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

**What is a health record?**

A health record contains information relating to a patient’s health. It includes physical health, mental health, and the condition of the patient. The health record includes the who, what, when, where, and how of patient care. It is used for many different reasons and by many people.

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

There are individual users and institutional users and they use the health record for many reasons. Some examples of these types of users are,

Individual users:

Providers rely on information in the health record to help make decisions about the care they provide to patients, and to document care.

Care managers and support staff use the health record to evaluate the services provided to patients. They look for patterns and trends to recommend changes to the process to improve outcomes and efficiency of the care provided

Law enforcement use the health record to investigate injuries resulting from a crime, they can also access documentation for information that will help protect the security of the country.

Institutional users:

Healthcare delivery organizations (hospitals, physician offices, home health agencies, etc) use the health record to provide care, submit claims for reimbursement, and evaluate the quality of care provided.

Third party payers are responsible for the reimbursement of healthcare services through an insurance program. They use the health record to justify the care provided.

Educational organizations use the health record as case studies as part of their educational programs when teaching and training students.

**Explain the health record processes.**

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

 There are a number of systems in for HIM. In paper records there is s serial numbering system, unit numbering system, serial-unit numbering system, and an alphabetic filing system. Each uses a different way to file and store the medical record. Electronically there is the EHR that stores and manages the medical record.

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

In paper based records there are some standards that should be followed to ensure quality, these include an average of 50 records will be filed ever hour, records for the ED with be retrieved within 10 minutes, and loose materials will be filed in either the record or the outguide pocket within 24 hours of the HIM dept receiving it. In EHRs quality control features include checking for warning signs or errors, limiting choices and label commands, perform consistency checks to ensure that combinations of data are correct, and more.

2. **Please define the following:**

Abstracting – can be the process of extracting information form a document to create a brief summary of a patient’s illness, treatment, and outcome, or can be the process of extracting elements of data from a source document or database and entering them into an automated system.

Addendum – is additional information provided in the health record, and should be dated the day it was written, not the date it’s referencing.

Aggregate data – data that has been extracted from individual health records and combined to form deidentified 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.

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

Computer assisted coding – uses HER data to assign codes.

Concurrent review – an ongoing review while the patient is still in the healthcare facility.

Correction – corrections to the healthcare record should be made my drawing a line through the mistake and writing “error” above it. Then it should be signed, dated, and timed.

Data – raw facts and figures

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

Deficiency slip – identifies the pertinent document and what needs to be done (dictated, completed, signed), and is often created by a computer system.

Delinquent record – an incomplete record not finished or completed within the time frame determined by the medical staff of the facility.

Demographics - basic information about a patient like their name, date of birth, address, and insurance information.

Deterministic algorithm – algorithm that requires exact matches in data elements such as the patient name, dob, 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. Automatically assigns prospective payment groups on the basis of clinical codes.

Meaningful Use – an incentive program for professionals, hospitals, and CAHs participating in medicare and medicaid programs that adopt and successfully demonstrate meaningful use of certified HER technology.

Outguide – identifies where the health record is located and when it was removed.

Overlap - when a patient has more than one health record number at different locations in an enterprise.

Overlay – a situation where a patient has been assigned a medical record number that has already been issued to another patient.

Probabilistic algorithm – the use of mathematic probabilities to determine the possibility that two patients are the same.

Qualitative analysis – is monitoring the quality of the documenation.

Quantitative analysis – is a review of the health record to determine if there are any missing reports, forms, or signatures.

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

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

Requisition – a request for a patient health record.

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

Unit number system – a patient is issued a health record number at the first encounter and that number is used for all subsequent encounters.

Voice recognition technology – a computer captures the dictation and converts what is said directly into text and no transcriptionist is needed.

**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?**

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

There are individual users and institutional users and they use the health record for many reasons. Some examples of these types of users are,

Individual users:

Providers rely on information in the health record to help make decisions about the care they provide to patients, and to document care.

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Institutional users:

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* **Name those functions of HIM that support patient care.**

HIM has many functions that assist in patient care. HIM manages record filing and the tracking of EHRs, record processing, and version control. Managing free text in the HER is a function of HIM, as well as the management and integration of digital dictation, transcription, and voice recognition. HIM also handles materials from other facilities.

