sample Flowchart for Basic Services Offered by a Health Information Management Services Department

Coding and Abstracting

Coding involves assigning numeric and alphanumeric codes to diagnoses, procedures, and services; this function is usually performed by credentialed individuals (e.g., certified coding specialists, certified professional coders, registered health information technicians). Coders assign ICD codes to diagnoses and procedures for inpatient cases and diagnoses for outpatient cases. Coders also assign CPT and HCPCS Level II (National) codes to procedures and services for outpatient cases. Coding can be performed by the use of coding manuals or with the assistance of software tools. **Encoders** are software tools that assist coders in the selection of diagnostic and procedure codes. **Groupers** are software tools that use the codes assigned for a patient admission/encounter determine a diagnostic-related group or other groupings that impact reimbursement. More detail on coding and HIM functions that impact reimbursement are discussed in Chapter 10 of this textbook. ***Current Procedural Terminology* (*CPT*®)**, published annually by the American Medical Association, consists of five-digit codes assigned to ambulatory procedures and services. The **International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)** is used in the United States to collect information about diseases and injuries and to classify diagnoses. ICD-10-PCS (International Classification of Diseases, Tenth Revision, Procedure Coding System) is used to report inpatient procedures. The **Health Care Procedure Coding System (HCPCS)** is comprised of Level I (CPT) and Level II (national) codes. **HCPCS Level II (national) codes**, developed by the CMS, are used to classify and report procedures and services. Codes are reported to third-party payers (e.g., insurance companies) for reimbursement purposes.

Note: HCPCS Level III (local) codes were discontinued in 2003.

Once the coding function is completed, **abstracting** of patient cases is performed to enter codes and other pertinent information (e.g., patient identification data, admission/discharge dates) utilizing computer software. The purpose of abstracting is to generate statistical reports and disease/procedure indexes, which are used for administrative decision-making and quality-management purposes.

Image Processing

Many health information departments perform image processing to convert paper records to an **electronic health record (EHR)**, which is an automated, accessible record that contains multimedia data (e.g., digital, scanned images, voice, video). To control access to the EHR and maintain patient confidentiality, only facility employees who have been granted *need-to-know status* are allowed to gain access to the EHR. Employees begin the process by completing an application requesting access to the EHR. To ensure the availability of information on an emergency basis, most facilities allow attending and resident physicians to access all but locked and behavioral health documents. (Behavioral health records can be viewed by medical staff members of the Departments of Behavioral Health and Emergency Services.) A security override feature is also incorporated into the EHR system so that physicians who are involved in current treatment episodes can gain access. Once an employee or medical staff member is granted access to the EHR, he or she receives training on system security, appropriate access to and utilization of patient information, password protection features, existence of audit trails and access monitoring, and consequences of inappropriate access and/or breach of patient confidentiality. Employees and medical staff members sign a statement indicating that they understand the confidential nature of patient information and the need to keep the information and their password secure.

> **Example** According to SteamlineHealth, their AccessANYware™ product provides enterprise access to a patient's document-based medical and financial records via a web-based technology. AccessANYware™ allows health care organizations to establish a private, secure **intranet**, which is a private network that utilizes Internet protocols and technology. Regardless of where they are located, users can immediately and simultaneously access any health care information across an intranet with complete security and audit trail.

Incomplete Record Processing

Incomplete record processing for paper medical records includes the assembly and analysis of discharged patient records. After a patient is discharged from a nursing unit, the record is retrieved and reports are assembled according to a hospital- and medical staff–approved order of assembly (Figure 1-4). Some facilities adopt a **universal chart order**, which means that the discharged patient record is organized in the same order as when the patient was on the nursing floor. This eliminates the time-consuming assembly task performed by the health information department.

Note: Inpatient reports are filed in reverse chronological date order within each section of the record. While discharged patient reports are usually assembled in chronological date order within each section of the record, some facilities maintain the reverse chronological

