Case Studies in Health Information Management 4th edition Schnering Solutions Manual

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Instructor's Manual to Accompany Case Studies in Health Information Management

Fourth Edition

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For the educators use in choosing appropriate cases studies for their classes, we have included Case Study Crosswalk for Associate and Baccalaureate Degrees Curriculum Competencies.

Case Study Crosswalk for Associate Degree Curriculum Competencies						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Use, Disclosure, Privacy & Security	Informatics, Analytics and Data Use	Revenue Cycle Management	Health Law & Compliance	Organizational Management & Leadership
Section 1						
Case 1-1	X					
Case 1-2	X					
Case 1-3	X	X	X			
Case 1-4	X	X	X			X
Case 1-5	X		X			
Case 1-6	X		X			
Case 1-7	X		X			
Case 1-8	X		X		X	
Case 1-9	X		X			
Case 1-10	X	X				
Case 1-11	X		X		X	
Case 1-12	X	X	X		x	X
Case 1-13	X		X		x	X
Case 1-14	X	X	X			
Case 1-15	X		X	X		X
Case 1-16	X	X	x		x	X
Case 1-17	X		X		X	X
Case 1-18	X	X	X		x	
Case 1-19	X	X	X			
Case 1-20	X		X		x	
Case 1-21	X					X
Case 1-22	X					
Case 1-23	X					X
Case 1-24	X	X	X			x
Case 1-25	X	X	X			x
Case 1-26	X		X	X	X	x
Section 2						
Case 2-1		X			X	
Case 2-2	X	X			X	X
Case 2-3		X			X	
Case 2-4		X				X
Case 2-5		X				X
Case 2-6	X	X				
Case 2-7		X				

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Case Study Crosswalk for Associate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Use, Disclosure, Privacy & Security	Informatics, Analytics and Data Use	Revenue Cycle Management	Health Law & Compliance	Organizational Management & Leadership
Case 2-8		X				
Case 2-9		X			X	
Case 2-10	X	X				
Case 2-11		X				
Case 2-12		X				
Case 2-13		X				
Case 2-14		X				
Case 2-15		X				
Case 2-16		X				
Case 2-17		X				
Case 2-18		X				
Case 2-19		X				
Case 2-20		X				
Case 2-21		X				
Case 2-22		X				
Case 2-23		X				
Case 2-24		X				
Case 2-25		X				
Case 2-26		X				
Case 2-27		X				
Case 2-28		X				
Case 2-29		X				
Case 2-30		X				
Case 2-31		X			X	
Case 2-32		X			X	
Case 2-33		X			X	X
Case 2-34		X				
Case 2-35		X				X
Case 2-36		X				
Case 2-37		X				
Case 2-38		X				
Case 2-39		X				
Case 2-40		X				
Case 2-41		X				
Case 2-42		X				
Case 2-43		X				
Case 2-44		X				

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Case 2-45		X				
Case 2-46		X				
Case 2-47		X				X
Case 2-48		X				
Case 2-49		X				
Case 2-50		X				
Case 2-51		X				
Case 2-52		X				
Section 3						
Case 3-1	X	Marked	X			
Case 3-2			X			
Case 3-3			X			
Case 3-4	X		X			
Case 3-5	X		X			
Case 3-6			X			X
Case 3-7	X	X	X			
Case 3-8	X		X			X
Case 3-9			X			
Case 3-10			X			
Case 3-11			X			
Case 3-12			X			
Case 3-13			X			
Case 3-14			X			
Case 3-15			X			
Case 3-16			X			X
Case 3-17			X			
Case 3-18	X		X			
Case 3-19			X			
Case 3-20			X			
Case 3-21	X	X	X			
Case 3-22			X			
Case 3-23			X			
Case 3-24			X			
Case 3-25			X			X
Case 3-26			X			
Case 3-27			X			X

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	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
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Case 3-28			X			
Case 3-29			X			X
Case 3-30		X	X			
Case 3-31		X	X			
Case 3-32			X			
Case 3-33			X			
Case 3-34			X			
Case 3-35			X			
Case 3-36			X			
Case 3-37		Marked	X			
Case 3-38			X			
Case 3-39			X			
Case 3-40			X			
Case 3-41			X			
Case 3-42			X			
Case 3-38		X	X	X	X	X
Case 3-39	X	X	X	X	X	X
Case 3-34	X	X	X	X	X	X
Case 3-35	X	X	X			X
Section 4						
Case 4-1				X		
Case 4-2				X		
Case 4-3				X		
Case 4-4				X		
Case 4-5				X		
Case 4-6				X		
Case 4-7				X		
Case 4-8				X		
Case 4-9				X		
Case 4-10			X	X		
Case 4-11				X		
Case 4-12				X		
Case 4-13				X		
Case 4-14				X		
Case 4-15				X		
Case 4-16				X		
Case 4-17				X		
Case 4-18				X		

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Case Study Crosswalk for Associate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Use, Disclosure, Privacy & Security	Informatics, Analytics and Data Use	Revenue Cycle Management	Health Law & Compliance	Organizational Management & Leadership
Case 4-19				X		
Case 4-20				X		
Case 4-21				X		
Case 4-22				X		
Case 4-23				X		
Case 4-24				X		
Case 4-25				X		
Case 4-26				X		
Case 4-27				X		
Section 5						
Case 5-1					X	
Case 5-2					X	
Case 5-3					X	
Case 5-4					X	
Case 5-5					X	
Case 5-6	X				X	
Case 5-7					X	
Case 5-8					X	
Case 5-9					X	
Case 5-10					X	
Case 5-11					X	
Case 5-12				X	X	
Case 5-13	X				X	
Case 5-14					X	
Case 5-15					X	
Case 5-16					X	
Case 5-17					X	
Case 5-18					X	
Case 5-19					X	
Case 5-20					X	
Case 5-21					X	
Case 5-21					X	
Case 5-22					X	
Case 5-23					X	
Case 5-24					X	
Case 5-25					X	
Case 5-26					X	
Case 5-27					X	

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	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Use, Disclosure, Privacy & Security	Informatics, Analytics and Data Use	Revenue Cycle Management	Health Law & Compliance	Organizational Management & Leadership
Section 6						
Case 6-1						X
Case 6-2		X				X
Case 6-3						X
Case 6-4						X
Case 6-5						X
Case 6-6						X
Case 6-7						X
Case 6-8						X
Case 6-9						X
Case 6-10						X
Case 6-11						X
Case 6-12						X
Case 6-13						X
Case 6-14						X
Case 6-15						X
Case 6-16						X
Case 6-17						X
Case 6-18						X
Case 6-19						X
Case 6-20						X
Case 6-21			X			X
Case 6-22						X
Case 6-23						X
Case 6-24						X
Case 6-25						X
Case 6-26						X
Case 6-27						X
Case 6-28						X
Case 6-29						X
Case 6-30						X
Case 6-31			X			X
Case 6-32						X
Case 6-33	X	X	X	X	X	X
Case 6-34	X	X	X	X	X	X
Case 6-35						X
Case 6-36						X
Case 6-37						X

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	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Use, Disclosure, Privacy & Security	Informatics, Analytics and Data Use	Revenue Cycle Management	Health Law & Compliance	Organizational Management & Leadership
Case 6-38						X
Case 6-39						X
Case 6-40			X			X
Case 6-41						X
Case 6-42						X
Case 6-43						X
Case 6-44						X
Case 6-45	X	X	X	X	X	X
Case 6-46	X	X	X			X
Case 6-47						X
Case 6-48						X
Case 6-49			X			X
Case 6-50		X				X
Section 7						
Case 7-1			X			X
Case 7-2			X			X
Case 7-3			X			X
Case 7-4			X			X
Case 7-5			X			X
Case 7-6			X			X
Case 7-7			X			X
Case 7-8			X			x
Case 7-9			X			X
Case 7-10			X			
Case 7-11			X			
Case 7-12	X		X		x	X
Case 7-13			X		x	X
Case 7-14			X		x	X
Case 7-15	X		X			X
Case 7-16			X			X
Case 7-17	X		X			x
Case 7-18	X		X		x	
Case 7-19			X			X
Case 7-20	X		X			X
Case 7-21			X			X
Case 7-22	X		X			
Case 7-23	X		X			X

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Case Study Crosswalk for Associate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Use, Disclosure, Privacy & Security	Informatics, Analytics and Data Use	Revenue Cycle Management	Health Law & Compliance	Organizational Management & Leadership
Case 7-24	X		X	x		X
Case 7-25	x		X			X
Case 7-26	X		X			X
Case 7-27	X		X			X
Case 7-28	X	X	X	X	X	X
Case 7-29		X	X			X
Case 7-30	X		X			X
Case 7-31	X		X		X	X
Case 7-32			X			X
Case 7-33	X		X			X
Case 7-34	X	X	X			X
Case 7-35			X	X	X	X

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Section 1						
Case 1-1	X					
Case 1-2	X					
Case 1-3	X	X	X			
Case 1-4	X	X	X			X
Case 1-5	X		X			
Case 1-6	X		X			
Case 1-7	X		X			
Case 1-8	X		X		X	
Case 1-9	X		X			
Case 1-10	X	X				
Case 1-11	X		X			
Case 1-12	X	X	X		X	
Case 1-13	X	X	X		X	
Case 1-14			X			
Case 1-15	X		X	X		
Case 1-16	X	X	X	X	X	X
Case 1-17	X					
Case 1-18	X				X	
Case 1-19	X		X			
Case 1-20					X	
Case 1-21	X					
Case 1-22	X					
Case 1-23	X					
Case 1-24	X	X	X			X
Case 1-25	X	X				X
Case 1-26	X					X
Section 2						
Case 2-1		X			X	
Case 2-2	X	X			X	X
Case 2-3		X			X	
Case 2-4		X				X
Case 2-5		X				X
Case 2-6	X	X				
Case 2-7		X				
Case 2-8		X				

