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

What is a health record? A record that contains information relating to the physical or mental 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 of the individual.

Who are the different users of the health record and how do they use it? There are two types of users of a health record, which are individuals and institutions. The following list are individual users along with how they use health records.

* Patient Care Providers – They rely on information in the health record to make decisions about the care provided to the patient.
* Patient Care Managers & Support Staff – They use the health records to evaluate the services provided by the patient care providers to detect trends and advise them of recommended changes needed.
* Coding & Billing Staff – The coding staff assign the appropriate diagnosis and procedure codes to the treatment received. The billing staff then submits the diagnosis and procedure codes to insurance companies.
* Patients – They may obtain copies of their health record in order to be an informed consumer in regards to their care.
* Employers – They may use the information in the health record to process health insurance claims and manage wellness programs.
* Lawyers – May need access to health records to support their clients for lawsuits involving automobile accidents, disability and such.
* Law Enforcement Officials – They may need to access health records when they are investigating a criminal activity. They may also access health records to protect the security of the country.
* Healthcare Researchers & Clinical Investigators – They may access health records to study the safety of drugs or the value of care provided.
* Government Policy Makers – They may access health records to develop future laws and evaluate current laws.

The following list are institutional users along with how they make use of health records.

* Healthcare Delivery Organizations – They use health records to provide care, submit claims for reimbursement, and evaluate the quality of care provided.
* Third-party Payors – These are organizations responsible for providing reimbursement for services provided through the insurance program. They may use the health record to justify the care provided.
* Medical Review Organizations – They use health records to evaluate the quality and appropriateness of care provided.
* Research Organizations – They use health records to conduct medical research.
* Educational Organizations – They use health records as case studies as part of the training of healthcare professionals.
* Accreditation Organizations – They use health records to determine compliance with documentation and patient care standards.
* Government Licensing Agencies – They use health records to ensure compliance with state licensing requirements.
* Policy-making Bodies – They use health records for decision making related to healthcare programs.

Explain the health record processes.

Explain the health information management information systems. -

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

2. **Please define the following:**

Abstracting – The process of extracting information from a document to create a brief summary of a patient’s illness, treatment, and outcome. It can also be 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.

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 include a date, time and signature.

Audit trail – A chronological set of computerized records that provides evidence of information system activity used to determine security violations. Also 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 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 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 information linked to a specific person.

 Deterministic algorithm – Algorithm that requires exact matches in data elements such as 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 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 (EPs), eligible hospitals, and CAHs participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified HER 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 – 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 – 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 – 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 (terminal digits) in the health 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 (but uses pauses when they are present) 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 - A record that contains information relating to the physical or mental 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 of the individual.

* Who are the users of the health record and why? – See question 1 above.
* Name those functions of HIM that support patient care. – Record processing, Monitoring of record completion, Transcription, Release of patient information and 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 facility. The MPI is comprised of Internal Patient Identification, Person name, Date of birth, Gender, Race, Ethnicity, Address, Telephone number, Alias/previous or maiden names, Social security number, Facility identification, Universal patient identifier, Account or visit number, Admission or visit number, Admission/Encounter/Visit data, Discharge or departure date, Encounter service type, Encounter primary physician and patient disposition.
* Describe  duplicate, overlay and overlap health record numbers. – Duplicate is when a patient has two or more health record numbers. Overlay is when a patient has been issued another patients health record number. Overlap is when the patient has more than one health record number from different locations from a multi-facility organization.
* Describe  Identification systems for paper records (4) – There are four identification systems for paper records, they are: 1) Serial Numbering System where the patient is given a unique identifier for each encounter, 2) Unit Numbering System where the patient is issued a number at the initial encounter and it is used for all subsequent encounters, 3) Serial-Unit Numbering System, where the patient is issued a new number with each encounter, however all documentation is moved to the new number, and 4) Alphabetic Filing System, where the patient is not assigned a number and is filed alphabetically ; Electronic health records – The unit numbering system is the most common system for Electronic Health Records.
* Describe numeric filing systems and Alphanumeric filing systems. – Numeric filing systems file health records by the number assigned to the record whereas an alphanumeric filing system is set up with letters and numbers, for example the first two letters of the patients last name and then a unique number.
* How are records located and retrieved? – In paper based records the record is tracked and retrieved using an outguide, however in electronic records the computer tracks the location of the record.

Electronic Environment:

* What are the advantages?? – Better access and control of the information. Better analytical capabilities to compile data.
* What is Indexing? – Organizing records alphabetically, numerically or alphanumerically.
* Describe the management of free text in the EHR. – The use of free text is limited in EHR’s by using radial buttons or drop down menus. This reduces the chance for errors.
* Name several quality control functions of the EHR. – Drop down menus, radial buttons, checkboxes.
* Describe the HYBRID record. – A HYBRID record is one that is part on paper and part electronic. These are found in organizations where they are in transition.
* Describe ROI  and what is the responsibility of the HIM  department and staff? – Release of information is the procedure of disclosing patient-identifiable information to another party. HIM staff are responsible to release this information in a timely manner as well as meeting their productivity requirements.
* Describe the  function of the ROI  software system. – The ROI system tracks the basic information that is entered by the HIM staff. The system will also track when the information was released as well as bill the parties requesting the information.