Section of Record	Organization of Reports within Section
Admission & Discharge	Face Sheet (or Admission/Discharge Record) **Note**: Consent for Medical Treatment, Authorization for Release of Information (to third-party payers), and Leave of Absence Authorization are usually found on reverse of Face Sheet. Authorization to Leave Against Medical Advice Request and Authorization for Transfer (to another health care facility) Advance Directive Checklist Discharge (or Death) Summary (or Clinical Résumé) Discharge Instructions Summary Sheet Anatomical Gift Form
Emergency & Transport	Emergency Department Record Ambulance Record
Medical Care & Treatment	History Physical Examination Consultation(s) Progress Notes Physician Orders
Operative Services	Consent to Operative Procedure Preanesthesia Evaluation Anesthesia Record Operative Report Recovery Room Record Postanesthesia Evaluation Pathology Report Cancer Staging Form (for AJCC TNM Staging) (if cancer case)
Diagnostic Tests	Clinical Laboratory Radiology Other ancillary reports (e.g., Echocardiography, EEG, EKG, EMG)
Rehabilitative Therapy	Audiology/Speech Occupational Physical Respiratory
Nursing	Medication Administration Record (MAR) Graphic Record Intake/Output Record Care Plan Clinical Care Pathway Assessments and Flowsheets Nurses' Notes

Figure 1-4 Sample of Discharged Patient Record Assembly Order (Reports are filed in chronological date order within each section.)

date order to save assembly time and allow for inpatient-to-discharged-patient record review consistency.

Once assembled, the discharged patient record is analyzed for deficiencies, logged into an incomplete-record computer tracking system, and filed in the incomplete-record workroom. The health information department notifies medical and hospital staff about the status of incomplete records, and upon request the records are retrieved for medical and hospital staff to complete (e.g., sign transcribed reports, dictate missing reports). As incomplete records are completed, updates are made in the incomplete-record computer tracking system.

In an electronic health record system incomplete record processing is maintained by the system as well as manually. Some electronic systems can monitor documents or screens that are not complete and alert the appropriate provider of care that the missing information needs to be completed. In the event that the electronic health record contains scanned documents, health information management staff will review the scanned document section of the record and alert providers and other departments of the missing information.

Medical Transcription

Medical transcription involves the accurate and timely transcription of dictated reports (e.g., history, physical examination, discharge summary). Once transcribed, printed reports are filed in the patient's record and the responsible provider reviews and signs them. For the EHR, transcribed reports are electronically routed to the patient's record for online review and electronic signature by the responsible provider.

An **electronic signature** encompasses all technology options available that can be used to authenticate a document. A **digital signature** is a type of electronic signature that uses **public key cryptography**, which attaches an alphanumeric number to a document that is unique to the document and to the person signing it. To begin the electronic signature process, a user authentication system requires log-in using a secure password; a **smart card**, a plastic card containing a small central processing unit, some memory, and a contact area that interacts with a smart-card reader; or **biometrics**, an identifier that measures a borrower's unique physical characteristics (e.g., fingerprints, hand or face geometry, retinal scan, or handwritten signature) or behavior and compares them to a stored digital template to authenticate the identity of the borrower. Once logged in, the user enters a code to electronically sign a document, and the computer system verifies the code, recording a date and time stamp.

Record Circulation

Record circulation in a paper medical record system includes the retrieval of patient records for the purpose of:

- Inpatient readmission (records are transported to nursing units)
- Scheduled and unscheduled outpatient clinic visits (records are transported to the clinics such as dermatology, orthopedics, and so on)
- Authorized quality-management studies (records remain in the health information department for review)
- Education and research (records remain in the health information department for review)

Records are requested by either calling the health information department or submitting a record request through an automated patient management system. Health information department staff retrieve the record, sign it out (either manually in a log book or electronically in a chart tracking system), and transport the record to the appropriate area of the facility. This topic is thoroughly discussed in Chapter 7.

In an electronic health record system the purposes of retrieving information is the same as in a paper medical record system. However, in a electronic health record system the individual needing and using the information can directly access the information within the electronic health record based on their access privileges.

Release of Information Processing

Written requests for release of information are reviewed for authenticity (e.g., appropriate authorization) and processed by health information department staff. Requests include those from patients, physicians and other health care providers, third-party payers, Social Security Disability, attorneys, and so on. (Release of information processing is thoroughly discussed in Chapter 9.)

Note: A smart card can also be used to store personal health information, as discussed in Chapter 8.

Contract Services

According to The Joint Commission, hospitals must ensure that contract staff are qualified, competent,

and provide quality patient care. In addition, hospital medical staff must be involved in the selection of vendors and the approval of vendor contracts, especially for clinical services. The best way to ensure compliance is to inventory all contract services used by the hospital and include what each contractor does for the organization and which staff members are responsible for overseeing the vendor's work and employees.

