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1. **What is a health record?**  
   Health Record is record that contains information relating to physical or mental health condition of an individual. It is made by or on behalf of a health professional. It includes the who, what, where, why and how of patient care and is used by many people.

**Who are the different users of the health record and how do they use it?**Users of the health record in healthcare include patient care providers, patient care managers and support staff, coding and billing staff, patients, employers, lawyers, law enforcement officials, healthcare researchers and clinical investigators, government policy makers, healthcare deliver organizations, third-party payers, medical review organizations, research organizations, educational organizations, accreditation organizations, government licensing agencies, and policy-making bodies.

They all use the health record in different ways. Patient care providers use the health record to make decisions about care for the patient. Patient care managers and support staff use the health record to evaluate the services provided by their employers. They use the information collected to make improvements in their outcomes and efficiency of the care provided. Coding and billing staff use it to for reimbursement and payment of care purposes. The patients use it when they act as informed consumers and obtain copies of their health records. Employers may use the health record when employer needs a note that an employee can come back to work or for a workmen’s compensation case. Lawyers use the health records for life insurance claims and for law suits related to their client’s health (motor vehicle accidents, disability claims, etc). Law enforcement officials use the health record for investigations. They need the medical documents about gunshot wounds and other injuries resulting from crimes. The health researchers and clinical investigators use health records to study if the drugs being given are safe and effective or the value of care being given. Government policy makers used the health record to develop and evaluate laws, regulations, and standards related to healthcare. Healthcare delivery organizations like hospitals or physicians’ offices use the health record to provide care and submit claims for reimbursement. Third-Party payers are organizations that are responsible for the reimbursement of services through insurance programs. They use the health record to justify the care provided before reimbursement. Medical review organizations use the health record to evaluate the quality and appropriateness of the care provided. Research organizations use the health record to conduct medical research. Educational organizations use the health record to teach their students. Accreditation organizations use the health record to verify compliance with their standards. Government and licensing agencies use the health record to ensure compliance with state licensing requirements and with the standard that enable the health facility to receive federal funding. Policy making bodies use the health record to make decision about healthcare programs.

**Explain the health record processes.**

**Record processing for paper based records-**

At the time the pt is admitted a search of the MPI is done to see if pt has been seen at the facility before. If the pt has been seen there before records from previous encounters are made available. After discharge the records go to the HIM department for processing. The first thing HIM department does is to make sure all records have been received, this is record reconciliation. Record assembly is the next step. It is the process of making sure that each page of the health record is organized in the standard format for the facility. All pages are reviewed to make sure they belong to the same patient and the same encounter. Next step in analysis, in this step the record I reviewed to make sure that the health record is complete. There are two parts of this analysis. Qualitative analysis which reviews the quality of the documentation and quantitative analysis which is makes sure that nothing is missing. If there are incomplete records the doctors are notified and asked to complete the documentation.

Record processing for an EHR systems is different. There is no need for paper or storage of paper records. When a patient is admitted they would still need to search for the patient to see if they have been there before. If they have they would immediately have access to the health records of the patient so the assembly process has been eliminated with the EHR system. When a facility receives paper records on a patient it is indexed for inclusion in the EHR. When records are indexed they are associated with the patient name, health record number, and document type among other information and scanned into their chart. Like the paper record system record reconciliation is required to make the record is complete for each encounter.

**Explain the health information management information systems.**

HIM department has many different systems that make it possible to complete the tasks of the department. Release of information system is a system that tracks requests for information. This systems keeps track of who requested the information, what was sent where and bills the requesting parties for copies when appropriate. It also tracks turnaround time. The Chart tracking system is a system that will soon be obsolete. It tracks the location of paper records, who checked what out when and when they are returned to the HIM department. The Coding system has two parts, encoder and grouper. The encoder assigns the diagnosis and procedure codes. The encoder system can prompt the coder to check is other related codes should be assigned as well. The grouper system uses the codes assigned to determine the diagnostic related group and other groupings. Some facilities are using computer assisted coding which uses the EHR to assign the codes. The coder would then check the quality of the codes the EHR assigned. The HIM department also uses a Billing system. The encoder and the grouper submits the codes and other data directly to the billing system or the coder enters it manually. The HIM department utilizes registries as well. A registry is a database on specific procedures or diseases. Information stored in the registry is used for research, patient care and quality monitoring. There are also quality improvement systems that have many different names and do many different names. Usually they are a collection of data that is used to track trends, generate statistics and monitor outcomes and improve quality of documentation. The EHR uses many systems to capture patient information. These system give the EHR the patients demographics, test results, dictated reports etc. It also has a component called Clinical Decision support which helps providers make decisions regarding medications, diagnoses etc based on information in the EHR.

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

There are a few different quality controls that can be put in place to manage the HIM functions. Some of the general guidelines for quality control include clear navigational buttons that direct user to the next step, clear labeling of buttons and data fields, availability of references at the appropriate data field, built in alerts to notify the use of possible errors etc. Quality controls of navigation design include consistent grammar and terminology, confirmation message for any critical functions, required field identified, etc. Quality controls of input design include simplified data collection, title screens, minimized key strokes, and text specific boxes to enter text. Quality controls for data validation include performing completeness checks to ensure that all required data has been entered, consistency checks to ensure that combinations of data are correct, database checks to compare data against a database or file to ensure data is entered correctly. Quality controls in output design include minimization of clicks required to reach data, and combing data into a single organized menu to eliminate layers of screens.

2. **Please define the following:**

Abstracting- The process of extracting elements of data from a source document or database and entering them in an automated system.

