**Module 2:**

**Electronic Health Record Function and Use**

**Acknowledgements**

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**Being an effective presenter:**

Knowing how to lecture well is a crucial skill to master. Effective lecturing is characterized by enthusiasm and expressiveness, clarity, and interaction (Murray in Perry & Smart, 1997). Consider using the tips below to introduce students to the subject and stimulate their enthusiasm about the course material.

* **Be Prepared**
  + Outline clear objectives for your lecture—both what students should know after the lecture and why it is important.
  + Develop a lecture outline and any audiovisuals.
  + If you are nervous about the lecture, write out your introduction and rehearse it.
* **Keep Your Focus**
  + Create effective visuals, analogies, demonstrations, and examples to reinforce the main points.
  + Share your outline with students.
  + Emphasize your objectives and key points in the beginning, as you get to them, and as a summary at the end.
* **Engage Your Audience**
  + Focus attention early on using a quote, a dramatic visual, an anecdote, or other material relevant to the topic.
  + Integrate visuals, multimedia, discussion, active learning strategies, small-group techniques, and peer instruction.
  + Link new material to students’ prior knowledge, such as common experiences or previous coursework.
  + Show enthusiasm for the topic and information. Remember, you are modeling your discipline.
  + Give students time to think and genuine opportunities to respond.
  + Plan for diverse learners. Use verbal, visual, and kinesthetic approaches such as hands-on exercises and simulations.
* **Get Feedback**
  + Observe students’ non-verbal communication: notetaking, response to questions, eye contact, seating patterns, and response to humor. Are they “with” you?

**Module 2: Electronic Health Record Function and Use**

**Introduction** (Slide #2)

In 2004 the federal government issued an Executive Order which stated that all medical facilities be “live” on an Electronic Health Record by January 2015. To date many facilities have complied, those that have not are being penalized on their reimbursement from Medicare.

This module will assist the student in understanding why it is important to have all medical facilities on an Electronic Health Record, what the core functions of a fully operative Electronic Health Record are, and how access is controlled and monitored. Students will also learn how information is captured in an Electronic Health Record, and how internal departments within our facility and those organizations outside of our facility use our patient information.

*Ask students if they think an electronic health record can assist with these concerns*

*Discuss whether your students have done any research on line about diseases and conditions, what resources are they using.*

*Ask students if they or someone they know keeps copies of their health care information*

**Module 2: Electronic Health Record Function and Use**

**Learning Outcomes** (Slide #3)

Upon completion of this course the learner will be able to:

* Describe the benefits of using an EHR to document patient care
* List and explain the functions of an EHR
* Describe how we use patient information in our facility and how we share it outside of our facility
* Explain how patient information is captured in an EHR
* Describe the relationship between an EHR and a PMS system
* Explain how user access is created and maintained and the function of audit trails
* Understand how the organization operates if the EHR is down

**Module 2: Electronic Health Record Function and Use**

**Syllabus**

**EHRs in your facility**

* + Why did the government make this a priority?
  + Hurdles to EHR implementation
  + Data Integrity
  + Paper vs EHR

**Core Functions**

* + Health Information & Data
  + Order Entry Management
  + Results Management
  + Decision Support
  + Communication & Connectivity
  + Administrative Processes
  + Patient Support
  + Reporting & Population Management

**Patient Portals**

* Access for patients to their health record

**Communication using EHRs**

* Patient Communication
* Communication with other departments at the facility
* Communication with outside organizations

**Capturing Information**

* + Point of Service data entry
  + Remote data entry

**Personal Health Records (PHR)**

* + General types of PHRs

**EHR/PMS Interface**

* + Information that flows from the PMS to the EHR
  + Information that flows from the EHR to the PMS

**Access and Auditing**

* + Determining extent of access in the EHR based on role
  + Mechanisms that audit activity in the EHR by users
  + Consequences for unauthorized access by employees
  + Strategies used to manage unauthorized remote access by non-employees

**Downtime**

* + What happens when the EHR system is down in regards to patient care, access and entering information once the EHR is operational

**Module 2: Electronic Health Record Function and Use**

**Instructor Teaching Points**

**Your Experiences with an EHR** (Slide #4)

*Have students discuss their experience with each system, EHR vs paper, as a patient.*

*Ask students if they think using an EHR will (or will not) improve patient care.*