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Case 2-9		X			X	
Case 2-10	X	X				
Case 2-11		X				
Case 2-12		X				
Case 2-13		X				
Case 2-14		X				
Case 2-15		X				
Case 2-16		X				
Case 2-17		X				
Case 2-18		X				
Case 2-19		X				
Case 2-20		X				
Case 2-21		X				
Case 2-22		X				
Case 2-23		X				
Case 2-24		X				
Case 2-25		X				
Case 2-26		X				
Case 2-27		X				
Case 2-28		X				
Case 2-29		X				
Case 2-30		X				
Case 2-31		X			X	
Case 2-32		X			X	
Case 2-33		X			X	X
Case 2-34		X				
Case 2-35		X				X
Case 2-36		X				
Case 2-37		X				
Case 2-38		X				
Case 2-39		X				
Case 2-40		X				
Case 2-41		X				
Case 2-42		X				
Case 2-43		X				
Case 2-44		X				

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Case 2-45		X				
Case 2-46		X				
Case 2-47		X				X
Case 2-48		X				
Case 2-49		X				
Case 2-50		X				
Case 2-51		X				
Case 2-52		X				
Section 3						
Case 3-1	X		X			
Case 3-2			X			
Case 3-3			X			
Case 3-4	X		X			
Case 3-5	X		X			
Case 3-6			X			X
Case 3-7	X	X	X			
Case 3-8	X		X			X
Case 3-9			X			
Case 3-10			X			
Case 3-11			X			
Case 3-12			X			
Case 3-13			X			
Case 3-14			X			
Case 3-15			X			
Case 3-16			X			X
Case 3-17			X			
Case 3-18	X		X			
Case 3-19			X			
Case 3-20			X			
Case 3-21	X	X	X			
Case 3-22			X			
Case 3-23			X			
Case 3-24			X			
Case 3-25			X			X
Case 3-26			X			
Case 3-27			X			X
Case 3-28			X			

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Case 3-29			X			
Case 3-30		X	X			
Case 3-31		X	X			
Case 3-32			X			
Case 3-33			X			
Case 3-34			X			
Case 3-35			X			
Case 3-36			X			
Case 3-37			X			
Case 3-38			X			
Case 3-39			X			
Case 3-40			X			
Case 3-41			X			
Case 3-42			X			
Section 4						
Case 4-1				X		
Case 4-2				X		
Case 4-3				X		
Case 4-4				X		
Case 4-5				X		
Case 4-6				X		
Case 4-7				X		
Case 4-8				X		
Case 4-9				X		
Case 4-10			X	X		
Case 4-11				X		
Case 4-12				X		
Case 4-13				X		
Case 4-14				X		
Case 4-15				X		
Case 4-16				X		
Case 4-17				X		
Case 4-18				X		
Case 4-19				X		
Case 4-20				X		
Case 4-21				X		
Case 4-22				X		

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Case 4-23				X		
Case 4-24				X		
Case 4-25				X		
Case 4-26				X		
Case 4-27				X		
Section 5						
Case 5-1					X	
Case 5-2					X	
Case 5-3					X	
Case 5-4					X	
Case 5-5					X	
Case 5-6	X				X	
Case 5-7					X	
Case 5-8					X	
Case 5-9					X	
Case 5-10					X	
Case 5-11					X	
Case 5-12				X	X	
Case 5-13	X				X	
Case 5-14					X	
Case 5-15					X	
Case 5-16					X	
Case 5-17					X	
Case 5-18					X	
Case 5-19					X	
Case 5-20					X	
Case 5-21					X	
Case 5-22					X	
Case 5-23					X	
Case 5-24					X	
Case 5-25					X	
Case 5-26					X	
Case 5-27					X	
Section 6						
Case 6-1						X
Case 6-2	X	X				X

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Case 6-5						X
Case 6-6						X
Case 6-7						X
Case 6-8					X	X
Case 6-9						X
Case 6-10						X
Case 6-11						X
Case 6-12						X
Case 6-13					X	X
Case 6-14						X
Case 6-15						X
Case 6-16						X
Case 6-17						X
Case 6-18						X
Case 6-19						X
Case 6-20						X
Case 6-21			X			X
Case 6-22						X
Case 6-23						X
Case 6-24						X
Case 6-25						X
Case 6-26						X
Case 6-27						X
Case 6-28						X
Case 6-29						X
Case 6-30			X			X
Case 6-31				X	X	X
Case 6-32			X			X
Case 6-33						X
Case 6-34			X			X
Case 6-35						X
Case 6-36						X
Case 6-37						X
Case 6-38						X
Case 6-39						X
Case 6-40			X			X
Case 6-41						X
Case 6-42						X
Case 6-43						X

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Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies *(continued)*						
	Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**	**Domain 6**
	Data Structure, Content & Information Governance	Information Protection: Access, Disclosure, Archival, Privacy & Security	Informatics, Analytics and Data Use	Revenue Management	Health Law & Compliance	Organizational Management & Leadership
Case 6-44						X
Case 6-45	X	X	X	X	X	X
Case 6-46	X	X	X			X
Case 6-47						X
Case 6-48						X
Case 6-49			X			X
Case 6-50		X				X
Section 7						
Case 7-1	X	X	X	X	X	X
Case 7-2	X		X			X
Case 7-3	X		X			X
Case 7-4	X		X			X
Case 7-5	X		X			X
Case 7-11	X		X			
Case 7-12	X	X	X			X
Case 7-13	X	X	X			X
Case 7-14	X	X	X			
Case 7-15	X	X	X			X
Case 7-16	X		X			X
Case 7-17	X		X			
Case 7-18	X		X			
Case 7-19	X	X	X			X
Case 7-20	X	X	X			X
Case 7-21	X	X	X			X
Case 7-22	X	X	X			X
Case 7-23	X	X	X			X
Case 7-24	X	X	X			X
Case 7-25		X	X			X
Case 7-26	X		X			X
Case 7-27	X		X			X
Case 7-28	X	X	X	X	X	X
Case 7-29		X	X			X
Case 7-30	X	X	X			X
Case 7-31	X	X	X	X	X	X
Case 7-32			X			X
Case 7-33	X	X	X			X
Case 7-34	X	X	X			X
Case 7-35		X	X	X	X	X

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Preface

Instructor Manual

The Instructor Manual includes:

- A **Case Study Crosswalk for Associate Degree Curriculum Competencies.** The crosswalk is aligned with the Commission on Accreditation of Health Information Technology Education (CAHIIM) standards for accreditation.
- A **Case Study Crosswalk for Baccalaureate Degree Curriculum Competencies.** The crosswalk is aligned with the Commission on Accreditation of Health Information Administration Education (CAHIIM) standards for accreditation.
- A **Guide to teaching Online**

Student assets include:

- **Web links by Section and case:**
- **Access the Comprehensive List of References by Section and Case.**
- **Cases that can be downloaded to assist student work**
- **Spreadsheets** to assist in completing individual case

How to Implement into Curriculum

For the educators' use in choosing appropriate case studies for their classes, we have included a table of competencies based on AHIMA Entry Level Competencies. It can be found in the instructor materials. Use the appropriate AHIMA Entry Level Competency for your program for assistance in choosing which course and level of taxonomy each case addresses.

Refer to http://www.cahiim.org/him/curriculumrequirements.html

To assist the instructor in using cases, this Instructor's Manual also contains answer keys, rationales, and references.

For continuity, when a table or figure appears in the Instructor's Manual as well as the case study book, it has the same title. If a table or figure is only in the instructor manual, it is labeled as a sample table or figure. Tables that need to be completed by students are completed in this manual for you with correct answers or suggested responses and are labeled the same as in the student text. Additionally, the tables from the text that need to be completed by students have been provided on the student companion website to facilitate completion.

When using websites for references, the URL is presented first, and then the specific address where the information was accessed is given. Although these secondary addresses may have changed from the date they were accessed, hopefully using the URL, and having the main website address will assist you in finding the materials.

Introduction

These Health Information Management case studies have been developed to provide the student with an opportunity to experience a wide range of HIM situations. They give students a chance to utilize the HIM

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principles in making decisions based on multiple variables. The case format can help students move from theory to application and analysis. Using the book with this Instructor Manual provides instructors with a transitional tool to help guide students in "bridging the gap" between content knowledge and on-the-job performance in actual HIM practice.

Critical thinking is a cornerstone to HIM practice. These case studies were designed to assist students of all levels in developing and strengthening their critical thinking skills. The case studies give the students a chance to utilize HIM principles in making decisions based on a changing HIM work field with multiple variables. Each case brings the user into the HIM setting and invites him or her to utilize HIM processes while considering all the variables that influence the protected information management situation. The cases represent a unique set of variables to offer a breadth of learning experiences and capture the reality of HIM practice. Students should not expect to be able to just look up the answers in the textbook. They will have to draw on everything they have learned in order to answer many of the questions in the case studies. Suggestions to help guide students have been provided in this Instructor Manual.

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Organization of the Cases in the Instructor Manual

The cases are grouped into seven sections:

- Data Content, Structure, and Information Governance
- Information Protection: Access, Archival, Privacy, and Security
- Informatics, Analytics, and Data Use
- Revenue Management
- Compliance
- Leadership
- Healthcare Statistics and Research Methods

Although reimbursement issues and coding go hand in hand, we have not included a variety of coding questions since there are a myriad of excellent coding texts and workbooks. Our focus is on principles and compliance rather than on specific codes.

Within each part, cases are organized by subject area and then from less difficult to more difficult. The classification of the cases is subjective and, as we all know, many of the HIM principles pertain to more than one HIM topic.

Of course, no instructor manual can be complete in providing everything that would be helpful in using the textbook it supports. This certainly is applicable to the case study responses presented within this text. The authors of this text have made a concentrated effort to assist instructors who would make use of it. Instructors and participants who work the case studies presented are encouraged to expand and improve upon these responses or to develop them more on their own.

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SECTION ONE

Data Content, Structure, Standards, and Information Governance

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CASE 1-1

Subjective, Objective, Assessment, and Plan (SOAP) Statements and the Problem-Oriented Health Record (POHR)

Questions and Suggested Answers

Evaluate whether each statement is a subjective (S), objective (O), assessment (A), or plan (P) entry from the patient records.

