What is a health record?

A health care record is a collection of your health information and medical records. These are files you physician keeps and updates whenever you pay them a visit for a checkup or other health care facilities.

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

Healthcare providers are the primary users of the health record. Health records are used to manage the healthcare facility and healthcare industry.

Individual Users are users that depend on the health record in order to complete their job. Included are Patient care providers who are physicians, nurses, and other health professionals who rely on health records to make decisions about care to the patient and also documents the care.

Patient care managers evaluate the services provided by their employers. Support Staff gathers information for the patient care managers to use.

Coding staff assign the appropriate code for treatment, while the billing staff obtains the codes from the coders and submits the bill to the insurance company.

Patients are informed consumers of their healthcare.

Employers may use health records when processing health records as well determining when employees are well enough to return to work.

Lawyers may need health records for their client for life insurance claims or a lawsuit. Law enforcement use health records to investigate injuries resulting from a crime.

Healthcare researchers use health records to study the safety of drugs or value of care provided.

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

Institutional users are organizations that access health records in order to accomplish their mission.

Healthcare delivery organizations provide care, submit claims, and evaluate the quality of care provided.

Third- party payers use health records to justify the care provided and are responsible for reimbursement of healthcare services through insurance programs.

Medical review organizations evaluate the quality of care provided to the patient. Research organizations do medical research.

Educational organizations use health records as case studies for part of the educational program.

Accreditation organizations reviews health records to determine compliance with documentation and patient care standards.

Policy making bodies is data submitted for healthcare claims to be analyzed for decision making related to healthcare programs.

Explain the health record processes.

A health record contains the who, what, where, why and how of patient care and is used for different reasons by many people. There was paper-based records. Documents were filed, managed, and retrieved paper-based. Now with the EHR patients documents are more accurate. The information can be shared through hospitals, clinics, physicians, and pharmacies.

Explain the health information management information systems.

The HIM department performs to support patient care and healthcare organization, insuring the quality, security and availability of the health record. The functions of the department include, record processing, monitoring of record completion, transcription, release of patient information, clinical coding, abstracting, and clinical data analysis. They may also include research and statistics, registries, birth and death certificate completion.

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

Quality control functions include data being collected in a number of ways. Scanning, data entry, barcodes, and transfer of data from other systems. One of the responsibilities of HIM is release of information. The ROI supervisor is responsible for ensuring polocies and procedures are followed, and requests are processed in a timely manner, and the staff meets their productivity requirements.

2. Please define the following:

Abstracting – The process of obtaining information from a document to create a brief summary of the patient’s illness, treatment, and outcome. The process of obtaining elements of data from a source document and entering them into an automated system.

Addendum – additional information provided in the health record

Aggregate data – data that has been obtained from individual health records and combined to form deidentified information about groups of patients that can be compared and analyzed

Amendment – clarification made to healthcare documentation after the original document has been signed

Audit trail – computerized records that provides evidence of information system activity used to determine security violations

Computer assisted coding – uses EHR data to assign the codes

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 line through it and writing the word “error” above the mistake

Data – dates, numbers, images, symbols, letter, and words that represent basic facts about people, measurements, and conditions

Data mining – the process of obtaining and analyzing large volumes of data from a database for the purpose of identifying hidden relationships or patterns and using those relationships to predict behaviors

Deficiency slip – identifies the pertinent document and what needs to be done

Delinquent record – incomplete health record for a specified number of days determined by the medical staff of the facility

Demographics – information about a patient that includes name, address, date of birth, and insurance information

Deterministic algorithm – exact matches in data elements that include patient name, date of birth, and social security number

Encoder – assigns the diagnosis and procedure codes

Grouper – uses codes assigned to determine the diagnostic related group or other grouping

Meaningful Use – a program for professionals, eligible hospitals, and CAH’s participating in 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 – when a patient is issued more than one medical record number from an organization with multiple facilities

Overlay – a patient is issued a medical record number that has been previously issued to a different patient

Probabilistic algorithm – uses mathematical probabilities to determine the possibilities to determine the possibility that two patients are the same

Qualitative analysis – review of the health record to make sure standards are met and to determine the adequacy of entries documenting the quality of care

Quantitative analysis - review of the health record to make sure standards are met and to determine the adequacy of entries documenting the quality of care

ROI - Release of Information – the process of disclosing patient identifiable information from the health record to another party.