*Have students discuss if they know why providers have resisted getting EHRs*

*Ask students if they care if their doctor uses an EHR and have them explain why or why not.*

*Ask students if they think technology takes away from that “personal touch” in healthcare*

**Why have an EHR?** (Slide #5)

* In 2004 President Bush announced he wanted all healthcare organizations to have fully operational EHRs by 2015.
* The Federal provided money to hospitals and doctors’ offices that bought a certified EHR. The federal government also set the standards for EHRs. They also penalized providers that did not implement an EHR system in their facility.
* The government's primary goal was to improve patient care, reduce medical errors that killed thousands of Americans every year and reduce healthcare costs by providing information for clinical decisions. They hoped by improving the continuity of care it would mean improving the information that followed the patient to new providers. To do that, EHRs had to be interoperable. That means one EHR can transfer a patient’s medical information to another EHR.

*Ask students if they feel that having patient information readily available to all of the patient’s providers can enhance patient care. Are you as a patient more confident in your provider’s ability to care with you if they have access to all your of your health care information*

* Hurdles to EHR adoption include lack of standards, system costs, lack of time to evaluate and implement systems, absence of interoperable systems, security and privacy issues, and lack of confidence by practitioners and consumers.
* EHRs should improve quality and reduce costs by reducing errors. They can also automatically report information to Public Health to reduce things like the transmission of TB.

**Data Integrity** (Slide #6)

*Ask the class: Why is accurate documentation in the EHR so important?*

*Answer: Documentation is part of the legal health record. It is used in litigation cases. It also provides the necessary information so providers can get paid properly.*

* Data Integrity is a term used to refer to the accuracy, completeness and reliability of clinical documentation, if the medical record is not correct providers will make mistakes.

**How can an EHR facilitate having data that has integrity?** (Slide #7)

* *Data Accuracy* – data is accurate for the field it is being captured in, i.e. the temperature being recorded for a patient is a true temperature value- 102.0 vs. 120.0
* *Data Timeliness* – refers to the recording of data with the appropriate time, preferably concurrent, at point of care, i.e. staff is taking a patient’s pulse at their bedside and recording it immediately
* *Data Consistency* – data is the same wherever it appears and by anyone who records it, i.e. all CNAs record activities of daily living the same way
* *Data Completeness* – refers to the collection/recording of data in its entirety, i.e. recording a vital sign without your signature, date and time
* Software can assist and prompt users to enter very specific types of information in templates. For example, a BP field would only allow numbers to be entered, within a specific range 94.0 – 105.9, and a particular format. This helps ensure that the data being entered is accurate.

*Pose these questions to the class*:

*Question:*

*Jennifer is nervous about the transition from paper-based records to EHRs because she is not used to a computer. What can the office manager do to ensure Jennifer will remain productive in her job after EHR implementation?*

*Answer:*

*Jennifer will require training, both for the EHR and basic computer skills. If the office manager provides early and repetitive training, Jennifer will likely feel more comfortable and confident using the software and performing her new job duties. Jennifer should feel supported by her manager and be offered some one on one training with her.*

*Question:*

*Why is the transition from paper-based records to EHRs taking so long for some medical offices?*

*Answer:*

*Many concerns arise when a doctor’s office makes the change to EHRs. Price, training, and resistances are a few. But the biggest hurdle is lack of information. Office managers must educate themselves about different EHR software packages and basic functions of EHRs.*

**Paper vs. Electronic Health Records** (Slide #8)

*Ask students if their doctor still uses paper records and if they feel that paper records have an impact on their overall health care.*

* Paper Records
  + *Access* – only one person can have access to a paper medical record at one time, what happens if record is misplaced or lost somewhere?
  + *Legibility* – A classic complaint about doctors is that their handwriting is terrible. Many medication and other errors are the result of illegible and misinterpreted doctor notes.
  + *Ability to Abstract Data* – it is nearly impossible to abstract information from paper records. Example – the FDA is taking a medication off the market, think about how difficult it would be to find all your patients that are that are actively on that medication you would potentially have to go through thousands of charts to identify those patients that you need to contact.
  + *Communication* – very difficult to coordinate care, waiting for results, ordering tests – all require staff and doctors to complete multiple forms and paperwork results come back to the provider slowly
  + *Documentation Standards* – paper documentation can be inconsistent among providers and staff, not using the same language or terminology, leads to incomplete documentation.
* Now let’s think about these items in an EHR…………
  + *Access* – multiple people can have access to the record simultaneously and remotely
  + *Legibility* – all documents and records are in text form, no more trying to interpret what the doctor is documenting
  + *Communication* – tests results are automatically uploaded and tasked to the ordering physician for review, prescriptions are e-prescribed directly to the pharmacy, CNAs and HHs can see the orders physicians have entered for their patients and record their interaction with the patient which goes right into the patient’s chart
  + *Documentation Standards* – template prompt users to enter complete and accurate information about patients, leading to more detailed and better documented record

