

Electronic Medical Records (certificate) : Electronic Health Records and Security

Lesson 1 Overview

The first lesson in your textbook begins with an introduction to Electronic Health Record (EHR). This chapter begins with the explanation of an EHR, who is able to document in the EHR, and the owner of the EHR. Further, the chapter discusses the transition from paper records and functions of the electronic software. Lastly, the chapter ends with both the advantages and disadvantages of EHR.

1.1 Describe the current use and contents of the EHR and describe advantages and disadvantages of EHR

Assignment 1: Introduction To Electronic Health Records

READING ASSIGNMENT

Read this assignment. Then read Chapter 1 in your textbook.

History of Medical Records

A patient's *medical record* is a complete physical collection of an individual's healthcare information. Medical records started as early as 200 BCE in China and have been used throughout history to document communicable diseases. Originally keeping medical

records weren't required, but federal laws have been put into place that require all patient care to be documented in a medical record. Paper records are few and far between and most medical records are found within an EHR.

Contents of EHR

A *health record* is a combination of all the health information and documents of a single individual. Each time a patient is seen in the clinic or contacts the clinic, it should be documented within the medical record. Keeping accurate and up to date records is essential for quality patient care. Medical records contain clinical information, administrative information, and legal documents, which may overlap. For example, a prior authorization form is an administrative form, but likely also contains health information.

Clinical Information

The medical record is the primary source for a patient's medical history and includes progress/clinic notes, medication lists, allergies, vital signs, immunizations, lab results, and imaging results. This information is primarily obtained during a visit with a physician or provider.

Administrative Information

Administrative information is information used by the front office staff and billing staff to maintain appointments and bill insurance companies appropriately. This type of information includes patient

demographics, insurance information, prior authorizations, referral letters, and so on.

Legal Documents

The entire health record is a legal document, since federal law requires documentation, but it's also used in court proceedings for malpractice lawsuits. There are also legal forms within the document, including consent forms, medical records release, advance directives, and do not resuscitate (DNR).

Who Documents in the Medical Record?

Anyone in the office who is directly involved in patient care will document in the chart, which includes receptionists, administrative and clinical medical assistants, nurses, medical coders/billers, and providers (physicians, physician assistants, and nurse practitioners). Each party documents in a specific area of the chart, but there may be overlap between areas of documentation.

Who Owns the Medical Record?

The medical record is considered the property of who created the medical record, which may vary on location. If a physician owns his own private practice, that provider is the owner of the records created within their practice. For a provider working within an institution, such as a hospital, the hospital or institution is the owner of the record. The patient controls the information in their record and is able to gain

access to any of their medical records by signing a release form and is also able to request amendments. The only exception is in the *doctrine of professional discretion*, which allows a provider to use their best judgment with sharing medical records when dealing with emotional or mental disturbances.

Transitioning from Paper to Electronic Records

Transitioning to electronic records has been slow, but the majority of medical offices now use an electronic record. *Meaningful use (MU)* is a payment incentive program for physicians who implement and use their EHR in a meaningful way to improve quality, safety, efficiency, reduce health disparities, engage patients and family, improve care coordination and population, and maintain privacy and security of patient health information.

Watch the following videos for better understanding of Meaningful Use.

- <https://www.youtube.com/watch?v=fTD3gZlPeko>
- <https://www.youtube.com/watch?v=qwuJ1P8MgH8>

EMR vs. EHR

Electronic medical record (EMR) is an electronic patient record created by a medical practice or hospital and the EHR is considered an interconnected aggregate of all the patient's health records from multiple providers and healthcare facilities, which makes the EMR a part of the EHR. For the most part, these terms are now

interchangeable, but EHR is the preferred term.

Electronic Health Records Software

There are multiple software systems for EHR on the market, but many have the same functionality and therefore adaptation to differing systems can be done with little difficulty. Basic Functions of EHR include progress notes, trending vital signs, document with free text or templates, provider review of labs and reports, storage of forms (that is, incident reports or release of information), electronic signatures, prescription templates with cross checks for allergies and interactions, patient portal, laboratory data, flagging of abnormal results, intraoffice messaging and email, fax and messaging functions, and reminders for screening and maintenance for patient.

