Chapter Outline

The Medical Record
- Important Uses of the Medical Record

Medical Record Formats
- Source-Oriented Medical Record (SOMR)
- Problem-Oriented Medical Record (POMR)
- Combining Formats

Contents of the Medical Record
- Administrative Information in a Medical Record
- Clinical Information in a Medical Record

Creating and Maintaining the Medical Record
- Documenting in the Medical Record
- Electronic Medical Records (EMRs)

Laws That Affect the Medical Record
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Ownership, Retention, and Disposal of Medical Records
- Fees Associated with Copying of Medical Records
- Retention of Medical Records
- Disposal of Medical Records

Essential Terms
- assessment
- business associate agreement
- Certification Commission for Healthcare Information Technology (CCHIT)
- chronological order
- concierge medicine
- electronic health record (EHR)
- electronic medical record (EMR)
- flow sheet
- health information technology (HIT)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- individually identifiable health information (IPI)
- notice of privacy practices

continues
CHAPTER 3

KEY COMPETENCIES

<table>
<thead>
<tr>
<th>CAAHEP</th>
<th>ABHES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating and Maintaining the Electronic Medical Record</td>
<td>III.C.3.C.2.c</td>
</tr>
<tr>
<td>Application of Electronic Technology</td>
<td>VI.A.1.a.2.n</td>
</tr>
</tbody>
</table>

Developmental Objectives

After completing this chapter, you should be able to:

1. Correctly spell and define the essential terms.
2. List three different types of medical records and describe each one.
3. List important reasons for keeping neat, structured medical records.
4. List the two major types of formats that are used for documenting in the patient’s record.
5. Describe the POMR approach and list the pros and cons for using this system.
6. Describe each letter of the SOAP format and list appropriate information to include under each section.
7. List administrative and clinical components of the medical record.
8. List common functionalities of the EMR and the benefits of this system.
9. List who is responsible for certifying EMRs.
10. Define HIPAA and give examples of ways that the office can become HIPAA compliant.
11. Determine which sections of the medical record are owned by the health care provider and which sections belong to the patient.
12. Describe how long medical records have to be retained and how to properly dispose of them.

Introduction

The medical record is the most important record kept in a medical office. A couple of different formats can be used to set up the medical record and to record entries within the patient’s chart. The medical record is divided into several sections, all of which contain different forms.

Electronic medical records (EMRs) are becoming more popular in ambulatory medicine. The medical assistant must become familiar with the functions, benefits, and restrictions related to EMRs.

There are laws that protect the private information contained in a patient’s chart and dictate how that information may be shared, with whom it may be shared, and how long a patient’s information should be stored once the relationship between the provider and patient is terminated.

As a result of studying the information in this chapter, you will become familiar with various documenting formats used in medical establishments and gain an understanding of laws that are in place to protect patient information. EMRs and their functions are described in depth, providing you with essential information that will assist you when working in paperless offices.
THE MEDICAL RECORD

The medical record is an analysis of a patient’s health status. It contains a medical history, current findings, considerations, test results, and treatment information related to conditions or diseases that ail the patient. Notes in the medical record are usually entered by the physician and other members of the health care team, including the medical assistant.

There are two major types of medical records that may be found in a medical practice: paper and paperless. Paper records are medical records that are stored in file folders. Paperless records are computerized records or records stored in digital format and are often referred to as electronic medical records (EMRs) or electronic health records (EHRs).

Another type of medical record, the personal health record (PHR), is a copy of the patient’s own medical record that may be in paper or digital format. Many Web sites catering to the needs of patients include instructions for creating a PHR. Some medical offices create a PHR for patients as a perk for joining the practice. This is particularly common in concierge medicine (practices in which patients pay a fee for special services). Any time the patient is seen, the practice prints copies of the progress note and related lab or diagnostic results and gives them to the patient to place in the patient’s personal file. Information may be transmitted in digital format for those patients with electronic records. The patient takes the PHR to all medical appointments to help improve continuity between providers.

The maintenance of the medical record is often assigned to administrative staff members; however, clinical staff members also have responsibilities in records maintenance. The clinical team is usually responsible for ensuring that all outstanding lab and x-ray results are entered into the record. They are also responsible for updating patient history and other data on a regular basis. Clinical staff members may have additional responsibilities such as removing data from the chart, copying the data, sending it to other health facilities, and returning any removed data to its original location.

Any time the patient has an encounter with the medical assistant, whether it is over the phone, through e-mail, or in person, it must be documented in the patient’s record.

With the latest rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the proliferation of EMRs, it is more important than ever for clinical staff members to have a clear understanding of their roles in entering and retrieving data from patient files and the federal guidelines that dictate how patient information can be shared.

Important Uses of the Medical Record

The most important purpose of a medical record is to provide the provider with precise health data to assist in formulating an accurate diagnosis, plan an appropriate treatment, and track a patient’s progress. The record also assists the provider in formulating disease prevention measures and overall health maintenance goals for the patient.

Other functions of the medical record are:

1. To provide a means of communication: It is a communication tool that is used between providers to improve the continuity of care and contains instructions for other health care employees to perform various diagnostic procedures or to administer particular treatments (Figure 3-1).
2. To be used for financial purposes: Chart notes are used by a medical practice to determine the complexity of the office visit, the diagnostic procedures performed, and any treatment rendered. The insurance company may also use progress notes from the chart to establish medical necessity for specified diagnostic procedures or treatments.
3. To serve as a legal document: The chart is a legal document that can protect the provider against frivolous lawsuits. On the other hand, it can be used as an incriminating piece of evidence by a plaintiff to prove negligence in a medical malpractice suit.

FIGURE 3-1 The patient’s medical chart provides valuable information so that both providers and medical assistants know how to proceed with the patient.
MEDICAL RECORDS FORMATS

There are two different documentation formats that are used for medical records, the source-oriented medical record and the problem-oriented medical record.

Source-Oriented Medical Record (SOMR)
The more traditional format used for recording data in the medical record is the source-oriented medical record (SOMR). Charts in which the SOMR format is used are divided into specific sections including: History and Physical, Progress Notes (notes that track the patient’s progress), Nursing/Medical Assisting Notes, Laboratory, and Diagnostic Testing. The “source” or individual providing the data enters the information within the appropriate section of the chart. There is no systematic cross-referencing of data from one section to the next. Progress notes are usually recorded in a narrative format, making it necessary to read the entire progress note before determining what is wrong with the patient. All reports and notes are kept in reverse chronological order, meaning the most recent note is on top.