**What can an EHR do? Core Functions of an EHR** (Slide #9)

* *Health Information and Data* – complete patient data must be present, the EHR must contain pertinent patient data so that the provider of care has all the information easily accessible for sound clinical decisions
* *Order Entry Management* – Entry of orders and prescriptions. Computerized orders for labs and tests improve work processes; eliminates lost orders, unclear instructions, handwriting discrepancies, duplication of orders, no more paper forms
* *Results Management* – Management and ordering of lab test and radiology test results. Computerized results can be accessed more easily, any time any place, reduced lag time between when the test was performed and when the results get back to the ordering physician, speedier feedback to patient regarding results and updates to treatment plan based on these results.
* *Decision Support* – Drug prescribing and dosage, disease screening, diagnosis and treatment and care quality improvements. Information can be accessed through the EHR for prescription details, drug to drug interactions, drug to allergy interactions, dosing information, diagnoses, management of diseases and symptoms, disease outbreak and adverse reactions or events. This function is vital to patient safety in regards to executing their treatment plan and is supported by evidence based data that has been found successful for other patients with similar conditions or circumstances.
* *Electronic Communication & Connectivity* – Accessing information between specialists, PCPs, radiology, laboratories and pharmacies. Interoperability between these offices, hospitals, labs systems. Connectivity is the ability to maintain a connection between two or more points in a telecommunications system. This also facilitates “transition of care” from one facility to another, i.e. patient being discharged from the hospital to a Nursing home or needs home health care per discharge instructions.
* *Administrative Processes* - Scheduling, billing, claims, authorizations and referrals. Provides clearer information about insurance eligibility, referral, and authorization management and clinical documentation would support code selection when billing for services.
* *Patient Support* – Home monitoring, patient education, telehealth. Improves the care quality and reduces medical costs by allowing patients to home or self monitor for specific findings which are upload to the physician. Also provides educational materials through their patient portal, EHR, and printed materials and instructions.
* *Reporting & Population Management* – Automating reporting to government agencies. Reporting of certain conditions, i.e. gunshot wounds, child/elder abuse, HIV, births, deaths, are mandated by local, state and federal government and can be easily done through an electronic transmission of this information vs. filling out paperwork.

**Patient Portals** (Slide #10)

*Discuss patient portals, ask the class if any of their physicians offer a patient portal and if so, do they see it as a benefit? How have they used their Patient Portal?*

* *Patient Portal*: secure Internet connection to a practice for communication and patient access to practice databases
* Interactions include: e-mailing questions, completing paperwork, requesting prescriptions or refills, obtaining test results, accessing a treatment record, disputing information in the record, transferring information from a PHR to the practice record (or vice versa), requesting that information from a record be sent to another provider outside the practice, updating demographic or financial or other information, reporting medical home test or medical monitor results, scheduling or changing appointments, checking billing statements, completing surveys and questionnaires, accessing patient education information, comparing health status to national norms

**Policies about Patient Communication** (Slide #11)

*Discuss your company’s procedures & policies about communications between patients and the office. What systems do you use or have seen, are there any privacy concerns with these communication systems? Tablets, cell phones, paper forms, etc.*

* User rights and access – access to a patient’s EHR is based on your role/job. You be given as much access as you need to efficiently perform your job and no more.

*Discuss your company’s procedures about documenting messages regarding patient’s clinical care, follow up on messages, etc. What do the students think is an appropriate turnaround time for communication with the office?*

*Ask the class if documentation needs to be professional and complete about a patient. Is “text talk” appropriate?*

* Any documentation that is clinical in nature will become part of the medical record, if the record was summoned to court would it be a strong defense for your physician or facility, or not. This may include emails, texts, written or oral correspondence.

