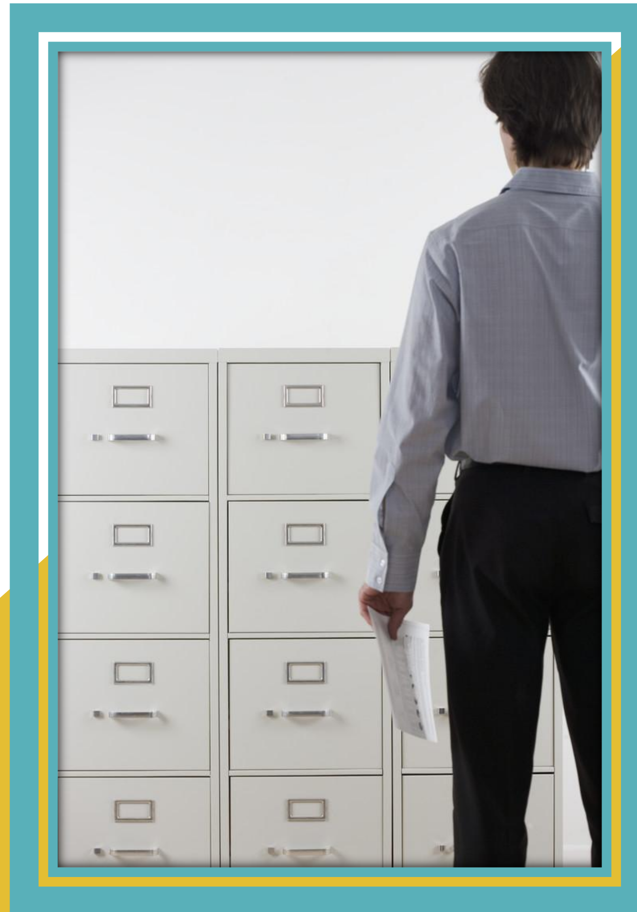
Records and Recordkeeping



Everything You Wanted To Know

What is a *patient record*?

The document that accurately reflects your evaluation and treatment of a patient

It is not a financial record – financial records are the business records you keep for tax purposes and to calculate your income and expenses and profits and losses from operating your dental practice

Who owns the *patient record*?

Sole proprietor; Partner; PC shareholder; Member of PLLC – all owners have ownership interest in all patient records, even for patients they never saw

Independent contractors – have exclusive ownership over patient records of patients they see; no ownership over other patient records for patients they do not see

Who owns the *Patient Record*?

Employees have no ownership over any patient records whether they see the patient or not

Ownership of patient records is a **property law** issue

Professional conduct laws also apply to maintaining records

Rules of Professional Conduct With *Patient Records*

Section 29.2(a)(3) of Title 8 of the Official Compilation of Codes, Rules and Regulations of the State of New York states that unprofessional conduct includes:

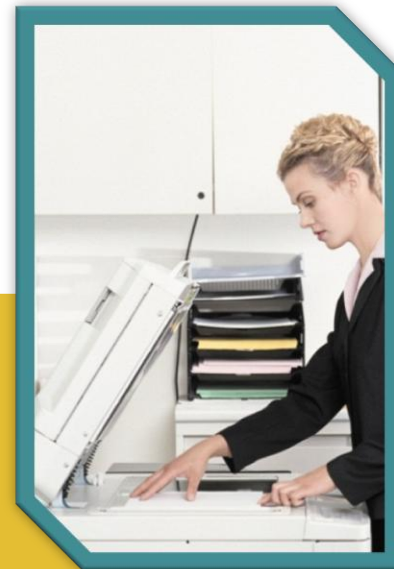
"failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient."

Rules of Professional Conduct With *Patient Records*

Every examining or treating dentist must comply with 29.2(a)(3) – the professional conduct obligation which is personal to each dentist

Make sure you maintain your own copies of patient records of patients you examine or treat – your employer does not legally have to give you copies once you leave employment and you have no rights to demand access to the originals

Keep financial records separate from patient records



What does a good *patient record* consist of?