Clinical Decision Support (CDS) allows providers to tailor care of a patient by making sure it adheres to guidelines for the specific diagnosis/disease. Some of the features of the CDS are to ensure that care complies with established screening recommendations for their specific disease with reminders for preventative testing (that is, colonoscopy, mammogram, immunization, or pap smear). Treatment can be planned through evidence-based medicine through the patient's clinical data, generation of patient data reports and summaries, documentation with templates specific to the patient's diagnosis, and performance of database searches to identify patient's that meet certain criteria to ensure they're receiving the appropriate care and screening. The main limitation to the CDS tool is the provider

taking advantage of this appropriately. In addition, if data isn't entered correctly, the function of CDS may be less effective.

Practice Management Software

Practice management software (PMS) allows for the electronic management of the business side of the practice, such as patient demographics, scheduling appointments, tracking billing and insurance, and processing payments:

- **Demographics.** Age, sex, marital status, language, race, contact information.
- **Billing and Insurance.** Insurance cards should be reviewed at every patient visit and scanned into the system.
- **Appointment scheduling.** Patient is scheduled to appear at the clinic on a specific day and time. There are time intervals for appointment slots, based on if the patient is new or established. An established patient has been seen by a provider in the office within three years and a new patient has either never been seen or it has been more than three years.
- **Advanced accounting procedures.** An *account ledger* is a document that contains the guarantor (responsible payer), patient's identifying and contact information, services provided, payments made, insurance reimbursements, account adjustments, and balance owed. After this is received, a claim is submitted to a third-party payer, which is typically the insurance company.

Advantage of EHR

EHR improves quality and continuity of care as there's immediate access to patient records, which can provide better and faster treatment for patients along with imaging and laboratory results available more quickly. *Continuity of care* is one of the most important ways the EHR can improve quality of care. For a patient with chronic medical conditions, there may be multiple specialists involved in the care of a specific illness, managing different medication, lab results, surgeries, and so on. Each specialist and the primary care provider having access to all of this information is important for continuation of quality and accurate patient care. As many EHRs are Internet-based, they can be accessed despite computers or a medical facility being destroyed by a disaster, leading to more accurate continuation of care. This was found to be true after Hurricane Katrina, as victims that were receiving care at the Veterans Health Administration received better, more timely care than patients whose paper records were destroyed.

EHRs provide increased efficiency as patient information is readily available to any user. Time that may have been spent looking through paper records and filing papers can now be spent on other office tasks. Improved documentation with the use of preset templates, drop down menus, and free typing all eliminate illegible hand-written notes, which in turn, eliminates errors. Records can be linked and compared, such as lab results and vital signs. Proper documentation is important to facilitate communication among providers, avoid delay of

reimbursement or denial of insurance claims, comply with insurance companies' and accreditation companies' documentation guidelines, aid work of investigators and regulators when legal issues arise, protection of practice for any malpractice suit, and establish evidence of care.

EHRs intend to make patient information easier to access at the point of care by interconnecting EHRs to decrease delay in initiation of care, since the patient's medical history would be accessible immediately. For example, with a patient that presents to the emergency department. EHRs provide better security as they're protected by a username and password, with the password changing periodically. Each user has a different amount of access and each user is audited to determine what each user has viewed or modified to protect patients from inappropriate access to their medical record. EHRs provide reduced expenses such as transcription fees and storage facility for paper charts are no longer needed, and duplicate tests aren't being performed. Improved job satisfaction occurs as providers are more confident in the delivery of high quality care and the support staff is more comfortable with day to day operations, such as phone calls, medication refills, and results of testing, all of which are handled appropriately. Improved patient satisfaction occurs as patient's feel that their phone message and refills are handled better with EHR. Most patients like having a patient portal where they can access their health information.

Disadvantages of EHR

A major disadvantage of EHRs is the lack of interoperability, as not all EHR systems are compatible with one another, but may be compatible with pharmacies, hospitals, or laboratory networks. This means that health records may not be available between a hospital, primary care, or specialty medical practices for a patient. This can decrease efficiency as more paperwork may be involved, or more data needs to be keyed into each EHR. Cost increase due to high start-up cost and the need to purchase the software and potentially update hardware to support the new system. The time to convert paper charts into the electronic format is time consuming and costly. Employees resist change due to concern with familiarity of computer technology, including office staff and providers close to retirement, and providers feeling they have more work and are less able to delegate tasks. Regimentation as a more standardized form in documentation of progress notes removes the lack of evidence of provider's reasoning or the narrative of the patient's story due to the use of templates and checkboxes. Security gaps cause safety concerns for how well protected EHRs are with power outages, viruses, backup procedures, and computer freezes.

