Chapter 3 HIM

1. **After reading the chapter and reviewing the power point presentation,  please answer the following questions.**

**What is a health record?** Contains information relating to the physical or mental health or condition of the individual, as made by or on behalf o of a health professional in connection with the care ascribed as to the why, what, where ,why and how of patient care used by different people for different reasons.

**Who are the different users of the health record and how do they use it?** The primary purpose is patient care used by the provider including the nurses, physicians and allied health professionals. It is a communication tool. Patient care managers and support staff used for evaluation of quality of care. It is used for the management of care and can be used to conduct research by local, state and national levels. The health record is also used for administrative purposes and used for billing, scheduling and staffing. Patients as informed consumers.

Secondary users medical, nursing and other allied health professionals to teach present and future healthcare providers how to document care provided. It can be used for legal, accreditation and policy development used to protect the facility from medical malpractice, monitor compliance and public health research used for best practice in healthcare.

**Explain the health record processes.** First a search of MPI is done and all records found and consolidated with the new records. Next assembly happens and each page should be examined to ensure it is the right patient. Analysis of the record happens next. First a qualitative analysis which monitors the quality of the records, than quantitative analysis to see if there are missing reports, forms or signatures. This can happen while the patient is in the facility by several different people, or it can be done after the patient leaves retrospectively. If a signature or form is missing a deficiency slip is created. The deficiency is expected to be completed in a timely fashion or a delinquent record is created. If a correction is needed on the record line through the error with the word error above the mistake. Sometimes an addendum is made which is an addition to the information in the records.

**Explain the health information management information systems.** It is a data collection system. It is used to support planning, management and how decisions are made. It is used to enhance other department including patient care, info governance, quality management, billing and patient registration.

**What quality controls can be put into place to manage health information management functions ?**making sure to have qualitative and quantitative analysis, have the documents all contain unique identifying numbers, each form should include original and revised dates, concise title of the form, making sure all records signed out are returned, making sure all deficiencies are taken care of in a timely fashion. Checking and cross checking the information in the file.

2. **Please define the following:**

**Abstracting**—can be either the process of extracting info from a document ot create a brief summary of a patient illness, treatment and outcome or the process of extracting elements of data from a source document or database and entering them into an automated system.

**Addendum**—additional information provided in the health record

**Aggregate data**—is data that has been extracted from individual health records and combined to form DE identified information about groups of patients that can be compared and analyzed.

**Amendment**—is a clarification made to healthcare documentation after the original document has been signed

**Audit trail**—is a chronological set of computerized records that provides evidence of information system activity used to determine security violations.

**Computer assisted coding**—uses ehr data to assign the codes

**Concurrent review**—quantitative analysis Can be performed by concurrent review an ongoing manner while the patient is still in the healthcare facility.

**Correction**—drawing single line through the erroneous information and writing the word error above the mistake

**Data**—Raw facts and figures while info is something that data has turned into something meaningful

**Data mining**—process of extracting and analyzing large volumes of data from a database for the purpose of identifying hidden and sometimes subtle relationships or patterns and using those relationships to predict behaviors

**Deficiency slip**—when a document or signature is missing, slip id’s the pertinent document and what is needed to be done.

**Delinquent record**—record remains incomplete for a specified amount of days the record is considered delinquent

**Demographics**—basic information about the patient such as their name, address, date of birth and insurance info

**Deterministic algorithm**—requires exact matches in data elements such as the patient name, date of birth and social security number.

**Encoder**—assigns the diagnosis and procedure codes

**Grouper**—uses the codes assigned to determine the diagnostic related group or other grouping

**Meaningful Use**—using certified electronic health record technology to improve quality safety, engage patients and family, improve care coordination, maintain privacy used for better clinical outcomes, improved population health and increase transparency

**Outguide**—where the health record is located and when it was removed

**Overlap**—when a patient has more than one health record number at different locations in an enterprise

**Overlay**—patient is erroneously assigned another person’s health record number

**Probabilistic algorithm**—uses mathematical probabilities to determine the possibility that two patients are the same.

**Qualitative analysis**—monitoring the quality of the documentation

**Quantitative analysis**—a review of the health record to determine if there are any missing reports forms or signatures

**ROI**—release of information is the process of disclosing patient identifiable info from the health record to another party

**Serial numbering system**—Patient receives a different MR on each admission

**Requisition**—request for the health record

**Terminal digit filing system**—partly numeric filed by last two digits called terminal digits, then middle two secondary unit, first two tertiary units.

**Unit number system**—Patient receives the same medical record number on every admission. All records same place in file best system

**Voice recognition technology**—computer captures the dictation and converts what is said directly into text and no transcriptionist is needed.

