Component I: Core

Module J: Electronic Health Records

Topic 2: Documentation

Statement of Purpose
To prepare the learner with knowledge of the Electronic Health Record, specifically how to document the patient visit, otherwise known as the encounter.

Student Learning Outcomes
Upon completion of this topic, the learner will be able to:

1. Spell and define the key terms.
2. Review the steps of medical documentation within the Electronic Health Record (EHR).
3. Explain specific steps for the front office medical staff (Receptionist or Administrative Medical Assistant).
4. Explain specific steps for the clinical staff (Clinical Medical Assistant or Registered Nurse).
5. Explain specific steps for the provider (Physician or Nurse Practitioner).
6. Describe Private Health Information (PHI) and Health Information Exchange (HIE).

Terminology

1. Administrative Medical Assistant
2. Case
3. Clinical Decision Support (CDS)
4. Clinical Medical Assistant
5. Computer Provider Order Entry (CPOE)
6. Decision support
7. Demographics
8. Electronic Health Record (EHR)
9. Electronic prescribing (ePrescribe)
10. Eligibility
11. Encounter
12. Encryption
13. Guarantor
14. Health Information Exchange (HIE)
15. Health Information Technology for Economic and Clinical Health (HITECH)
16. History of Present Illness (HPI)
17. Meaningful Use (MU)
18. Medical record
19. Notice of Privacy Practices (NPP)
20. Nurse practitioner
21. Past Medical History (PMH)
22. Patient Education
23. Patient Portal
24. Physical Examination (PE)
25. Practice Management (PM)
26. Progress note/SOAP note (Subjective, Objective, Assessment and Plan)
27. Protected Health Information (PHI)
28. Provider
29. Registered Nurse
30. Review of Systems (ROS)
31. The Health Insurance Portability and Accountability Act (HIPAA)
32. Workflow

References

1. Correa, C. (2011). G*etting Started in the Computerized Medical Office: Fundamentals and Practice* (2nd Ed.). Clifton Park, NY, Delmar Cengage Learning.
2. Davis, F.A. (2013). *Taber's Cyclopedic Medical Dictionary* (22nd Ed.). Philadelphia: F.A. Davis.

3. Gartee, R. (2012). *Essentials of Electronic Health Records* (1st Ed.) Upper Saddle River, NJ: Pearson Prentice Hall.
4. Larsen, W. (2011). *Computerized Medical Office Procedures: A Worktext Using Medisoft v16* (3rd Ed.). Philadelphia, PA: Saunders Elsevier.
5. Sanderson, S. (2012). *Practice Management and EHR: A Total Patient Encounter for Medisoft Clinical* (1stEd.). McGraw-Hill.
6. Dennerll, J.T., & Davis, P.E. (2010). *Medical Terminology: A Programmed Systems Approach (10th Ed.).* Clifton Park, NY: Delmar, Cengage Learning.

Content Outline/Theory Objectives	Suggested Learning Activities
Objective 1 **Spell and define key terms.** A. Review the terms listed in the terminology section. B. Spell the listed terms accurately. C. Pronounce the terms correctly. D. Use the terms in their proper context.	A. Matching exercise. B. Administer vocabulary pre-test and post-test. C. Discuss learning gaps and plan for applying vocabulary.
Objective 2 **Review the steps of Medical Documentation within the Electronic Health Record (EHR)** Documentation is used to organize a patient's health record in chronological order, using a systematic, logical and consistent method. All of the patient's health history, exams, labs, x-rays, procedures/surgeries and more are documented within the Electronic Health Record. However, the workflow can be somewhat different in the EHR as opposed to the paper chart. The following are steps for documenting specific patient encounters (excluding billing on the Practice Management side in a fully integrated PM/EHR). A. Step One: Preregister Patients 1. Information is obtained via telephone or the Internet (via the Patient Portal). 2. Obtain basic demographics (include race/ethnicity and language for Meaningful Use (MU). 3. Contact information. 4. New or Established Patient. 5. Chief Complaint. 6. Insurance. B. Step Two: Schedule Appointment (in fully integrated PM/EHR) 1. New Patient or Established Patient appointment. 2. Select provider. 3. Select date. 4. Select time. 5. Enter name, phone number, chief complaint, length of visit (open case or encounter). C. Step Three: Establish Financial Responsibility 1. Within the (case or encounter) enter patient's primary insurance. If the patient has secondary insurance, enter that under the policy tab. Multiple insurance plans can be entered depending upon the particular system. 2. The policy information would include the policyholder, policy number, co-payment and/or deductible. 3. Assign Guarantor if required. 4. Real-time eligibility status may be obtained from	A. Lecture/Discussion B. Assigned Readings C. Have students compare and contrast the paper record vs. the electronic record by discussion or brainstorming activity

the patient's primary insurance. D. Step Four: Check-In 1. Gather additional patient information and enter into the system. 2. Review patient's registration form and enter new information. 3. Scan patient Driver License and Insurance Card. 4. Quick check on patient balance due (e.g. previous balance, co-pay or deductible). 5. Collect balance due and enter amount. 6. Scan in HIPAA forms signed by patient. 7. Scan consent forms. 8. Any additional practice forms can be scanned. 9. Review medical history and scan or key in. 10. Indicate within the PM/EHR that the patient has been checked in and is ready for back office staff. E. Step Five: Documenting the Examination 1. Clinical staff member escorts patient to the exam room. 2. Vitals are taken and entered into the Progress Note. 3. Patient's medical history, allergies and chief complaint/reason for visit are documented in the Progress Note. 4. CDS (Clinical Decision Support) is a built-in feature that alerts the clinical staff or provider of upcoming immunizations, vaccines or tests for patients. The clinical staff or provider will ask if these need to be scheduled or if they have been completed elsewhere. 5. Clinical staff indicates that the patient is ready for the provider. 6. Provider enters the SOAP (Subjective, Objective, Assessment and Plan) portion of the note. Depending on the template used for the visit, it might also have HPI (History of Present Illness), PMH (Past Medical History), Social History, ROS (Review of Systems) and PE (Physical Examination). All notes will include the Assessment and Plan. F. Step Six: Orders within the Progress Note 1. If orders need to be placed for the patient (e.g. labs, x-rays or new medications), the provider will select the Assessment/Diagnosis and link this to the treatment plan within the progress note using the CPOE (Computer Provider Order Entry) feature. 2. Each assessment/diagnosis will be linked to one plan/recommendation with individual orders when there is more than one assessment/diagnosis. 3. Prescriptions for new medications can then be	