Problem-Oriented Medical Record (POMR)
The problem-oriented medical record (POMR), also known as the POR, was developed by Lawrence L. Weed in the early 1970s. The POMR system incorporates structure and organization within the medical chart, stimulating better communication between those reading and those entering data within the chart.

The POMR is developed using four categorizations or stages:

1. Develop a database: The database should include patient history, physical findings, and baseline readings for diagnostic and laboratory testing.
2. Assemble a detailed problem list: The problem list should record specific problems identified from the patient history form and should list new problems as they arise. Each problem is numbered and should include the name of the condition or diagnosis. Each time the patient is seen for a particular problem, the progress note will reference the number listed on the problem list. If the problem is resolved, the date that the problem is resolved is entered onto the problem list. See Figure 3-2 for an example of a detailed problem list.
3. Formulate a plan of action for each problem: The plan for each problem may be found as a separate listing within the chart or may be included in the problem list. This section should include plans for testing, treatment, and education.
4. Provide ongoing progress notes for each problem on the problem list.

SOAP Notes
The POMR system uses the subjective, objective, assessment, plan (SOAP) note format for each progress note. Table 3-1 lists each section of a SOAP note, the type of information included in each section, and states which personnel is responsible for entering information within each section. Figure 3-3 illustrates an example of a complete SOAP note.

There are a number of advantages of using the POMR including:

1. It makes exploration of the chart much more efficient.
2. It decreases ambiguity of prior problems and treatment goals.
3. It encourages uniformity amongst those using the chart.
4. It simplifies record keeping.

Combining Formats
Some offices may combine particular aspects of the SOMR and POMR formats. The record may be set up using the SOMR format, but the provider may use the SOAP approach when entering information on the progress note and may include an abbreviated problem list on the front inside cover of the chart. Regardless of which system is used, the medical assistant will need to learn how charts are set up within each office and the proper method for documenting information in the medical record.

CONTENTS OF THE MEDICAL RECORD
Sections contained within the medical record will vary from one office to the next. Factors that influence which sections will be incorporated into the medical record include:
TABLE 3-1 SOAP Notes Defined

<table>
<thead>
<tr>
<th>SECTION NAME</th>
<th>DESCRIPTION</th>
<th>EXAMPLES OF WHAT IS INCLUDED IN EACH SECTION</th>
<th>PERSONNEL WHO TYPICALLY DOCUMENTS WITHIN EACH SECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective impressions (S)</td>
<td>Information provided by the patient</td>
<td>Patient's chief complaint or reason for visit in the patient's own words</td>
<td>Medical assistant, nurse</td>
</tr>
<tr>
<td>Objective impressions (O)</td>
<td>Information provided by the health care professional; includes a list of measurable reproducible data</td>
<td>Provider's physical findings, patient's vital signs, height and weight, laboratory results or other diagnostic data</td>
<td>Provider, nurse, medical assistant, other health care personnel who perform diagnostic testing</td>
</tr>
<tr>
<td>Assessment (A)</td>
<td>Interpretation of the subjective and objective findings</td>
<td>Diagnosis</td>
<td>Provider</td>
</tr>
<tr>
<td>Plan (P)</td>
<td>Provider's plan for diagnosing and treating the patient</td>
<td>Names of lab and diagnostic tests to be performed, forms of treatment, and educational plans</td>
<td>Provider</td>
</tr>
</tbody>
</table>

- Physician's personal preference
- Type of practice
- Cost of supplies
- Regulatory requirements

Many of the forms found in a medical chart can be purchased through a supplier and can be printed with the name, address, and phone number of the practice located at the top of each form. Generally, charts are divided into two major sections:

- Administrative information
- Clinical information

The chart’s front cover should include the patient’s name or identification number, and color-coded stickers.
that identify the last year the patient was seen. It may also include stickers that alert staff members when a patient is allergic to a particular drug.

**Administrative Information in a Medical Record**

Administrative information is information that is used most often by administrative staff members. Occasionally, members of the clinical team may also need to refer to these sections. Administrative sections within the medical record may include the following:

- **Demographic**: A patient registration or acquaintance form that includes personal information about the patient including address, phone number, insurance information, etc.
- **Insurance**: Copy of the insurance card, referrals, and precertification requests
- **Correspondence**: Letters from insurance companies, attorneys, etc.
- **Legal**: Copy of the patient’s privacy statement, living will, and advance directives

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**FIGURE 3-3** An example of a POMR progress note page (Courtesy of Bibbero Systems, Inc., Petaluma, CA, 800-242-2376, www.bibbero.com.)
Information within each section is usually placed in reverse chronological order, or the most recent date on top.

**Clinical Information in a Medical Record**

The majority of information found in a patient’s chart is considered to be clinical data. Clinical data is information that providers use to help diagnose, prescribe, and treat patients. Clinical information should also be placed in reverse chronological order. The following is a description of each section of clinical data found in a patient’s chart.

**Medical History**

The medical history form is normally completed during the patient’s initial visit and updated during subsequent visits. This form may be completed by the patient, provider, or medical assistant. It is a tool used for assessment purposes. It gives the provider subjective information about the patient and patient’s family and provides a database that can be used to build upon. See Chapter 5 for more information regarding the medical history section.

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**EMR APPLICATION**

Some EMR software programs have a medical history component that can be completed rather easily. The user simply identifies each disease or condition that is applicable by clicking on the “Yes” response, and clicking on the “No” response for conditions that are nonapplicable. A new template of questions may appear, allowing the user to expand on “Yes” responses. The majority of software programs allow users an opportunity to personalize the medical history to coincide with their particular specialty.

Patients may also participate in completing the electronic history by using a kiosk in the examination room or by completing the requested health information online, prior to the first appointment. If there is no medical history component built within the EMR software, the medical assistant may need to scan the history form within the patient’s electronic file. Figure 3-4 illustrates an example of a computerized history form.

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**FIGURE 3-4** An example of a computerized patient history (SynapseEHR 1.0 screen shots courtesy of E.S. Butler.)
CHAPTER 3

Physical Exam

The physical examination is a key component of the diagnostic approach for each patient and provides an overview of the patient’s general condition. The physical exam involves a head-to-toe evaluation of the patient, organized by body system. It is an important tool for discovering any new problems and monitoring previously identified problems. A physical exam is usually performed during the patient’s initial office visit and every one to three years thereafter. The frequency of physical exams depends on the following:

❖ The patient’s overall health status and age
❖ Insurance protocol
❖ The type of physical (annual, sports, work, or presurgical)

The patient’s insurance company or payer usually sets specific guidelines for the time span between physicals. When a patient requests a physical, the office staff should check to determine that the timing or reason for the physical falls within the payer’s parameters. If the parameters do not meet insurance guidelines, the patient should be warned by a member of the health care team beforehand of the exact financial responsibility.