Facilities use **contract services** for health information services (Table 1-9) in addition to general services such as housekeeping, medical waste disposal, and clinical services such as physical therapy, emergency care, and speech pathology. The purpose of contracting out these services is to improve quality (e.g., credentialed staffs are employed by contractor) while containing costs (e.g., hospital doesn't have to pay benefits to contract employees).

Exercise 1–4 Health Care Facility Organization Structure and Operation

Short Answer I: Identify the medical specialty for each description.

_____ 1. Diagnosis and treatment of skin disorders

_____ 2. Management of pregnancy, from prenatal to puerperium

_____ 3. Diagnosis and treatment of eye disorders

Table 1-9 Contract Services for Health Information Management

Service	Description
Cancer Registry	Certified tumor registrars (CTRs) organize and assess cancer registry programs, assist in the preparation of an annual report, and perform the following technical functions: cancer case abstracting, patient care evaluation and research studies, follow-up for survival analysis, management of cancer data collection, and survey preparation/compliance with ACS standards
Coding	Credentialed coding staff provide outsourced coding support (e.g., for facilities experiencing coding staff shortages), perform coding compliance audits to determine the accuracy of codes and to ensure that Office of Inspector General (OIG) guidelines are met, review chargemasters for accuracy, and conduct reimbursement validation studies (e.g., to determine accuracy of DRG assignment)
Document Conversion	Companies that specialize in document-conversion procedures convert paper-based documents and data (e.g., scanning), automate data entry using optical character readers (OCR), publish records on the Internet, manage messaging systems, and provide storage solutions (including providing immediate access to information)
Master Patient Index (MPI) Duplication Review	Companies use software to identify, correct, and eliminate duplicate MPI records, increasing patient identification accuracy and patient care safety (e.g., patient records can be more quickly retrieved for patient care purposes)
Medical Transcription	Local and national medical transcription services provide Internet-based and pickup/delivery of medical transcription to health care facilities. Characteristics of services include quality, convenience, and accessibility (e.g., 24/7 availability).
Release of Information Processing	Use of an outside copy service to process release of information requests
Trauma Registry	Credentialed professionals create and maintain a registry of all trauma admissions and deaths in the emergency department due to trauma, recording data elements for each entry that become part of a national registry developed by the ACS. The registry used for education, prevention, quality improvement, and research activities

_____ 4. Surgical management of diseases with the chest

_____ 5. Diagnosis and treatment of musculoskeletal disease/injury

_____ 6. Diagnosis and treatment of diseases of the nervous system

_____ 7. Diagnosis and treatment of behavioral health diseases

Short Answer II: Identify the committee described.

_____ 8. Concerned with quality care provided to patients

_____ 9. Acts on reports and recommendations from medical staff committees

_____ 10. Reviews preoperative and pathologic diagnoses to determine the necessity of surgery

_____ 11. Serves as liaison between the governing body and administration

_____ 12. Meets to discuss ethical issues and problems

Licensure, Regulation, and Accreditation

State laws require health care facilities and providers (e.g., physicians) to obtain **licensure** (a license to operate or practice medicine) before providing health care services to a patient population. A **state department of health** issues the license, which requires facilities and providers to comply with state laws and regulations. Licensed facilities and providers are required to comply with both general licensure regulations as well as those specific to services provided (e.g., home health care, long-term care).

A **regulation** is an interpretation of a law that is written by the responsible regulatory agency. For example, the Conditions of Participation (CoP) are regulations written by the CMS. Congress writes and passes an act, the President signs the act into law, and CMS interprets the law creating a regulation.

Federal and state laws are passed by legislative bodies (e.g., federal congress and state legislatures). These laws are then implemented as regulations. Federal regulations govern programs such as Medicare, Medicaid, TRICARE, and the Federal Employees Health Benefit Plans (FEHBP). State laws regulate insurance companies, patient record-keeping practices, and provider licensing. The ***Code of Federal Regulations* (CFR)** is the codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government. It is divided into 50 titles that represent broad areas subject to federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis. Each title is divided into chapters, which usually bear the name of the issuing agency. The ***Federal Register*** is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It is available in paper form, on microfiche, and online.