A record that is accurate, complete, and authentic

- **Accurate** – information is true and correctly recorded
- **Complete** – all required information is included
- **Authentic** – information is reliable and has not been altered

Recordkeeping Systems

You want a regular process to be followed to ensure consistency in recordkeeping

Use it for every patient, every visit

Review and update process regularly to ensure it is working

Identify office responsibilities for making entries to patient records

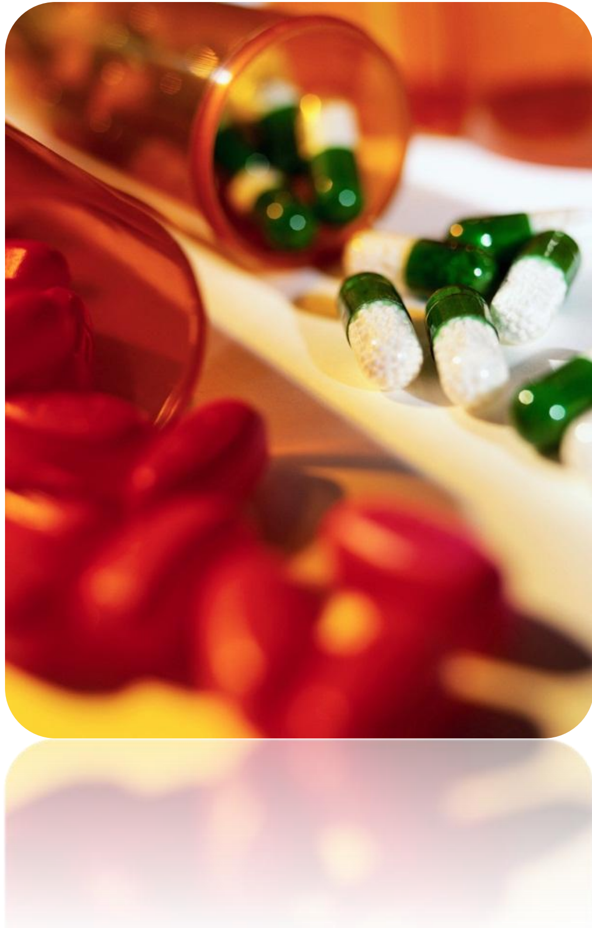
Use the same forms and information entry styles on the forms – variety is the spice of disaster

What goes in a *patient record*?

- Medical History
- Dental History
- Radiographs
- Study Models (Diagnostic Tools)
- Copies Of Prescriptions (Lab And Pharmacy)
- Consultation And Referral Reports
- Signed Consent Forms
- Correspondence

WHAT IS GOOD MEDICAL HISTORY?

- Thorough and reliable
- Use medical history form with combination of narrative and checklist
- Name & phone number of the patient's physician(s)
- Date of last physical examination
- Your evaluation of the general health and appearance of the patient
- List of any systemic diseases (such as: diabetes, hepatitis, rheumatic fever)