3**.   Check your Understanding answers.**

3.1

1. d—patient care

2. c—research

3. a—third party payer

4. c—patient

5. b. public health and research

3.2

1. A. roll

2. c. mobile filing units

3. c. color coding

4. c. outguide

5. a. corrective action should be taken

6. a. provides oversight for the development, review, and control of forms and computer screens

7. b. assembly

8. c. analysis

9. b. overlay

10 b. delinquent records

3.3

1. A. control the workflow electronically

2. D. the amendment must have a separate signature date and time

3. B. policies and procedures to control which version is displayed

4. C. Copying the note in the wrong patient’s record

5. B. input mask

**4.  Answer the following:**

 What is the purpose of the Health Record.

* **Who are the users of the health record and why?**
  + A. patient care providers—to make decisions about the care
  + B. Patient care managers and support staff—evaluate the services provided
  + C. coding and billing staff—basis for reimbursement or payment for the care provided
  + D. patients—informed consumer
  + E. employers—processing health claims and managing wellness programs.
  + F. Lawyer—support a client or a provider
  + G. law enforcement officials—protect security of country or in a crime.
  + H. healthcare researchers and clinical investigations—to study safety of drugs and approve new treatments
  + I. government policy makers—evaluate current and future laws.
  + J. Institutional users including healthcare deliver organization, third party payers, medical review organizations, research organizations, educational organizations, accreditation organizations, government licensing agencies and policy making bodies.
* **Name those functions of HIM that support patient care**. The functions focus on ensuring the quality, security and availability of the health record. These functions include record processing, monitoring of record completion, transcription, release of patient information and clinclical coding. Some other functions are research and statistics, registries and birth and death certificate completion.
* **Describe the  Master patient index and it many core data elements.** Permanent record of all patients treated at a healthcare facility. Used to look up patient demographics, dates of care, health record number and other info.
* **Describe  duplicate**, patient has 2 or more record numbers assigned **overlay** patient is erroneously assigned another person’s health record number and **overlap** patient has more than one health record number at a different location **health record numbers**.
* **Describe  Identification systems for paper records** (4) Serial numbering systems—unique numerical identifier for every encounter, inefficient and most costly, unit numbering system—common in large facilities not as inefficient, health record number on first encounter and same number used on all subsequent encounters, serial unit numbering system—combo of serial and number systems, issued new number each encounter but then moved up to the most recent, alphabetic filing system—used by small clinics by patients last name then first and then middle initial disadvantage similar names; Electronic health records. **Digital record**—unit numbering system is the most common system used in the EHR. Can use other identifiers as well such as name, date of birth or account number
* Describe **numeric filing systems** –filed by the health record number. More advantages and less errors to this way. Straight numerical filing system based on health record number terminal digital filing most efficient distributes charts evenly throughout the filing units. Filed by the last two digits called the terminal digits then the middle two known as the secondary then filed by first two or three known as the tertiary units. and **Alphanumeric filing systems**.—filed with first two letters of the last name than followed by a unique numeric identifier. Requires an mpi
* **How are records located and retrieved?** The use of an outguide which identifies where the health record is located and when it was removed. It is a place holder of colored vinyl in place of where the borrowed document was. Loose material can be kept in a pocket prior to it getting filed. A requisition is used to request the health record. The requisition gives specifics of what the person is looking for. Many times this is automated and keeps up electronically with who checks the health record out. The outguide is still used though, for holding documents to be filed.

Electronic Environment:

* **What are the advantages??** It reduces filing, leaves audit trail, assembly process is eliminated, can be completed at remote locations as it is electronic, can work on records in any order, many documentation sources can be included in the Ehr which couldn’t be in the paper record, search, retrieve and manipulate data.
* **What is Indexing?** The linking of patient name, health record number, document type, and other identifying information to the scanned document
* **Describe the management of free text in the EHR.** The amount of text should be limited, Structured data prevents make the free text more consistent and retrieval easier, copy and paste shouldn’t be used as issues can arise.
* **Name several quality control functions of the EHR.** When entering a ssn an input mask should be used, the use of drop down boxes for things such as the state, check box for yes or no, radio buttons allow people to choose for small number of choices, clear navigation buttons, clear labeling of buttons and data fields, limiting the use of abbreviations on buttons, consistent location on the screen of navigation buttons, built in alerts, availability of references a the appropriate data field, prompt for more info, checks for warning sign or errors, navigation design, input design, data validation, output design, all should have checks and balances.
* **Describe the HYBRID record.** Combo of paper and electronic. For example the lab results, radiology results and other components of the record are stored in her while progress notes nurses notes and other documents are in paper record.
* Describe ROI  and what is the responsibility of the HIM  department and staff?
* Describe the  function of the ROI  software system.