Role of the Healthcare Professional Using the EHR

Patient care is the primary goal when using the EHR. It's important to understand medical terminology and anatomy and physiology when deciphering through the EHR to interpret information presented in the chart. Basic typing and computer skills, organizational skills, and interpersonal skills are all attributes to excel at when using the EHR.

Professional Organizations

Healthcare is a constantly changing field and therefore staying up to date on current information and continuing to learn is an important part of being in the medical field. Becoming a member of a professional organization has benefits, such as certificate examinations, sponsor conferences and workshops, and continuing education units (CEU). Each organization targets a particular field, such as American Health Information Management Association (AHIMA), American Academy of Professional Coders (AAPC), American Association of Medical Assistants (AAMA), and American Medical Technologists (AMT).

Contacting SimChart Support

READING STUDY MATERIAL

Contacting Support via Ticket Submission

1. Visit <http://evolvesupport.elsevier.com>
2. Select **Evolve Products**.
3. Select **SimChart**.
4. Scroll down and choose **Email**.
5. Select your role ("Education / Faculty" or "Student") .
6. Type "**PENN_FOSTER**" in the Subject field, making certain to include the underscore symbol.
7. Fill out all other required information and click **Continue**.
8. Review the information and click **Submit**.
9. An experienced Customer Representative will be in contact with you shortly.

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You can contact us locally on the following support number:

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Our support line can be reached at the following times:

Monday-Friday: 7am-11pm CST

Saturday: 8am-6pm CST

Sunday: 12pm-10pm CST

It would be helpful for you to inform the Support Representative that you are attending class at Penn Foster.

SimCharts

READING ASSIGNMENT

Accessing SimChart

Access Code

The access code is found on the inside cover of the textbook *The Electronic Health Record for the Physician's Office with SimChart for the Medical Office* or it may come on a separate card with the book.

Course Code

To access SimChart for the Medical Office, you'll need a course code. You'll receive your course code in your Penn Foster Message Center, which can be accessed on your student portal and at the email address currently on file in your student account.

If you did not receive your course code, please contact your instructor at 1-800-982-1288 for assistance.

Enrolling into an Instructor-Led Course

Register for Evolve

Please follow the steps below to enroll into your instructor-led course on Evolve.

1. Visit the student home page of [Evolve](#).
2. Enter the Course ID in the *Redeem an Access Code* field and

click the **Submit** button.

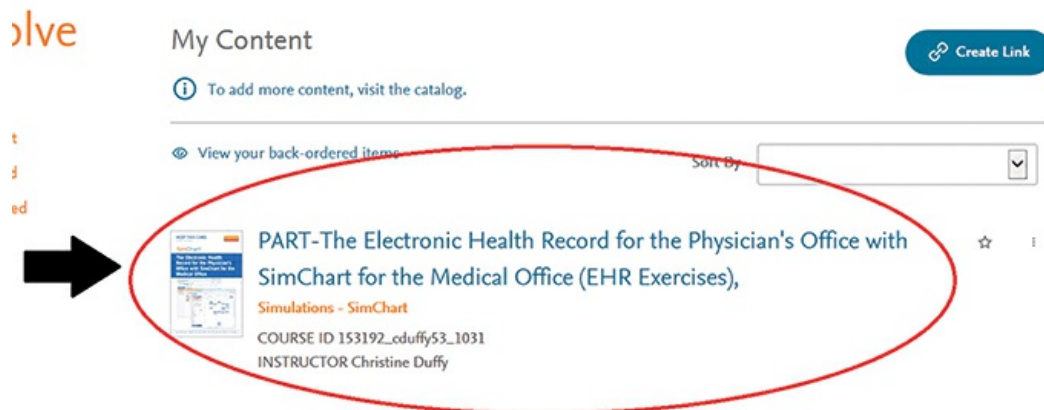
3. You'll be prompted to purchase access or to enter your access code at this time. Enter the 12 character access code and click the **I have an access code** button. Type your code in the field provided, click **Apply**, then **Checkout/Redeem**.

Access codes may only be used one time.

If you're new to Evolve, enter your name, email address, desired password, and institution information (Penn Foster), then click **Continue**.

4. Click the **Registered User Agreement** link located at the bottom right. Once you've read this information, check the Yes, I accept the Registered User Agreement box if you agree. Click **Submit**.
5. Your enrollment confirmation will appear on the next page. A confirmation email will additionally be sent to your instructor to inform them of your enrollment. If you're a new user, your Evolve username and password will also be emailed to you after you've registered.
6. Click the **Get Started** link to get to your course located in the My Evolve area. Visit and bookmark <http://evolve.elsevier.com/student> for future reference.