1. __P__ Rule out myocardial infarction.
2. __S__ Patient complains of pain in the left ear and upon neck movement.
3. __O__ BP 130/80. Pulse 85. Respiration 20. Temperature 98.6°F. Lungs clear. Heart regular. Abdomen nontender.
4. __P__ Compare baseline mammogram from 2006 to current mammogram.
5. __A__ Uncontrolled hypertension.
6. __S__ Chest pain.
7. __O__ Pedal edema was 2+.
8. __A__ Possible aortic aneurysm.
9. __P__ Rule out cancerous tumor following biopsy of thyroid lesion.
10. __S__ Patient complained of headache, fatigue, and photosensitivity.
11. __S__ Patient states, “I am thirsty all the time.”
12. __P__ Discharge home with home health nursing and durable medical equipment. Follow-up in 1 week with Dr. Brantley. Home medications of Plavix 75 mg, Zetia 10 mg, Norvasc 25 mg, and Tricor 145 mg.
13. __O__ BUN 21.0 mg/dL, ALB 6.0 g/dL, bilirubin total 6.3 mg/dL.
14. __O__ Percussion was normal.
15. __A__ MRI brain with and without contrast: negative findings.
16. __S__ Complaining of pain in the low back.
17. __A__ Chest X-ray: negative. EKG: A-fibrillation. Total LDH: 145.
18. __O__ Laceration measured 2 cm above right brow.
19. __P__ Determine treatment following results of radiology studies.
20. __A__ Surgical Pathology Frozen Section: Lung LLL Wedge Biopsy reflects non–small cell carcinoma involving pleural nodule.

References

Bowie
McWay
Oachs and Watters
Sayles and Gordon

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CASE 1-2

Problem-Oriented Health Record Format

Questions and Suggested Answers

1. What is the patient's chief complaint?

   Severe pain in the left hip.

2. What information in the scenario is "subjective"?

   Severe pain in left hip sustained from fall out of wheelchair.

3. What information in the scenario is "objective"?

   Intertrochanteric fracture of the left hip, shortening of left leg, and good bilateral pedal pulses prior to surgery. After surgery, there was diffuse osteopenia and near alignment of intertrochanteric femoral neck.

4. Does Dr. Jenkins have a definitive assessment of Ms. Gerry's problem?

   Prior to surgery, the patient was diagnosed with fracture of left intertrochanteric hip.

5. What is the plan for this patient?

   Vitamin K to decrease protime, Bucks traction, and open reduction with internal fixation of left hip upon receipt of a medical clearance.

References

Bowie
McWay
Oachs and Watters
Sayles and Gordon

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CASE 1-3

Master Patient Index and Duplicate Health Record Number Assignment

Questions and Suggested Answers

1. For each pair of patients listed, which health record number should be retained based on the hospital policy?

   The survivorship number should be the MR# retained per policy. The original or initial MR# assigned would be the survivorship in each case:

   - *Case 1 is MR# 016792*
   - *Case 2 is MR# 019156*
   - *Case 3 is MR# 114682*
   - *Case 4 is MR# 015467*
   - *Case 5 is MR# 122199*
   - *Case 6 is MR# 098972*

2. Which numbers listed do you think will require further documentation review to determine whether the patients are the same or not?

   Case numbers 3 and 5 will require further investigation to verify if they are the same patient. However, case numbers 2, 4, and 6 are unlikely the same patient.

3. Which record documentation or data elements from the patient record could be used for determining "matches" of same patient versus different patients?

   When the demographic data from the MPI are ambiguous, record documentation that includes signature from the patient or patient representatives, signature of the guarantor, or insurance policy and/or policy number should be used to validate if a patient match exists.

References

Bowie
McWay
Oachs and Watters
Sayles and Gordon

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CASE 1-4

Enterprise MPI (E-MPI)

Questions and Suggested Answers

1. **Level 1:** Research the recommended core elements of a single-entity master patient index (MPI) and a multi-facility enterprise MPI through professional journals, and develop a list of references used (e.g., *Journal of AHIMA*).

   Student could refer to Journal of AHIMA *practice brief. The core elements include Internal Patient Identifier, Person Name, Date of Birth, Gender, Race, Ethnicity, Address, Telephone Number, Alias/Previous/Maiden Name, SSN, Facility Identifier, Account/Visit Number, Admission/Encounter/Visit Date, Discharge or Departure Date, Encounter/Service Type, Encounter/Service Location, Encounter Primary Physician, and Patient Disposition. Additional recommended elements to the core elements exist for an enterprise MPI found in the article.*

2. **Level 2:** Develop a data dictionary defining each of the data elements needed.

   A sample table of definitions is provided in Table 1-4A.

3. **Level 3:** Design a data display screen of a multi-facility enterprise MPI screen.

   A sample enterprise MPI (E-MPI) is shown in Figure 1-4A.

References

McWay
Oachs and Watters
Sayles and Gordon

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TABLE 1-4A Definitions for Data Dictionary

Data Element	Definition	Data Format Type (with HL7 Abbreviation)
Enterprise ID#	Primary identifier used by the enterprise to identify the patient (Enterprise #)	
Facility Identifier	Primary identifier used by the enterprise to identify facility (Facility Code)	
Internal Patient Identification	Primary identifier used by the facility to identify patient admission (MR #)	Extended composite ID with check digit (CX)
Person Name	Legal name of patient, including suffixes (Doctor, Father, Jr., III) and prefixes	Extended person name (XPN)
Date of Birth	Patient's date of birth. Year, month, and day are entered (e.g., YYYY, MM, DD). Essential that year is entered as four digits	Time stamp (TS)
Gender	Gender of patient	Coded value in user-defined table (IS)
Race	Race of patient largely to identify based on physical characteristics by descent (e.g., American, Indian/Eskimo/Aleut, Asian or Pacific Islander, black, white, other, unknown)	Coded element (CE)
Ethnicity	Ethnicity of patient largely to identification based on shared cultural characteristics or geographic origin (e.g., Hispanic, non-Hispanic, unknown)	Coded element (CE)
Residence	Address or location of patient residence. Include street, apartment number, city, state or province, ZIP, postal code, country, type address (mailing or permanent)	Extended address (XAD)
Alias/Previous/ Maiden Name	Any names patient has used other than the current legal name. Include nicknames, maiden, previous	Extended person name (XPN)
Social Security Number	Personal identification number assigned by U.S. Social Security Administration	String data (ST)
Telephone Number	Telephone number at which the patient can be contacted. Include home, business, or friend	Extended telecommunication number (XTN)

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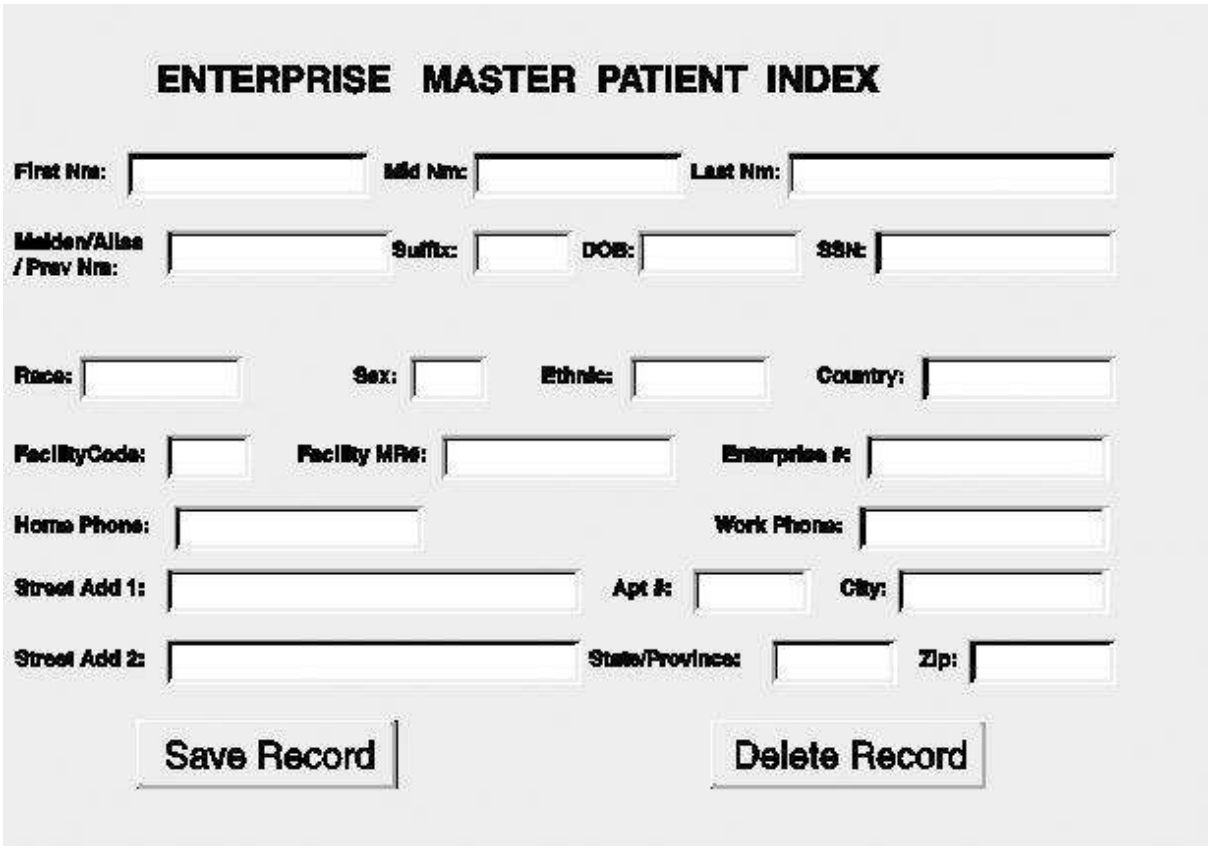


FIGURE 1-4A EMPI

Reference

American Health Information Management Association (AHIMA) (2010)

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CASE 1-5

Chart Check-Out Template Screen Design and Data Quality

Questions and Suggested Answers

Identify ways to improve data quality.