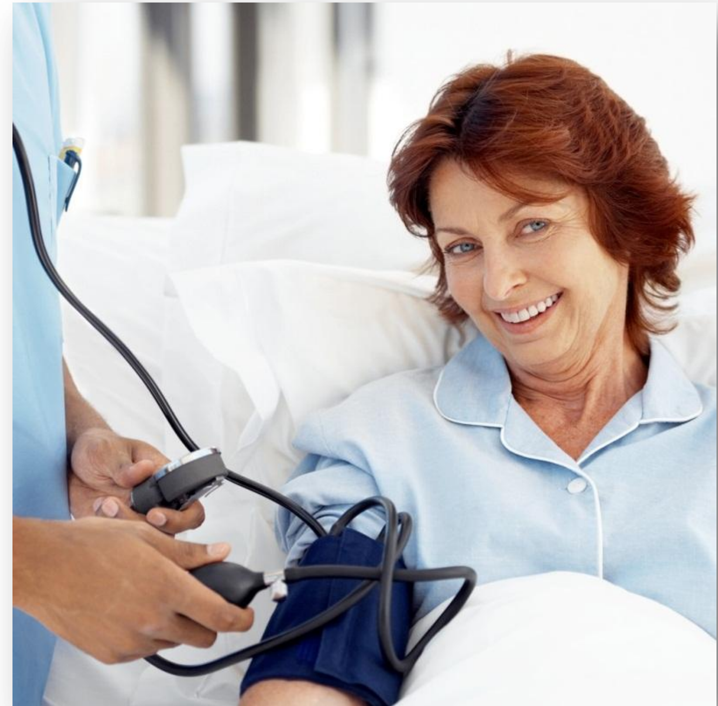
- **Medicines currently being taken including:**
  - birth control pills
  - aspirin
  - any recreational drugs
- **Current treatments**
- **Bleeding disorders or problems**
- **Drug allergies**
- **Adverse reaction to dental anesthetics**

- **History of smoking, drinking, radiation and chemotherapy**
- **Any prosthetic joint replacements**
- **Mitral valve prolapse**
- **Record blood pressure and pulse for any cardiac condition**
- **Your evaluation of the patient's physical and emotional ability to tolerate dental procedures safely**

- The best way to get a thorough medical history is for the dentist to sit down and discuss the patient's medical history with the patient

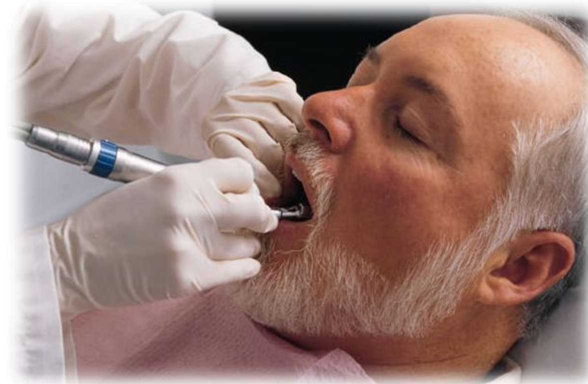
- There is no substitute for the chairside interview with the patient and guardian PRIOR to treatment to obtain an accurate history

- Record on the medical history form that the above discussion took place, initialed by dentist and patient



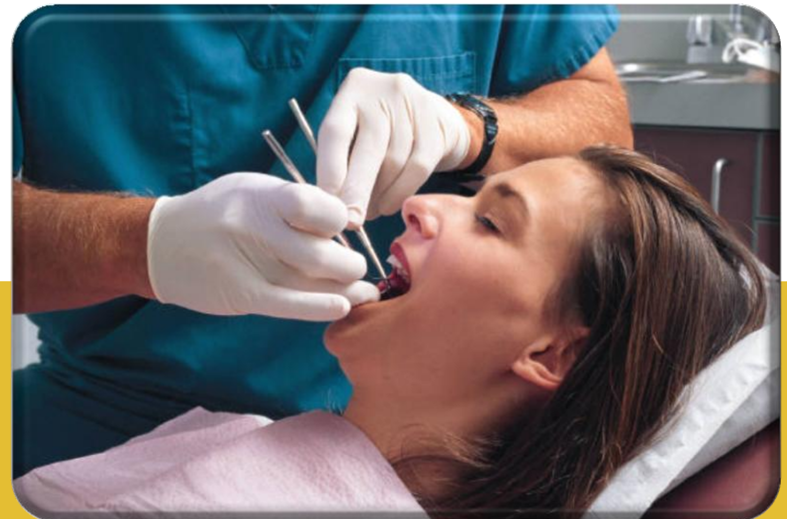
WHAT IS GOOD DENTAL HISTORY?