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

Requisition – request for health record

Terminal digit filing system – record identification and filing in which the last digit or group of digits in the health record determines fil placement

Unit number system – a number that 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

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.

Health records document the history of examination, diagnosis and treatment of patient. The information is important for all providers involved in the patient’s care and for any new provider who assumes responsibility for the patient.

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

The healthcare providers are the primary users of the health record. Individual users depend on health records in order to complete their job. Institutional users need access to health records to accomplish their mission as an organization.

•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, Research and statistics, Registries, including, cancer, trauma, birth defects, and organ transplant, Birth and death certificate completion

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

Master patient index is the permanent record of all patients treated at a healthcare facility.

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, or visit data, Discharge or departure date, Encounter service type, Encounter primary physician, Patient disposition (AHIMA 2010)

•Describe duplicate, overlay and overlap health record numbers.

A patient may give their new married name or maybe even a nick name, this results in a duplicate health record. This meaning the patient has two or more health record numbers issued. A patient that is assigned another patients health record number by mistake is an overlay. An overlap occurs when a patient has more than one health record number at different locations in an enterprise.

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

The identification systems for paper records are numeric, alphabetic, and alphanumeric systems. The identification systems are serial numbering systems, unit numbering systems, serial-unit numbering systems, and alphabetic filing systems. The serial numbering system is when a patient is issued a unique numerical identifier for every encounter at the healthcare facility. Unit number systems is when the patient is issued a health record number at the first encounter and that number is used for all other encounters. Serial-unit numbering system the patient is issued a new health record with each encounter but all the documentation is moved also. Alphabetic filing system is used in small clinics and physician offices. Folders are filed alphabetically by the patients last name.

The EHR has a patient account number. A number is assigned by a healthcare facility for billing purposes that is unique to a particular episode of care. A new account number is assigned each time the patient receives care or services at the facility.

•Describe numeric filing systems and Alphanumeric filing systems.

The numeric filing system is records filed by the health record number. Files that have both alphabetic and numeric characters to sort health records in the system. The first two letters of the patients last name are followed by a unique numeric identifier.

•How are records located and retrieved?

The documentation is stored alphabetically or numerically in a file folder. There are several options that are available to store paper records. They include, filing cabinets, shelving units, microfilm, off site storage, and image based storage. A common way of tracking the location of a health record is the outguide, which identifies where the health record is located and when it was removed. Today a requisition, or request for the health record. An automated chart tracking system, the computer keeps up with the location of the health record.

Electronic Environment:

•What are the advantages??

The HER better manages patient care by getting accurate and complete information. There is no paper records to store, manage, and retrieve. There’s easier access to clinical data, fewer medical errors, improved patient safety and stronger support for clinical decision making, and the availability to share information with hospitals, clinics, labs, and pharmacies.

•What is Indexing?

The linking of patient name, health record number, document type, and other identifying information to the scanned document.

•Describe the management of free text in the EHR.

The unstructured data that is a result of a person typing data into an information system. The typist can type anything into the field or document, it could be unidentified, unlimited, and unstructured. In the EHR , the user is able to copy and paste free text from one patient or patient encounter to another. There are risks, its dangerous, and inaccurate information can easily be copied.

•Name several quality control functions of the HER

Clear labeling of buttons and data fields, limiting the use of abbreviations on buttons and data fields, built in alerts to notify the user of possible errors, limit choices and label commands, use consistant grammer and terminology, perform a completeness check to ensure that all required data have been entered, minimize the number of clicks needed to reach data or a specific screen, combine data into a single, organized menu to eliminate layers of screens

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•Describe the HYBRID record.

Documentation of an individual’s health information that is tracked in multiple forms and stored in multiple places. A health record that includes both paper and electronic elements.

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

ROI is the process of disclosing patient identifiable information from the health record to another party. The HIM department receives a request for access to patient information, makes sure the request is appropriate for release and then submits the information for patient care, insurance claims, or legal claims.

•Describe the function of the ROI software system

Ensures the records are available first and foremost for patient care, the requested documents and only the requested documents are submitted.