Once registered, click on the link to The Electronic Health Record for the Physician's Office with SimChart for the Medical Office (EHR Exercises).



Next, click **Course** under Course Content on the left-hand sidebar.



A drop-down menu will appear revealing more options. Click **SimChart for the Medical Office**.

Course Home

COURSE TOOLS

Course Calendar

Search

COURSE CONTENT

Content Home

Course

- Announcements
- Before You Begin
- Content Updates
- Conversion Plan
- SimChart for the Medical Office**
- Vendor Lab

Course
The Electronic Health Record for the Physician's Office with

the Electronic Health Record for the PHYSICIAN with Sim

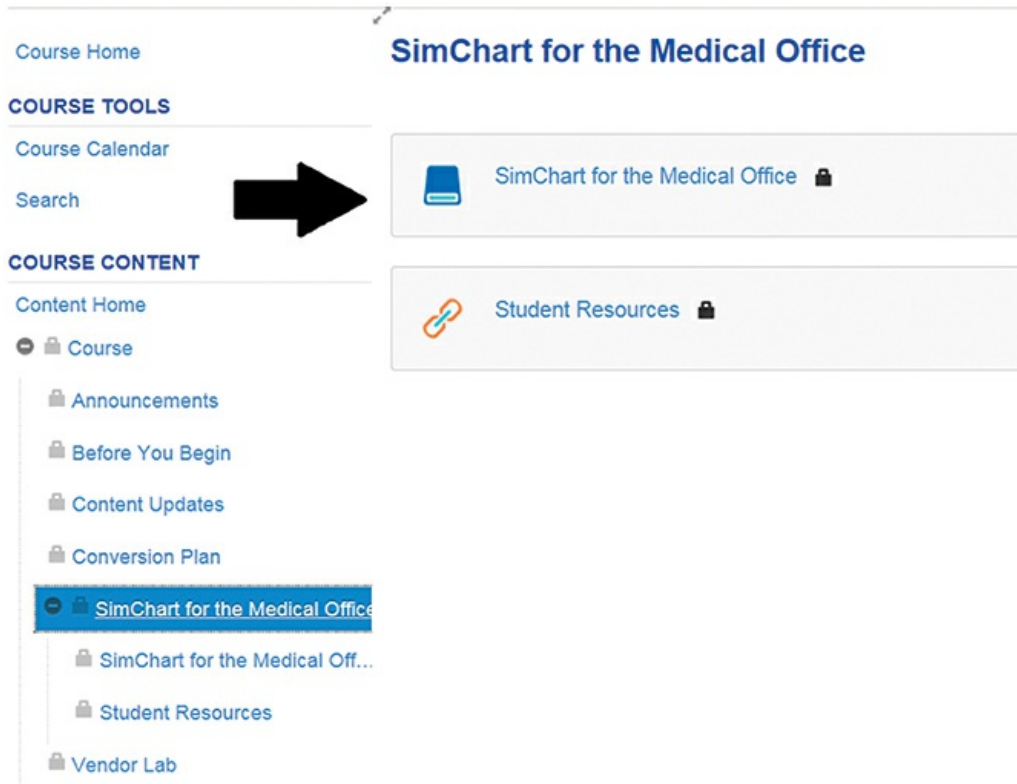
Announcements

Before You Begin

Content Updates

Conversion Plan

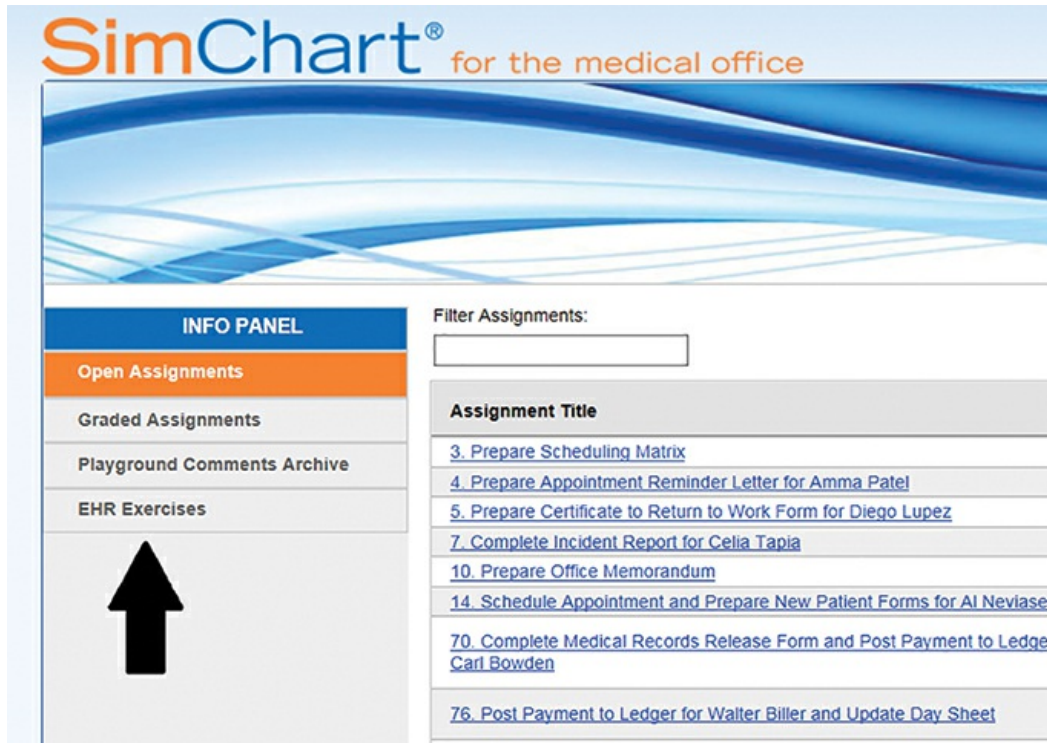
This will open up new content on the main part of the screen. Click on **SimChart for the Medical Office** next to the data drive icon.



Next, click the **Open** button that will appear underneath the main header.



You'll complete EHR Exercises (found in your textbook starting in Chapter 2) in the EHR Exercises tab, indicated by the arrow.



After completing all 8 chapters in your textbook and their exercises, you're now ready to start your Graded Project. In the Open Assignment Area, these are your Graded Project Assignments:

- 3. Prepare Scheduling Matrix
- 4. Prepare Appointment Reminder Letter
- 5. Prepare Certificate to Return to Work Form for Diego Lupez
- 7. Complete Incident Report for Celia Tapia
- 10. Prepare Office Memorandum
- 14. Schedule Appointment and Prepare New Patient Forms for Al Neviaser
- 70. Complete Medical Records Release Form & Post Payment to Ledger for Carl Bowden
- 76. Post Payment to Ledger for Walter Biller & Update Day Sheet

98. Create Bank Deposit Slip for Walter Biller

106. Generate a Prior Authorization for Ken Thomas

INFO PANEL

Open Assignments

Graded Assignments

