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 information relating to the physical/mental health or condition of an individual created by a healthcare professional. It is the documentation of a patients care.

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

* Healthcare providers (Physicians, nurses, and other allied professionals)- To provide complete care for a patient
* Coding/Billing staff- to reimburse the hospital or office for the care provided
* Government Policy makers- to develop and evaluate government healthcare programs

Explain the health record processes.

A health record is a collection of patient data translated into information in the patient health record that will follow the patient through the continuum of their health care. The process of a record is to collect patients’ information for each encounter and then translate it into data.

Explain the health information management information systems.

* ROI system, the tracking of requests for information and bills the requester when necessary.
* Chart Tracking, tracks the location of a patient health record. Who has it, where it is, how long it has been there.
* Coding, assignment of codes to diagnosis and treatments through encoders and groupers.
* Registries, databases for specific diseases or procedures like cancer or transplants.
* Quality improvement systems monitor trends, statistics, outcomes, ad improve quality of documentation.
* Electronic Health Records uses a number of information systems to capture a patient’s information.

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

Establishment of information government, to dictate who has access to what records to keep patient information secure. Checks for errors, completeness, and consistency. Ensure policies and procedures are followed. The use of HIM software like chart tracking, registries, and coding.

2. Please define the following:

Abstracting- The process of extracting information from a document to create a summary of a patient’s illness, treatment, and outcome

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

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 healthcare documentation after the original document has been signed; it should be date, timed, and signed.

Audit trail- A chronological set of computerized records that provides evidence of logins, logouts, and file accesses of the information system, used to determine security violations.

Computer assisted coding- CAC: The process of extracting and translating dictated and the transcribed free-text data into ICD-10-CM and CPT evaluations and management codes for billing and coding purposes.

Concurrent review- Screening for medical necessity and the appropriateness and timeliness of 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 “error” over it. The practitioner should sign and date 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- 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- 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 and individual, such as name, address, gender, age, and other information related to a specific person.

Deterministic algorithm- Algorithm that requires exact matches 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- Computer program that uses data elements to assign patients, clients, or residents to groups, categories, or classes.

Meaningful Use- Regulation issued by CMS 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 EHR technology.

Outguide- A device used in paper medical 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 previously been issued to a different patient.

Probabilistic algorithm- 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 standards are met and to determine the adequacy of entries documenting the quality of care.

Quantitative analysis- Review of 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 property.

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 they will have five different health record numbers.

Requisition- Request for health records.

Terminal digit filing system- System of health record identification and filing in which the last digit or group of digits (terminal digits) in the health record number determines file placement.

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

Voice recognition technology- 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; also called continuous speech recognition.

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. A: Open-shelf units
3. C. Color Coding
4. B: Outguide
5. C: The formula for determining the rate may need to be adjusted
6. A: Provides the oversight for the development, review, and control of forms
7. B: Assembly
8. C: Analysis
9. B: Overlay
10. B: Delinquent Records

3.3

1. A: Control workflow
2. D: The amendment must have a separate signature, date, and time.
3. B. Policies and Procedures to control which version(s) is displayed.
4. C: Copying the note in the wrong patients record.
5. B: Input mask

3.4

1. C: Personal Health Record
2. B: Health record in any format
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.

* The purposes of health records are to provide better patient care, manage patient care, billing services, determine local diseases and conditions, research outbreaks, and used to establish healthcare policies.

Who are the users of the health record and why?

* There are Individual and Institutional users. Individual users are those who depend on it to do their job, like physicians to look up a patients prior treatment. Institutional users are organizations that use health records to accomplish a mission; Educational organizations use this information as case studies as part of the educational programs.

Name those functions of HIM that support patient care.

* HIM department functions usually include: Record processing, monitoring record completion, transcription, release of patient information, abstracting, research, registries, and birth and death certificates. The HIM department uses these functions in conjunction with other departments to provide the patient with complete care.

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

The MPI is a permanent record for all patients who have received care at a healthcare facility. It stores all of the patient’s demographics, internal patient identification, race, ethnicity, SSN, Admission dates and departure dates.

Describe duplicate, overlay and overlap health record numbers.

Duplicate Records result from a patient being issued two or more health record numbers; there information is then put in under two different numbers, in two files. Overlay is when a patient is erroneously assigned another person’s health record number, the patient’s information is the commingled and care decisions may become misguided. Overlap is when a patient has more than one record number at different locations in an organization.

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

* Serial Numbering System- A patient is issued a unique numerical identifier for each encounter. This is very inefficient as each file is filed separately.
* Unit Numbering System- Patient is issued a record number at first encounter and that number is used for all following encounters, most commonly used in large healthcare facilities.
* Serial-Unit numbering system- Combination of serial and unit where a patient is issued a new record number with each encounter but all documents are moved from the last number to the new number.
* Alphabetic Filing system- folders are filed alphabetically by a patients last name, typically used in small clinics and physicians offices.

Describe numeric filing systems and Alphanumeric filing systems.

* Numeric filing systems file the records by the health record number in either a straight numeric or terminal-digit filing system, ex. 12-34-46. In the Alphanumeric filing system files records by a patients first two letters of their last name, ex. SA2267.

How are records located and retrieved?

* Records are located by use of the master patient index, which is a permanent record of all patients treated at a healthcare facility.
* Records are also located and retrieved by either the patients name or their issued health record number.

Electronic Environment:

What are the advantages? Easy access in every facility of a healthcare system, less paper consumption.

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

Describe the management of free text in the EHR. Free text is undefined, unlimited, and unstructured; it has no limit unless an organization implements a policy or procedure to reduce risks.

Name several quality control functions of the EHR. Input Masks, limited choices/commands, confirmation messages, completeness checks, and consistency checks.

Describe the HYBRID record. A hybrid record is a record that is partly on paper media and partly EHR. Most often you can find the original paper record scanned into the EHR.

Describe ROI and what is the responsibility of the HIM department and staff? ROI is the Release Of Information, the process of disclosing patient-identifiable information from the health record to another party. The HIM department ensures the request is is appropriate for release and then will submit the information if deemed so.

Describe the function of the ROI software system. The ROI systems tracks requests for information, bill requesters for the copies of records if appropriate, and monitor productivity and turnaround time.