ePrescribed (sent electronically to the patient's pharmacy). 4. Labs can also be sent electronically to any lab set up with an interface (otherwise a lab slip can still be given to the patient). 5. X-rays will eventually be sent electronically with the ambulatory setting. Hospitals currently have this capability. G. Step Seven: Referrals 1. If the patient requires a referral to a specialist, the provider can do a formal search and select the facility and provider. The provider will then send the referral electronically along with any attachments from the patient record. 2. New physicians can be added to the system. 3. Patients can still be given a paper referral, however this will not count for Meaningful Use (MU). H. Step Eight: Patient Education 1. If the patient requires patient education material, this can be selected and printed. 2. Additionally, the provider can ask the clinical staff to perform patient education and document that instructions were given to the patient. I. Step Nine: Follow-up Appointment 1. If determined that the patient needs a follow-up appointment, the provider can select that appointment during the visit or indicate to the clinical staff that this needs to happen at checkout. 2. Repeated appointments can be set up in the system if needed. J. Step Ten: Check-out 1. Patient leaves the exam room and is ready for check-out. 2. Front desk may give the patient a follow-up appointment, patient education materials and directions to the lab or x-ray facilities. 3. If the patient owes money to the practice in the form of a co-pay or balance due that was not collected at check-In, this would then be collected. 4. A Clinical Visit Summary (Meaningful Use requirement) is then printed for the patient. This generally includes: Assessment and Plan, next appointment, any orders (e.g. labs), new medications and possible referral.	
Objective 3 **Explain specific steps for the front office medical staff (Receptionist/Administrative Medical Assistant)**. A. Front office medical staff will be required to use a variety of functions within the fully integrated PM/EHR. The	A. Lecture/Discussion B. Assigned Readings

following steps reflect the majority of these tasks. Please note that many other workflow tasks are assigned to the front office medical staff, however these steps reflect the electronic portion only. 1. Step One: Preregistration. 2. Step Two: Schedule Appointment. 3. Step Three: Establish Financial Responsibility. 4. Step Four: Check-In. 5. Step Ten: Check-Out. B. Please note the break in steps as clinical staff and the provider see the patients between Check-In and Check-Out.	
Objective 4 **Explain specific steps for the Clinical Medical Assistant or Registered Nurse.** A. Once the patient has been officially checked in by the front office staff, the clinical staff will perform the following steps 1. Step Five: #1-5 Documenting the Examination. 2. Please note that the provider is responsible for documenting the Physical Examination or the Progress Note/SOAP Note which is #6. B. The clinical staff will indicate that the patient is ready for the provider and log off.	A. Lecture/Discussion B. Assigned Readings
Objective 5 **Explain specific steps for the provider (Physician or Nurse Practitioner).** A. Once the clinical staff have completed Step Five #1-5 (see above), the provider (physician or nurse practitioner) will finish documenting the physical examination or progress note 1. Step Five #6: Documenting the Examination 2. Step Six: Orders within the Progress Note 3. Step Seven: Referrals 4. Step Eight: Patient Education 5. Step Nine: Follow-up Appointment B. Please note that there may be some crossover between staff member workflow and duties in Steps 7-9	A. Lecture/Discussion B. Assigned Readings
Objective 6 **Describe shared Protected Health Information (PHI) and Health Information Exchange (HIE)** A. PHI is defined as “individually identifiable health information that is transmitted or maintained by electronic media (such as over the Internet) or that is transmitted or maintained in other form or medium.” Covered entities must follow HIPAA regulations 1. Notice of Privacy Practices (NPP) a. All practices are required to give this notice to each new patient. b. Patients are not required to read the	A. Lecture/Discussion B. Assigned Readings

document in your presence. 2. Acknowledgment of Receipt of Notice of Privacy Practices a. All patients who receive the NPP will sign an acknowledgment of receipt. b. This document will explain how and when the practice will use their PHI. B. Providers who wish to share or exchange information with other providers, hospitals or statewide agencies are required to send that data through local, state and regional health information networks. Collectively, these networks allow providers to do this in a secure manner. C. Health Information Exchange (HIE) enables the sharing of health-related information among provider organizations according to nationally recognized standards 1. HIE includes sharing patient records with: a. Outside physicians (other than within the practice). b. Hospitals. c. Pharmacies. d. Labs. e. X-ray/radiology facilities. f. Local and state agencies. 2. The goal of HIE is to facilitate access to clinical information for the purpose of providing quality care to patients. 3. The HITECH Act provides funding to increase connectivity and information sharing within and between states, including the development of health information exchanges (HIEs). D. Encryption is the process of converting data into an unreadable format before it is distributed. In order to read the message, the recipient must have a key that deciphers the information 1. New patients will provide their email to the provider office allowing them to receive this key. 2. Their PHI can then be sent to the practice's Patient Portal where the patient can log on using this key to decipher the information.	