- *Figure 1-2 has inefficient use of space.*
- *Data fields should be sequenced with workflow and read horizontally on screen, from left to right.*
- *Ensure data quality and data checks are built into the screen to capture the correct type of data and field width.*
- *Utilize drop-down windows, check boxes, or radio buttons in capture of data (e.g., a drop-down box could be used for the location field to ensure that only valid locations could be entered).*
- *Good operations management would allow a print option to give a slip (or list with multiple record request), indicating a due date for return in abidance with hospital policy.*
- *Checked-out date chart could be assigned by the system automatically to prevent data entry errors and to save time.*
- *Patient name should be automatically populated when the medical record number is entered.*
- *The user should be recorded based on sign-on, so there is no need for the initial field.*

References

Abdelhak
AHIMA Workgroup
Amatayakul
Oachs and Watters
Sayles and Gordon
Williams

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CASE 1-6

Patient Demographic Data Entry Template Screen Design and Data Quality

Questions and Suggested Answers

Identify ways to improve data quality.

- *Figure 1-3 has inefficient use of space.*
- *Data fields should be sequenced with workflow and read horizontally on screen, from left to right.*
- *The hair color field should be dropped because it is irrelevant to the data being collected.*
- *For normalization purposes, the city and state should be broken down into two separate fields. The state field could be a drop box from which the user could select the appropriate state. The state in which the facility is located should be the default. The city field could be populated by ZIP code.*
- *The demographics captured on this field are very basic. There are additional demographic data elements that should be captured including, but not limited to, race, gender, religion, and phone number including area code.*
- *Recommend field for date of birth (DOB) to be added and to be sequenced with workflow in gathering patient information at time of registration.*
- *Ensure that data quality and data checks are built into the capture of data type.*
- *Utilize drop-down windows, check boxes, or radio buttons in capture of data (e.g., state).*

References

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AHIMA Workgroup
Amatayakul
Oachs and Watters
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CASE 1-7

Encounter Abstract Template Screen Design and Data Quality

Questions and Suggested Answers

Identify ways to improve data quality.

- *Data elements requested in Figure 1-4 appear comprehensive enough; however, there is inadequate use of space.*
- *Admission date could default to the day that the entry is being created but should allow the user to change the admission date in case the system is down, and the user needs to enter admissions from the previous day.*
- *Data fields should be sequenced with workflow and read horizontally on screen, from left to right.*
- *Ensure that data quality and data checks are built into the capture of data type.*
- *The default to the advanced directive field should be specified by the hospital policy. If the advanced directive is provided to the patient and the patient's signature is obtained at each admission, then the default could be Yes. Otherwise, it would be No.*
- *The data field requesting Notice of Privacy Practice Given needs to be repositioned with response radio buttons appearing either stacked vertically or aligned horizontally.*
- *Utilize drop-down windows, check boxes, or radio buttons in capture of data. Examples of fields for using drop-down boxes are as follows:*
  - *Admitting physician field should be a drop-down box.*
  - *The bed could be a drop-down list of all beds available for occupancy. The format could be changed so that instead of a long list, the user could select the unit and then a list of available beds would appear.*

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Amatayakul
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CASE 1-8

Coding Abstract Data Entry Template Screen Design and Data Quality

Questions and Suggested Answers

Identify ways to improve data quality.

- *Data elements requested in Figure 1-5 appear comprehensive enough; however, there is inefficient use of space.*
- *Data fields should be sequenced with workflow and read horizontally on screen, from left to right.*
- *Ensure that data quality and data checks are built into the capture of data type.*
- *Utilize drop-down windows, check boxes, or radio buttons in capture of data.*
- *The patient name should appear automatically via an interface with the hospital information system.*
- *There should be a way to select a particular patient visit so that you can assign the appropriate diagnosis and procedure codes. Currently, you only enter the patient's name and number.*
- *The procedure fields, the surgeon field, as well as the date of surgery are missing.*
- *The admitting diagnosis field is missing.*
- *The codes should be checked to ensure that they are valid.*

References

Abdelhak
AHIMA Workgroup
Amatayakul
Oachs and Watters
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Williams

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CASE 1-9

Design a Template Screen for Radiology and Imaging Service Examinations

Questions and Suggested Answers

Develop a requisition and imaging report to be used for radiology and imaging service exams.
The students should employ good design principles for the screen design that:

- *Include a screen title and identify organization name and address.*
- *Have a consistent organized format.*
- *Should reflect a form/template number.*
- *Should reflect a review/approval date.*
- *Sequence data fields with workflow and read horizontally on screen, from left to right.*
- *Ensure that data quality and data checks are built into the capture of data type.*
- *Utilize drop-down windows, check boxes, or radio buttons in capture of data.*
- *Automatically show patient name on an interface with the hospital information system.*
- *Gives an option to select a particular patient visit so that you can assign the appropriate diagnosis and procedure codes.*
- *Should reflect clear data fields with boxed field names in a smaller font.*
- *Have each student or teams of students create the form, and then critique each of the forms created as a class.*

References

Abdelhak
AHIMA Workgroup
Amatayakul
Oachs and Watters
Sayles and Gordon
Williams

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CASE 1-10

Documentation Requirements for the History and Physical Report

Questions and Suggested Answers

Research the Joint Commission, Centers for Medicare and Medicaid Services (CMS), and Det Norske Veritas (DNV) standards for the documentation of the history and physical report for an acute hospital admission to discover the differences in requirements. Create a table showing the differences between Joint Commission standards, the Conditions of Participation (COP) with CMS, and the DNV.

Table 1-10A shows a sample of the differences in requirements.

TABLE 1-10A Differences in Requirements for the History and Physical Report

Joint Commission Standard	CMS COP Standard	DNV Standard
History and physical (H&P) must be performed and documented in the patient record within 24 hours after admission as an acute care hospital inpatient.	An H&P must be performed no more than 7 days prior to admission or within 48 hours after admission.	
If an H&P was completed within 30 days prior to admission and reviewed and updated, it may be placed on the record within 24 hours after admission.		SR.1 The medical staff bylaws shall include a requirement that a medical history and physical examination (H&P) for each patient shall be completed and documented in the medical record no more than 30 days before or 24 hours after an admission or registration, and prior to surgery, or procedures requiring anesthesia services, and placed in the patient's medical record within 24 hours after admission. The H&P shall be in the medical record prior to surgery or other procedure requiring anesthesia services.

References

AHIMA. "Ensuring the Integrity of the EHR." *Journal of AHIMA* 90, no. 1 (January 2019): 34–37.
Bowie
Joint Commission (2020, April 28, 2)
Oachs and Watters
Sayles and Gordon

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CASE 1-11

Focused Review of Patient Record Documentation: Operative Report

Questions and Suggested Answers

Create a lists of required data elements that would be applicable in development of an audit data collection tool for operative reports, inclusive of the time requirement for completion.

Joint Commission Medical Record Documentation Requirements for Operative Reports

Immediate Post-Operative Note Required Elements & Time Requirements:

Name(s) of primary surgeon/physician and assistants
Pre-operative diagnosis
Post-operative diagnosis
Name of the Procedure performed
Findings of the Procedure
Specimens removed
Estimated Blood Loss
Date and Time Recorded—time is very important as it confirms that the note was recorded prior to moving the patient to the next level of care.

Operative Report Required Elements & Time Requirements:

Detailed OP reports should contain, in addition to the elements listed above,
- *Indications for the procedure*
- *Intra-operative complications*
- *A full description of the Procedure*
- *Note: OP Reports should be dictated or handwritten immediately or within 24 hours following procedure*

Every entry in the Medical Record needs to be SIGNED, DATED, and TIMED EVERY TIME.

References

Joint Commission (2020, April 28, 6).
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CASE 1-12

Data Collection in Long-Term Care: Minimum Data Set Version 3.0

Questions and Suggested Answers

1. **Level 1**: For informational purposes, visit the CMS website and review the official MDS and provide the following information:

   Level 1, MDS 3.0 training:
   https://www.youtube.com/watch?v=5-gwkGs9coI&list=PLRdCQfrB2mlofD-C14NDxJcJxTi9n951M
   https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
   https://www.youtube.com/watch?v=sZLjJMntcPQ&feature=youtu.be

   (a) MDS 3.0 required data sections.
   The MDS 3.0 is a standardized data set used in long-term care containing sections labeled A to Q, V, X, and Z for reporting to Centers for Medicare and Medicaid Services (CMS). It is important to note that data sections do not exist for R–U, W, and Y. The MDS 3.0 requires collection of various types of data utilizing the resident assessment instrument (RAI).

   (b) The types of data included under each section.
   Data are collected on each patient utilizing the RAI and appropriate coding convention for administrative, clinical, and patient-specific data. The types of data found under each section include A = Identification Information, B = Hearing, Speech, and Vision, C = Cognitive Patterns, D = Mood, E = Behavior, F = Preferences for Customary Routine and Activities, G = Functional Status, H = Bladder and Bowel, I = Active Disease Diagnosis, J = Health Conditions, K = Swallowing/Nutritional Status, L = Oral/Dental Status, M = Skin Conditions, N = Medications, O = Special Treatment and Procedures, P = Restraints, Q = Participation in Assessment and Goal Setting, V = Care Area Assessment Summary, X = Correction Request, and Z = Assessment Administration.

   (c) Where in the medical record you would expect to find the data to complete each section of the MDS?
   The MDS data are relatively comprehensive and will require a review of the entire medical record for collection of data of many sections and resident and/or family interview for other sections in the MDS 3.0. The suggested reports within the medical record where data may be found in completing various sections of the MDS 3.0 are given in the following table.