*In small groups, ask students to discuss social media. Can information about the organization they work for be posted on social media, why or why not? How about patient information, whether the patient is identified or not, is it appropriate to post this on social media? Should organizations have policies about social media use both on the job and about the organization, what are your policies?*

*Use examples to stress the importance of remaining professional even on their social media pages.*

**EHR Supporting Other Departments** (Slide #12)

* An EHR not only stores the patient’s protected health information but also supports many other functions of your organization.
* *Financial* – EHR documentation supports every procedure and disease code we use to facilitate reimbursement for your organization. “If it isn’t documented, it didn’t happen.” Services that are not properly documented and have a medically necessary diagnosis code to support the service happening will not be reimbursed by the insurance company. Also, proper use of the EHR may be linked to the purchasing of supplies and maintaining inventories for your company. For example, it is documented that a patient was given a pair of crutches at their visit, this would take the crutches out of inventory and alert the medical supply purchasing department that the inventory for that item has gone down and an order may need to be placed.
* *Clinical* – EHR documentation links to or may trigger an event to occur at other clinical areas within an organizational. For example, a patient may be in the ED and will be admitted to the hospital, this information could be sent directly to the Admissions, Nursing, Housekeeping, Dietary, etc. departments to put them on alert that a patient is being admitted.
* *Support* – EHR documentation supports the HIM department functions which deal with coding, abstracting, analyzing medical records, and release of information. Proper case management and discharge procedures are supported using this documentation.

**How and why do we share information with outside facilities?** (Slide #13)

*Have students discuss whether sharing health information between care providers and facilities is a positive or negative practice*

* *Interoperable* - The ability of systems to communicate and exchange information with one another. Have students discuss whether sharing health information between care providers and facilitates is a positive or negative practice.

*Relay an example of the consequences of systems that lack interoperability. Example: Patient is scheduled for knee replacement surgery. The nurse anesthetist takes the patient’s history for anesthesia clearance. All of the patient’s responses are entered into the anesthesia database. The patient then has to meet with an intake nurse for his nursing history. Because the anesthesia group uses one computer system, and the hospital uses another, all of the questions have to be repeated and the data captured a second time.*

* HIV status and substance abuse, if not directly related to the patient’s care must be protected and only disclosed with the patient’s permission.

*Give students examples or have them brainstorm examples of when minimum necessary should be imposed. Example: A female patient was an inpatient seven years ago due to appendicitis. She was admitted recently as a result of a car accident. The insurance company requests any and all records related to the accident. In that case the appendicitis does not need to be released.*

* *Research* plays an important role in the United States, accounting for many of the medical advances that have become commonplace today. If a facility or its patients are involved in research studies, the EHR must provide the capability to gather information needed and to report treatment outcomes as noted in the research protocol. Office staff functions may also require adjustments for research participant patients, so it is important for all in the health care practice to be introduced to the research process. For example, the CDC has been working to reduce influenza and pneumonia outbreaks by requiring providers to vaccinate everyone. The CDC also is collecting data from providers related to urinary tract infections caused by Foley catheters that are left in for more than a couple of days. An EHR facilitates collecting this information and providing a method to share this with the CDC very easily.
* *Registries* are often sponsored by government agencies to gather specific pieces of health care data on designated populations, helping to identify geographic areas where diseases are found, effective treatments, life span of those with the disease, conditions under which the disease occurs, and so forth; reporting to specific registries may be required by law in some states
* *Reportable Events*—state laws may require reporting of illegal or suspected events such as child or elder abuse or injury caused by violent means, certain contagious diseases, and sexually transmitted diseases; data is required to ensure follow-up treatment, for notification of exposure to other individuals, and to investigate illegal activities
* *Continuity of Care*—health care providers need to have accurate information about the patient’s current diagnoses, medications, health status, and important test results in order to provide quality care; sharing also eliminates duplicate testing and decreases errors; patients in emergency situations are not able to communicate information that may be vital for survival; current patient information is important when patients are referred to a specialist or other provider for care

*Ask students what other facilities your organization shares patient information with and what other facilities share information with you? Have them consider continuity of care.*

**How is information captured in an EHR?** (Slide #14)

* Ensure that the patient presenting for care is who they say they are, need to identify potential medical identity fraud.
* Ensure that you have selected the correct patient’s record. Many patients have the same name and maybe the same DOB. Use several pieces of the patient’s demographic information to be sure you have the correct record open, name, DOB, phone number, address are examples
* Having the proper training and technology is key to efficiently entering information into an EHR. Templates are created to assist users to enter the correct information into the fields accurately, completely, etc. to ensure the data has integrity and is useful to others that will use it.
* Error correction of documentation—can use delete or modify functions bringing up an “in error” or “modified” notation; audit trail available to permanently keep track of what was changed

*Ask the students: “Why is it important that the employee, who made the documentation error, make the correction?”*

* Remote data capture – much of the information that is entered into the patient’s electronic health record is done remotely, the patient is not always in the facility.