Addendum- A late entry added to a health record to provide additional information in conjunction with a previous entry. The late entry should be timely and bear the current date and reason for additional information being added to the health record.

Aggregate data- Data extracted from individual health records and combined to form de-identified information 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; it should be dated, timed and signed.

Audit trail- 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 ICD-10-CM and CPT evaluation 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 health record by drawing a single line through the erroneous information and writing the word “error ‘above the mistake. The practitioner should sign, date and time the correction.

Data-The dates, numbers, images, symbols, letters, and words that represent basic facts and observations about people, processes, measurements and conditions.

Data mining- The process of extracting and analyzing large volumes of data from a database for the purpose of identifying hidden and sometimes subtle relationships for 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 (dictated, completed and signed)

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 information linked to a specific person

Deterministic algorithm- An algorithm that requires an exact match in data elements such as the patient name, date of birth, and social security number

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

Grouper- Specialty software that automatically assigns prospective payment groups on the basis of clinical codes.

Meaningful Use- A regulation that was issued by CMS outlining an incentive program for professionals eligible hospitals and CAHS participating in the Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology.

Outguide-A device used in paper-based health record systems to track the location of records removed from the file storage area.

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- An algorithm that uses mathematical 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 information from the health record to another party.

Serial numbering system- a system where a patient is issued a unique numerical identifier for every encounter at the healthcare facility

Requisition- Request 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 healthier 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 the intent of the speaker.

1. **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. B. 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 workflow

2. D. automatically appended to the original note. No additional signature is required,

3. B. Policies and procedures to control which version(s) display

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

5. B. Input mask

**3.4**

1. C. Personal Health record

2. A. Electronic health record

3. B. Release of information

4. B. Quality improvement

5. A. Front-end

**4.  Answer the following:**

**What is the purpose of the Health Record.**

Health Record is record that contains information relating to physical or mental health condition of an individual. It is made by or on behalf of a health professional. It includes the who, what, where, why and how of patient care and is used by many people.

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

Users of the health record in healthcare include patient care providers, patient care managers and support staff, coding and billing staff, patients, employers, lawyers, law enforcement officials, healthcare researchers and clinical investigators, government policy makers, healthcare deliver organizations, third-party payers, medical review organizations, research organizations, educational organizations, accreditation organizations, government licensing agencies, policy-making bodies.

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**Name those functions of HIM that support patient care.**

Record processing, monitoring of record completion, transcription

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 (MPI) is the permanent record for all patients treated at that healthcare facility. Core data for the MPI includes name, DOB, Gender, race, ethnicity, address, phone number, nicknames, SNN#’s, universal Patient Identifier, etc.

**Describe duplicate, overlay and overlap health record numbers.**

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.

Duplicate **–** situation in which a patient is issued two or more medical record numbers and the patients’ medical record is fragmented.

**Describe Identification systems for paper records (4)**

**Serial numbering system-** a system where a patient is issued a unique numerical identifier for every encounter at the healthcare facility

**Unit numbering 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

**Serial-unit numbering system-**A combination of the serial and unit numbering systems; the patient is issued a new health record number with each encounter but all of the documentation is moved from the last number to the new number.

**Alphabetic filing system-**A system of health record identification and storage that uses the patient’s last name as the first component of identification and his or her first name and middle name or initial for further definition.

**Electronic health records**- The unit numbering system is the most common system used in EHR environment.

**Describe numeric filing systems and Alphanumeric filing systems.**

Numeric filing system is a paper based record filing system that the folders are stored in shelving units or in filing cabinets based on the patient’s medical record number. Straight files on the straight numeric ordered based on MRN. Alphanumeric filing system which uses a combo of numbers and letter to sort.

**How are records located and retrieved**?

A common way for records to be located and retrieved in the paper records environment and an outguide. In the EHR the outguide is replaced by the a requisition.

**Electronic Environment:**

* **What are the advantages??**  
  No need for paper records or paper storage. No need to assemble the patients records at every encounter. Record completion is done on a computer so healthcare professionals can complete them from any accessible location. EHR allows more documents to be included into the health record like emails, test results and imgiang. It is easier to add materials from other facilities, easier to search, retrieve and manipulate the health record as needed, amendments and corrections are done more easily as well.
* **What is Indexing?**

Indexing is done when records are sent to a healthcare facility from another and the records need to be added to the chart. Indexing is linking the patient name, MRN, document type and other identifying information to the scanned document.

* **Describe the management of free text in the EHR.**

Free text is unstructured narrative data resulting from a person entering data into an information system. It is undefined, unlimited and unstructured. This means they can literally type anything into this section. EHR system should limit how much free text can be entered because the ability to manipulate the data is diminished. One example of managing free text in the EHR is by giving them user options to click rather than a box to type in, like in the care of gender the user is given female or male buttons to click.

* **Name several quality control functions of the EHR.**

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* **Describe the HYBRID record. -**  
  A hybrid record is a record that is partly on paper and partly in the EHR. This is usually used as a transition from paper to electronic record keeping.
* **Describe ROI and what is the responsibility of the HIM department and staff?**

An ROI stands for release of information. In the HIM department that is the process of disclosing patient-identifiable information from their health record to another party. The HIM department is responsible for receiving requests, ensuring request is appropriate for release and submits information for use in patient care, insurance claims, or legal claims.

* **Describe the function of the ROI software system.**

The ROI system keeps track of requests for information. It tracks who request what information on what patient when. Once the request has been processed the HIM staff will add what was released to who and when. This system has the ability to bill requesting parties for copies when that is necessary.