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TABLE 1-12a MDS 3.0 Required Data Sections

MDS 3.0 required data sections		
MDS 3.0 required data sections	**MDS 3.0 required data sections**	**MDS 3.0 required data sections**

2. **Level 2**: Answer the following questions:
   http://www.youtube.com/watch?v=cmBeuxSnbUs *(Accessed by author on Dec 28, 2016)*

   (a) Which MDS 3.0 section requires using the resident's medical record for completion?
   The sections requiring the medical record would include A, B, E, G, H, I, K, L, M, N, O, P, V, and Z. Section A (ID Information), Section B (Hearing, Speech, and Vision), Section E (Behavior), Section G (Functional Status), Section H (Bladder and Bowel), Section I (Active Disease Diagnosis), Section K (Swallowing/Nutritional Status), Section L (Oral/Dental Status), Section M (Skin Conditions), Section N (Medications), Section O (Special Treatments and Procedures), Section P (Restraints), Section V (Care Area Assessment Summary), and Section Z (Assessment Administration).

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(b) What problems are likely to be encountered while completing the MDS 3.0?
Problems that may be incurred include falsification or inaccuracy of documentation due to lack of staff knowledge in using correct coding convention of data elements pertinent to the MDS sections.

(c) What suggestions would you make to overcome these problems?
Suggestions to overcome identified problems include repeated training of staff in correct coding and completion of the various sections throughout the MDS. Provide training on conducting interviews correctly with residents and/or family that focus on the resident's needs.

3. **Level 3:** Answer the following questions.
CMS VIVE: https://www.youtube.com/watch?v=Ereawm4_F7k

(a) What sections of MDS 3.0 must be completed by interview?
Sections requiring completion by interview technique include C, D, F, and J. These sections are Cognitive Patterns (C), Mood (D), Preferences for Customary Routine and Activities (F), and Health Conditions (J).

(b) What are the advantages of using an interview format for gathering this data?
Advantages are to improve assessment of resident in establishing higher quality of care to meet the resident's needs.

(c) How long do these interviews typically take, according to the training video?
The average time for interviews is approximately 17 minutes.

(d) Describe some of the techniques suggested for the interview process.
Techniques for the interview format include using external listening agent or amplifier, arranging a quiet private setting, establishing a good rapport and comfort with resident, establishing comfortable seating distance in front of the resident, assuring proper lighting, assuring comfortable room temperature, and ensuring clearly visible font Que Card when visual aids are used.

References

Centers for Medicare and Medicaid Services:
https://www.cms.gov/
CFR-2011-title42-vol5.pdf

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.0
MDS-30-RAI-Manual-V114-October- 2020

Minimum Data Set (MDS)-Version 3.0 Resident Assessment and Care and Screening
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Archive-Draft-of-the-MDS-30-Nursing-Home-Comprehensive-NC-Version-1140.pdf

MDS 3.0 Training
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials

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MDS 3.0 Training Update: An interactive training video on Section M: Skin Conditions is now available under Related Links below and at:
http://surveyortraining.cms.hhs.gov/Courses/126/SectionMVideo/SectionMVideo.html.

MDS 3.0 Training Update: An interactive training video on Section M: Skin Conditions is now available under Related Links below and at:
http://surveyortraining.cms.hhs.gov/Courses/126/SectionMVideo/SectionMVideo.html.

A four-part video series on Section GG is available as a playlist on the CMS YouTube Channel. The playlist is available from the following link:
https://www.youtube.com/playlist?list=PLaV7m2-zFKpgYhG0FQv82l9dcqNl_9eO4.

This four-part video series presents MDS 3.0 Section GG:

Part 1: MDS 3.0 Section GG, Functional Abilities and Goals: GG0130 Self-Care

- Intent of Section GG
- Look-back periods of each item
- Section GG coding scenarios

Part 2: MDS 3.0 Section GG, Functional Abilities and Goals: GG0130 Sections A-C

- Eating
- Oral Hygiene
- Toileting Hygiene
- 5-Day PPS Assessment
- Part A PPS Discharge Assessment
- 6-Point Scale
- Dash Usage

Part 3: MDS 3.0 Section GG, Functional Abilities and Goals: GG0170 Mobility Sections B-C

- Admission/Discharge Performance
- Goal identification
- Sit to lying. Lying to sitting on side of bed.
- Gateway questions or screening questions

Part 4: MDS 3.0 Section GG, Functional Abilities and Goals: GG0170 Mobility Sections D-S

- Transfers
- Ambulation
- Wheelchair/scooter use

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CASE 1-13

Data Collection for Joint Commission ORYX Performance Measures

Questions and Suggested Answers

As the HIM manager, you initially plan to visit www.jointcommission.org and review literature published on the Joint Commission ORYX performance measures for comparable metrics.
You are particularly interested in the current year.

Develop a report for the committee, with a brief introduction explaining what ORYX reporting requirements are, purpose of reporting, and method of reporting using eCQM data submission.

The ORYX performance measures are disease processes collected and reported to the Joint Commission by hospitals and critical care hospitals. The measures align as closely as possible as those required by the Center for Medicare and Medicaid Services (CMS). The ORYX measures are also used by the JC to integrate into the accreditation process.

The eCQM acronym stands for electronic clinical quality measure and is specified in a standard electronic format designed to use structured, encoded data present in the electronic health record. The eCQMs used by The Joint Commission are updated on an annual basis to account for changes in clinical evidence, measure logic, and coding updates. The eCQM utilizes a direct data submission platform for hospitals to extract and report select measures to the Joint Commission.

2. Develop a list of current year measures for reporting.

   Students answers will change with applicable "current year" of course taught.

   Eight of the ten eCQMs offered by The Joint Commission for 2020 ORYX measure reporting are listed below. They are in alignment with CMS and utilize the same measure specifications. The ten eCQMs are:

   1. *eED-2 Admit Decision Time to ED Departure Time for Admitted Patients*
   2. *ePC-01 Elective Delivery (retained)*
   3. *ePC-02 Cesarean Birth (adopted as of 1/1/2020 discharges)*
   4. *ePC-05 Exclusive Breast Milk Feeding*
   5. *eSTK-2 Discharged on Antithrombotic Therapy*
   6. *eSTK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter*
   7. *eSTK-5 Antithrombotic Therapy by End of Hospital Day Two*
   8. *eSTK-6 Discharged on Statin Medication*
   9. *eVTE-1 Venous Thromboembolism Prophylaxis*
   10. *eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis*

3. Summarize the report with recommendation whether you feel your organization should adopt eCQM reporting and why. Include online reference sources, including working links to literature to support development of the committee report.

   Answers will vary among the students.

Reference

Joint Commission (n.d. 8)
Joint Commission (n.d. 9)

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CASE 1-14

Birth Certificate Reporting Project

Questions and Suggested Answers

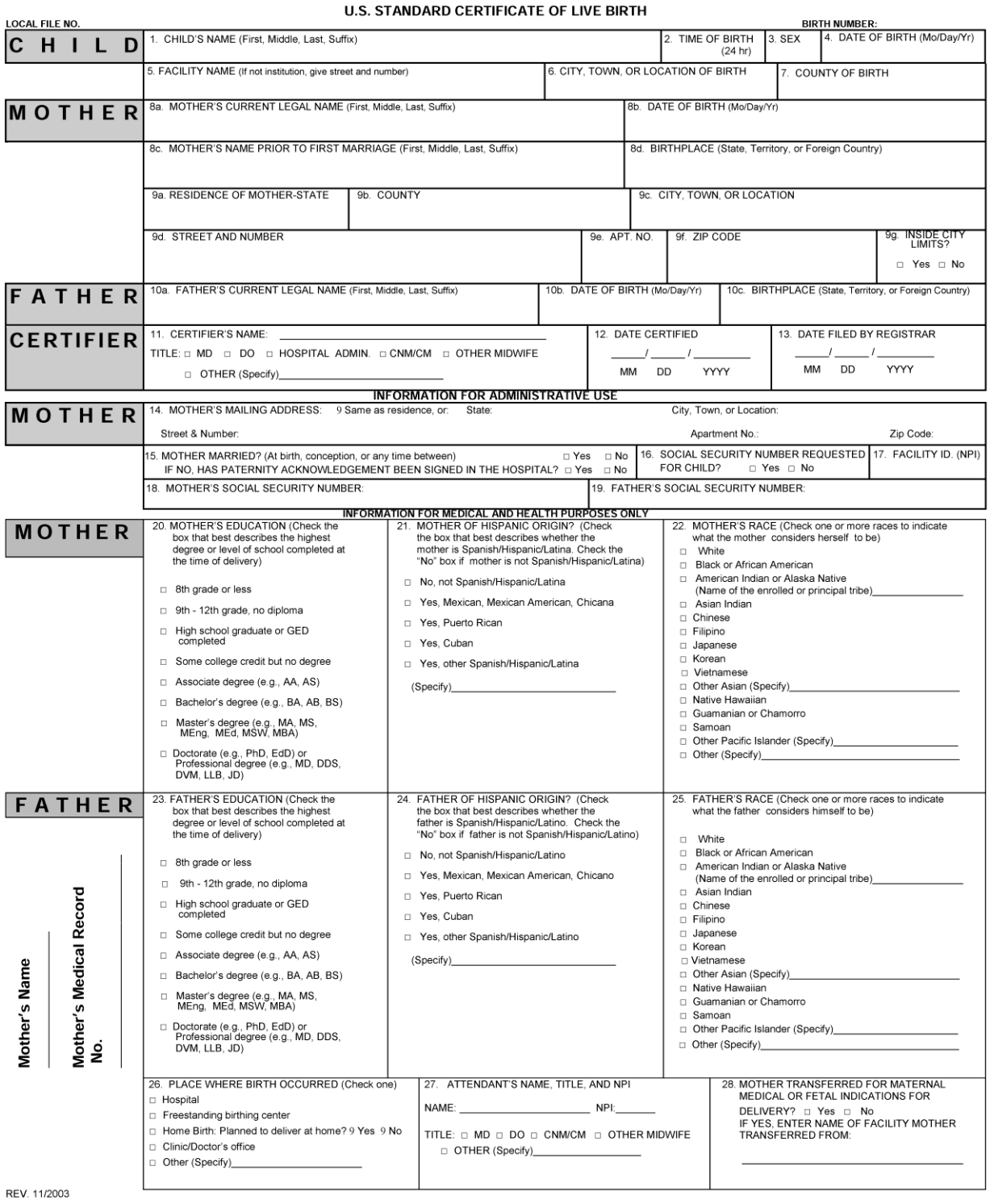
Use the information in the interview with the mother and abstract information from the obstetric record to complete the birth certificate form shown in Figure 1-8.