*Ask students about what devices they think would capture data remotely, Smart phones, PDAs, tablets, patient recording devices. Do the students think there are advantages to remote data collection, if so why?*

*Ask the students if they believe there are any disadvantages of remote data capture, security of transmission, security of device*

**Personal Health Record (PHR)** (Slide #15)

* A PHR is a tool that allows the patient or patient’s caregiver to plan and manage his or her own health care. The patient gathers their demographic, insurance and health data and enters it into a formatted record. The result is a record that the patient possesses, and contains a complete overview of the patient’s history and current care.
* Allows the patient to track and update health information from multiple doctors and facilities, coordinate care among providers and healthcare facilities not connected to one another; avoid duplication of tests and procedures, monitor prescriptions, allergies, and wellness.
* A PHR empowers the patient to have control and access to their information and control who has access to their PHR. PHRs should give patients ownership of their information and can be easily accessible secure, private and confidential.

*Ask students if they think patient’s like access to their health care information? How does that impact your job in recording information accurately?*

**General Types of PHR** (Slide #16)

* *Paper Based* – Keeping a paper record of health care encounters
  + Advantages – low cost method of record keeping, no worries about cyber security
  + Disadvantages – no remote access, may forget to bring PHR to appointments, no logical format to assemble, organize and update, difficult for patient to ensure secure access to the PHR
* *Computer Based* – or software based allows the patient to download or install software designed to facilitate keeping their healthcare information in a logical format. It is not designed to interact with other systems, the patient enters the information themselves, or scans in documents and images. When visiting a facility, the patient can print a copy of their PHR or save it to a portable device, i.e. flash drive, CD
  + Advantages – much more portability than paper based, often password protected, not connected to the Internet, back up of data helps to prevent loss of information
  + Disadvantages – the data is only as good as the accuracy used in entering it, typing errors by the patient can result in an inaccurate record, no Internet connectivity, if you forget to print copies or bring your flash drive, facilities may not allow an outside device (flash drive) to be inserted into their system in fear of viruses and other malware that may be on that device.
* *Web Based* – can be attached to a specific health information system (tethered), or not attached to a specific health information system (untethered)
  + Examples of *tethered* – patient’s insurance company, employer, healthcare facility. Access is gained through that organization’s patient portal
  + Examples of *untethered* – software that is available to the patient that resides in the “cloud” or on the web site host’s server. The software is not installed on the patient’s computer. Access is granted through usernames and passwords created by the patient for themselves or others that they wish to grant access to their PHR
  + Advantages – remote access with an Internet connection
  + Disadvantage – worries about breaches or hacking into the web site’s servers

**EHR/PMS Interface: How does it work?** (Slide #17)

* When these 2 systems are integrated it facilities workflow between the 2 systems. The patient is only set up once in the PMS system which automatically creates a chart in the EHR system. Information from PMS that is needed in the EHR will populate the appropriate fields in the EHR, such as patient name, age, DOB, insurance, etc. Information from the EHR goes back to the PMS to facilitate other needs for the patient, billing, follow up appointments, fulfilling treatment plans from the provider.
* It is all about streamlining workflow, cutting down on paperwork and trying to make sure nothing falls through cracks for our patients.
* The workflow for billing and coding begins at the time the appointment is made and continues until payment is received. As the provider is documenting their care and findings of the patient, behind the scenes the charges for those services are beginning to calculate and diagnosis codes reported by the physician at the end of the encounter are linked and automatically sent to the coding and billing office for review and submission to the insurance company.
* Particularly important in reimbursement for home health care and nursing home facilities is that much of the documentation by HH and CNAs can directly affect the reimbursement allowed for that patient’s care.
* As you can see, interoperability between the billing system and the medical record is vital to financial well being of the organization. As far as the insurance company is concerned, “if it isn’t documented, it didn’t happen”, and if audited by the insurance company and the medical record does not support what was reimbursed, they will take money back. If it is determined that this is a wide spread problem at this organization, the organization may lose their ability to participate with that insurance company, may have penalties or criminal charges including imprisonment if fraud and/or abuse to determined.