- Chief complaint
- Past dental records
- Past dental treatments
- Radiographs
- Patient's view of oral hygiene status
- Oral hygiene status
- Oral hygiene habits
- Treatment plan/referral information
- Progress notes
- Discharge/termination notes



Have patients describe their dental history in their own words as much as possible. What they tell you can be a safeguard.

- Ask patient to describe any unusual sensitivities or discomforts regarding the mouth
- Ask patient to describe any areas of food impaction

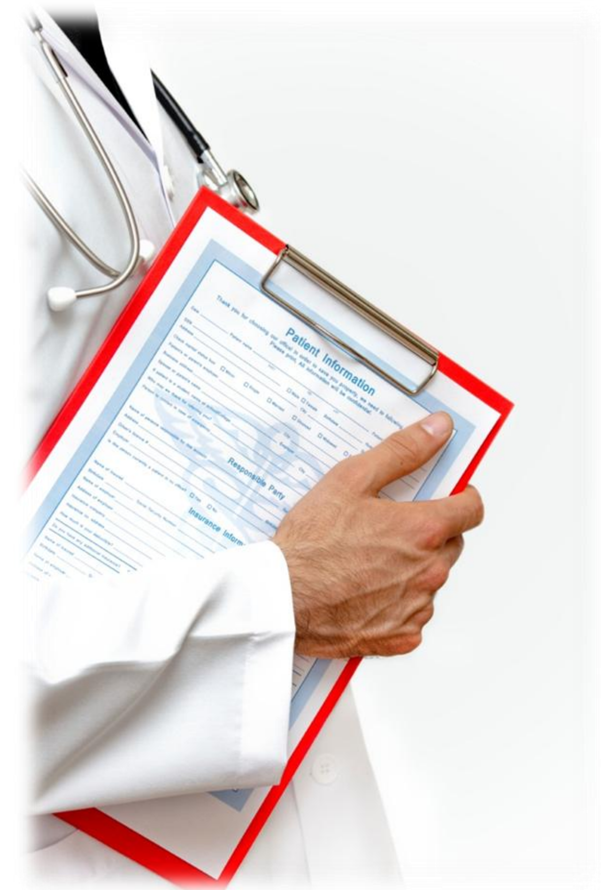


- Record any patient awareness of grinding or clenching
- Record patient's view on local and general anesthesia
- Record dental hygiene information: how often they brush and floss

Patient personal information:

- name, address, phone number
- age, date of birth
- physician's name and phone number
- emergency contact information

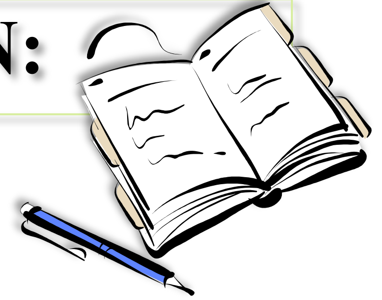
Record these items in fixed form that is not easily altered



WHAT HAPPENED DURING THE PATIENT'S VISIT:

- services provided
- instructions to the patient
- drugs administered and prescriptions made
- unusual patient reactions
- patient comments and complaints
- diagnoses and treatment plans

OTHER KEY INFORMATION:



- referral notes and reports
- cancellations and missed appointments
- failures or refusals to follow referrals
- telephone conversations with patient, physician, or other health care provider – include dates and times

CREATING AN AUTHENTIC RECORD

- All entries to the patient record should be dated, with times, and initialed by the person making the entry

- All written records should have entries made in ink, not pencil

- All entries should be readily legible and understandable to a casual observer

- All entries should be written in a professional manner that demonstrates concern for the patient

Date and sign any corrections made to a record, explain the reason for the correction – differs from altering a record in that you are not trying to obliterate or hide previous entries, or backdate new entries

Single-line cross out is recommended for showing an intended deletion

HOW LONG DO I KEEP MY NOW PERFECT RECORD?