References

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Oachs and Watters
Sayles and Gordon

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U.S. STANDARD CERTIFICATE OF LIVE BIRTH

LOCAL FILE NO. BIRTH NUMBER:

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)
2. TIME OF BIRTH (24 hr)
3. SEX
4. DATE OF BIRTH (Mo/Day/Yr)
5. FACILITY NAME (If not institution, give street and number)
6. CITY, TOWN, OR LOCATION OF BIRTH
7. COUNTY OF BIRTH

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
8b. DATE OF BIRTH (Mo/Day/Yr)
8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
8d. BIRTHPLACE (State, Territory, or Foreign Country)
9a. RESIDENCE OF MOTHER-STATE
9b. COUNTY
9c. CITY, TOWN, OR LOCATION
9d. STREET AND NUMBER
9e. APT. NO.
9f. ZIP CODE
9g. INSIDE CITY LIMITS? □ Yes □ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME: _____
TITLE: □ MD □ DO □ HOSPITAL ADMIN. □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)_____
12. DATE CERTIFIED _____/_____/_____ MM DD YYYY
13. DATE FILED BY REGISTRAR _____/_____/_____ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: 9 Same as residence, or: State: City, Town, or Location:
Street & Number: Apartment No.: Zip Code:
15. MOTHER MARRIED? (At birth, conception, or any time between) □ Yes □ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? □ Yes □ No
16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? □ Yes □ No
17. FACILITY ID. (NPI)
18. MOTHER'S SOCIAL SECURITY NUMBER:
19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
□ 8th grade or less
□ 9th - 12th grade, no diploma
□ High school graduate or GED completed
□ Some college credit but no degree
□ Associate degree (e.g., AA, AS)
□ Bachelor's degree (e.g., BA, AB, BS)
□ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
□ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)
□ No, not Spanish/Hispanic/Latina
□ Yes, Mexican, Mexican American, Chicana
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, other Spanish/Hispanic/Latina
(Specify)_____

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
□ White
□ Black or African American
□ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian (Specify)_____
□ Native Hawaiian
□ Guamanian or Chamorro
□ Samoan
□ Other Pacific Islander (Specify)_____
□ Other (Specify)_____

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
□ 8th grade or less
□ 9th - 12th grade, no diploma
□ High school graduate or GED completed
□ Some college credit but no degree
□ Associate degree (e.g., AA, AS)
□ Bachelor's degree (e.g., BA, AB, BS)
□ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
□ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)
□ No, not Spanish/Hispanic/Latino
□ Yes, Mexican, Mexican American, Chicano
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, other Spanish/Hispanic/Latino
(Specify)_____

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
□ White
□ Black or African American
□ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian (Specify)_____
□ Native Hawaiian
□ Guamanian or Chamorro
□ Samoan
□ Other Pacific Islander (Specify)_____
□ Other (Specify)_____

Mother's Name

Mother's Medical Record No.

26. PLACE WHERE BIRTH OCCURRED (Check one)
□ Hospital
□ Freestanding birthing center
□ Home Birth: Planned to deliver at home? 9 Yes 9 No
□ Clinic/Doctor's office
□ Other (Specify)_____

27. ATTENDANT'S NAME, TITLE, AND NPI
NAME: _____ NPI:_____
TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)_____

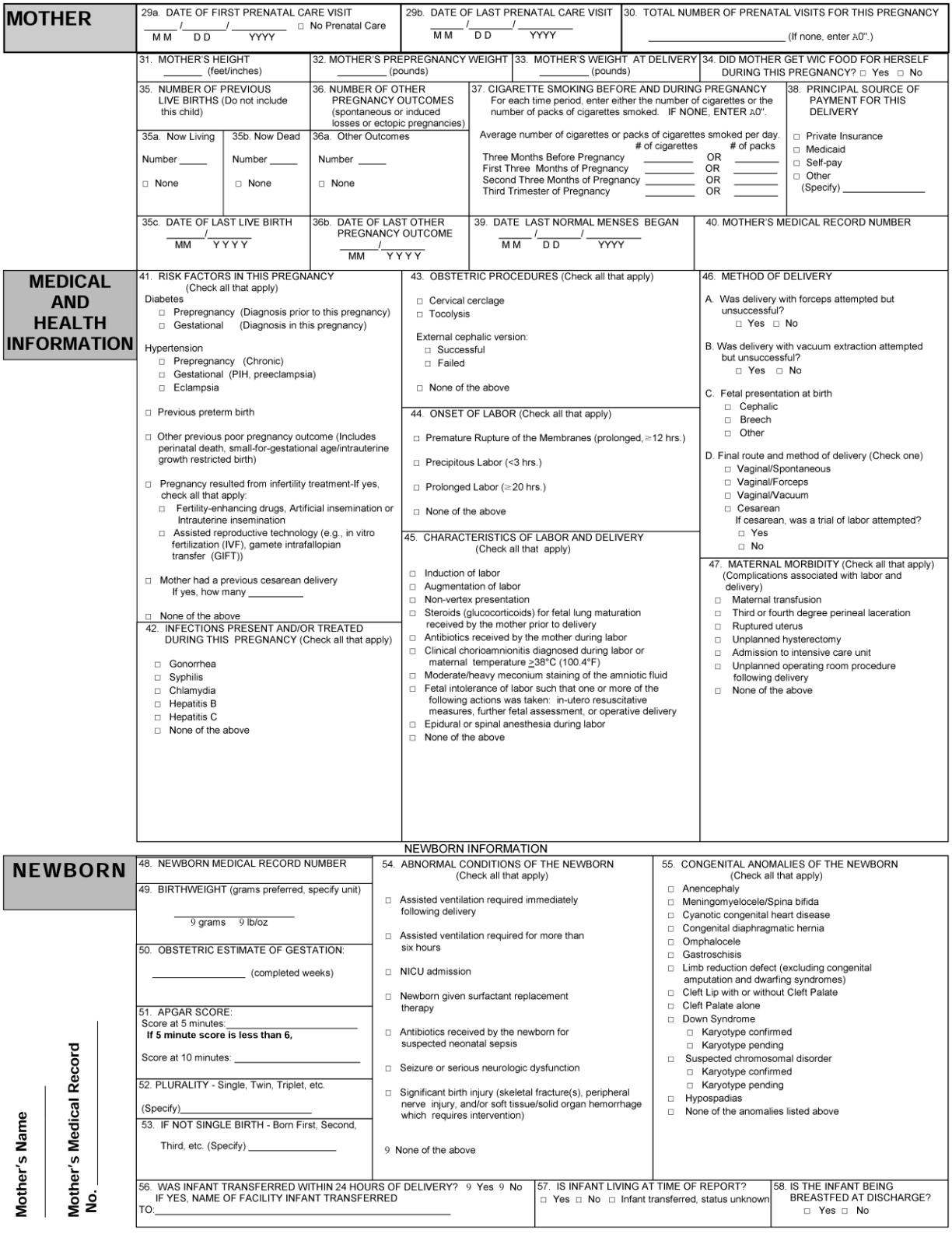
28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □ Yes □ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:
_____

REV. 11/2003

FIGURE 1-8 Manual Birth Certificate

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MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT _____/_____/_____ (MM DD YYYY) ☐ No Prenatal Care

29b. DATE OF LAST PRENATAL CARE VISIT _____/_____/_____ (MM DD YYYY)

30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (If none, enter "0".)

31. MOTHER'S HEIGHT _____ (feet/inches)

32. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)

33. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)

35a. Now Living Number _____ ☐ None

35b. Now Dead Number _____ ☐ None

36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

36a. Other Outcomes Number _____ ☐ None

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
☐ Private Insurance
☐ Medicaid
☐ Self-pay
☐ Other (Specify) _____

35c. DATE OF LAST LIVE BIRTH _____/_____ (MM YYYY)

36b. DATE OF LAST OTHER PREGNANCY OUTCOME _____/_____ (MM YYYY)

39. DATE LAST NORMAL MENSES BEGAN _____/_____/_____ (MM DD YYYY)

40. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATION

41. RISK FACTORS IN THIS PREGNANCY (Check all that apply)
Diabetes
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)
Hypertension
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia
☐ Previous preterm birth
☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
☐ Pregnancy resulted from infertility treatment-If yes, check all that apply:
☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
☐ Mother had a previous cesarean delivery If yes, how many _____
☐ None of the above

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
☐ Cervical cerclage
☐ Tocolysis
External cephalic version:
☐ Successful
☐ Failed
☐ None of the above

44. ONSET OF LABOR (Check all that apply)
☐ Premature Rupture of the Membranes (prolonged, ≥12 hrs.)
☐ Precipitous Labor (<3 hrs.)
☐ Prolonged Labor (≥20 hrs.)
☐ None of the above

45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
☐ Antibiotics received by the mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above

46. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No
C. Fetal presentation at birth
☐ Cephalic
☐ Breech
☐ Other
D. Final route and method of delivery (Check one)
☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean
If cesarean, was a trial of labor attempted?
☐ Yes
☐ No

47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)
☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit) _____ 9 grams 9 lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION: _____ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes: _____
If 5 minute score is less than 6,
Score at 10 minutes: _____

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify) _____

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____

54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
☐ Assisted ventilation required immediately following delivery
☐ Assisted ventilation required for more than six hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
9 None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
☐ Anencephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ Cleft Lip with or without Cleft Palate
☐ Cleft Palate alone
☐ Down Syndrome
☐ Karyotype confirmed
☐ Karyotype pending
☐ Suspected chromosomal disorder
☐ Karyotype confirmed
☐ Karyotype pending
☐ Hypospadias
☐ None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____

57. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No ☐ Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No

Mother's Name _____ Mother's Medical Record No. _____

FIGURE 1-8 Manual Birth Certificate *(continued)*

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CASE 1-15

Clinical Coding Systems and Technology

Questions and Suggested Answers

1. Compare and contrast how the NLP and CAC might be used differently.

   The coder role will review the accuracy of the code for validation in either the NLP or CAC. Both categories of technology could be used to improve accuracy and consistency of code assignments. They also reduce the risk of fraud with the Office of Inspector General (OIG) from erroneous code assignments.