**How is access determined for users?** (Slide #18)

* The facility determines who has access to their systems and the level of access for each employee. Many times access is created based on your role at the organization. Providers have access to the entire patient record but may not have access to billing and coding; CNAs and HHs may only have access to selected templates that they use in their job and no more. Organizations must be diligent about only giving access to employees to their job, everyone should not have access to the entire system. Access is granted on a “need to know” basis.

*In small groups, ask students to consider some ethical questions about access. Some examples could be:*

*One employee leaves her desk but remains logged in, another employee sits down at that workstation and begins to enter information or access a patient’s record – does the second employee have the right to do this, should there be some disciplinary action taken on one or the other, or both employees, what would be that discipline, termination, verbal/written warning, retraining….*

*Discussion*

*Should employers have access to your work e-mail account, why or why not?*

*What if a famous person or local elected official was a patient at your facility, should access be restricted? If an employee accesses this kind of record and is not part of that patient’s care, they are just “curious” should there be any disciplinary actions taken with that employee?*

*If students were the system administrator, what strategies would they use in making up passwords? Have students make up the requirements of a password (small or caps, numbers, symbols, length), how often the password should be changed, reusing an old password? Have them pass them around to other students and give their opinions of whether the password they created is “secure” enough.*

*User rights are based on your role at the organization. Have students discuss how rights and access may differ between employees (providers, nurses, medical records, scheduling, discharge planners, case managers, administrators, CNAs, HHs, etc) Have them give examples of these rights for each role.*

*In small groups, ask students to discuss social media.*

*Can information about the organization they work for be posted on social media, why or why not? How about patient information, whether the patient is identified or not, is it appropriate to post this on social media? Should organizations have policies about social media use both on the job and about the organization, what are your policies? Use examples to stress the importance of remaining professional even on their social media pages.*

**HIPAA Compliance: Auditing** (Slide #19)

*Ask why HIPAA requires the ability to audit who accessed a record and see what they did, shouldn’t your employer “trust” you?*

*Should there be policies about access and consequences of unauthorized access, if so ask students what the consequences should be for misuse of user names and passwords, termination, written warning, etc.*

**HIPAA Compliance: Keeping the System Secure** (Slide #20)

*Ask students to think about recent data breaches that may have heard about on the news. Can there ever be too much protection of patient information? Why or why not.*

* Securing the system is an on-going job, there will always be individuals that are trying to hack into a system whether or not they mean to do harm if they are successful. It is everyone in the organization that must be diligent to ensure that PHI about our patient remains safe, secure and confidential.
* There are laws that govern the protection of patient information that facilities and their employees must comply with otherwise they are essentially breaking the law!
* *Firewalls* are software installed on the organization’s servers to prevent unauthorized access; this software must be constantly monitored and updated.
* Policies
* *Lock down* – A device should automatically log off a user after a certain amount of idle time
* *Passwords* – Should be complex enough so another employee could not figure it out, they should not be written down where others can see them
* *Back Ups* – Now that much of the patient’s PHI is being managed electronically it is important that back-ups are done at least every day and verified that they are complete backups of all servers. Keep back-ups off site in case the facility has a disaster. (talk about Hurricane Katrina or another natural disaster that may have caused patient records to be destroyed)
* *Encryption* – All information that is being transmitted electronically must be encrypted so that anyone intercepting the information can’t read the information.
* *Portable Devices* – The tools we use to capture information are becoming more portable which adds another layer of security. Ask students to think about having a company tablet that they use on or off site and what their role is in keeping that device secure. (Examples: Not leaving it in their car, letting their kids use it, using it for private use, dropping it, etc.)
* *Disposing of Equipment* – Care has to be taken to ensure that when old computers, laptops etc are being disposed of, that the hard drives are wiped clean as there may be residual information left on that device that someone can access.

**Downtime**(Slide #21)

*Discuss with the class how the facility can remain operational (treating of patients) even though there is no access to the EHR; use paper forms, dictate, etc*

*Once the EHR is operational, how do we input information that was captured during this downtime??*

**Module 2 Summary: Electronic Health Record Function and Use**

Key concepts from this presentation:

* Understand the importance of accurate documentation in an Electronic Health Record and how the information you enter affects the overall care for patients as well as the needs of the organization.
* Have an overall understanding of the many functions of an Electronic Health Record and their use in managing patient care.
* Appreciate the value of sharing patient information back and forth between other providers of care for your patients.
* Comprehend how clinical document affects reimbursement.
* Realize that you are responsible for the data you enter into an Electronic Health Records and the organizations’ responsibility to ensure that the data has integrity though auditing users access and activity.