It is also customary for patients to have a physical prior to a surgical procedure. The patient may be examined by the surgeon or the primary care physician. A copy of the history form should be faxed or e-mailed to the hospital where the surgery is to be performed.

Specialty forms may be used for physical exams or the physical exam findings may be documented on a standard progress note.

EMR APPLICATION

Entering information within the progress note is quite simple. The user may use standardized templates for entering patient data, or may copy and paste information from prior visits and make the appropriate adjustments. The user can integrate information from other sections of the chart directly onto the progress note—such as lab findings, history information, and the patient’s medication history—by simply clicking on the appropriate tabs. EMR reduces documentation time significantly and can save the practice thousands of dollars in the long run. Figure 3-5 illustrates a progress note in which information from other parts of the chart have been integrated within the progress note.

TOOL BOX

FIGURE 3-5 An example of a computerized progress note (SynapseEHR 1.0 screen shots courtesy of E.S. Butler.)
Progress Notes
Progress notes are the heart of the patient record. They serve as a chronological listing of the patient’s overall health status. Data pertaining to the findings from the visit are entered on a progress note, usually in the SOAP format. The progress note form may also be used for recording telephone encounters, procedures, treatments, and other interactions that take place with the patient. The header on the progress note should include the patient’s name, birth date, and any allergy alerts. Before entering any information on the progress note, ensure that you have the correct chart by asking the patient to verify his full name and birth date.

Medication Records
Some offices have patient charts with a separate section for medication entries; other offices have team members document medication treatments directly onto

TOOL BOX

EMR APPLICATION
Many EMR programs have a prescription component that can be accessed by clicking on the prescription tab. The prescription software can store thousands of common drug names with their usual dosages. The user brings up the patient’s electronic chart, clicks on the prescription tab, and selects the name and dosage of the ordered drug (Figure 3-6). The number of refills to be given is selected, as well as the name of the physician ordering the prescription. There is normally an option for printing, faxing, or e-mailing the order. The software may have individual patient logs for immunizations, narcotics, and other drugs administered within the office. Universal or global logs may also be stored within the EMR to track drugs administered to all patients for reporting purposes.

FIGURE 3-6 An example of an electronic prescription screen. With just a few clicks, an entire prescription can be created. (SynapseEHR 1.0 screen shots courtesy of E.S. Butler.)
the progress note. Prescribed drugs may be logged in a separate section from those administered or dispensed. The medical assistant should avoid using abbreviations when documenting medications or use only standard abbreviations that are not listed on the “Do Not Use” abbreviation list in Appendix B of this text. Medical assistants should always check the individual policies of the office in which they work.

**Phone Reports**

Any time a patient calls to change an appointment, give a progress report, obtain test results, or request a prescription refill, the call should be recorded either on the progress note or on a special phone form and placed within a special section of the chart. Medical assistants should check the policy of the office in which they work for specific details.

**Education Sessions** At times, it is necessary to give the patient home care instructions including postoperative, test preparation, disease management, and medication instructions. The patient should be given both verbal and written instructions. The session should be documented on a progress note and within the appropriate logs.

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**EMR APPLICATION**

Many EMRs have special phone templates that make it easy to record information. The user clicks on the telephone icon or tab and completes the requested information by clicking on a few more tabs (Figure 3-7). A message is sent to the “Task” box of the provider instructing the provider to pull up the telephone entry. The provider may then send a message back to the medical assistant with instructions to perform a specific action.

![Figure 3-7](image_url)
Laboratory Documents

All lab forms should be placed in reverse chronological order and placed in the lab section of the chart. Some offices use the shingling method for filing lab reports when reports are not on a standard size piece of paper. Lab reports are attached to a special shingling form that coincides with the lab reporting form. The forms may be color coded to match one another. Only like or similar reporting forms are placed on the same shingling form (for example, all urinalysis reports, all CBC reports, etc.). Adhesive strips on the shingling form allow lab reports to adhere to the front of the form. The first lab report on each form is placed so that it
is even with the bottom edge of the shingling form. Each subsequent report is shingled upward about a half an inch above the previous lab report (see Figure 3-9 for an example of the shingling method). Lab tests are used to aid providers in formulating a diagnosis, monitoring specific diseases or conditions, and monitoring medication levels. Common laboratory reports include hematology, urinalysis, microbiology, cytology, and chemistry reports. When using paper charts, the medical assistant must attach a copy of the report to the front of the chart and place it on the provider’s desk for review. Any abnormal results should be given directly to the provider or placed at the top of the chart pile for immediate review.

**Diagnostic Reports**

Copies of the patient’s nonlab-related procedures should be placed in the diagnostic reports section of the chart. Procedures such as imaging reports, EKGs, and heart catheterizations are examples of diagnostic procedures. When using paper charts, the medical assistant must attach a copy of the report to the front of the chart and

![LABORATORY REPORTS](Image)
The procedure for inserting diagnostic reports will vary depending on the EMR software and the electronic capabilities of the diagnostic testing center. If there is a direct link between the two, the reports are handled similarly to the way that lab tests are handled; otherwise, the results are scanned directly within the EMR. In-house computerized diagnostic equipment may link directly to the EMR software. Once the test is performed, the medical assistant is able to upload the results electronically into the patient’s electronic record.

**Nursing Home Reports**

Nursing home documents are frequently faxed or e-mailed from nursing homes and extended care facilities. This is especially true in family practice and geriatric offices. It is very important that these documents be given to the provider prior to being filed in the patient’s chart. If the office is using paper charts, the correspondence is attached to the front of the chart prior to giving it to the physician. With EMR, the information is either downloaded or scanned into the patient’s EMR.

**Therapeutic Reports**

Therapeutic reports may also be faxed or sent electronically from various facilities and may include reports from medical personnel, such as a physical or occupational therapist, who provide rehabilitative or therapeutic treatments for the patient. Once again, these reports should be read by the physician before they are filed into the patient’s chart. With EMR, the information is either downloaded or scanned into the patient’s EMR.

**Hospital Reports**

Any time a patient visits the hospital, a report of that visit will be sent to the patient’s primary care provider (PCP) and other pertinent health care providers. Hospital reports may include history and physical reports, operative reports, emergency room reports, and discharge summaries. Most patients will be instructed to follow up with their PCP once they leave the hospital.

