**Introduction to Health Information Technology:**

**A Guide for Entry Level Healthcare Professionals**

***Student Handout***

**Module 2:**

**Electronic Health Record Function and Use**

**Acknowledgements**

This curriculum was developed with grant funding from The Healthcare Workforce Transformation Fund through the Commonwealth of Massachusetts, Executive office of Labor and Workforce Development. The grant project was administered by Commonwealth Corporation and The Massachusetts eHealth Institute.



**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**

**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.

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

**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

**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

**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

**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

**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

**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

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

1. True
2. False
3. Sometimes

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

1. Yes
2. No

**9. PMS and EHR systems cannot interface with one anotEHR?**

1. True
2. False

**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

**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