* **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 healthcare facility. The HIM dept uses it to look up patient demographics, dates of care, the patient’s health record number, and other information. The recommended core data elements for the EMPI are internal patient identification, person name, DOB, gender, race, ethnicity, address, phone number, alias, previous, or maiden names, social security number, facility identification, universal patient identifier account or visit number, admission, encounter, or visit date, encounter service type, encounter primary physician, and patient disposition.

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

Duplicate health records happen when a patient has 2 or more health record numbers issued. This can happen when registration doesn’t do a thorough enough search for the patient, or the patient gives a different name or nickname. An overlay happens when a patient is assigned to a health record number that has already been assigned to another patient. The information from both patients becomes commingled. An overlap occurs when a patient has more than one health record number at different locations in an organization.

* **Describe identification systems for paper records (4); Electronic health records**

Identification systems for paper records begins with the serial numbering system where patients are given a numerical identifier for every encounter at a health care facility. The documentation for each encounter is filed separately and all records must be retrieved in order to view the complete record. In unit numbering system a patient is issued a MRN at the first encounter and all encounters after that will use the same MRN. All of the information on a patient is in one location. The serial-unit numbering system is a combination of the serial and unit numbering systems. The patient is issued a new health record number with each encounter but all of the documentation is moved from the last number to the new number. The alphabetic filing system uses the patients last name to file records.

In electronic health records the unit numbering system is the most common system used. For each encounter of care there is a patient account number that is assigned for billing purposes.

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

In a numeric filing system health records are filed by the health record number. The MPI is used to find the health record number and the number is then used to find the health record. Straight numeric filing system and terminal digit filing system are the most commonly used types of numeric filing systems.

Alphanumeric filing systems use both alphabetic and numeric characters to create a unique identifier using the patient’s first two letters of their last name and numbers. This system also uses an MPI.

* **How are records located and retrieved?**

There are a few different ways to locate and retrieve records in both a paper world and electronically. In paper there are a number of filing systems that are used to store records and however they are filed is how you will retrieve a record. Electronically there is a MPI that holds all of the health record numbers assigned to a health record. You would search for a number then retrieve the record.

**Electronic Environment:**

* **What are the advantages?**

I think there are many advantages to the EHR. There is almost no paper used, making filing nearly a thing of the past, locating and retrieving a record is faster than in paper form, and managing and tracking the EHR is simpler as well

* **What is Indexing?**

Loose paper records are scanned and indexed into the EHR, this is called indexing. In indexing the patient name, health record number, document type, and other information are linked to a document to be imported to the health record.

* **Describe the management of free text in the EHR.**

Free text data is the unstructured narrative data that is the result of a person typing data into an information system. This is undefined, unlimited, and unstructured, so the user can type anything they want. Free text should be limited as the ability to manipulate is diminished.

* **Name several quality control functions of the EHR.**

The information systems have measures in place to ensure the quality of the data entered into the EHR. Some examples of this are built-in alerts to notify the user of possible errors, providing a confirmation message for any critical function, providing a title for each screen, perform a completeness check to ensure that all required data have been entered, and combine data into a single, organized menu to eliminate layers of screens.

* **Describe the HYBRID record.**

Because the transition from paper record to EHR can take years to complete, and the hybrid record is a result of this. Until the health record is completely in electronic form it will be considered a hybrid record because some components are still in paper form.

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

ROI is the responsibility of the HIM dept and is the process of releasing and disclosing patient information from the medical record to another office, or third party. The HIM dept receives a request for patient information and they make sure the request is appropriate for release, and then submits patient information for use in care, insurance claims, or legal claims. The HIM dept is responsible for making sure policies and procedures are followed and the requests are processes in a timely manner. They also track and keep record of all releases.

* **Describe the function of the ROI software system.**

This system tracks requests for information. The HIM staff enter basic information from the request, like who is requesting the information, the patient’s whose information is to be released, and their medical record number. After the information is released the staff enters what information was released and the date it was sent. The ROI system can also bill for the requests.