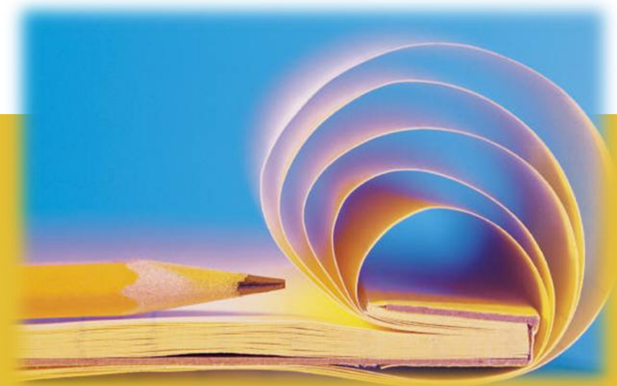
- Rules of law, common sense, and the true ideal
- True ideal: keep all records forever; it guards against all the most bizarre possibilities (but if not electronic records, it is the most expensive choice)
- Legal minimum: 6 years from the date you last saw the patient (for all adult patients 18 or older)

- Legal minimum: 6 years or until the patient turns 22, whichever would be longer (for all minor patients under the age of 18)

- Common sense: use the true ideal (although to cover most situations, 10 years should be adequate and for minor patients at least until they turn 22)

ELECTRONIC RECORDS

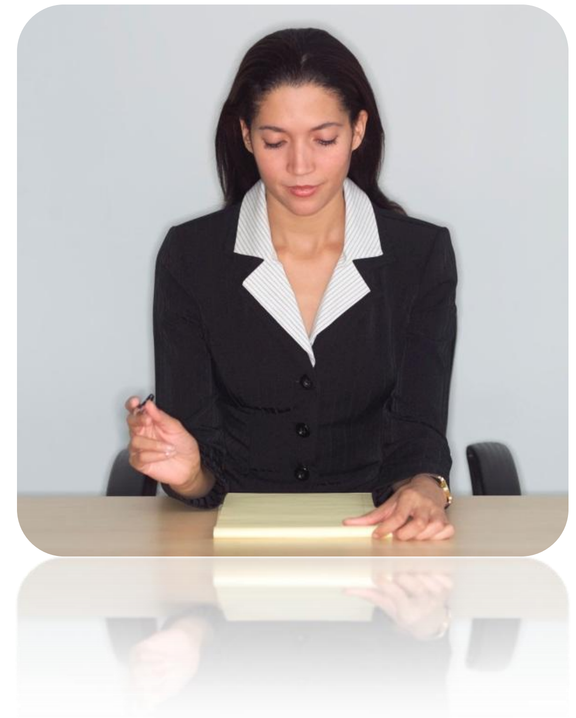
- Always have been allowed in New York (previous disadvantages of being too easily altered long cured by technological advances in locking entries)
- No law, either state or federal, requires using electronic records now or at any date in the future
- Major advantages to using them, includes enhanced reimbursement from Medicaid
- Major disadvantage is cost of implementing them



"MEANINGFUL USE"

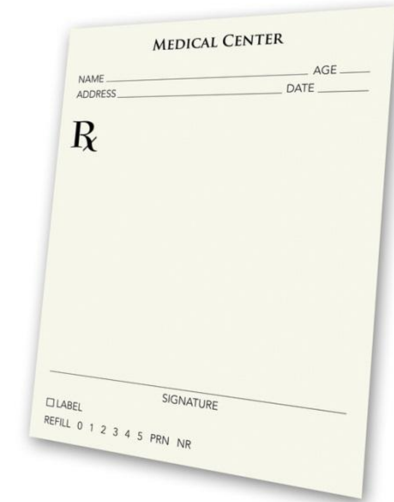
- Legal standard to qualify for enhanced reimbursement for using electronic records

- **"Meaningful use"** means dentists need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.



