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

What is a health record?

A health record is the information 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.

Who are the different users of the health record and how do they use it?

The different users of the health records are Individual and Institutional Users. The Individual Users depend on the health records in order to complete their job. These are Patient care providers, Patient care managers and support staff, Billing and coding staff, Patients, Employers, Lawyers, Law enforcement officials, Healthcare researchers and clinical investigators, and Government policy makers.

The Intitutional Users are organizations who access health records to accomplish their mission. These are the Healthcare delivery organizations, Third-party payers, Medical review organizations, Research organizations, Educational organizations, Accreditation organizations, Government licensing agencies and Policy-making bodies.

Patient care providers like physicians, nurses, and allied health professionals professionals use health records to make decisions about the care provided to the patient and for documentation purposes.

Patient care managers and support staff also use health records to evaluate services provided by their employees.

Coding and Billing staff use health records to as the basis for reimbursement for care provided.

Patients sometimes obtain copies of their health record in order to be informed of their health.

Employers use health records to determine whether employees are well enough to return to work and also, use it to claim disability due to work-related incidents.

Lawyers need health record to support their clients for insurance claims and lawsuits.

Healthcare researchers and clinical investigators use health records to study the safety and efficacy of drugs and the value of care provided.

Government policy makers use health records and data collected to develop and evaluate future and current laws and regulations, and standards related to healthcare.

Institutional Users of health records like the Healthcare delivery organisations, for example, Hospitals, Home health agencies, Doctors offices, etc. also use health records to provide care, submit claims for reimbursementand to evaluate quality of care provided to patients.

Third-party payers use health records to reimburse healthcare servies through insurance programs like managed care organizations, government insurance programsaccountable car organizations and self-insured employers.

Medical review organizations use health records to evaluate the appropriateness and quality of care provided to a patient.

Research organizations also use health records to conduct medical researches and include state diseses registries.

Educational organizations use health records as case studies to train healthcare professionals.

Accreditation organizations also use health records to determine compliance with documentation and patient care standards in order to grant and maintain accreditation to healthcare organizations.

Government licensing agencies use health records to ensure complieance with state licensing requirements.

And finally, the Policy-making bodies use health records as the data submitted for healthcare claims to governmental databeses are analyzed for decision making for healthcare programs.

Explain the health record processes.

The HIM staff store paper-based health records in files, cabinets and shelves, and retrieve them for authorized users. They also prevent unauthorized users from gaining access to the health records.

Paper-based health records are stored or filed alphabetically, numerically, alphanumeric, centralized unit filing systems, etc. These health records are put in special file folders and filed in cabinets and shelves.

Some healthcare facilities also file their paper-based records off-site and some, on microfilms or scan them digitally and store them as scanned documents. Some are also image-based.

Health records can also be are processed electronically. Here, HIM staff capture and store data directly into computers. Healthcare professionals are able to access these health records from any location.

HIM staff use indexing to link patients names, health record numbers, document types and other information to identify patients to the scanned documents.

Explain the health information management information systems.

The HIM staff are responsible for storing and maintaining both paper-based and electronic health records and retrieve them for authorized users and prevent them from unauthorized users.

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

Many quality control measures are available to manage health information management functions, and some of these are best practices for designing and evaluating the entry secreens of the HIM professionals. For example, setting general guidelines for HIM staff, new and improved Navigating, Input and output designs, and data validation to ensure quality documentation to achieve quality care.

2. **Please define the following:**

Abstracting: - It is the process of extracting elements of data from a source document or database and entering them into an automated system.

Addendum: - An addendum is an additional information provided in the health record.

Aggregate data: - Aggregate data is data that has been extracted from individual health records and combined to form deidentified information about groups of patients that can be compared and analyzed.

Amendment: - It is a clarification made to healthcare documentation after the original document has been signed.

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

Computer assisted coding: - This uses ‘electronic Health Record data to assign the codes.

Concurrent review : - It is a review in an ongoing manner while the patient is still in the healthcare facility.

Correction: - This is done by drawing a single line through the erroneous information and writing the word “error” above the mistake.

Data: - The dates, numbers, images, symbols, and observations about people, processes measurements, and conditions,

Data mining: - It is the 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: - This identifies the pertinent document and what needs to be done.

Delinquent record: - If a health record remains incomplete for a specified number of days as defined in the medical staff rules and regulations, the record is considered to be a delinquent record.

Demographics: - These are basic information about the patient such as their names, address, date of birth, and insurance information.

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

Encoder - An encoder assigns the diagnosis and procedure codes.