Accreditation is a voluntary process that a health care facility or organization (e.g., hospital) undergoes to demonstrate that it has met standards beyond those required by law. Accreditation organizations (Table 1-10) develop **standards**, which are measurements of a health care organization's level of performance in specific areas and are usually more rigorous than regulations. A **survey** (evaluation) process is conducted both off-site (e.g., hospital submits a self-study document for review) and on-site (at the hospital) to determine whether the facility complies with standards. When a facility undergoes accreditation, it communicates to the public that it is willing to go "above and beyond" what is required to offer the best quality health care possible.

Table 1-10 Accrediting Organizations

Accrediting Organization	Description
Accreditation Association for Ambulatory Health Care (AAAHC)	AAAHC was incorporated in 1979 as a multidisciplinary accreditation organization to focus exclusively on ambulatory health care. The *AAAHC Accreditation Handbook* for ambulatory care is revised annually, and over 1,400 organizations nationwide are accredited by the AAAHC. Core standards include rights of patients, governance, administration, quality of care, quality management and improvement, clinical records and health information, professional improvement, and facilities and environment. (AAAHC also surveys managed care organizations.)

(Continues)

Table 1-10 Accrediting Organizations *(continued)*

Accrediting Organization	Description
American Osteopathic Association (AOA)	The AOA's Healthcare Facilities Accreditation Program (HFAP) was implemented in 1945, originally to make sure that osteopathic students received training in facilities that provided a high quality of patient care. AOA transferred administrative responsibility for the HFAP to the American Osteopathic Information Association (AOIA), founded in 1999. HFAP accreditation activities and decisions remain the responsibility of the AOA and its Bureau of Healthcare Facilities Accreditation (BHFA). The AOA received deeming authority to survey hospitals under the Medicare Conditions of Participation (CoP) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). **Deeming authority** means that an accrediting organization's standards have met or exceeded CMS's Conditions of Participation for Medicare certification, accredited facilities are eligible for reimbursement under Medicare and Medicaid, and CMS is less likely to conduct an on-site survey of its own.
Commission on Accreditation of Rehabilitation Facilities (CARF)	CARF was established in 1966 as an independent, not-for-profit accrediting organization for rehabilitation facilities. CARF "establishes customer-focused standards to help providers measure and improve the quality, value, and outcomes of their services." Types of rehabilitation facilities accredited include adult day services, assisted living, behavioral health, employment and community services, and medical rehabilitation.
Community Health Accreditation Program (CHAP)	Since 1965, CHAP has specialized in accrediting community-based health care organizations (e.g., home health, hospice, home medical equipment). CHAP has received deeming authority from CMS for home health, hospice, and home medical equipment (HME) agencies.
The Joint Commission	According to its corporate brochure, The Joint Commission (formerly Joint Commission on Accreditation of Health Care Organizations, JCAHO) has offered and maintained state-of-the-art accreditation programs for health care organizations since 1951 and provides organizations with standards, performance improvement tools, and an external evaluation of performance. The Joint Commission's approach to accreditation is patient centered and data driven. Surveyors observe actual experiences of a sample of patients as they interact with their health care team to evaluate the actual provision of care, and they examine specific high-risk components of the health care organization (e.g., medication management). • The Joint Commission was granted *deemed status* by the federal government, which means it is recognized by the CMS as an equivalent substitute for CMS inspections. State agencies (e.g., state departments of health) also rely on The Joint Commission to perform independent quality evaluations of health care organizations and programs (instead of states conducting their own inspections). • The Joint Commission's **ORYX® initiative** integrates outcomes and other performance measurement data into the accreditation process for quality improvement (QI) purposes. *Performance measures* guide the standards-based survey process by continuously monitoring actual performance and impacting continuous improvement in health care organizations. Accredited organizations submit core performance measurement data (or core measures) to The Joint Commission. The Joint Commission and CMS work together to standardize common measures called the *National Hospital Quality Measures*. • The Joint Commission's **Shared Visions—New Pathways™** initiative changed the scoring and accreditation process, focusing on whether organizations are making improvements system-wide. The continuous survey process requires organizations to score *elements of performance* (to ensure safe, high-quality care, treatment, and services) to determine compliance with standards.