EXAMPLES OF MEANINGFUL USE:

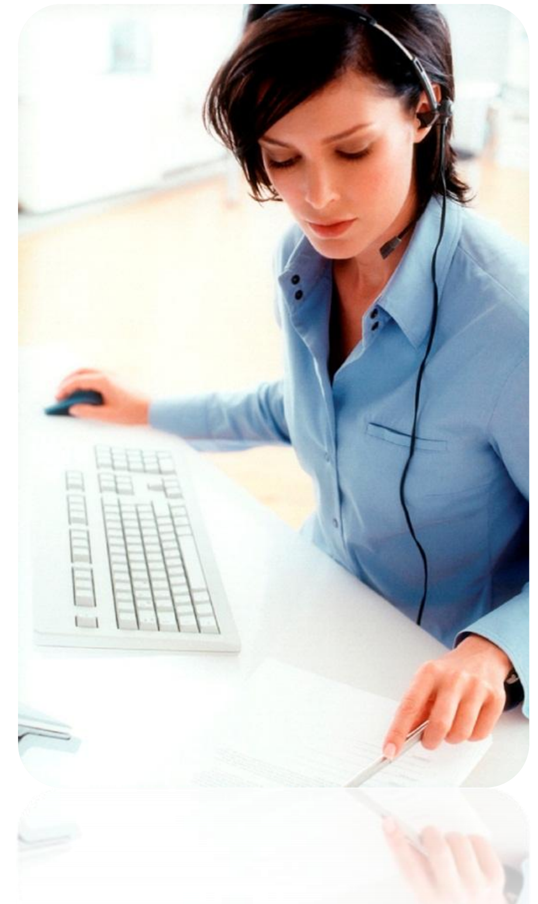
- The use of a certified EHR in a meaningful manner, such as e-prescribing
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care
- The use of certified EHR technology to submit clinical quality and other measures



The criteria for meaningful use will be staged in three steps over the course of the next five years.

Stage 1 (2011-2013) sets the baseline for electronic data capture and information sharing.

Stage 2 (expected to be implemented in 2014) and Stage 3 (expected to be implemented in 2016) will continue to expand on this baseline and be developed through future rule making.



HOW TO SHOW MEANINGFUL USE

Medicare EHR Incentive Program—Eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must successfully demonstrate meaningful use of certified electronic health record technology every year they participate in the program.

Medicaid EHR Incentive Program—Eligible professionals and eligible hospitals may qualify for incentive payments if they adopt, implement, upgrade or demonstrate meaningful use in their first year of participation. They must successfully demonstrate meaningful use for subsequent participation years.

Adopted: Acquired and installed certified EHR technology. (For example, can show evidence of installation.)

Implemented: Began using certified EHR technology. (For example, provide staff training or data entry of patient demographic information into EHR.)

Upgraded: Expanded existing technology to meet certification requirements. (For example, upgrade to certified EHR technology or add new functionality to meet the definition of certified EHR technology.)

STAGE 1

Meaningful use includes both a core set and a menu set of objectives that are specific to eligible professionals or eligible hospitals and CAHs.

For eligible professionals, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met.

- There are 15 required core objectives
- The remaining 5 objectives may be chosen from the list of 10 menu set objectives

To demonstrate **meaningful use** successfully, eligible professionals, are required also to report clinical quality measures specific to eligible professionals.

Eligible professionals must report on 6 total clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).

WHAT ARE BASELINE MEASURES?

CORE OBJECTIVES: NEED 15

(1) Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

(2) Implement drug-drug and drug-allergy interaction checks.

(3) Maintain an up-to-date problem list of current and active diagnoses.

(4) Generate and transmit permissible prescriptions electronically (eRx).

(5) Maintain active medication list.

(6) Maintain active medication allergy list.

