. **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 the physical or mental health or condition of an individual made by a health professional in connection with the individuals care.

Who are the different users of the health record and how do they use it? Healthcare providers are the primary users but there are others that also use the records, such as, individual users which are, patient care providers, coding and billing staff, patients, employers, lawyers, law enforcement officers, healthcare researchers, government policy makers. Then there are institutional users such as, healthcare delivery organizations, third party payers, medical review organizations, research organizations, educational organizations, accreditation organizations, government licensing agencies and policy making bodies. They all use it to manage the healthcare facility and the healthcare industry. Some use the records directly while others use the data or information that has been aggregated from multiple records.

Explain the health record processes.  There are three types of health records. Paper, electronic and hybrid.

Explain the health information management information systems. HE performs many functions. HE supports patient care and the healthcare organization. They focus on ensuring the quality, security, and availability of the health record.

What quality controls can be put into place to manage health information management functions?   They must have processes in place to maintain and correct the MPI against quality issues of duplicates overlays, and overlaps on a continuous basis. Algorithms are used to match patients so the patient information can be merged. Deterministic algorithm, probabilistic algorithm and rule based algorithm is the clean up process to help manage health information.

2. **Please define the following:**

Abstracting-the process of extracting information from a document to create a brief summary of a patients illness, treatment, and outcome.

Addendum-a late entry added to a health 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 be dated, timed, and signed.

Audit trail-A chronological set of computerized records that provide evidence of information system activity used to determine security violations.

Computer assisted coding-the process of extracting and translating dictated and then transcribed free text data (or dictated and then computer generated discrete 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.

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 data base 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 the 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.

Meaningful Use-a regulation that was issued by CMS on July 28, 2010, outlining an incentive program for professionals, eligible hospitals and CAHs participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified HER technology.

Out guide-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-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.

Requisition-request for healthcare records.

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 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 and of interpreting at least some of the signals content as words or the intent of the speaker.

3**.   Check your Understanding answers.**

**4.  Answer the following:**

 What is the purpose of the Health Record? The health record has many primary and secondary purposes. The primary purpose are those which it is developed and used for patient care. The secondary purposes are those where the health record is used for healthcare purposes not directly related to patient care.

* Who are the users of the health record and why? Individuals and institutional users.
* 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 transplants and birth and death certificate completion.
* Describe the Master patient index and it many core data elements. Links the patient’s information at the different facilities. The elements are internal patient identification, person name, date of birth, gender, race, ethnicity, address, telephone number, alias, social security number, facility identification, universal patient identifier, account or visit number, admission or visit number, admission, discharge, encounter service type, encounter primary physician and patient disposition.
* Describe duplicate, overlay and overlap health record numbers. Duplicate health record happens when a patient has two or more health record numbers issued. Overlay is where a patient is erroneously assigned another person’s health record number, and overlap is 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. Numeric, alphabetic and alphanumeric the identifications systems are serial, unit, serial unit and alphabetic filing system.
* Describe numeric filing systems and alphanumeric filing systems. The electronic health records are the unit numbering system. Numeric filing system- the health records are filed by the health record number. Alphanumeric system both alphabetic and numeric characters are used to sort health records in the system.
* How are records located and retrieved? A common way to track the location of health records is the out guide. The out guide identities where the health record is located and when it was removed.

Electronic Environment: electronic record of health related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization.

* What are the advantages??Records can be recognized by authorized clinicians and staff across more than one healthcare organization.
* What is Indexing? Organizing list of specific data that serves to guide, indicate, or otherwise facilitate reference to the data.
* Describe the management of free text in the EHR. The management of the free text is the unstructured narrative data that is the result of a person typing data into an information system.
* Name several quality control functions of the EHR. Clear labeling of buttons and data fields, limiting the use of abbreviations on buttons and data fields, consistent location on the screen of navigation buttons, built in alerts to notify the user of possible errors, prompt for more information where appropriate, checks for warning signs or errors.
* Describe the HYBRID record. Part of the health record on paper and part of it electronic.
* Describe ROI and what is the responsibility of the HIM department and staff? Is the process of disclosing patient identifiable information, from the health record to another party? They receive the request for access to patient information, ensures that the request is appropriate for release and then submits the information for use in patient care, insurance claims, or legal claims.
* Describe the function of the ROI software system.  The department cannot efficiently perform the functions of the department without the use of software. Some of these systems are becoming more important with the implementation of the HER and others may be phased out completely as the SHE makes it obsolete.