Playground Comments Archive

EHR Exercises

Filter Assignments:

Assignment Title	Module	Duration	Status
3. Prepare Scheduling Matrix	Front Office	00:25	Not Started
4. Prepare Appointment Reminder Letter for Amma Patel	Front Office	00:20	Not Started
5. Prepare Certificate to Return to Work Form for Diego Lupez	Front Office	00:30	Not Started
7. Complete Incident Report for Celia Tapia	Front Office	00:40	Not Started
10. Prepare Office Memorandum	Front Office	00:20	Not Started
14. Schedule Appointment and Prepare New Patient Forms for Al Neviasser	Front Office	00:30	Not Started
70. Complete Medical Records Release Form and Post Payment to Ledger for Carl Bowden	Front Office Coding & Billing	00:35	Not Started
76. Post Payment to Ledger for Walter Biller and Update Day Sheet	Coding & Billing	00:20	Not Started
98. Create Bank Deposit Slip for Walter Biller	Coding & Billing	00:10	Not Started
106. Generate a Prior Authorization for Ken Thomas	Front Office	00:15	Not Started

Simulation Playground

When you're ready to begin, click on your first assignment.

Assignment Title	Module
3. Prepare Scheduling Matrix	Front Office
4. Prepare Appointment Reminder Letter for Amma Patel	Front Office
5. Prepare Certificate to Return to Work Form for Diego Lupez	Front Office
7. Complete Incident Report for Celia Tapia	Front Office
10. Prepare Office Memorandum	Front Office
14. Schedule Appointment and Prepare New Patient Forms for Al Neviasser	Front Office
70. Complete Medical Records Release Form and Post Payment to Ledger for Carl Bowden	Front Office Coding & Billing
76. Post Payment to Ledger for Walter Biller and Update Day Sheet	Coding & Billing
98. Create Bank Deposit Slip for Walter Biller	Coding & Billing
106. Generate a Prior Authorization for Ken Thomas	Front Office

The assignment objectives and description will appear on the screen. To begin the assignment, click **Start Assignment** in the bottom right-hand corner.


