**Chapter 3**

**Health Information Functions, Purpose, and Users** *Nanette B. Sayles, EdD, RHIA, CCS, CHDA, CHPS, CPHIMS, FAHIMA*

**Real-World Case 3.1**

General Hospital knew they had a problem with duplicate health records and needed to clean up the MPI before the implementation date for the EHR in order to get the best results. A consulting firm was hired and a review of the data confirmed this problem when they 3,000 potential duplicate health records issued over the past five years were identified. The hospital started the MPI clean-up process by educating their patient registration staff on proper search strategies, questions to ask the patient, the importance of a unit health record, and other related topics. This education was an important first step so that additional duplicate health records would not be assigned while the clean-up process was going on. Once the training was complete, the consulting firm began cleaning up the MPI. The consultants reviewed the potential duplicate health records and merged the records where appropriate. They also ensured the health records were merged in other information systems used throughout the healthcare facility. They provided documentation to General Hospital showing which health records were and were not duplicates based on their review.

# Real-World Case Discussion Questions

1. What would you include in the training? I would also include what would happen if there are errors in the MPI and the impact of those errors.

2. What role can the consultants play in the MPI clean-up? The could confirm that the information that is currently in the system is correct.

3. Why did the facility find itself in this situation? They might not have had a way to search if a patient had been there on a previous occasion, so they just assigned a new number to everyone that was seen at the facility.

**Real-World Case 3.2**

The University of Wisconsin Hospital and Clinics (UWHC) received AHIMA’s first Grace Award. This award is given to a healthcare organization that is innovative in the use of health information. UWHC collects all documentation electronically either through direct entry, scanning, or from a variety of information systems throughout the organization. Information from other facilities can be directly faxed into the EHR and be available for access within two hours. Patients are able to access information to schedule appointments and access test results. Physicians are reminded that the patient is due for tests or other services (Dooling and Wiedemann 2012).

Dooling, J. and L.A. Wiedemann. 2012 (November). AHIMA issues first Grace Award: University of Wisconsin Hospital and Clinics receives HIM excellence award. Journal of AHIMA. 83(11):26–27.

# Real-World Case Discussion Questions

1. What is the Grace Award? It is an award recognizing Excellence in Health Information Management it honors healthcare delivery organizations that demonstrate industry-leading approaches to AHIMA’s core mission of transforming quality healthcare through informatics, information governance, and trusted health information.

2. Who are other Grace Award winners and what did they do to earn the award?

 The Ohio State University Wexner Medical Center (2016)

 Texas Health Resources (2016 honorable mention)

 Allina Health of Minneapolis (2015)

 Texas Health Resources (2015 Honorable Mention)

 Children’s Medical Center of Dallas (2014)

3. What did theUniversity of Wisconsin Hospital and Clinics do to earn the award?

 They earned this away by demonstrating an outstanding and innovative approaches in health information management.

# Application Exercises

*Instructions:* Answer the following questions.

1. Go to the AHIMA website or another health-related site and search for articles related to the uses and users of health records. Select two articles to read and write a paragraph on each, such as who uses health record data, why type of data is used, and why the data is important to the users. Why did you select each article? What do you think is important about each article?

2. Interview an HIM professional in the HIM department of a healthcare facility about the differences in working in a paper, hybrid, or electronic health record environment. Write a summary of your interview.

3. Compare and contrast the functions of the paper and electronic health records.

 Paper health records take up more space and take longer to search for patient files. By having electronic health records a patient care provider can provide the proper care faster by finding past medical history faster and other information, than having to search through paper health records.

4. Put the following names in alphabetical order according to the rules provided in the chapter.

**Names to be Alphabetized**

Carson, D’ann

Dodd, B. R.

Dodd, Bobbie A

Dodd, Bobbie, R

Fletcher, Cindy

Gates, Xavier

Lincoln, Mark

McDonald, Rachel

Powell, Samantha

Quinn, Simone

Roberts, Marie

St. John, Phillip

Smith, Tobias

Thomas-Sewell, Rose

Washington, Florence C.

5. Organize the following health record numbers in terminal digit order.

**Health Record Numbers for Terminal Digit Activity**

43-42-00 21-59-42 29-57-89

52-43-01 53-59-45 29-95-91

02-23-02 29-57-51 34-42-92

38-32-02 29-57-53 46-85-92

33-55-05 29-57-55 20-40-99

26-42-06 29-59-66 50-42-99

20-08-13 29-57-67

20-18-13 30-59-70

33-55-26 02-42-76

57-97-29 50-59-81

23-42-34 23-42-83

01-59-40 28-59-85

**Review Quiz**

*Instructions:* For each item, complete the statement correctly or choose the most appropriate answer.