   Student responses will differ. There is an understanding that natural language processing (NLP) technology uses complex algorithms that read data already entered into an electronic health record (EHR) to assign the codes automatically. The NLP uses computational linguistics, including linguistics, semantics, and computer science, whereas the CAC provides technological assistance in proper assignment of codes. The CAC system provides software that will automatically assign a set of medical codes. Proper technology and training of staff will be necessary for each coding system to apply to each of the different coding systems used.

2. Recommend in summation your analysis to state which technology you feel is most advantageous and why. Include the reference sources utilized in your analysis.

   The students' summaries will vary depending on which system they feel is more advantageous.

References

American Health Information Management Association (AHIMA) (July 2010)
Amatayakul
Oachs and Watters
Sayles and Gordon

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CASE 1-16

Text Messaging of ePHI

Questions and Suggested Answers

1. Develop a report to present next month to the committee.

   Each student's response will differ but should reflect an introductory paragraph on the purpose of the report and regulatory requirements of texting ePHI, inclusive of Joint Commission and HIPAA legislation. In addition, a reflection of current best practice, cell phone usage by clinicians regarding ePHI in hospital settings, should be given. The student's reference source used should be provided to support response given.

2. Propose a policy and procedure to be considered by the committee. You should use the policy and procedure form from Figure 1-9 for Port Bismarck Hospital.

   Have students use the policy and procedure form from Figure 1-9 for Port Bismarck Hospital to create their texting of ePHI policy and procedures.

References

AHIMA (2012)
Gellert, G.
HIPAA Journal

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CASE 1-17

Joint Commission Mock Survey

Questions and Suggested Answers

Create an outline of suggestions to present at the next Mock Joint Commission Survey team meeting.

I. *Some suggested activities for a mock on-site survey include:*
The format of an actual on-site survey will be structured to include the following bullet points. The mock survey could be formatted to simulate the entire survey process with these key components. However, the opening conference and leadership session would involve various management staff inclusive of the c-suite and departmental directors.

- *An initial survey planning session*
- *Opening conference and orientation*
- *Leadership session*
- *System/individual tracers conducted*
- *Competence assessment process*
- *Building tour and environment of care session*
- *Exit conference*

A. ***Patient (aka individual) tracers*** *could be conducted from different points of care for selected patients.*
   - *The surveyor might pick up a patient in the emergency department and follow the care and treatment forward through the care process.*
   - *A similar patient tracer could be conducted of a patient selected after his or her episode of care has begun whereby he or she is already placed in a patient room, so the care is traced backward through the care process. Remember that selected cases often are based on the organization's most represented patient population and data collected via ORYX™ core measure reporting.*
   - *Another patient tracer may be by surveyor asking you to navigate a patient's EHR to trace the patient's care via associated documentation. The surveyor will be asked to show the documentation in the EHR to support the orders, assessment, etc.*

B. *The administrator surveyor could give the HIM director the* ***Medical Records Statistic Report*** *to complete the past 12 months of delinquent record statistics.*

C. *A* ***system tracer*** *could be performed on the medication administration system whereby the surveyor observes and interviews staff in their performance of entering orders into the medications order entry information system; the pharmacy's receipt and dispensing of the order; and the medication nurse during the administration of the medications. Another system tracer may include an infection control tracer.*
The Communication of ***National Patient Safety Goals*** *(NPSGs) could be surveyed through a review of in-house patient records to validate that there have not been unacceptable abbreviations, acronyms, or symbols documented in the patient records. Additional elements can be reviewed to ascertain that verbal orders (VOs) and reporting of critical test results reflect that the authorized transcriber (i.e., nurse, therapist) is being documented, and the care provider (transcribed) heard and "read back" the complete order or test result accurately and that it is documented accordingly in the patient record.*

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References

Joint Commission (n.d.3)
https://www.jointcommissioninternational.org/pathway/jci2015/documents/How_to_Conduct_a_Mock_Tracer.pdf

Joint Commission (n.d. 4)
https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/survey-process-and-survey-activity-guide/2020-all-programs-organization-sag.pdf

McWay
Sayles and Gordon

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CASE 1-18

Authentication of Patient Record Documentation

Questions and Suggested Answers

Students should research the topic for Joint Commission authentication requirements of medical record documentation to report to the Accreditation Committee Meeting and the Federal Register COP for Medical Record Services.

The student response may include that all medical reports in the patient record require completion with authentication. The time frame will differ by report in order to meet JC and COP requirements. However, all orders, including verbal orders, must be legible, dated, timed, and authenticated by the ordering physician or another practitioner responsible for the care of the patient and who is authorized to write orders by policy in accordance with their state law. In the absence of a state law designation of an authentication time frame, all verbal orders must be authenticated within 48 hours.

Federal and state laws specify how an electronic authentication is acceptable via a computer-generated code.

References

Electronic Code of Federal Regulations, Title 42, Sec 482.24
Joint Commission (n.d. 4)

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CASE 1-19

Copy and Paste in the EHR

Questions and Suggested Answers

Create an essay of your literature findings including advantages, disadvantages, and best practices when copy and paste function is enabled for clinician to use in a hospital EHR system. Give references in APA format on the last page of your essay.

Conclude your essay with a summary paragraph justifying your opinion whether copy and paste should be allowed in a hospital EHR system.

The students' essays will vary but should reflect best practices found from research (AHIMA BoK) on copy and paste use within the EHR. Essays should include that an organizational policy should exist on the appropriate and inappropriate use of copy and paste for the organization's specific EHR system. It should include a training program for clinicians on the EHR system and if the organization's policy limits on which document data elements that copy/paste function will be allowed. The organization should also develop an audit policy reflecting how often audits will be performed, percentage of records or clinicians to be reviewed, how inappropriate use will be identified, and how identified offenders will be reported. The policy should include what and when sanctions are to be enforced for inappropriate use of the copy and paste function within the patient records. The essay should include references of three peer-reviewed articles with one being on best practices of copy and paste functionality.

Reference

Joint Commission (n.d. 4)
AHIMA Toolkit (2016 Update). Copy Functionality Toolkit

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CASE 1-20

Case Finding for Tumor Registry

Questions and Suggested Answers

What are your sources for obtaining the information to compile a list?

Diagnosis registries are used for the "case definition" process to screen all bladder and colon cancer code ranges from the ICD-9 or ICD-10 code systems. The applicable code system would be based on the time period the COO is requesting cases from. Should the period overlap during transition of ICD-9 to ICD-10 code system, GEMs mapping may be used as a crosswalk to find appropriate cancers. After the case definition has been identified for applicable code ranges, the data must be extracted through "case finding" of patients seen and treated at the county hospital via outpatient and inpatient services. The report should be developed in a spreadsheet to include demographic identifier fields of resident zip code, city, and county origins to allow various means of manipulating and reporting data. Also, cases may be identified through a review of pathology reports completed during the six months requested.

References

Abdelhak
Oachs and Watters
Sayles and Gordon

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CASE 1-21

Face Validity of QI Study on Births

Questions and Suggested Answers

1. Determine how many patients are primigravida.

   Four reflected having first (G) gravida pregnancy.

2. Evaluate the number of total pregnancies of these 17 patients.

   Total of 42 reflected pregnancies.

3. How many full-term births are reported?

   There were 18 reflected (T) term births.

4. How many premature births are reported?

   There were four reflected (P) para preterm births.

5. How many aborted pregnancies are reported?

   There were four reflected (A) aborted pregnancies.

6. How many living children are reported?

   There were 20 reflected (L) living children.

References

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Oachs and Watters
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CASE 1-22

Reproductive History Interpretation

Questions and Suggested Answers

Explain patient reproductive histories at the time of their admission.

MR # 050309—The patient's reproductive history reflects GTPAL of 2-1-0-0-1, implying she has experienced two pregnancies, carried one full-term birth, had no preterm births, had no abortions, and has one living child as of her July admission.

MR# 047738—The patient's reproductive history reflects GTPAL of 4-2-1-0-2, implying she has experienced four pregnancies, carried two full-term births, had one preterm birth, had no abortions, and has two living children as of her July admission.

MR# 050185—The patient's reproductive history reflects GTPAL of 2-1-0-1-0, implying she has experienced two pregnancies, carried one full-term birth, had no preterm births, had one abortion, and has no living children as of her July admission.