Assignment Objectives

- Prepare a scheduling matrix according to established guidelines.

Assignment Description

The Walden-Martin medical office just implemented an electronic health record system with a scheduling feature. Dr. Walden would like to block time every day for a 30-minute lunch break at 11:30 am. Dr. Martin would like to block time every day for a 30-minute lunch break at 12:00 pm and rounds from 8:00 am to 9:00 am. Jean Burke, NP would like to block time every day for a 30-minute lunch break at 12:30 pm and next Wednesday for an out-of-office meeting from 2:00 pm to 4:00 pm. Block the schedule for lunch breaks, rounds, and meetings for the next month.

Created by
Elsevier



[Print](#)
[Start Assignment](#)

This will take you to the Calendar View. Click the **Assignment Details** button on the right-hand to get the description of the assignment.

SimChart® for the medical office

Assignment Name: 3. Prepare Scheduling Matrix

Front Office Clinical Care Coding & Billing

Calendar

Calendar View

Add Appointment

May 2017

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Search

Search by patient

Filter By

Provider: -Select-

Appointment Type

All

Patient Visit


Block

Other

May 7 — 13, 2017

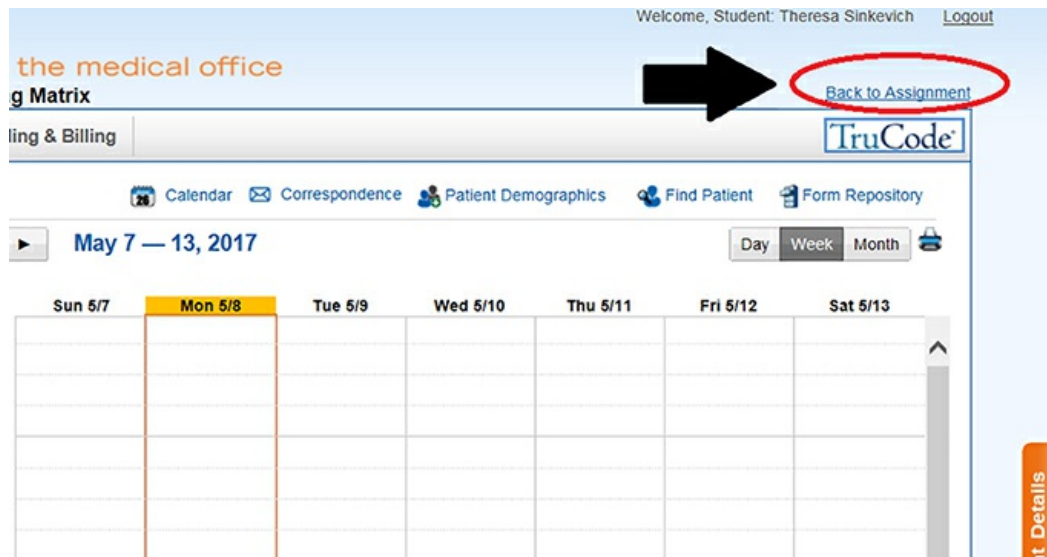
Day Week Month

	Sun 5/7	Mon 5/8	Tue 5/9	Wed 5/10	Thu 5/11	Fri 5/12	Sat 5/13
8am							
9am							
10am							
11am							
12pm							
1pm							

