Component II: Administrative

Module B: Medical Office Records

Topic 1: Health Information Management

Statement of Purpose
To prepare the learner with basic knowledge and skills necessary to create, organize and maintain paper and electronic health records.

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

1. Spell and define key terms.
2. Identify supplies and equipment needed to create, maintain and file paper medical records.
3. List the information and documents contained in a medical record.
4. Describe the organization of information and documents in a medical record.
5. Create a medical record and prepare all information and documents with proper documentation.
6. Understand correct documentation technique. Compare the pros and cons of paper records versus the Electronic Health Record.
7. Describe the legal implication of medical records.

Terminology

1. Active patient file
2. Advanced Directive
3. Alphabetic filing
4. Audit clinical charting format
5. Chief complaint
6. Closed patient file
7. Clinical charting format
8. Confidentiality
9. Correcting errors
10. Cross-reference
11. Durable Power of Attorney
12. Medical documentation
13. Electronic Health Record (EHR)
14. Electronic signature
15. Filing system
16. Focus, Data, Action, Results (F-DAR) clinical charting
17. Health Insurance Portability and Accountability Act (HIPAA)
18. Compliance
19. Inactive patient file
20. Indexing
21. Living will
22. Medical record
23. Narrative chart note
24. Numeric filing
25. The Patient Protection and Affordable Care Act
26. Problem Implementation Evaluation (PIE) clinical charting
27. Problem Orientated Medical Record (POMR)
28. Progress notes
29. Purge
30. Shingling
31. Subjective, Objective, Assessment, Plan, Evaluation (SOAPE) charting
32. Source Orientated Medical Record (SOMR)
33. Statute of limitations
34. Straight digit filing
35. Subject filing
36. Terminal digit filing

References

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5. Proctor, D. B., & Young-Adams, A. P. (2011). *Kinn's The Medical Assistant: An Applied Learning Approach* (11th Ed.). Philadelphia, PA: Saunders Elsevier.

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. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman and concentration. B. Administer vocabulary pre-test and post-test. C. Discuss learning gaps and plan for applying vocabulary.
Objective 2 **Identify supplies and equipment needed to create, maintain and file paper medical records.** A. Equipment 1. Selection and use of different filing cabinets a. Shelf files or stationary files. b. Drawer, vertical files, or file cabinet with drawers that pull toward you. c. Rotary circular files are manually or electronically powered to rotate or move files in position to be accessed, maximizes use of space. d. Lateral files have stationary shelves and door cover that slides up and back into cabinet. e. Lateral drawer (horizontal) file cabinet has movable shelves that roll out sideways, records filed from right to left. f. Automated files are used in large facilities because of their cost and space requirements. g. Card files. h. Tickler (follow-up) files. B. Medical records supplies 1. File folders. 2. Internal fasteners and holders. 3. Dividers/ guides. 4. Labels identify contents of the file a. Name labels. b. Alphabetical labels. c. Numeric labels. d. Special color coded systems. e. Year (aging) labels.	A. Lecture/Discussion B. Assigned Reading C. Show samples of a complete medical record with labeling, forms, and all patient information. D. Students assemble and prepare a medical record file for a fictitious patient.
Objective 3 **List the information and documents contained in a medical record.** A. Medical record documentation 1. Patient information form.	A. Lecture/Discussion B. Assigned Reading

2. Release of medical records. 3. Health insurance information. 4. Copy of picture ID. 5. History of present illness. 6. Past history. 7. Review of systems (symptoms). 8. Chief complaint. 9. Progress notes. 10. Treatments. 11. Laboratory reports. 12. Radiology reports. 13. Consultation reports. 14. Medication administration lists. 15. Diagnosis or medical impressions. 16. Documentation of advance directives a. Advance Directive/Living Will/Durable Power of Attorney. 17. All correspondence pertaining to the patient and the treatment plan. 18. Prescriptions. 19. Special forms for automobile insurance, workman's compensation, crime victim documentation. 20. Patient education. 21. Referrals. B. Medical records are classified into three areas 1. Active records are kept for patients who have been seen within the past 1-3 years, or as designated by office policies 2. Inactive records are for patients who have not been seen in more than 5 years or as designated by the office policies 3. Closed records are for those patients who have terminated their relationship with the physician or medical plan	C. Review sample forms and documents.
Objective 4 **Describe the organization of information and documents in a medical record.** A. Source Oriented Medical Records (SOMR) 1. Similar sources of information or categories are grouped together. 2. Documents are placed categorically in chronological order. 3. Groupings normally consist of six basic areas, but may vary with specialty a. Progress notes. b. Physician orders. c. Laboratory results. d. Radiology and related specialty reports. e. Billing and insurance information. f. Consultations and other hospital reports	A. Lecture/Discussion B. Assigned Reading C. Show proper charting entry using the SOAPE method. 1. Write each entry legibly in black ink. 2. Record date and time of each entry. (military time is preferred) 3. Check the spelling of any unfamiliar terms and do not use diagnostic terms unless dictated by physician