References

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Oachs and Watters
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CASE 1-23

Extract Pertinent Inpatient Medical Documentation

Questions and Suggested Answers

1. Patient demographic data—*Registration Record (aka face sheet)*
2. Evidence that the patient was informed of benefits, risks, and alternatives prior to a particular surgery—*Informed Consent*
3. Reason for admission and review of body systems—*History & Physical*
4. An evaluation of patient prior to induction of anesthesia—*Preanesthesia Evaluation*
5. Chest radiology interpretation—*Radiology Report (aka x-ray)*
6. Name of surgeon and assistant surgeon, and estimated blood loss—*Operative Report*
7. Family and social history—*History*
8. CBC and urinalysis test results—*Laboratory Reports*
9. Course of events throughout hospital stay—*Discharge Summary (aka Death Summary in event of death)*
10. Vital signs; fluid input and urine output—*Graphics or Flow sheets*
11. Chronological entries made about patient's condition by nurses—*Nurses Progress Notes*
12. Chronological entries made about patient's condition by physician—*Physician Progress Notes*
13. Patient's blood type and Rh factor—*Blood Type and Crosshatch Report*
14. Discharge diagnosis and discharge instructions with follow-up care—*Discharge Summary*
15. Date, time, name of drug, drug dose, and route of administration—*Medication Administration Record*
16. Name of person designated by patient to make healthcare decisions should patient become incapacitated—*perhaps by having a Healthcare Proxy or Durable Power of Attorney for Healthcare*

References

Abdelhak
Oachs and Watters
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CASE 1-24

Choosing a Personal Health Record

Questions and Suggested Answers

1. Identify benefits you would expect to encounter when you implement your PHR.
   This depends on the system, but some expected responses would be the following:
   - *Internet accessibility*
   - *Improvement in quality of care*
   - *Accessibility in the event of a disaster*
   - *24/7/365 accessibility*

2. Recommend other information you might want to know.
   The students could come up with some of the following questions:
   - *Who is the provider of the PHR?*
   - *Is the PHR comprehensive?*
   - *Who owns the PHR?*
   - *Is the information portable?*
   - *How is the information populated?*

References

American Health Information Management Association (AHIMA) (2016)
American Health Information Management Association (AHIMA) (n.d. 2)
Sayles and Gordon
McWay

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CASE 1-25

Personal Health Record Education

Questions and Suggested Answers

Create the PHR information sheet.

The student is to write a one-page information sheet that defines the PHR, explains the benefits of the PHR/patient portal, and tells about the PHR that your facility is offering. With the PHR, patients will have access to test results, key clinical findings, and a secure e-mail to communicate with their doctors.

Reference

Amatayakul
American Health Information Management Association (AHIMA) (n.d. 2)
AHIMA (2016)
Sayles and Gordon
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CASE 1-26

Clinical Vocabularies

Questions and Suggested Answers

You have been hearing the subject of clinical vocabularies discussed frequently at several meetings. Since the concept will impact the HIM department of your ambulatory surgical center, you recognize the need to research the subject more thoroughly to be able to articulate the needs not only of your department but also of the facility in general.

Definition of a clinical vocabulary:

In a clinical vocabulary, each term must correspond to at least one meaning, have no more than one meaning, and meanings correspond to no more than one term, though synonyms are allowed. In essence, a concept is a specific idea or thought.

1. What vocabularies do you have to choose from?

   CPT
   ICD-10-CM
   LOINC
   SNOMED CT

2. What are the functions of each of these vocabularies?

   CPT *(Current Procedural Terminology) is a medical* ***code*** *set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations.*

   ICD-10-CM/PCS

   ICD-10CM *is the code set for diagnosis coding and is used for all healthcare settings in the United States.*

   ICD-10PCS*, on the other hand, is used in hospital inpatient settings for inpatient procedure coding.*

   ICD-10-CM *(The International Classification of Diseases, Tenth Revision, Clinical Modification) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with healthcare in the United States.*

   ICD-10-PCS *(The International Classification of Disease, Tenth Revision, Procedure Coding System) is a system of medical classification used for procedural codes that track various health interventions taken by medical professionals.*

   LOINC *(Logical Observation Identifiers Names and Codes) was developed to provide a definitive standard for identifying clinical information in electronic reports. The LOINC database provides a set of universal names and ID codes for identifying laboratory and clinical test results in the context of existing HL7, ASTM E1238, and CEN TC251 observation report messages. One of the main goals of LOINC is to facilitate the exchange and pooling of results for clinical care, outcomes management, and research. LOINC codes are intended to identify the test result or clinical observation. Other fields in the message can transmit the identity of the source laboratory and special details about the sample.*

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SNOMED CT *(Systematized Nomenclature of Medicine Clinical Terms) was developed mainly to encode the clinical data in a patient record. It is available for use in the United States via licensing by the National Library of Medicine (NLM) for country-wide use. It is also used by many other countries and is managed by the International Health Terminology Standards Development Organization (IHTSDO). Because of its clinical focus, it is considered a useful standard for encoding clinical data sent between systems or organizations. It is a terminology that can cross-map to other international terminologies, classifications, and code systems. The purpose of mapping is to provide a link between one international terminology, classification, and code system and another to obtain a number of benefits.*

SNOMED CT specification and content provide guidance when mapping to and from other international terminologies, classifications, and code systems. These resources support the creation of simple, complex, and extended mappings.

These include:

- *Data reuse, that is, SNOMED CT-based clinical data can be reused to report statistical and management data using other terminologies, classifications, and code systems*
- *Retention of the value of data when migrating to newer database formats and schemas*
- *Avoidance of entering data multiple times and the associated risk of increased cost and errors*
- *Interoperability among international terminologies, classifications, and code systems*

3. Is the vocabulary appropriate for your setting and purposes?

   ICD-10-CM
   CPT

4. Base on your description, which vocabulary or vocabularies would you choose? Justify your decisions.

   ICD-10-CM will be used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with healthcare in the United States.

   CPT will be used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations.

Reference

AHIMA (2016)
Oachs and Watters
Sayles and Gordon

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CASE 1-27

Clinical Documentation Improvement Meeting

Questions and Suggested Answers

1. After review of the AHIMA toolkit, briefly identify why SLHS needs a formal CDI program. Support this with literature and benefits to be gained. You might be creative in developing scenario of hospital or health system status to substantiate your response.

   Students answers will vary. After a review of AHIMA CDI Toolkit, the responses might include:
   - Improve clinical documentation in EHR to support CCs and MCCs for appropriate MS-DRGs assigned.
   - Improve clinical documentation in EHR to support severity of Illness (SOI) and risk of mortality (ROM) reported accurately.
   - Improve communication among physicians and others of healthcare team.
   - Promote health record completion concurrently during care, promoting patient safety.
   - Promote awareness and education during patient's care.
   - Improve coders clinical knowledge.
   - Improved patient outcomes.

2. List who project stakeholders should be to sit on the CDI Implementation project team. Support each job title/role with reason they are appropriate.

   HIM Director, Coding Manager, Case Manager, Physician Liaison (i.e., Chief of Surgery/Chief of Medicine), IT Staff, Financial Manager, Revenue Cycle Manager, Executive from C-Suite (i.e., CFO/COO), Nursing, Quality/Risk or Compliance Officer.

3. Identify key systems in a successful CDI program and whether you feel SLHS upgrades or additions are needed to have a successful implementation.

   Systems critical to effective CDI might not only be a CDI system. They may also include an integrated EHR, Computer Assisted Coding (CAC) system, and integrated ADT system in tracking patients.

Reference

Oachs and Watters
Sayles and Gordon

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CASE 1-28

Breaking Down Classification Systems and Clinical Terminologies

Read the referenced articles and your class textbook on the subject before answering the following questions.

- SNOMED-CT and the EHR: Why Should a HIM Professional Care? (2018)
- Clinical Terminology and Clinical Classification Systems: A Critique Using AHIMAs Data Quality Management Model (2016)

Questions and Suggested Answers

1. Define clinical classification.

   A clinical vocabulary, terminology, or nomenclature that lists words or phrases with their meanings and provides for proper use of clinical words as names or symbols.

2. Explain how clinical classification is used in a healthcare organization.

   Students might say coders use ICD-10-CM and ICD-10-PCS classification systems for coding inpatient diagnoses and procedures. CPT is used in coding outpatient procedures or physician office visits.

3. Define clinical vocabulary.

   A formally recognized list of preferred medical terms. It is similar to clinical terminology, except it includes the meanings or definitions of words.

4. Provide an example how clinical vocabulary can be used in a healthcare organization.

   Student responses will vary. Some examples might include Logical Observation Identifiers Names and Codes (LOINC) exchange standard used by the clinical laboratory for reporting lab test results. RxNorm is a standardized nomenclature used for clinical drugs and provides information on ingredients, strengths, and form to be administered. The pharmacy system might use RxNorm standards in developing hospital formulary for interoperability to brand named and generic named clinical drugs.

5. Define clinical terminology.

   A set of standardized terms and their synonyms that record patient findings, circumstances, events, and interventions with sufficient detail to support clinical care, decision support, outcomes research, and quality improvement. It is a common language used between healthcare providers.

6. Give an example of how clinical terminology might be used in a healthcare organization.

   A controlled terminology used in natural language processing is SNOMED-CT. The articles explain how SNOMED-CT is used for recording and sharing clinical data across information systems

Reference

Oachs and Watters
Sayles and Gordon

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CASE 1-29

Documentation Standards for the Hospital Based Health Record

Questions and Suggested Answers

1. Review the Joint Commission website (www.jointcommission.org) for new releases that have occurred within the hospital sector and select **three** standard updates within the past three years, that could impact a hospital's accreditation due to information management aspects. Realize the standard change may not explicitly state information management, but as a HIM professional, you realize the standard impacts the care process and health record documentation requirement to substantiate service provided. Identify each standard change below chosen by the Joint Commission, including the standard number and title, and provide the working link to each release web address you selected.

   Students' answers will vary dependent on new release chosen.

2. As a HIM manager, respond briefly in three paragraphs what policy and procedure should be implemented to ensure the hospital complies with each new JC standard requirement to meet documentation needs.

   Students' answers will vary dependent on new release chosen. However, each student's response should correspond with identified news releases answer they provide under question #1.

References

Joint Commission www.jointcommission.org
Oachs and Watters
Sayles and Gordon

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American Health Information Management Association (AHIMA). (August 2011). "HIM functions in healthcare quality and patient safety. Appendix C: HIM's role in data capture, validation, and maintenance." *Journal of AHIMA* 82, no. 8: expanded online version.

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Centers for Medicare and Medicaid Services. (n.d.). Accessed May, 13, 2017, from www.cms.gov//EHRincentiveprograms.

Centers for Medicare and Medicaid Services. (2016). Minimum data set version 3.0.

Related Links to http://www.cms.gov/.

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- 2. MDS 3.0 RAI Manual v1.14 and Change Tables October 2016
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