[Chapter 3 Health Information Functions, Purpose, and Users: KEY TERMS, Questions](https://cmconnect.cmcc.edu/ICS/Academics/MCO/MCO__110/1617_FA-MCO__110-51___N/Coursework.jnz?portlet=Coursework&screen=StudentAssignmentDetailView&screenType=change&id=8aea5cf5-b2d4-4ae8-ac8d-a1ce92418767) Now open

Homework due **Sunday, September 18 at 11:55 PM** (Required)

The chapter introduces us to the users of health records. It is important work that the HIM professional does in supporting critical roles and users of the data and the information contained in the health record.  Note that privacy, confidentiality, and security of the health information is discussed here.  HIM professionals are patient advocates to safeguard an individual's health information from unauthorized access.

The chapter also explains the functions required by the processing of paper records, hybrid records, and the electronic health record. Storage and maintenance of the health record is the most fundamental HIM function and affects all other functions.  If records and information are not stored and maintained appropriately, then it is almost impossible to perform other tasks.  The chapter also discusses filing system, storage systems, microfilming, remote storage, chart tracking, and quality monitoring of paper based record systems, as well as screen design and forms.

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

What is a health record? A health record contains info relating to the physical or mental health or condition of an individual as made by or on behalf of a health professional in connection with the care ascribed that individual. It’s the WHO, WHAT, WHERE, WHY and HOW of a patient’s care.

Who are the different users of the health record and how do they use it? Different users of the health record include primary and secondary purposes. Primary purposes are:

Patient care, Management of patient care, and administrative purposes.

Secondary purposes are:

Education of healthcare professionals, legal accreditation, and policy development, lastly, public health and research.

Explain the health record processes.



The health record process begins with the patient coming into a facility. The patient’s information is entered into the facility and all information is document into this particular record. The doctor may put in some notes, and so may the nurse. Once the visit is completed the patient is then filed within the facility via computer or in an actual file.

Explain the health information management information systems.

Information systems of Health Information Management are: Serial numbering systems: a patient is issued a unique numerical Identifier for every encounter at eh healthcare facility. Unit numbering system is when a patient is issued a health record number at the first encounter and it is the someone for all encounters. The serial unit numbering system is the patient is issued a new health record number with each encounter but all of the info from the previous encounter is moved to the new number. There is also alphabetic filing system where a patient if filed by last name then first name then middle initial.

What quality controls can be put into place to manage health information management functions?

Quality controls that can be put into place to manage HIM functions are audit trails to provide evidence of information system activities like logins and logouts, file accesses to determine security violations. In paper records an average of 50 records will be filed an hour. Records for an ER department will get retrieved within 10 minutes of a request. Loose material will be filed in either the health record or out guide pocket. Standards must be established in both a paper and EHR system.

2. **Please define the following:**

Abstracting: The process of extracting info from a document to create a brief summary of a patient’s illness, treatment, and outcome. The process of extracting elements of data from a source document or database and entering them into an automated system.



Addendum: A late entry added to a health record to provide additional info in conjunction with a previous entry.

Aggregate data: Data extracted from individual records and combined to form de identified info about groups of patients that can be compared and analyzed

Amendment: A clarification made to health care documentation after the original document has been signed.

Audit trail: A chronological set of computerized records that provides evidence of info system activity (logouts/in, file accesses) used to determine security violations and a record that shows who has accessed a computer system, when it was accessed, and what operations were performed.

Computer assisted coding: The process of extracting and translating dictated and then transcribed free text data (or dictated and then computer generated discrete data) into IDC-10-CM and CPT evil and management codes for billing and coding purposes.

Concurrent review: Screening for medical necessity and the appropriateness and timeliness of the delivery of medical care from the time of admission until discharge.

Correction: Edit made to the record by drawing a single line through the error and writing the word error above the mistake, the practitioner should sign, date, and time the correction.

Data: Raw facts and figures i.e.: dates, times, facts

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

Deficiency slip: Notification when a document or signature is missing that identifies the pertinent document and what needs to be done.

Delinquent record: An incomplete record not finished or made complete within the time frame determined by the medical staff of the facility.

Demographics: Information used to identify an individual, such as name, address, gender, age and other info linked to a specific person.

 Deterministic algorithm: Algorithm that requires exact matches in data elements such as the patient name, date of birth, and SSI.

Encoder: Specialty software used to facilitate the assignment of diagnostic and procedural codes according to the rules of the coding system.

Grouper: A computer program that uses specific data elements to assign patients, clients, or residents to groups, categories or classes. A computer software program that automatically assigns prospective payment groups on the basis of clinical codes.

Meaningful Use: A regulation that was issued by CMS on July 28, 2010, outlining an incentive program for professionals, eligible hospitals, and CAHs participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified HER tech.

Out guide: A device used in paper based Health record to track the location of records removed from file storage.

Overlap: Situation in which a patient is issued more than one medical record number from an organization with multiple facilities

Overlay: Situation in which a patient is issued a medical record number that has been previously issued to a different patient

Probabilistic algorithm: Algorithm that uses math probabilities to determine the possibility that two patients are the same

Qualitative analysis: A review of the health record to ensure that standards are met and to determine the adequacy of entries documenting the quality of care.

Quantitative analysis: A review of the health record to determine its completeness and accuracy

ROI: Release of Information: The process of disclosing patient identifiable info from the health record to another party.

Serial numbering system: System where a patient is issued a unique numerical identifier for every encounter at the healthcare facility, if a patient is admitted to the healthcare facility five times he or she will have five different health record numbers.