and important information. B. Problem Oriented Medical Records (POMR) 1. Have a problem listed and assigned a number. 2. The problems are followed in the same orderly manner. 3. This type of record is divided into four main areas a. Chief complaint. b. Present illness. c. Patient profile or history. d. Review of systems. C. Physician examinations. D. Laboratory reports. E. Problem list, including each patient problem requiring evaluation and response. F. Treatment plan, including the workup, management and therapy related to each problem. G. Progress notes, which are written statements corresponding to each patient problem. These are commonly written in one of four forms 1. Narrative, a paragraph describing the problem, treatment, and outcomes 2. SOAPE is a more structured way of denoting patient information a. Subjective, patient's complaint b. Objective, medical team and physician's observations c. Assessment, physician's impression of the problem d. Plan, a list of the physician's plan of intervention and treatment e. Evaluation, assessment of the patient's ability to understand and comply with treatment 3. Problem Implementation Evaluation (PIE) charting is another systematic approach a. Problem, a brief statement of the patient's complaint b. Implementation, lists the interventions c. Evaluation. a statement that reflects how the patient is progressing 4. Focus-Data, Action, Results (F-DAR) a. Column one provides the date and time. b. Column two states the problem in 3-4 words. c. Column three gives the patient notes with data, action, and result divisions. 5. Two newer versions of charting include a. Charting by exception, only abnormal events are charted in narrative form. Normal results are checked off on a flow	4. Use abbreviations preferred by your facility or physician. 5. Chart a patient's statement in quotation marks. D. Discuss the advantages and disadvantages of each medical record organization.

sheet. b. Computerized charting, the formatting may vary with each facility but usually follows one of the above mentioned methods with computer or PDA prompts or questions.	
Objective 5 **Create a medical record and prepare all information and documents with proper documentation.** A. Criteria for creating a medical record 1. Place patient name, medical number, and date of birth at the top of every document included in the medical record. 2. Place personal information and documents on left side of chart. 3. Place medical information and documents on right side of chart. 4. Place most recent document on top. B. Criteria for maintaining a medical records chart 1. Document every detail from missed appointments to telephone calls and information exchanged. 2. Do not document for another medical team member and do not have them document for you. 3. Confirm all personal information and health insurance information at each visit. C. All entries must be accurate, legible and complete to allow the physician to show what has taken place during the patient's treatment. D. All entries must have a date, time and a signature. E. Verify that all information on encounter form is consistent with physician notes on present illness. F. Show the proper method of correcting a charting error 1. Do not erase, white out, or change documentation to correct a mistake. 2. Draw a line through the incorrect entry and write what was the error, the date, your initials and document the correct information as closely as possible to the original erroneous entry. 3. Have error verified by physician or office manager.	A. Lecture/Discussion B. Assigned Reading C. Have students add documents and information to their chart. D. Present students with hypothetical situations for charting. E. Exchange charts with classmate and audit chart for accuracy and completeness and HIPAA compliance. F. Have students practice entering narrative chart entries using accepted chart abbreviations.
Objective 7 **Compare the pros and cons of paper records versus the Electronic Health Record.** A. Safety Against Loss 1. Paper records and files can easily be lost or destroyed, such as in a fire or flood. 2. An electronic database safely keeps medical records backed up. B. Less Errors	A. Lecture/Discussion B. Assigned Reading C. Open a sample electronic health record from the Internet and have students compare their paper medical record with the

1. Handwritten records are subject to human errors due to misspelling, illegibility and different use of terminology. 2. Electronic medical records eliminate handwriting and offer spell check. C. Accuracy and consistency 1. Use of key phrases and templates allow for accuracy and consistency. D. Efficiency 1. Electronic medical records are cost efficient. 2. They eliminate many expenses associated with printing, paper and other office supplies. E. Security 1. Patients may feel that their records are secure. 2. Some patients may feel that their electronic medical records could become be compromised. F. Loss of Computer 1. Medical records will be backed up, but technical glitches or loss of power could occur during a doctor's appointment. 2. This could prevent the doctor from seeing the electronic patient record.	tabs and information folders in the electronic health record.
Objective 8 **Describe the types of filing systems.** A. Alphabetical 1. System using letters of patient names to orderly file a. Use indexing rules for alphabetic filing. b. Color coding can also be instituted. B. Numerical 1. Straight number filing, read from left to right a. This type needs to be cross-referenced for complete and unique identification. b. The cross-reference for type is used for confidential reports that must be in a secure area. 2. Terminal digit filing, read last two digits	A. Lecture/Discussion B. Assigned Reading C. Demonstrate use of the alphabetic and numeric filing system, using the indexing rules. D. Students will place a list of alphabetic, straight digit, and terminal digit files in correct order.
C. Documentation of consent. D. Statute of limitations is the period of time after which a law suit cannot be filed. E. Ownership of the medical record, physician or medical facility owns the record; the patient has the right to access the information within the chart. F. Making corrections to the medical record. G. Retention and destruction 1. When no other rules apply the best course is to keep the records for ten years. 2. For minors record should be kept until the minor has reached the age of majority plus three years.	A. Lecture/Discussion B. Assigned Reading C. Review the most current laws and recommendations. D. Discuss possible malpractice and HIPAA compliance violation scenarios caused by improper documentation.

H. Audit for correct documentation and organization. I. The Patient Protection and Affordable Care Act includes a mandate for standardized electronic patient records, set to take effect in 2014. J. Electronic health records require identification and authentication for access.	