1. Which of the following is a secondary purpose of the health record?

a. Document patient care delivery

b. Assist caregivers in patient care management

c. Aid in billing and reimbursement functions

 d. Educate medical students

2. Which of the following is an institutional user of the health record?

a. Patient care provider

b. Third-party payer

c. Coding and billing staff

d. Government policy maker

3. How do patient care managers and support staff use the data documented in the health record?

a. Evaluate the performance of employees

b. Communicate vital information among departments and across disciplines and settings

c. Generate patient bills or third-party payer claims for reimbursement

d. Determine the extent and effects of occupational hazards

4. An HIM student asked an HIM director why the hybrid record is so challenging. What is the HIM director’s response?

a. It is because we are focusing on the EHR.

b. It is because we have to maintain all of the traditional HIM functions.

c. It is because HIM professionals do not have the skills to manage the EHR.

d. It is because we have to manage both the electronic and paper media.

5. What is the process of ensuring that a record is available for every patient seen at the healthcare facility?

 a. Overlap

b. Delinquent chart

c. Abstracting

d. Reconciliation

6. Dr. Smith dictated his report and then immediately edited it. What type of speech recognition is being used?

 a. Back-end

 b. Front-end

 c. Physician

 d. Outsourced

7. Critique this statement: Data and information mean the same thing.

 a. This is a true statement.

 b. This is a false statement because data is used for administrative purposes and information is used for clinical purposes.

 c. This is a false statement because data is raw facts and figures and information is data converted into a meaningful format.

 d. This is a true statement because information is raw facts and figures and data is information converted into a meaningful format.

8. Which information system will track information provided to a requester?

 a. Registry

 b. Quality improvement

 c. Chart tracking

 d. Release of information

9. The use of the health record by a clinician to facilitate quality patient care is considered \_\_\_\_\_\_\_\_\_\_\_\_.

 a. A primary purpose of the health record

 b. Patient care support

 c. A secondary purpose of the health record

 d. Patient care effectiveness

10. Why is only the most current version of a document displayed?

 a. All previous versions are deleted

 b. To ensure there is no confusion on the correct document

 c. Only the physician has access to previous versions of a document

 d. The user decides which version to see

11. How do accreditation organizations use the health record?

 a. To serve as a source for case study information

 b. To determine whether the documentation supports the provider’s claim for reimbursement

 c. To provide healthcare services

 d. To determine whether standards are being met

12. How long should the MPI be retained?

 a. Permanently

 b. 25 years

 c. 50 years

 d. 10 years

13. Deficiencies in a health record include which of the following?

 a. Mistake in the patient’s age

 b. Missing document

 c. Contradictory content

 d. Illegible content

14. Critique this statement: Patient care managers are individual users of health records.

 a. This is a true statement.

 b. This is a false statement as they do not require patient information to do their job.

 c. This is a false statement as they require patient information to do their job.

 d. This is a false statement as patient care managers are institutional users.

15. Removing health records of patients who have not been treated at the facility for a specific period of time from the storage area to allow space for more current records is called:

 a. Purging records

 b. Assembling records

 c. Logging records

 d. Cycling records

16. Which type of microfilm does not allow for a unit record to be maintained?

 a. Roll microfilm

 b. Jacket microfilm

 c. Microfiche

 d. Micrographics

17. Which of the following is true about document imaging?

 a. Data in the scanned documents can be manipulated

 b. Scanned documents can only be viewed by one person at a time

 c. Outguides are required

 d. Documents can be indexed

18. Which system records the location of health records removed from the filing system and documents the return of the health records?

 a. Chart deficiency system

 b. Chart tracking system

 c. Abstracting system

 d. Registry system

19. “Loose” reports are health record forms that:

 a. Are maintained separately from the health record

 b. Are not part of the legal health record

c. Are received by the HIM department and added to the health record after it has been processed

 d. Are misfiled

20. Which of the following is the most efficient filing system?

 a. Serial numbering system

 b. Unit numbering system

 c. Serial unit numbering system

 d. Middle-digit filing system

21. Which of the following is the key to the identification and location of a patient’s health record?

 a. Disease index

 b. Outguide

 c. Deficiency slip

 d. MPI

22. Which of the following numbering system assigns multiple health record number, or, one per visit?

 a. Unit

 b. Serial-unit

 c. Serial

 d. Alphabetic

23. In which numbering system does a patient admitted to a healthcare facility on three different occasions receive three different health record numbers but the content is filed under the most recent health record number?

 a. Unit

 b. Serial

 c. Serial-unit number

 d. Alphabetic

24. Which of the following is part of qualitative analysis review?

a. Checking that only approved abbreviations are used

 b. Checking that all forms and reports are present

 c. Checking that documents have patient identification information

 d. Checking that reports requiring authentication have signatures

25. Which of the following is true of good forms design for paper forms?

 a. Every form should have a unique identification number

 b. Barcodes are never included

 c. Bright color paper should be used to identify forms.

d. Paper size should be 8.5 inches by 14 inches