



Health Information Management (HIM)

Course: MPI, Record Completion and Release of Information



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Introduction:

The Health Information Management HIM course on MPI, record completion and release of information is a 5-day course for managers and supervisors of hospital health information units that ends with an HIM Department Operations Improvement Plan for a case hospital. Hospitals face split patient histories, overdue incomplete charts, slow or unsafe disclosure of records and thin evidence at accreditation surveys when the health information function runs without measured controls. Nominees already supervise records staff, and they learn through case studies built on duplicate-record lists, deficiency reports and disclosure logs. CoreConcept Training Center delivers this HIM operations course.

Course Objectives:

- Map the health information department's functions, workloads and turnaround times against a documented baseline
- Maintain master patient index integrity by applying matching rules and resolving duplicate, overlay and overlap records
- Run record completion routines that track deficiencies, escalate delinquent charts and close them within policy time limits
- Process release of information, patient access and amendment requests with validated authorisations and a disclosure log
- Control retention, scanning, indexing and chart retrieval so that records stay findable, legible and complete
- Build an HIM KPI scorecard and evidence file that support accreditation surveys and internal audits

Target Audience:

- Managers responsible for the hospital health information or medical records department
 - Supervisors responsible for record completion, chart analysis and deficiency follow-up teams
 - Officers responsible for master patient index maintenance and patient identity data quality
 - Unit leads responsible for release of information, patient access requests and disclosure logging
 - Section heads responsible for scanning, archive storage, retention and chart retrieval services
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Course Outline:

Day 1: HIM Department Functions, Workflows and Current-State Baseline

- HIM Department Function Map from Admission to Archive
- Primary and Secondary Health Record Use Inventory
- AHIMA Data Quality Management Model Characteristics Review
- HIM Workload Volume and Turnaround Baseline Sheet
- HIM Section Structure and Productivity Standards per Role

Day 2: Master Patient Index Integrity and Patient Identity Controls

- Master Patient Index Core Data Elements and Identifiers
- Deterministic and Probabilistic Patient Matching Rules Compared
- Duplicate, Overlay and Overlap Record Classification Criteria
- Data Steward Work Queue for Merge and Unmerge
- MPI Duplicate Rate Measurement and Monthly Cleansing Routine

Day 3: Record Completion, Deficiency Tracking and Release of Information

- Discharge Record Assembly and Quantitative Analysis Checklist
- Deficiency Tracking Log for Missing Signatures and Reports
- Delinquent Record Escalation Ladder and Clinician Notification Letters
- Release of Information Request Validation and Authorisation Review
- Patient Access and Amendment Request Handling Procedure

Day 4: Retention, Scanning, Disclosure Risk and Survey Readiness

- Health Record Retention Periods for Adults and Minors
- Scanning, Indexing and Image Quality Control Workflow
- Chart Retrieval Tracking and Loose Sheet Filing Controls
- Wrong-Patient Disclosure Incident Response and Accounting Log
- Accreditation Survey Evidence File for HIM Standards

Day 5: Case Study on the HIM Department Operations Improvement Plan

- Case Hospital Duplicate Record and Deficiency Data Review
 - Case Hospital Release of Information Backlog Root Cause Analysis
 - HIM KPI Scorecard with Targets and Review Cadence
 - HIM Staffing and Workflow Redesign for the Case
 - HIM Department Operations Improvement Plan Presentation to Panel
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Skills You Will Gain:

- Patient Identity Matching
- Duplicate Record Resolution
- Chart Deficiency Management
- Disclosure Request Validation
- Retention Period Control
- Scanning Quality Assurance
- HIM Performance Measurement
- Survey Evidence Preparation

Why Attend This Course:

- Deliver an HIM Department Operations Improvement Plan for a case hospital to the medical director and the quality lead
- Decide when to merge, unmerge or hold a suspected duplicate patient record on documented matching evidence
- Avoid wrong-patient disclosures, overdue incomplete charts and missing survey evidence that expose the hospital
- Coach records, scanning and disclosure staff on the checklists, logs and escalation steps used in the case work

Conclusion:

Back at work, the participant presents the HIM Department Operations Improvement Plan to the medical director and the quality lead. They use it to agree the duplicate-record cleansing routine, the deficiency escalation ladder, the disclosure validation steps and the retention and scanning controls, and to set the HIM KPIs reported each month. After the first quarter of use, the department should compare duplicate rates, delinquent chart counts, disclosure turnaround and survey findings with the baseline and adjust targets and staffing where results fall short.

Frequently Asked Questions FAQ:

What should participants know before a Health Information Management HIM course on MPI and release of information?

Participants should already supervise or work in a hospital health information or medical records unit. Bringing anonymised deficiency reports, duplicate-record lists or disclosure logs from their own department helps them apply the case exercises to real conditions.

How does a Health Information Management HIM operations course differ from a clinical coding or documentation improvement course?

This course runs the department itself: patient index integrity, record completion, disclosure, retention, scanning and KPIs. Coding courses assign diagnosis and procedure codes, while documentation improvement courses review clinical notes and query physicians about content.

Why does master patient index integrity matter in Health Information Management HIM?

Every record depends on it. A duplicate splits a patient's history, an overlay mixes two patients in one file, and both lead to unsafe care decisions, wrong disclosures and unreliable data for reporting and surveys.

What do participants take back from a Health Information Management HIM course on record completion and release of information?

Participants take back an HIM Department Operations Improvement Plan: a duplicate-record cleansing routine, a deficiency escalation ladder, disclosure validation steps, retention and scanning controls, a staffing review and a KPI scorecard with targets.