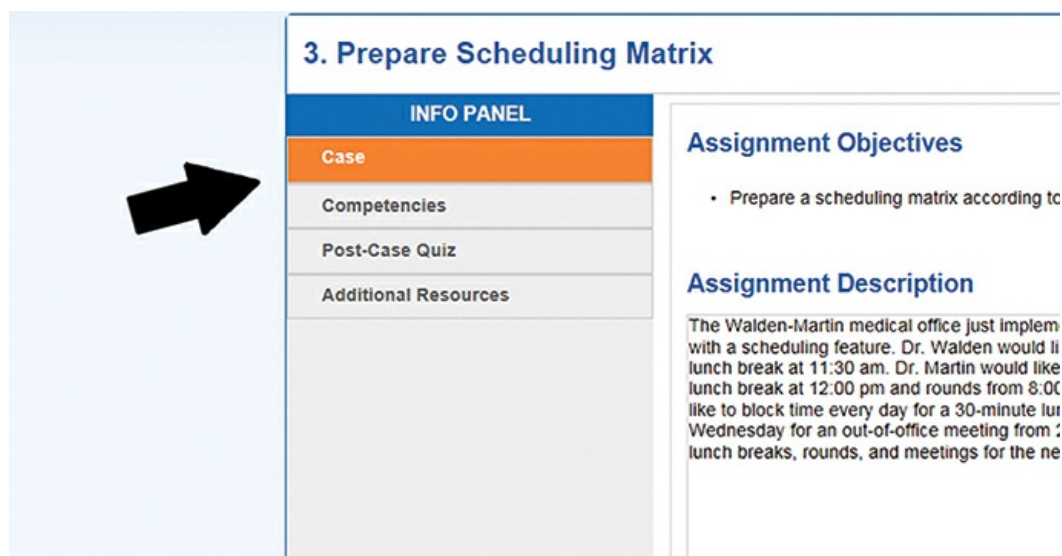


[Assignment Details](#)

When you've completed the assignment, click on **Back to Assignment**.



You'll now be taken back to the assignment description.



Before submitting your assignment, click on **Post-Case Quiz** under the Info Panel.

The number of questions differs for each assignment. After you select

your answer, click the orange **Save** button to go on to the next question.

3. Prepare Scheduling Matrix

INFO PANEL

Case

Competencies

Post-Case Quiz

Additional Resources

Please answer all questions in the assignment before submitting

1

2

3

4

5

The action of blocking time when a physician is unavailable is referred to as:

- ☐ plan.
- ☐ book.
- ☐ calendar.
- ☐ matrix.

Submit Assignment

Save

When you're finished with all of the questions and have saved your answers, click on the orange **Submit Assignment** button in the bottom left-hand corner.

3. Prepare Scheduling Matrix


INFO PANEL

Case

Competencies

Post-Case Quiz

Additional Resources



Submit Assignment

Please answer all questions in the assignment before submitting

1

2

3

4

5

The action of blocking time when a physician is unavailable is referred to as:

- ☐ plan.
- ☐ book.
- ☐ calendar.
- ☐ matrix.


Save

You'll then see this prompt once you click the **Submit Assignment** button asking if you wish to submit. No further changes can be made after submission.

True or false? When scheduling a procedure such as a sigmoidoscopy, the medical assistant must consider availability as well as the availability of the exam room.

True


Confirmation



Are you sure you want to Submit? Once you submit your assignment, no further changes can be made.

Submit

Cancel



You'll get a prompt notifying you your assignment has been submitted

for grading. Click **OK** to continue.


Please answer all questions in the assignment before submitting.

1 2 3 4 5 6 7

True or false? When scheduling a procedure such as a sigmoidoscopy, the medical assistant must consider availability as well as the availability of the exam room.

☒ True
☐ False

Information

 Your assignment has been submitted for grading.

OK

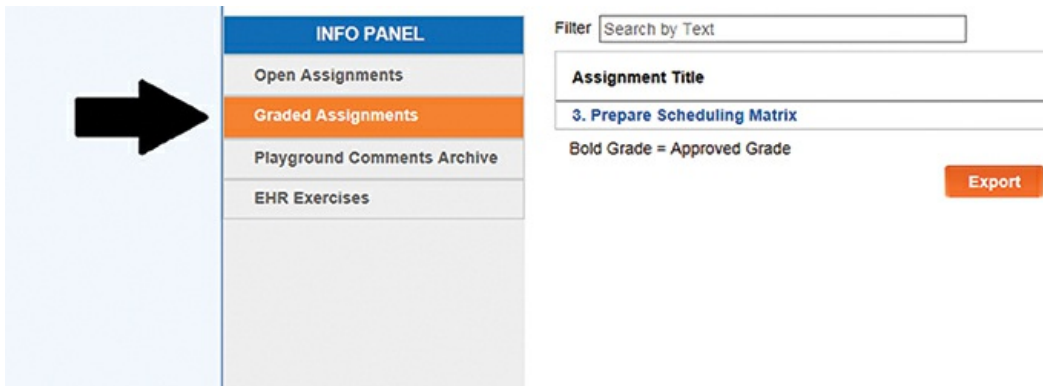
Please wait...