(7) Record all of the following demographics:

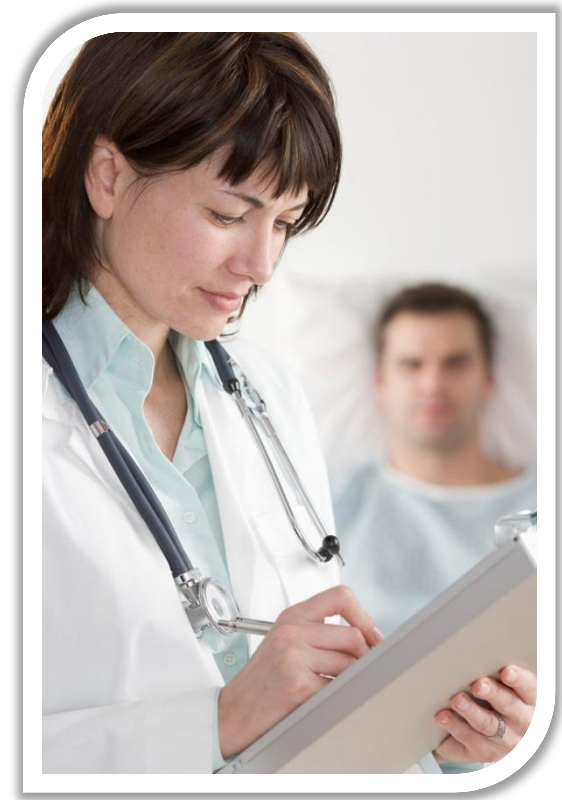
(A) Preferred language

(B) Gender

(C) Race

(D) Ethnicity

(E) Date of birth



(8) Record and chart changes in the following vital signs:

(A) Height

(B) Weight

(C) Blood pressure

(D) Calculate and display body mass index (BMI)

(E) Plot and display growth charts for children 2–20 years, including BMI

(9) Record smoking status for patients **13 years old or older.**

(10) Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.

(11) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

(12) Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.

(13) Provide clinical summaries for patients for each office visit.

(14) Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

(15) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

MENU OBJECTIVES NEED 5 OUT OF 10

(1) Implement drug formulary checks.

(2) Incorporate clinical lab-test results into EHR as structured data.

(3) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

(4) Send patient reminders per patient preference for preventive/follow-up care.

(5) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

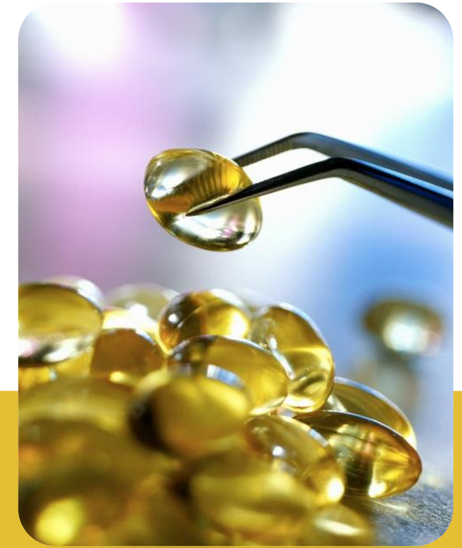
(6) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

(7) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

(8) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

(9) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

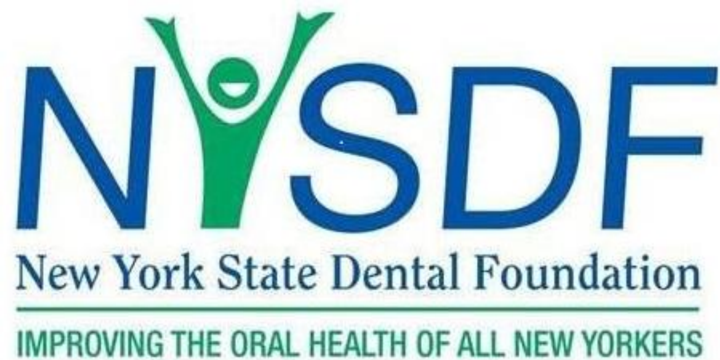
(10) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.



WHAT ARE CLINICAL QUALITY MEASURES?

Eligible professionals must report on 6 total clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).

https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp



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