Reports from nursing homes, providers of therapeutic services, and hospitals are either placed on the provider’s desk or hand directly to the provider when results are abnormal.

**Consultation Reports**

The days of one provider treating all that ails the patient are gone. Practitioners frequently send patients to specialists for further examination. The specialist will send thank-you letters to the referring provider and will provide a report of particular findings and plans for the referral patient. When using paper charts, the medical assistant must attach a copy of the consultation report to the front of the chart before giving it to the provider.

**Nursing Home Reports, Therapeutic Service Reports, and Hospital Reports**

Other reports that may be placed under the Consultation, Miscellaneous, or Correspondence tabs include reports from nursing homes, providers of therapeutic services, and hospitals.
EMR APPLICATION

Electronic exchange of information makes it much easier for providers to communicate with one another. When using EMR, referral letters, thank-you letters, and consultation reports can be sent electronically between the primary care provider and specialist. A clinical summary (Figure 3-10) that displays the patient’s problem list, medication list, allergy list, and family history is usually sent to the consultant at the time the referral is made. Once reports are received, they are downloaded and saved in the consultation or correspondence section of the chart. An electronic task is sent to the provider referring them to the patient’s chart and report.

DOUGLASVILLE MEDICINE ASSOCIATES
5076 BRAND BLVD
DOUGLASVILLE, NY 01234
(123) 456-7890

CLINICAL SUMMARY
Page 1, printed on 10/30/2008

White, Blanche

date of birth: 2/18/1934

Current Problem List
1. Hypertension
2. Osteoporosis
3. Depression

Medicine List

<table>
<thead>
<tr>
<th>Medicine</th>
<th>dose</th>
<th>unit</th>
<th>instructions</th>
<th>begin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardizem</td>
<td>60</td>
<td>mg</td>
<td>Take 1 capsule daily</td>
<td>3/12/2008</td>
</tr>
<tr>
<td>Fosamax</td>
<td>70</td>
<td>mg</td>
<td>Take 1 tablet per week</td>
<td>3/12/2008</td>
</tr>
<tr>
<td>Paxil</td>
<td>20</td>
<td>mg</td>
<td>Take 1 tablet each morning</td>
<td>3/12/2008</td>
</tr>
</tbody>
</table>

Drug Allergies
1. Peanuts
2. Codeine

Old Problem List

Old Medicine List & Prescription Refills
Amoxicillin 500 mg Rx’ed d/c’ed 10/10/2007 10/20/2007

Family History
Heart disease

Special Notes
Patient prefers to be addressed by her first name.

FIGURE 3-10 This clinical summary form displays key information about the patient that will assist other health care providers caring for the patient.
Flow Sheets

Flow sheets are logs found in the patient’s chart that assist the provider in monitoring specific repetitive information, at one glance. These may also be referred to as “health care screenings.” Types of flow sheets include PT/INR results, glucose or HgbA1c results, and blood pressure readings. A variety of patients may have flow sheets including those who are diabetic, those on Coumadin therapy, and hypertensive patients. Any time a patient has a test or procedure performed that is listed on the flow sheet, it should be documented onto the flow sheet as well as the lab form. Flow sheets may also be used to track routine health screenings such as mammograms, pap smears, and PSA levels. Figure 3-11 shows an example of a flow sheet.

**CREATING AND MAINTAINING THE MEDICAL RECORD**

Steps for creating the medical record will vary depending on whether the office is using a paper or paperless system. The chart is usually created by administrative

**TOOL BOX**

**EMR APPLICATION**

EMR flow sheets work well not only because of their ability to group results but also because they can automatically alert the provider when a patient is past due for a particular health screening. The user just clicks on the designated button and a message comes up that informs the user of any screenings the patient is behind on.

Some EMR software incorporates features that will automatically enter lab results directly into the patient’s electronic flow sheet. Every time that lab result is filed in the patient’s lab file, the test name, result, and date will also be added to the electronic flow sheet.

**TOOL BOX**

**SITE CHECK**

As a chart auditor for the insurance company, I check to see if the patient is up to date on all preventative maintenance testing, examinations, and immunizations such as mammograms, pap tests, and infant vaccinations. The practice should be able to verify that the patient was offered the testing, even if the patient failed to comply.

**FIGURE 3-11** Because lab reports are placed in chronological order, lab results should be entered in the paper chart starting with the last line and working upward. All results outside the normal range should be written in red or another color that stands out.

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**DOUGLASVILLE MEDICINE ASSOCIATES**

5076 BRAND BLVD

DOUGLASVILLE, NY 01234

(123) 456-7890

**HgbA1c FLOW SHEET**

Patient’s Name: Cindy McDonald

Patient’s ID # 45687

Provider’s Name: Dr. Laura Samoni

<table>
<thead>
<tr>
<th>Date of Test</th>
<th>Result</th>
<th>Current Med</th>
<th>Current Dosage</th>
<th>Recommended Change in Dose (If any)</th>
<th>Provider Making the Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/10/XX</td>
<td>6.8</td>
<td>Avandia</td>
<td>8 mg</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triglide</td>
<td>160 mg</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>03/16/XX</td>
<td>8.2</td>
<td>Avandia</td>
<td>4 mg</td>
<td>8 mg</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triglide</td>
<td>160 mg</td>
<td>None</td>
<td>Dr. Samoni</td>
</tr>
<tr>
<td>09/19/XX</td>
<td>7.0</td>
<td>Avandia</td>
<td>4 mg</td>
<td>None</td>
<td>None</td>
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<tr>
<td></td>
<td></td>
<td>Triglide</td>
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<td>None</td>
<td></td>
</tr>
<tr>
<td>03/20/XX</td>
<td>6.6</td>
<td>Avandia</td>
<td>4 mg</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triglide</td>
<td>160 mg</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>08/29/XX</td>
<td>6.8</td>
<td>Avandia</td>
<td>4 mg</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triglide</td>
<td>160 mg</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
staff members, but maintained by both clinical and administrative staff members. The clinical staff may need to file items within the patient’s chart, insert new forms, and make minor repairs to the chart.

**Maintaining the Medical Record**

Once a patient record is created it must be properly maintained. The chart is regularly inspected and any physical tears mended. Loose labels should be firmly reattached. Misplaced reports should be reviewed to determine if they have been released for filing and then placed in the appropriate section of the record. When forms such as progress notes and flow sheets are over 75% complete, new forms should be placed nearby so that they are easily assessable when needed.