(Continues)

Table 1-10 Accrediting Organizations *(continued)*

Accrediting Organization	Description
The Joint Commission (*continued*)	• The Joint Commission implements a continuous (ongoing) survey process. It has developed a *Periodic Performance Review (PPR)* tool that helps organizations meet the continuous demand for accountability and is used for self-evaluation of an organization's compliance with standards. The Joint Commission's on-site survey process includes a *tracer methodology* evaluation process, during which surveyors use a patient's record as a "road map" to services provided; the services are assessed and evaluated to determine whether the organization is compliant with standards of providing care and services. • The Joint Commission's *National Patient Safety Goals* and random unannounced surveys help organizations focus on providing high-quality patient care. Organizations participate in the identification and voluntary reporting of *sentinel events* (unexpected incidents or occurrences that involve patient death or serious physical or psychological injury, or risk thereof) to facilitate evaluation and prevention.
National Committee for Quality Assurance (NCQA)	Private, not-for-profit organization established in 1989 to assess and report on the quality of managed care plans. Created the **Health Plan Employer Data and Information Set (HEDIS)**, which is the "tool used by health plans to collect data about the quality of care and service they provide."
National Commission on Correctional Health Care (NCCHC)	Correctional facilities that provide contracted or on-site health care services to inmates are eligible for NCCHC accreditation.
National Integrated Accreditation for Healthcare Organizations (NIAHO)	An alternative to other hospital accreditation organizations, the NIAHO is the accreditation program for Det Norske Veritas Healthcare, Inc. (DNV) that conducts surveys annually, integrating ISO 9001 with the Medicare *Conditions of Participation*. The NIAHO has been granted *deemed status* by the CMS. DNV Healthcare's hospital-accreditation program is unique in that it integrates the ISO 9001 standards (international quality standards that define minimum requirements for a quality-management system) and the Medicare hospital regulations (e.g., conditions for coverage, conditions of participation) *Note:* In 2010, DNV was selected as the investigative contractor by the federal government's Joint Investigation Team of the departments of the Interior and Homeland Security. DNV performed the forensic examination of the blowout preventer and lower marine riser package that was fitted to the Macondo well in the Gulf of Mexico, which was the site of the disastrous Deepwater Horizon oil spill.

Note: It is important to make a distinction between the terms *regulation* and *accreditation.* Think of *regulation* as being *required* and *accreditation* as being *voluntary.*

Exercise 1–5 Licensure, Regulation, and Accreditation

Matching: Enter a 1 if the abbreviation represents an accrediting agency and a 2 if it represents a regulatory agency.

_____ 1. AAAHC

_____ 2. AOA

_____ 3. CARF

_____ 4. CMS

_____ 5. CDC

Short Answer: Enter the meaning of each abbreviation.

6. AAAHC _____

7. AOA _____

8. CARF _____

9. CMS _____

10. NCQA _____

Internet Links

Accreditation Association for Ambulatory Health Care
http://www.aaahc.org

American College of Surgeons
http://www.facs.org

American Hospital Association
http://www.aha.org

American Medical Association
http://www.ama-assn.org

American Osteopathic Association
http://www.osteopathic.org

Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov

Commission on Accreditation of Rehabilitation Facilities
http://www.carf.org

Community Health Accreditation Program
http://www.chapinc.org

Det Norske Veritas (DNV)
http://dnvglhealthcare.com

The Joint Commission
http://www.jointcommission.org

National Commission on Correctional Health Care
http://www.ncchc.org

National Committee for Quality Assurance
http://www.ncqa.org

National Practitioner Data Bank
http://www.npdb.hrsa.gov

NCQA's Health Plan Report Card
http://reportcard.ncqa.org

Summary

Information about historical health care delivery practices comes primarily from the study of textual references, artistic illustrations, and the study of human remains. While diagnoses and treatments associated with prehistoric and ancient medicine were mostly a product of ignorance and superstition, an occasional discovery actually worked. Health care delivery in the United States is based on beliefs about disease and health that evolved over the past centuries. A complete range of programs and services is called a *continuum of care*, with the *type of health care* indicating the *health care services provided*. The continuum of care contains three levels: primary, secondary, and tertiary. (Quaternary care is part of the tertiary level of care.) Hospital ownership is either *for-profit* or *not-for-profit* and categorized as government (not-for-profit), proprietary (for-profit), and voluntary (not-for-profit). Most health care facilities use a *top-down format* so that authority and responsibility flow downward through a chain of command. State laws require health care facilities to obtain licensure before providing health care services to a patient population. Licensed facilities are required to comply with general licensure regulations and those specific to services provided. A *regulation* is an interpretation of a law, and it is written by the responsible regulatory agency. *Accreditation* is a voluntary process that a health care facility or organization undergoes to demonstrate that it has met *standards*, which are usually more rigorous than regulations.

