**Homework assignment week 3- Anita Hakala**

**What is a health record?**

A health record is the storage place for data and information about health care services provided to an individual patient.

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

Clinical professionals and allied health professionals use the record to make informed decisions about diagnoses and treatment, as well, as a communication tool for the caregivers to ensure continuity of care.

Patient care management use the record to evaluate the services by their employees, evaluate quality of care and to look at patterns and trending. The record helps to analyze various illnesses, formulate practice guidelines and evaluate the quality of care.

Patient care support services encompasses the activity related to the handling of the healthcare organization’s resources, analysis of trends and the communication information among different clinical departs.

Coding and billing staff processes utilize the record to determine payment for the care provided.

Lawyers may use the record for life insurance or lawsuits.

Law Enforcement individuals may investigate injuries from crime or to protect security issues.

Healthcare researchers study safety and efficacy of drugs or value of care.

Government policy makers may use the health record to develop and evaluate current and future laws and regulation s or standards to healthcare

Patient self-management involves active management of one’s own health record.

Healthcare delivery organizations use it to provide care, submit claims and evaluate quality.

Third party payors use it to justify the care provided for reimbursement purposes.

Medical review organizations use it to evaluate quality and appropriateness of care.

Research organizations conduct medical research.

Educational organizations use it to train health professionals.

Accreditation organizations use it to validate compliance with their standards.

Governmental licensing agencies use it to validate compliance with their licensing requirements and standards compliance.

Policy making bodies use it to analyze and utilize the information for healthcare decision making.

**Explain the health record processes**.

 Record processing of paper-based record ensures the health records are organized and meets standards. Record processing of the EHR is computer based. Each function can be completed independently so one does not have to wait for the chart to complete their function.

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

The paper health record is available completely on paper and need to be filed. The electronic is a digital record that conforms to standards that allows for access across more than one organization. The hybrid is a combination of paper and electronic.

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

The EHR quality is dependent upon accurate data collection at the time of the observation or rendering treatment. Standards have been developed to assure quality. The standards include accuracy, meaning the data is correct; accessibility, meaning the data is easily obtainable; comprehensiveness, meaning all the required data elements are included in the health record; consistency, meaning the data is reliable; currency, meaning the data is up-to-date; clear definition for interpreting data, granularity, meaning the attributes and values of the data be defined at the correct level for its intended use; precision is the term use to describe expected data values; relevancy means that the data is useful; and timeliness means the information is recorded at or near the time of the event or observation.

2. **Please define the following:**

Abstracting is the process of extracting information from a document to create a summary of the patient’s illness, treatment and outcome or extracting data from a source document or data base and entering them into an automated system.

Addendum is a supplement to a signed report that provides additional health information into the record.

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

Amendment is a clarification made to health information after the original documentation has been final signed by the provider.

Audit trail is a software program that tracks every single access to the data in the computer system, logging the name of the individual who accessed the data, the date and time. And the action taken.

Computer assisted coding utilizes EHR data to assign the codes

Concurrent review is a review of the health record while the patient tis still hospitalized or under treatment.

Correction is an edit made to the health record by drawing a single line through the erroneous information and writing the word error above the mistake, then signing , dating and timing the correction.

Data represent the basic facts about people, processes, measurements, conditions and can be collected in the form of dates, numerical measurements and statistics, textual descriptions, checklists, images, and symbols.

Data mining is the process of extracting information from a data base and then quantifying and filtering discrete structured data. It identifies patterns and relationships.

Deficiency slip is a device for tracking information missing from a paper-based record.

Delinquent record is an incomplete record not finished or made complete within the timeframe determined by the medical staff of the facility.

Demographics is the information used to identify an individual, such as name, address, gender, age and other information linked to that individual person.

Deterministic algorithm is often part of the Master Patient Index application program. This algorithm requires an exact match of combined data elements such as name, birthdate, sex and Social Security number.

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

Grouper software v34.0 classifies hospital case types into groups expected to have similar hospital resource use. Medicare uses this classification to pay for inpatient hospital care. Hospitals are paid a fixed price by Diagnosis Related Group (DRG) for treating Medicare patients. The groupings are based on diagnoses, procedures, other demographic information, and the presence of complications or co-morbidities.