Part of maintaining a chart is making certain that all information is updated. The record should be checked regularly to make certain that all labs are up to date and that the patient is current on health maintenance screenings. Once the provider and medical assistant are finished using the chart, it should be released for filing.

**Documenting in the Medical Record**

Documenting within the patient’s record is a common task performed by medical assistants. As stated earlier in the chapter, all patient encounters are to be documented within the patient’s chart. Documentation should be accurate and thorough yet concise. Medical assisting students should practice all types of documentation throughout their training period (see Chapter 4 for documentation guidelines).

**Electronic Medical Records (EMRs)**

An EMR is a patient’s medical record in digital format. It provides users with secure real-time information about the patient at the point of care and from remote locations. The term electronic health record (EHR) is often used interchangeably with EMR; however, there is a formal distinction between the two among medical record organizations and those involved in health informatics. C. Peter Waegemann, CEO of the Medical Records Institute, differentiates the two by describing EMR as “an electronic record with full interoperability within an enterprise (hospital, clinic, practice)” and EHR as “a generic term for all electronic patient care systems.”

To get a sense of the interoperability of EHR consider a patient entering an emergency room (ER) complaining of chest pain. The patient had a physical the previous week with his PCP. Because the patient had some prior chest pain symptoms earlier in the week, the PCP ordered a stress test, heart ultrasound, and multiple lab tests, all of which were performed at an outside facility.

Figure 3-12 illustrates what occurs within an electronic health network. The connection is initiated when the PCP sends an electronic task to the medical assistant asking her to order the tests for the patient (a). The medical assistant sends electronic orders to the facility where the tests are to be performed (b). The testing facility receives the orders and sends the results back electronically to the PCP (c), where they are reviewed and downloaded into the patient’s EMR (d). The ER physician calls the PCP for some insight on the patient’s condition, and the PCP sends the findings from the physical, all diagnostic and lab reports, and a copy of the patient’s clinical summary back to the ER physician (e). In a matter of minutes, the ER physician has vital information that is necessary for determining necessary testing, making a diagnosis, and treating the patient (f).

**Features of EMRs**

The electronic record has many features designed to improve patient care and staff efficiency. The type of software that a medical practice selects will depend on
many factors including the type of practice, the number of practitioners within the practice, the goals of the practice, and the individual preferences of the clinicians and staff.

An overview of various EMR functions includes:

- Creates customized progress notes and builds notes efficiently through standardized templates and copy/paste features
- Enables the provider and staff members to e-mail or fax progress notes, prescriptions, and orders directly from the point of care
- Allows team members to schedule appointments from the point of care
- Automatically files and displays lab results in a variety of different formats
- Graphs lab values, pediatric growth patterns, and vital signs
- Displays several parts of the chart at one time
- Allows multiple users access to different parts of the chart at the same time
- Provides electronic tasking features to help keep staff members organized and greatly improves time management
- Provides full remote access of patient records for those authorized to view them
- Interfaces with the clinic’s practice manager program, making billing more efficient
- Provides reporting and benchmarking capabilities that allow users to compare patient outcomes or to track other statistical data

EMRs have enhanced the organization and structure of the traditional paper medical record. As more facilities move toward EMRs, the more elaborate these programs will become, providing more options than what are currently available.

**Pitfalls of EMRs**

EMRs have many benefits, but there are also a few pitfalls such as:

- Cost of the software
- Training time and costs to the facility
- Problems that occur when the system goes down
- Increased risk of unauthorized persons obtaining identifiable health information about the patient

Remember that all records are confidential, so a patient’s file should never be accessed unless it is absolutely necessary.

**Creating and Maintaining an EMR**

The medical assistant may have responsibilities in both creating and maintaining an EMR. The amount of responsibility will be determined by office protocol. In general, the medical assistant may be responsible for any of the following when dealing with EMRs: creating the patient’s electronic chart, updating basic demographic information, completing an electronic history, updating legal information, documenting subjective findings within progress notes, documenting vital signs and other procedures into the appropriate sections of the chart, creating electronic lab requisitions and prescriptions based on the physician’s order, creating letters from templates stored within the EMR, downloading lab and diagnostic testing results from outside facilities, documenting within specialized patient logs (such as immunization, educational, etc), and scanning paper items into an electronic format.

Attention to detail is important when performing these tasks. The medical record—whether in paper or electronic format—is a legal document that can be used in a court of law. See Procedure 3-1 on how to create and maintain an electronic medical record.

**Amending Information in an EMR**

When documenting information within an EMR, the user may need to omit or add items. There normally is no problem making changes during the initial entry, but once the entry is submitted, the user may only have a limited amount of time before that information is stored and any further changes to the original entry are prevented. To correct an error, the user must access the note that needs to be amended and select the appropriate amendment option. This may vary depending on the specific EMR software. Any changes that are made to the progress note following submission are tracked and stored for future reference.

**PATIENT PERSPECTIVE**

I have mixed feelings about electronic medical records. I understand their value, but I’m worried about the different people that can access my personal information. I hope that the staff will demonstrate integrity and respect my right to confidentiality when working in my file.
Certification of EMRs

In September of 2005, the U.S. Department of Health and Human Services (HHS) awarded a contract to the Certification Commission for Healthcare Information Technology (CCHIT) to develop and evaluate the certification criteria and inspection process for EHRs. In order for a health information technology (HIT) vendor—a company that develops software for health care organizations—to get their product certified, the software must meet the basic criteria of the CCHIT for functionality, interoperability, and security. This certification reassures consumers that the product complies with all governmental requirements. CCHIT announced its first ambulatory certified products in 2006 and posts an updated list of software routinely. The CCHIT certified its first inpatient EHR products in 2007. For a listing of certified products, visit the CCHIT Web site (www.cchit.org).

The Push for EMR

In 2004, President Bush put forth an executive order pushing for most Americans to have electronic health records by 2014. The Centers for Medicare and Medicaid Services (CMS) is developing a variety of incentives for health care providers to adopt EMR, such as increases in Medicare and Medicaid reimbursements to those practices using EMR and supplying qualifying offices with federal grants to purchase EMR software.

LAWs THAT AFFECT THE MEDICAL RECORD

Many laws affect medical records. It is important to become familiar with both state and federal guidelines to ensure compliance and avoid noncompliance penalties related to the violation of such laws.