Grouper - The grouper uses the codes assigned to determine the diagnostic-related group or other grouping

Meaningful Use: - It is a program managed by the Center for Medicare and Medicaid Services to certify electronic health record Technology.

Outguide: - a common way of tracking the location of a health record

Overlap: - It is when a patient has more than one health record number at different locations in an enterprise.

Overlay: - This is where a patient is erroneously assigned another person’s health record number.

Probabilistic algorithm - This is the usage of mathematical probabilities to determine the possibility that two patients are the same.

Qualitative analysis - This is monitoring the quality of the documentation.

Quantitative analysis - It is a review of the health record to determine if there ware any missing reports forms, or signatures.

ROI - Release of Information

Serial numbering system - It is a system where a paetient is sissued a unique numerical identifier for every encounter at the healthcare facility; if a patient is admitted to the healthare facitlity five times he or she will have five different health record numbers.

Requisition: - Request for health record

Terminal digit filing system - It is a system of health record identification and filing in which the last digit or group of digits (terminal digits) in the health record number determine file placement

Unit number system: - It is a health record identification sstem in which the patient recives a unique medical record

number at the time of the first encounter that is used for all subsequent encounters.

Voice recognition technology: - It is a method of encoding speech signals that do not require speaker pauses (nut uses pauses when they are present) and of interpreting at least some of the signals’ content as words or the intent of the speaker; also called continuous speech technology.

3**.   Check your Understanding answers.**

**4.  Answer the following:**

 What is the purpose of the Health Record.

The primary purpose of the health record is to have proper documentation by healthcare providers to ensure quality care for patients.

The secondary purpose of the health record is for organizations use it to accomplish their tasks.

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

The users of health records are physicians, nurses, and allied health professionals.

* Name those functions of HIM that support patient care.

The functions of HIM that support patient care are Record Processing, Monitoring of record completion, Tanscriptin, Release of patient information, Clinical coding, abstracting, and clinical data analysis.

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

The Master patient index is the permanent record of all patients treated at a healthcare cility which the HIM professionals use to look up for patients’ demographics, date of care, health record number and other information.

The core data elements are Internal patient identification,

Person name, Date of birth, Gender, Race, Ethnicity, Address, Telephone number, Alias, previous, o maiden names, Social Security number, facility identification, Universal patient identifier, Account or visit number, Admission or visit number, Discharge or departure date, Encounter service type, Encounter primary physician and Patient disposition (AHIMA 2010).

* Describe  duplicate, overlay and overlap health record numbers.

Duplicate is when a patient has two or more health record numbers issued .Overlay is when a patient is assigned another patient’s health record number

Overlap is when a patient has more than one health record number.

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

Identification systems for paper records are the Serial Numbering System, Unit Numbering System, Serial-Unit Numbering System and the Alphabetic Filing system.

Identification systems for Electronic health records is mainly the Unit numbering system.

* Describe numeric filing systems and Alphanumeric filing systems.

The numeric filing system uses the Health record number to file, and sort health records whiles the Alphanumeric filing system uses both alphabetic and numeric characters to file and sort health records from the system.

* How are records located and retrieved?

Records are located and retrieved by the use of outguide, which tells you where the record can be located.

Electronic Environment: In this environment, HIM staff file, track and manage health records electronically.

* What are the advantages??

More space is created in the offices which can be used for other purposes

Filing of health records are reduced significantly

More data is captured directly into the system directly.

* What is Indexing?

It is the linking of patient name, health record number, document type and other identifying informatin to the schanned document.

* Describe the management of free text in the EHR.

When a free text data is typed into an information system, structured texts or terms must be used to ensure consistency. Also the terms or texts must be put in the system, so that people entering data can just point and click to select.

* Name several quality control functions of the EHR.

Some quality control functions are Clear labeling of buttons and data fields, Limiting the use of abbreviations on buttons and data fields

Useage of consistent grammar and terminology

Provision of undo buttons to make mistakes easy to override.

Simplify data collection

Provide title for each screen

Perform a completeness check to ensure that all required data have beee tered.

* Describe the HYBRID record.

The HYBRID record is having part of the health records on paper and part of it electronic.

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

ROI is the release of information. In this process, the HIM department and staff are able to disclose patient-identifiable information from the health record to another party upon the official request of the party.

* Describe the function of the ROI  software system.

The ROI software system tracks requests for information. After the HIM staff enters the demographics of the patient and who is requesting the health record, the information is released and the HIM staff records the released information, afterwhich the system bills requestios for the copies of ecords when appropriate.