**Module 2: Electronic Health Record Function and Use**

**Exam with Answer Key**

**Module 2 – Quiz**

1. Which of the following have been hurdles to EHR adoption?

1. Costs
2. Systems not fully interoperable
3. Security & privacy issues
4. All of the above

*D – All of these have been seen as obstacles to EHR implementation*

2. Why is data integrity so important?

1. To ensure standardization of systems
2. To allow for sharing of patient information to other providers for continuity of care
3. To demonstrate how smart providers are
4. To reprimand staff that enter information incorrectly into the EHR

*B – The ability for all providers of care both internally and externally is vital to patients receiving the appropriate care by the right provider at the right time.*

3. Paper records have been used for a long time, what’s wrong with continuing to use them?

1. Paper records are handwritten
2. Paper records always in the office
3. Paper records cannot be easily shared with outside facilities
4. Paper records are easy to report from

*C – Paper records cannot be accessible readily outside the organization.*

4. Patient portals are used by patients to:

1. Request appointments
2. Request prescription refills
3. Access to lab and immunization records
4. All of the above

*D – Patient portals provide patients access to their health care record at their convenience. Patients are able to request appointments and prescription refills, and obtain copy of important records and results.*

5. What other department in a facility can use patient information from an EHR?

1. Billing & coding department
2. Case Management department
3. Nutrition department
4. All of these departments use information from an EHR

*D - These departments are a few of the many departments that need patient information in order to function effectively and efficiently.*

6. What outside facilities do we share patient information with?

1. Doctors offices
2. Long term care facilities
3. Home healthcare agencies
4. All of the above

*D - Since all of these facilities may be taking care of the same patient, it is important to be able to share or have access to information timely and securely.*

7. A well documented EHR will in turn allow patients to maintain a good, dependable PHR.

1. True
2. False
3. Sometimes

*A - True, patients can only have a dependable PHR if the information in their EHR has integrity.*

8. Should we use more than one patient identifier in order to locate them in our EHR?

1. Yes
2. No

*A - Yes, many patients have the same or similar names, maybe even the same DOB. Other pieces of information we can confirm that we have the correct patient in our EHR in addition to name and DOB could be; telephone number, patient ID number, home address. The national standard is to use 2 sources identifying information.*

9. PMS and EHR systems cannot interface with one another?

1. True
2. False

*B - These systems can interface with one another even if they were purchased from different software vendor companies.*

10. Of the 4 roles below, who should have the most access to a patient’s EHR?

1. Billing and coding staff
2. CNAs
3. Home health aides
4. Doctors

*D - Doctors need full access to patients EHRs in order to document fully encounters with patients, write prescriptions, send orders and provide high quality patient care.*

11. What can a system administrator use to track what staff and doctors are doing in the EHR?

1. Audit trail
2. Accounting system
3. General ledger
4. Virus software

*A - Audit trails allow system administrators to track all user access and activities in the EHR, including, adding, modifying, deleting, printing, sharing to another facility, etc.*

**Module 2: Electronic Health Record Function and Use**

**Glossary of Terms**

**CCR – Continuity of Care Record:** Abstract data elements from participating provider’s records to share with other providers so that current and some historical patient information is available while the patient is being treated

**EHR – Electronic Health Record:** Clinical documentation of patient’s care in an electronic format using software

**HIPAA – Health Insurance Portability and Accounting Act:** Law that provides guidelines in dealing with PHI, privacy, patient rights as it pertains to their medical record and security of health information in an electronic format

**Patient Portal:** Access granted to a patient through their healthcare providers’ organization to access parts of their medical record, request appointment, prescription refills, update patient histories, etc.

**PHI – Protected Health Information:** Any information about the patient that identifies the patient both demographically and clinically

**PHR – Personal Health Record:** Allows the patient to become an interactive source of health information and management. Patient maintains their own medical record in a desired format which they must personally manage use and disclosure of the information within that record.

**PMS – Practice Management System:** Software that handles the billing, coding, scheduling and financial operations of the facility.