Governmental agencies, such as the CMS and the HHS, continuously make changes that may impact the way health care workers handle patient information. One such law dealing with patient information comes from the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Currently, HIPAA has seven subdivisions, each with its own title. This section will address Title II of this bill, which has the greatest impact on medical offices. The CMS is responsible for implementing various provisions of HIPAA.

Title II of HIPAA encourages the use of electronic data interchange in health care. One of the most important aspects of this subdivision is the privacy rule. Title II requires that the medical office and all affiliates of the medical office adopt measures to protect the security and privacy of patient health data. To assure the accountability of those who have access to protected health information (PHI) or individually identifiable health information (IIHI), Congress requires the imposition of civil and criminal penalties for any person or entity that uses PHI improperly.

Patient Protections

According to the HHS, “The privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals, and other covered entities can use patients’ personal medical information or PHI. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally.” Key provisions of the new standards include:

1. Access to Medical Records: Patients should be able to obtain copies of their medical records and request corrections if they identify errors or mistakes. Access should take place within 30 days of the request.
2. Notice of Privacy Practices: Patients should receive a notice of how their personal medical information may be used. This will be expanded upon below.
3. Limits on Use of Personal Medical Information: PHI may not be used for outside business purposes unrelated to health.
4. Prohibition on Marketing: The provisions set restrictions and limits on the use of patient information for marketing purposes without the written consent of the patient.
5. Stronger State Laws: The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. When a state law requires a certain disclosure, such as reporting an infectious disease, the federal regulations do not preempt the state law.
6. Confidential Communications: All information that is contained in the patient’s chart is considered confidential. Health care workers should never release information without a written authorization. Patients may also request the office to call them at their place of business instead of their home. The office should comply with the patient’s wishes, when the request is reasonably able to be accommodated.
7. Complaints: Consumers may file a formal complaint regarding the privacy practices of a covered health plan.

**Notice of Privacy Practices**

One of the changes listed above included providing patients with a notice of privacy practices. This notice should disclose the different ways in which the patient's PHI may be used. See Figure 3-13 for an example of a notice of privacy practices form.

Examples of information for uses and disclosures of PHI that may be found in the practice’s privacy statement include:

1. Sending information to other health care providers, such as laboratories, physicians, and pharmacies, for consultation or treatment purposes
2. Sending information to insurance companies or clearing houses for payment purposes
3. Using PHI for “health care operations” purposes, which may include the ability of the practice to evaluate the quality of care patients receive, information sent to attorneys or accountants to conduct cost-management, and business planning activities for the practice
4. Using PHI for communication purposes with the patient’s family including relaying appointments,

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**Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our health care providers work together to provide the best care to their patients. As allowed by law and only if needed, health information is shared to provide the best treatment, arrange for payment, and improve how we provide care in the future. The purpose of this notice is to tell you how we share your information and how you can find out more about our information sharing practices. You will be asked to acknowledge receipt of this Notice of Privacy Practices.

I. We Have a Legal Duty to Protect Your Health Information:

By law, we must keep your health information private and tell you that we are doing so. This includes your past, present, and future health information (your condition, care provided to you, or payment). We must follow the terms of this notice. If they change, we will change the notice so you will be aware of the changes. You can get a copy of any revised notice by contacting Douglasville Medicine Associates, 5076 Brand Blvd., Suite 401, Douglasville, NY 01234.

II. We May Use and Disclose (Share) Your Health Information:

1. Treatment/Care—Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

2. Payment—Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

3. Health care operations—Your health information may be used as necessary to support the day-to-day activities and management of Douglasville Medicine Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

4. Contact—Your health information may be used by us to contact you about your visit. Also, we may use your health information to contact you about treatment alternatives or health related benefits and services that may be of interest to you. Any information about your visit may not be left on an answering machine, voice mail, or with an individual other than yourself who may answer the phone.

5. Law enforcement—Your health information may be disclosed to law enforcement agencies, without your permission as needed:
   - To report wounds, injuries, and crimes
   - To support government audits and inspections
   - To facilitate law-enforcement investigations
   - If we suspect child abuse or neglect
   - If we believe you are a victim of abuse, neglect, or domestic violence
   - Under court order
   - To comply with government mandated reporting.

6. Public health reporting—Your health information may be disclosed to public health agencies as required by law. For example, reporting injuries, births, deaths and we are required to report certain communicable diseases to the state’s public health department. For deceased patients, by law and only if needed, we must share your health information with coroners and funeral directors.

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**FIGURE 3-13** An example of the first page of a HIPAA privacy statement.
messages to have the patient call the office, or to disclose health information to family members in the event of an emergency
5. Using PHI in the event of an ownership change
6. Using PHI when notifying public health authorities for reporting communicable diseases and abuse situations
7. Using PHI in lawsuits and similar proceedings

The form should also list rights of the patient regarding their health information and should have a section stating with whom information can be shared when the patient is unavailable.

Security Measures for HIPAA Compliance
Because this chapter focuses heavily on EMR, it is important to also address security measures for EMR. These measures include:

1. Reviewing the office’s business operations to identify which HIPAA electronic transactions apply
2. Assigning a HIPAA coordinator/officer who will be responsible for making the organization HIPAA compliant
3. Identifying partners that have access to PHI such as health plans, clearinghouses, software vendors, and billing companies. Partners should be queried to ensure their HIPAA compliance. All business partners should sign a business associate agreement that describes exactly how protected information is to be handled
4. Implementing testing measures to ensure business partners are HIPAA compliant
5. Using a third-party certification service or tool that can make certain that the practice is HIPAA compliant

Internal security measures may include the following:

1. Backing up computers at the end of each day and storing the backup in a secure place outside the office, such as a bank deposit box
2. Using encrypted passwords
3. Creating limited accessibility accounts for employees
4. Changing pass codes on a regular basis
5. Providing HIPAA training for all staff members

Table 3-2 lists good privacy practices and practices to avoid pertaining to HIPAA.

Penalties for Violation of HIPAA Laws
Penalties for violating HIPAA laws include fines that range from $100 to $250,000 and prison time that ranges from 1 to 10 years depending on the number and type of violations. See a breakdown of penalties in Table 3-3.

Confidentiality issues are serious. Unauthorized access to medical information can affect the patient’s employment status, family life, and personal relationships. Accessing patient records without cause may result in termination from employment. Many health care facilities have software that can track where employees have accessed patient records and identify who is adding or changing information in the medical record. This is referred to as an “audit trail” and is a vital component toward maintaining patient confidentiality. Because of the sensitivity and confidentiality issues related to patient information, it is crucial for all providers and staff to avoid situations in which personal integrity can be challenged.