Requisition: Requests for the health record

Terminal digit filing system: A system of health record identification and filing in which the last digit or group of digits in the record number determines file placement

Unit number system: A health record identification system in which the patient receives a unique medical record number at the time of the first encounter that is used for all subsequent encounters.

Voice recognition technology: A method of encoding speech signals that do not require speaker pauses and of interpreting at least some of the signals’ content as words or the intent of the speaker.

3**.   Check your Understanding answers.**

3.1

1. D

2. C

3. A

4. C

5. B

3.2

1. A

2. C

3. C

4. B

5. A

6. A

7. B

8. C

9. B

10. B

3.3

1. A

2. D

3. B

4. C

5. B

3.4

1. C

2. A

3. B

4. B

5. A

**4.  Answer the following:**

 What is the purpose of the Health Record?

The purpose of the health record is for patient care or for those where the health record is used for Healcare purposes that don’t directly relate to the patient’s care.

* Who are the users of the health record and why?

Users of the health record may be individual users or institutional users. Individual users are those who depend of the health record in order to complete their job. A physician or nurse need to know how to care for the patient. Institutional users are organizations that need to access the health record in order to accomplish a mission. Sometimes it is for research, Medical review organizations, educational organizations and even the hospital.

* Name those functions of HIM that support patient care.

Record processing, monitoring of record completion, transcription, release of patient info, clinical coding, abstracting, and clinical data analysis, research and statistics, registries, and birth and death certificate completion support patient care.

* Describe the Master patient index and it many core data elements.

The MPI is the permanent record of all patients that are treated at a Healcare facility. It is used by the HIM department to look up patient demographics, dates of care, patient’s health record number. The CORE data elements included are:

Internal patient identification, person’s name, DOB, bender, race, ethnicity, address, phone number, alias, previous/maiden names, SSI, Facility ID, Universal patient identifier, account or visit number, admission number, admission encounter or visit data, discharge date, encounter service type, encounter primary physician, patient disposition.

* Describe duplicate, overlay and overlap health record numbers.

A duplicate health record happens when the patient has two or more health record numbers issued. An overlay is when a patient is assigned to another person’s health record number, an overlap is when a patient has more than one record number at different locations in an enterprise.

* Describe Identification systems for paper records (4); Electronic health records

Identification systems for paper records are as follows:

Serial numbering system- a patient is issued a unique numerical identifier for EVERY encounter the facility.

Unit numbering system- is used in large facilities. A patient is issued a health record number at the first visit and that number is used for all subsequent encounters.

Serial unit numbering systems is a combination of the serial and unit numbering systems. The patient is issued a new record number with each encounter but all of the documentation is moved from the last number to the new number.

Alphabetic filing system is used in small facilities. The folders are filed alphabetically by last name then first name and lastly middle initial

In electronic Health Systems they mostly use the UNIT numbering system. Also, a patient receives a patient account number for billing purposes and is unique for a particular episode of care. A new account number is assigned each time the patient receives care or services.

* Describe numeric filing systems and Alphanumeric filing systems.

The NUMERIC filing system are health records filed by the health record number. The STRAIGHT NUMERIC Filing system files the records in straight numeric order based on the health record number. The TERMINAL DIGIT Filing system may sound backward, but it is considered the most efficient way for numeric filing. They health record is filed by the last two digits then the middle two digits then the first two or three numbers.

* How are records located and retrieved?

Electronic records are located easily by searching the person’s name and date and using data of the person to ensure it is them. With paper record the record is located by knowing the person’s name, record number, date of birth and more. When it is located

Electronic Environment:

* What are the advantages??

Advantages of the EHR include the ability to record information of system activity, eliminating the assembly process, reducing lost paperwork, not being overburdened with space for the records (filing cabinets), eliminate “free text data”, easier retrieval, easier search, retrieval and manipulation, and also the ability to use algorithms and programs to search for mistakes without wasting human time.

* What is Indexing?

Indexing is the linking of patient name, health record number, document type and other identifying if to a scanned document.

* Describe the management of free text in the EHR.

Free text is managed by creating a more structured text where you point and click or select data choices. Free text is typing data into a system. It is undefined, unlimited and unstructured. It should be minimized to reduce manipulation. You now manage the data by using options and clicks rather than fill ins. An example is by clicking male or female under gender rather than free typing male.

* Name several quality control functions of the EHR.

Several quality control functions of the HER include:

* 1. Clear labeling of buttons and data fields
  2. Limiting the use of abbreviations
  3. Consistent location on the screen of navigation buttons
  4. All controls should be clear
  5. Use neutral colors and limit highlighting
  6. Limit choices and label commands
  7. Provide undo buttons to override mistakes
  8. Use consistent grammar and terminology
  9. Simplify data collection
  10. Provide a title for each screen
  11. Use popup menus
  12. Use a selection box to allow the user to select a value
  13. Perform format check to ensure all required data has been filled
  14. Perform a range check to ensure numeric data are in the correct range
  15. Minimize the number of clicks needed to reach data or a specific screen



* Describe the HYBRID record.

A hybrid record is combining a paper based record and electronic record. It’s usually when a company is transitioning over to electronic records. It’s a combinination of paper records and electronic records for certain tasks.

* Describe ROI and what is the responsibility of the HIM department and staff?

ROI is the release of information of a patient’s record part or all. The HIM department/staff must ensure the request is appropriate to be released and then they submit the info for use in patient care, insurance claims or legal claims.

* Describe the function of the ROI software system.

The ROI software system tracks requests for information. Then the HIM staff enters basic information from the request like: patient name, health record number and the requester. Once the information is released the staff records what is released and the date. The system automatically bills requesters for the copies of records, if needed. It also can monitor productivity and turnaround time.