Study Checklist

- Read the textbook chapter and highlight key concepts. (Use colored highlighter sparingly throughout the chapter.)
- Create an index card for each key term. (Write the key term on one side of the index card and the concept on the other. Learn the definition of each key term, and match the term to the concept.)
- Access chapter Internet links to learn more about concepts.
- Answer the chapter exercises and review questions, verifying answers with your instructor.
- Form a study group with classmates to discuss chapter concepts in preparation for an exam.

Chapter Review

True/False: Indicate whether each statement is true (T) or false (F).

____ 1. Administrative simplification regulations that govern privacy, security, and electronic transactions standards for health care information were mandated by the Health Insurance Portability and Accountability Act.

____ 2. Anton van Leeuwenhoek established the germ theory of disease.

____ 3. Diagnosis-related groups required hospitals to be reimbursed a per diem amount.

____ 4. Hippocrates was the first physician to consider medicine a science and art separate from the practice of religion.

____ 5. Medicare, also known as Title 19, was established to provide comprehensive health care for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

____ 6. The American Medical Association was established in 1901 as a national organization of state and local associations.

____ 7. The AMA developed the Minimum Standard for Hospitals to outline the protocol for on-site inspections of hospitals.

____ 8. The Centers for Medicare & Medicaid Services (CMS) was previously known as the Health Care Financing Administration.

____ 9. The primary purpose of The Joint Commission is to provide voluntary accreditation.

____ 10. Tertiary care centers include services such as neurosurgery, radiation oncology, and pediatric surgery.

Multiple Choice: Select the most appropriate response.

11. Which is a characteristic of a governing board?
    a. It is also known as the medical staff.
    b. Its membership is represented by professionals from the community.
    c. It is responsible for administering care to patients.
    d. It reports directly to the medical staff and administration.

12. A patient is seen in the emergency department with glass in her eye. The attending emergency department physician feels it is necessary for the patient to be seen by a specialist. The specialist that most likely would see the patient would be from
    a. anesthesiology.
    b. dermatology.
    c. ophthalmology.
    d. urology.

13. The medical staff committee that reviews and verifies medical staff application data is the
    a. credentials committee.
    b. infection control committee.
    c. joint conference committee.
    d. tissue review committee.

14. Which of the following is a function of the admitting department?
    a. Register inpatients and outpatients.
    b. Provide patients with names of individuals who will sign an advance directive.
    c. Obtain patient signature for surgical consents.
    d. Document admission orders in the patient record.

15. Someone who is responsible for working with case managers of insurance companies to determine the appropriateness of admissions is employed in which hospital department?
    a. Admitting
    b. Community relations
    c. Nursing
    d. Utilization management

16. Health information management services include which of the following?
    a. Patient billing
    b. Coding and abstracting
    c. Patient registration
    d. Discharge planning

17. The assembly and analysis of discharged patient records is called
    a. abstracting.
    b. document conversion.
    c. image processing.
    d. incomplete-record processing.

18. The CPT coding book is published annually by the AMA to assign what type(s) of code?
    a. Diagnostic
    b. Diagnostic and procedure
    c. Procedures and durable medical equipment
    d. Procedures and services

19. A hospital committee that is responsible for analyzing trends of accidents and establishing priorities for dealing with high-risk areas is
    a. disaster control.
    b. risk management.
    c. safety management.
    d. utilization review.

20. United States health care delivery has been impacted by which of the following?
    a. Decreasing health care costs
    b. Absence of medical necessity requirements
    c. Review of appropriateness of admissions
    d. Lack of quality and effective treatments

Fill-in-the-Blank: Enter the appropriate term(s) to complete each statement below.

21. The private, not-for-profit organization established to assess and report on the quality of managed care plans is called the _____.

22. In the last decade health care consumers are more educated in regards to their health and are now seeking health care with higher _____.

23. The implementation of standards for sanitation, ventilation, hygiene, and nutrition occurred during _____ medicine.

24. An oath that was adopted as an expression of early medical ethics is known as the _____.

25. The Vaccine for Children Program established free immunizations for all children in low income families in _____.

26. French physicists Pierre and Marie Curie, in 1898, discovered that radium provided a powerful weapon against _____.

27. The medical specialty that diagnoses and treats disorders of the genitourinary system and the adrenal gland is _____.

28. Services that include preventative and acute care and are provided by a general practitioner are known as _____ services.