Ownership, Retention, and Disposal of Medical Records
In general, medical records are the property of the practice or treating physician or hospital. The practice or physician owns the physical part of the record, but the patient is the owner of the information stored within the chart. Patients are entitled access to their medical records and may request copies of it. If a patient requests a copy, the patient must sign a release. Only copies—and not the originals—of the record should be sent to the patient. When working with electronic records, the medical assistant should make a copy of
good Privacy Practices and Practices to Avoid

<table>
<thead>
<tr>
<th>GOOD PRIVACY PRACTICES</th>
<th>PRACTICES TO AVOID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only access a patient’s file when it is absolutely necessary.</td>
<td>Never access a patient’s file because a friend or relative wants to find out information about the patient.</td>
</tr>
<tr>
<td>When sending information about a patient to a covered entity, only send the minimal amount of information that is necessary to handle the request.</td>
<td>Never send more information than what is necessary.</td>
</tr>
<tr>
<td>Turn computer monitors away from patients, or keep them out of the patient’s sight.</td>
<td>Do not allow computer monitors to display patient files in areas where the patients are in viewing range. (If using electronic records in the patient rooms, be certain all information from the previous patient has been cleared before bringing in a new patient.)</td>
</tr>
<tr>
<td>Use sign-in sheets that require minimal information to acknowledge the patient’s arrival and the time of arrival or have patients sign in via computer.</td>
<td>Sign-in sheets should not ask patient to list any changes since the last visit, such as changes in insurance or other demographic information.</td>
</tr>
<tr>
<td>Talk to the patient in private regarding billing or health-related information.</td>
<td>Do not discuss private information about or with a patient in an area where others can hear what you are discussing.</td>
</tr>
<tr>
<td>Allow the patient access to the patient’s medical record and the ability to review and request changes within 30 days of request.</td>
<td>Do not forbid the patient access to the patient’s medical record. Remember the patient is the owner of the information stored in the chart.</td>
</tr>
<tr>
<td>Only discuss parts of the patient’s record or health status with those individuals who have the authority to receive the information.</td>
<td>Do not discuss parts of the patient’s record with anyone other than the patient or those listed in the privacy statement. Do not discuss PHI with members of the health care team, unless it is absolutely necessary in order for them to carry out the duties of their job.</td>
</tr>
<tr>
<td>In the event of an emergency, provide the minimal amount of information that is necessary to handle that emergency.</td>
<td>Do not communicate more information than is absolutely necessary to handle an emergency. Keep voices low to ensure privacy.</td>
</tr>
<tr>
<td>Respect the patient’s right to privacy away from the office.</td>
<td>Do not tell friends or family members that a particular patient was in for an appointment. Even if you do not disclose the reason for the visit, it is a violation of HIPAA rules.</td>
</tr>
</tbody>
</table>

the record on a CD or forward the record electronically to the next provider.

Fees Associated with Copying of Medical Records
“Reasonable fees” for copying a patient’s medical records will usually be dictated by state statutes. In most cases, the practice can charge fees for retrieving, copying, and mailing the medical record. Check each state’s policies for specific details.

Retention of Medical Records
Federal and state guidelines for retention of medical records will vary depending upon the type of record. In general, adult records should be retained for 7 to 10 years and records of minors should be retained several years past the age of majority. Check the state and federal laws that apply to the practice. It is prudent to follow the guidelines of the agencies that have the most stringent standards.

If a practice decides to cease operations or physicians within the practice plan to change locations, the practice should notify patients to determine how their records should be handled. Each patient should be consulted to determine if records should be transferred to another location of the patient’s choice, or if they should be moved with the transferring physician. If neither occurs, the patient should be alerted to where
CHAPTER 3

the records are being stored in case the information is needed by the patient at a later date.

**Disposal of Medical Records**

Occasionally, the medical record itself or parts of the medical record need to be discarded. Privacy laws state that PHI disposal must occur by shredding the documents; therefore, a shredder should always be used when disposing of information from a patient’s medical record. Many businesses hire a shredding company to perform their shredding. In that case, the medical facility must select a reliable vendor that has thorough knowledge of HIPAA guidelines and should have the company sign a business associate agreement that states that the records are not to be used for any other purpose but for shredding and that the company is to provide a certificate of destruction once the task has been performed.

### TABLE 3-3 HIPAA Penalties

<table>
<thead>
<tr>
<th>TYPE OF PENALTY</th>
<th>DESCRIPTION OF PENALTY</th>
<th>FINE</th>
<th>PRISON TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil</td>
<td>Violations of simplification requirements</td>
<td>$100 per violation, up to $25,000 per year</td>
<td></td>
</tr>
<tr>
<td>Criminal</td>
<td>Knowingly obtains or discloses IIHI</td>
<td>Up to $50,000</td>
<td>1 year</td>
</tr>
<tr>
<td>Criminal</td>
<td>Offenses committed under false pretenses</td>
<td>$100,000</td>
<td>5 years</td>
</tr>
<tr>
<td>Criminal</td>
<td>Offenses committed with the intent to sell, transfer, or use IIHI for commercial gain, personal gain, or malicious harm</td>
<td>$250,000</td>
<td>10 years</td>
</tr>
</tbody>
</table>

**PROCEDURE 3-1 Create and Maintain the EMR Using SynapseEHR 1.0 Software**

**Objective:**

To create an EMR and perform various tasks within the record.

**Equipment/Supplies:**

- Computer
- Printer
- SynapseEHR 1.0 software CD-ROM located in the back of the workbook

**PROCEDURAL STEPS**

1. Create the chart by clicking on the “New Patients” icon and completing all of the screens within the patient information section.

   RATIONALE

   In SynapseEHR 1.0, this step is what actually creates the chart and assigns a number that will link the patient to other sections within the EMR.

2. Perform an electronic history on the patient by clicking on the “Patient History” tab and completing the requested information.

