1 health record contains info relating to the physical or mental health of an individual made on behalf of a health professional in connection with the care ascribed that individual.

People who care for patient, management of care and administrative billing pro. It is used for education of health pro and public health research. Lawyers and medical review users.

Recorded by provider or staff giving patients health and treatment when seen by provider. Is used for treatment is a permanent record is used for and purposes billing legal research education and public health information

A record made by provider on patient’s condition and treatment at time of being seen. Is a permeant record which is store and is available for future treatment legal needs govt agency’s for public health? and billing and purposes. It is stored on site electronically or in a remote location and must be available for future access.

Algorithms are put in place to check for duplication and overlaps. Most errors are human and need to be rechecked continuously. systems of identification and numbering need to be in place and followed.

Abstracting the process of extraction info from a document to create a brief summary of a patient’s condition or treatment

Addendum a later entry to a health care record needs to be timely and beard date and reason for addition needs to be added to record

Aggregate data take from health records and combined to de-identified info about groups of patients that can be compared and analyzed.

Amendment a clarification made to a record after the or

original doc has been signed it should be dated signed and timed.

Audit trail a record that shows who accessed computer system when accessed what was performed log in or out used to detect security violations.

Computer assisted coding process of extracting and transcribing dictated and then free text data into icd 10 cm and cpt evaluation and management codes for billing and coding process

Concurrent review of medical necessity and appropriateness of med care from time of admission to discharge.

Correction edit made by drawing a single line through record writing word error needs to be date timed and signed by corrector.

Data date time numbers and facts that represent observations of people process measurements and conditions

Data mining extracting and analyzing data from database to identify hidden or subtle patterns

Deficiency slip identifies what is missing or deficient in a document and needs to be fixed

Delinquent record incomplete record not complete within the time frame determined by medical staff of facility

Demographics info used to identify induvial or other info linked to specific person

Deterministic algorithm required exact matches in data such as patients name ss or date of birth

Encoder Software to facility assignment of diagnosis and procedure codes according rules of coding system

Grouper computer program uses sceptics data elements to assign patients clients to groups categories or classes or assigns payment groups on the basics of clinical codes

Meaningful use regulation outlining incentive program for ep pro’s participating in the Medicare or Medicaid programs that adopt and use HER technology.

Outguide device in paper storage systems to track records removed from file storage.

Overlap patient is issued more than one ihr from an organization with more than 1 facilities

Overlay patient issued a ihr that had previously been issued to another patient

Problem algorithm uses mathematical possibilities to check if 2 patients are the same.

Qualitative analysis a review of health records to check if standards are met and accuricity and quality of care

Quantive analysis review of health record to check its completeness and accuracy

Roi is the release of information of health record to another party

Serial number system where a patient is assigned a new number each time admitted to facility

Requisition search for health record

Terminal digit system a system where the last group of numbers determines where file is placed

Unit number system a system where patient receives a number on first encounter and uses it for all encounters

Voice recognition technology method of encoding that do not require pauses and interputs speakers words as in intent of speaker

4 patient care providers to make decisions on care mangers and support staff to document patterns and eval quality of care coding and billing for reimbursement and for insurance co. patients to inform employers to manage healthcare and see when able to return work and see if work related lawyers for suits and legal needs law enforcements to investigate and for national security researchers and investigators to study safety value of care and stop unsafe treatments gov policy makers for laws best practices and prevent fraud

Record processing monitoring of records transcription roi clinical coding abstracting data analysis research registries birth and death certification completion

Permanent record of all patients treated at healthcare facility. Includes patient id number name date of birth race ethnicity address phone # alias or maiden name ss #facility id patient id visit # admission# and data service type PP patient disposition

Duplicate record when a patient has 2 or more health numbers issued

Overlay a patient is assigned another person’s health record number

Overlap patient has more then1 health record number

Serial number systems issued a unique # for each encounter unit numbering system patient is issued a number at first encounter and is used for all encounters serial unit numbering patient is filled alphabetically by last name

Electronic filling unit numbering is most common used can use patients name and patient account# can be used to retrieved data

Alphabetic system records filled alphabetic order works well in small volume systems

Numeric filling filled by health record number

Alphanumeric both of the two are used to sort health records

Easier to retrieve and file less chance of errors can be used from different facilities can be accessed by providers more easily

List or way to guide facilities to more easily access get data

Data that is narrative in nature it is unstructed unlimited undefined meaning the typist can type anything into the field of document

Prompt for more Infor clear labeling of buttons and fields built in alerts checks for warning signs or errors clear navigation buttons limiting use of abbreviations conscience location of on screen buttons

A system using both paper and er records often used in change overs to electronic records

Is the process of disclosing patient identifiable information from the health care record to another party? The him receives request ensures request is appropriate then submits the info the roi staff is responsible for documenting to whom they released the info when releases and when sent the roi supervisor make sure the rules are followed in a timely and productive requirements ensuring records are available first and foremost for patient care

HIM staff needs the software to assist in managing the er it serves many different functions from patient tracking record retrieval quality control and managing data also used by health official to track health issues without the software the electronic records would not be able to function