29. A hospital that is privately owned and whose excess income is distributed to shareholders and owners is a _____ hospital.

30. The medical specialty that diagnoses and treats female reproductive and urinary system disorders is _____.

Short Answer: Briefly respond to each question.

31. Define the term *multidisciplinary* as it relates to hospital committees, and list at least three hospital committees.

32. Describe the uses of diagnosis and procedure indexes.

33. Compare the terms *electronic signature* and *digital signature.*

34. Describe three contract services that a health information department would use.

35. Distinguish between the terms *regulation* and *accreditation.*

36. List the types of organizations that The Joint Commission accredits.

37. Explain the relationship between *abstracting* and the *generation of diagnosis and procedure indexes.*

38. Compare *primary care, secondary care,* and *tertiary/quaternary care* services. Include an example of each service.

39. Differentiate between a *proprietary* and a *voluntary* hospital.

40. Summarize the purposes of record circulation.

Chapter 2

Health Information Management Professionals

Chapter Outline

Key Terms

cancer registrar
case manager
Certified Documentation Improvement Practitioner (CDIP)
Certified Health Data Analyst (CHDA)
Certified in Healthcare Privacy and Security (CHPS)
Chief Information Officer (CIO)
Chief Knowledge Officer (CKO)
claims examiner
clinical documentation improvement (CDI) program
coding and reimbursement specialist
coding specialist
Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM)
consultant
cultural competence
cultural diversity
ethics
health information manager
health insurance specialist
health services manager
listserv
medical assistant
medical office administrator
medical office manager
medical staff coordinator
medical transcriptionist
privacy officer
professional practice experience
professional practice experience supervisor
quality manager
reciprocity
risk manager
tumor registrar
utilization manager
vendor salesperson

Objectives

At the end of this chapter, you should be able to:

1. Differentiate among the job responsibilities, credentials, and education of different health information management roles
2. Describe the requirements and benefits of professional associations available to health information management professionals
3. Describe ethical conduct in health information management
4. Summarize AHIMA's code of ethics
5. Identify how cultural issues impact health care and health care quality
6. Identify cultural disparities in health care
7. Explain cultural competence for health care professionals
8. State the purpose of a professional practice experience
9. Identify professional practice sites
10. Describe the student's responsibilities during a professional practice experience
11. Trace the development of the American Health Information Management Association and its predecessor organizations

Introduction

This chapter will focus on a variety of career opportunities in health care and health information management, ethical standards of practice and cultural diversity, the role of the **professional practice experience** (externship or internship), the importance of joining professional associations, the interpretation of professional codes of ethics, the impact of networking with other professionals, and the development of opportunities for professional advancement.

Health Information Management Careers

Health information management careers have evolved as technology has impacted the collection, storage and use of medical information that relates to patient care and the delivery of care. Currently the American Health Information Management Association (AHIMA) is a not-for-profit global organization that originated in 1928 as the Association of Record Librarians of North America and is considered an industry leader in the management of health information. The primary mission is to increase the standards of clinical information that was used in medical organizations such as hospitals, physician offices, and other organizations. Over time as technology has advanced, the profession and association has evolved and changed its name. The names that have been used include:

- Association of Record Librarians of North America: 1928–1938
- American Association of Medical Record Librarians: 1938–1970
- American Medical Record Association: 1970–1991
- American Health Information Management Association: 1991–Present

Detail regarding the history of AHIMA can be found at: https://ahima.org/who-we-are/about-us/history/.

Currently AHIMA is a professional organization with over 100,000 members. Many of the AHIMA members are credentialed professionals. The specific credentials that AHIMA offers will be discussed later in this chapter. AHIMA has various membership categories that include: professional, professional premier, professional emeritus, professional global, and student. To learn about the specific membership categories and the benefits of each category go to: https://www.ahima.org/ahima-membership/membership-types-and-benefits/. I would encourage you to review the information about student membership as this provides benefits that will enhance your educational experience, such as access to AHIMA professional publications, a way to connect with other HIM students and professionals.

As the HIM profession grew educational programs were established to advance the profession. In 1934 the first educational program was accredited. As the profession grew and as the need for more educational programs expanded AHIMA, in 2004, established the **Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM)**. CAHIIM functions as an independent accreditation commission to establish standards for HIM educational programs. Individuals who graduate from CAHIIM approved programs can sit for the Registered Health Information Technician (RHIT) and Registered Health Information Administrator (RHIA) national credentialing examinations.