   RATIONALE

   The history provides important information to help diagnose current diseases and conditions and assists in predicting future problems.
### PROCEDURAL STEPS

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Update information within the legal screen by clicking on the “Legal” icon and completing the requested information.</td>
</tr>
<tr>
<td>4.</td>
<td>Create a progress note on the patient by clicking on the “Chart Notes” icon and clicking on the “New Office Visit” tab.</td>
</tr>
<tr>
<td>5.</td>
<td>Enter the date and time into the appropriate fields.</td>
</tr>
<tr>
<td>6.</td>
<td>Click on the “Subjective” tab and complete the appropriate information. Save and update the information to the progress note.</td>
</tr>
<tr>
<td>7.</td>
<td>Click on the “Objective” tab and enter the patient’s vital signs. Save and update the information to the progress note.</td>
</tr>
<tr>
<td>8.</td>
<td>Create the requested lab requisitions by clicking on the “Labs” icon and following the prompts on the screen.</td>
</tr>
<tr>
<td>9.</td>
<td>Create the requested prescriptions by clicking on the “Rx” icon and following the prompts.</td>
</tr>
<tr>
<td>10.</td>
<td>Document requested information within the appropriate logs by clicking on the “Logs” icon in the main menu for global logs, and clicking on the “Immunization” icon within the patient information menu. Enter requested information into each field and save.</td>
</tr>
<tr>
<td>11.</td>
<td>Create any letters ordered by the provider by clicking on the “Patient Template” icon within the patient information menu and selecting the appropriate template. Complete the requested information and print a copy of the forms for the patient.</td>
</tr>
<tr>
<td>12.</td>
<td>Pull up the requested educational forms by clicking on the “Patient Education Forms” icon and selecting the appropriate material.</td>
</tr>
</tbody>
</table>

### RATIONALE

- **Step 3**: The legal screen in SynapseEHR 1.0 allows the user to enter facts regarding discussions that occur with the patient in regards to medical/legal documents such as DNR orders, living will, durable power of attorney, etc.
- **Step 4**: The progress note details the reason for the visit. The progress note in SynapseEHR 1.0 contains four separate tabs for each part of a SOAP note.
- **Step 5**: The date and time are important reference items that are used when referring to the note at a later date.
- **Step 6**: The subjective information in SynapseEHR 1.0 refers to the patient’s chief complaint and is normally recorded by the medical assistant. In SynapseEHR 1.0, saving the information does not transfer it to the progress note. The medical assistant must click on “Update Progress Notes” to send the information to the progress note.
- **Step 7**: Objective information is information provided by medical staff members. The only objective findings that the medical assistant will record in SynapseEHR 1.0 are the vital signs. Once these findings are documented, they too will need to be sent to the progress note.
- **Step 8**: Electronic lab orders can save everyone a great deal of time and can alert the lab that the specimens for testing are on their way.
- **Step 9**: Prescriptions that are electronic reduce reading errors that occur from poorly written prescriptions. SynapseEHR 1.0 allows users to print the prescriptions, but many programs allow users to fax and e-mail prescriptions directly to the pharmacy.
- **Step 10**: Logs within the patient’s personal EMR track immunizations and other medications that are administered to the patient. Global logs track medications administered and prescribed on all patients in the practice and important lab information.
- **Step 11**: Creating letters and forms within the patient’s personal EMR tailors the letter to the individual patient and saves a great deal of time for the medical assistant.
- **Step 12**: Patient education is one of the most important elements during the patient’s visit. Having these materials stored in the EMR allow users to print, e-mail, or fax the forms to the patient.
**Chapter Summary**

The medical record is an important tool in maintaining patient health. Understanding the sections of the medical record and knowing what information pertains to each section will save time for everyone who uses the chart. An organized medical record promotes good communications from one staff member to the next and better care for the patient.

Electronic medical records (EMRs) are quickly replacing paper records. The advantages of using EMRs include better communication, organization, electronic networking with outside facilities, and increased efficiency. Eventually EMR use will be a requirement for offices that submit federal claims in order to receive the highest compensation possible.

Federal and state laws dictate how the medical community uses PHI, what rights patients have to medical information, security measures designed to protect patient information, and the length of time records should be kept. Becoming familiar with standard procedures for documenting within a medical record and comprehending laws that protect information stored within the record will result in better care for the patient and a secure environment for protected health information.

**FIELD APPLICATION CHALLENGE**

As a medical assisting student, you perform your externship in an office that uses EMR. You were able to see the wonderful advantages of EMR and are hopeful that you will get a position in an office that uses EMR. Unfortunately, the office that hires you still uses paper records. The physician has stated several times that he is hesitant to use EMR because of the software cost.

Write a proposal to the physician stating why the office should go from paper records to EMR. To help you prepare, complete the following:

1. On a separate sheet of paper, list at least 10 functions of EMR.
2. List at least five advantages for using EMR.
3. Using an Internet search engine, look up three different EMR software vendors and price their software.
Chapter Assessment

1. Important uses of the medical record include all of the following except:
   a. means of communication.
   b. statistical data.
   c. payment data.
   d. information to pharmaceutical companies.

2. Which format has no systematic cross-referencing of information?
   a. POMR
   b. Organizational
   c. SOAP
   d. SOMR

3. In the POMR format, the category that includes patient history, physician findings, and baseline results is the:
   a. problem list.
   b. database.
   c. plan.
   d. progress notes.

4. Which organization has been approved to certify products from HIT vendors?
   a. CCHIT
   b. CMS
   c. OSHA
   d. HHS

5. Internal security measures to protect PHI include:
   a. using encrypted passwords.
   b. limiting account accessibility.
   c. changing pass codes on a regular basis.
   d. all of the above.

6. Which of the following would be considered a subjective finding?
   a. Vital signs
   b. Physical exam findings
   c. Diagnostic test results
   d. Patient's chief complaint

7. Nonlaboratory test results should be filed in which section of the medical record?
   a. Demographic section
   b. Diagnostic reports
   c. Progress notes
   d. Lab reports

8. HIPAA helps protect:
   a. PHI
   b. IHI
   c. PMI
   d. PPE

9. In order to give personal health information to a relative, the patient must:
   a. state the name of the individual on the privacy statement.
   b. have written consent from the patient to share information.
   c. both a and b.
   d. none of the above.

Web Activities

1. In reference to the last question in the Field Application Challenge, go to www.cchit.org and list which vendors have certified products.

2. Check your State Medical Board’s Web site for information on the length of time that medical records must be kept.

StudyWARE Connection

Using your StudyWARE CD-ROM:
   ✤ Complete the Crossword Puzzle activity for this chapter.
   ✤ Complete the Quiz for this chapter in Test Mode.

The DVD Link

On your StudyWARE CD-ROM, go to the DVD Challenge for this chapter. View the DVD clip and respond to the following questions:

1. How did Irv try to prevent the patient from overhearing another patient’s information?

2. List other ways that Irv and the physician could have preserved the patient’s anonymity.

3. Do you agree with the way that the medical assistant addresses the physician? How would you address the physician?