Meaningful Use is a term used in ARRA/HITECH legislation for provers to qualify for incentives for using a EHR includes three requirements, 1. Use of certified EHR technology in a meaningful manner; 2. That it is connected in a manner that provides for the exchange of health information to improve quality of care; and 3. In using the certified technology, the provider submits information on quality measures.

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

Overlap is a situation in which a patient is issued more than one medical record number from an organization with multiple facilities.

Overlay is a situation in which a patient is issued more than one medical record number that has been previously issued to a different patient.

Probabilistic algorithm is based on a complicated mathematical formula that analyzes facility specific MPT data to determine precisely matched weight probabilities for attribute values of various data element.

Qualitative analysis a review of Medical Record entries for documentation practices that may
indicate the Medical Record is inaccurate or incomplete.

Quantitative analysis is a review of a health record to determine its completeness and accuracy.

ROI means release of information

Serial numbering system is a type of health record identification and filing system in which patients are assigned a different but unique numerical identifier for every admission.

Requisition is a request from a clinical or other area of an organization to charge out a specific medical record.

Terminal digit filing system is a system of health record identification and filing in which the last digit or group of digits in the health record number determines file placement.

Unit number system is 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 is a method of encoding speech signals that do not require speaker pauses and interpreting at least some of the signals’ content as words or intent of the speaker.

3**.   Check your Understanding answers.**

**3.1 3.2 3.3 3.4**

**1. D 1.A 1. A 1. C**

**2. C 2. C 2. D 2. A**

**3. A 3. C 3. B 3. B**

**4. C 4. B 4. C 4. B**

**5. B 5. A 5. B 5. A**

 **6. A**

  7. B

 8. C

 9. B

 10. B

**4.  Answer the following:**

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

The primary purpose of the health record is patient care. The secondary purposes is used for non-patient care.

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

* Clinical professionals and allied health professionals use the record to make informed decisions about diagnoses and treatment, as well, as a communication tool for the caregivers to ensure continuity of care.
* Patient care management use the record to evaluate the services by their employees, evaluate quality of care and to look at patterns and trending. The record helps to analyze various illnesses, formulate practice guidelines and evaluate the quality of care.
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**Name those functions of HIM that support patient care.**

Record processing, monitoring completion, transcription, release of patient information, coding, abstracting and clinical data analysis

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

The MPI is the permanent record of all patient treated at a healthcare facility. Core elements are patient demographics, dates of care, health record number.

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

A duplicate health record is when a patient has two or more health record numbers. An overlay is when a patient is assigned another person’s health record number. An overlap is when a patient has more than one health record number at different locations.

**Describe Identification systems for paper records (4) ;** identification systems for paper based include Serial numbering systems, unit numbering systems serial-numbering systems and alphabetic filing system **Electronic health records** most common system is the unit numbering system

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

The unit numbering system is a patient issued health record number issued at the first encounter that is used for all subsequent encounters. The serial-unit numbering system issues a new health record number with each encounter with all document moved from the last number to the new number. The Alphabetic filing system is where the file are filed alphabetically.

**How are records located and retrieved?**

Paper based files need to be requested, electronic are easily accessed.

**Electronic Environment:**

* **What are the advantages??**
	+ Improved patient care, increased patient participation, improved care coordination, practice efficiencies and cost savings.
* **What is Indexing?**
	+ It involves complete management of the patients’ medical records such as demographic details, medical history, treatment data, reports, health service provider’s notes, health insurance ID, EOBs and insurance entitlements
* **Describe the management of free text in the EHR.**
	+ It should be limited because the data is more difficult to retrieve. Policies and procedures should be in place to reduce risk.
* **Name several quality control functions of the EHR**.
	+ General guidelines, navigational design, input design, data validation and output design.
* **Describe the HYBRID record.**
	+ A combination of paper based and electronic record.
* **Describe ROI and what is the responsibility of the HIM department and staff?**
	+ ROI is the release of information. The HIM department ensure that the request is appropriate for release and then submits the information to the appropriate requester.
* **Describe the function of the ROI software system.**
	+ It tracks request for information and cab bill the requesters for copies of records when appropriate. I can monitor productivity and turnaround time.