The assignment you submitted will disappear from your Open Assignments area and go to your Graded Assignments section.

INFO PANEL		Filter Assignments:	Simulation Playground	
Open Assignments				
Graded Assignments				
Playground Comments Archive				
EHR Exercises				
Assignment Title		Module	Duration	Status
4. Prepare Appointment Reminder Letter for Amma Patel		Front Office	00:20	Not Started
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105. Generate a Prior Authorization for Ken Thomas		Front Office	00:15	Not Started

Now click on the **Graded Assignments** tab.

If the grade is *not* in bold, it's only reflecting your Post-Case Quiz, which is only worth 10% of your overall grade for that particular simulation.



Please allow 3 to 5 business days for your simulation work to be graded. In that time, check back on this site to see if the assignment has been returned for a re-attempt.

You may call Penn Foster with any questions at 800-982-1288.

Computer Maintenance Tips: Clearing Cache and Cookies

1. Log out of Evolve by clicking the Account icon in the top right corner of the screen.
 - If you're using Internet Explorer, Edge, Firefox, or Chrome on Windows, hold **Ctrl** and **Shift** and press **Delete**.
 - If you're using Firefox or Chrome on a Mac, hold **Shift** and **Command** and press **Delete**.
 - If you're using Safari, click the Safari menu in the top left corner and select **Clear History**.
2. Perform the following actions based on which browser you're using:
 - In Internet Explorer or Edge: Remove the check from the box for Preserve Favorites website data, if there's one, and check the boxes for Temporary Internet files and website

files and Cookies and website data. Then click **Delete**.

- In Firefox: When you see the time range drop-down menu, set this to everything and check the boxes for Cookies, Cache, and Offline Website Data. Then click the **Clear Now** button.
- In Chrome: When you see the clear items drop-down menu, set it to the beginning of time and check the boxes for Cookies and other site data and Cached images and files. Then click the **Clear Browsing Data** button.
- In Safari: Set to clear all history and click the **Clear History** button.

3. After these items have been cleared, close the browser, restart the browser, and log back into Evolve.

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Contact Support Via Ticket Submission

1. Visit [Elsevier Support](#).
2. Select Evolve Products.
3. Select SimChart.
4. Scroll down and choose Email.
5. Select your role (“Education / Faculty” or “Student”).
6. Type “PENN_FOSTER” in the Subject field, and be sure to

include the underscore symbol.

7. Fill out all other required information, and click Continue.
8. Review the information, and click Submit.
9. An experienced Customer Representatives will be in contact with you shortly.

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4. Scroll down and choose Chat.
5. Fill out the required information.
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7. Click Submit Request.
8. The next available chat agent will assist you.

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Saturday: 8am–6pm CST

Sunday: 12pm–10pm CST

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Discover More: The Use of EHR

Complete the key term review in the Chapter Review Activities found at the end of Chapter 1.

Discover More Answer Key:

Discover More: The Use of EHR

1. d
2. h
3. e
4. a
5. c
6. b
7. i
8. f
9. g
10. j

1.2 Explain student resources and EHR available for SimChart for the Medical Office

Assignment 2: Overview Of Simchart For The Medical Office

READING ASSIGNMENT

Read this assignment. Then read Chapter 2 in your textbook.

The Medical Practice Goes Digital

Becoming proficient with an EHR is an important role as a Medical Assistant. Learning SimChart for the Medical Office (SCMO) will help you to become familiar with real-life application of an EHR, therefore you'll have the tools necessary to become comfortable with any EHR.

Getting Comfortable with Electronic Health Records Software

SimChart for Medical Office (SCMO) is a specialized type of software, called Software as a Service (SaaS), meaning the software is housed in a central location and it can be accessed through the internet and therefore can be accessed in a variety of locations. It contains all components, including front-office, clinical care, and billing/coding. All users have their own access and therefore your work will not affect other users.

Modules

SCMO is organized into three modules to simulate the workflow in an office for each patient, which are Front Office, Clinical Care, and Coding & Billing. Front Office uses the calendar as the default for this page. Appointments can be created, deleted, or edited. Schedules can be blocked for meetings or lunch hours. Patient letters, emails, and phone calls can be created. This will be discussed further in Chapter

4. Clinical Care is where all patient care can be viewed and documented. Documentation must occur within a patient encounter. Any clinical imaging, labs, or forms can be uploaded with the form repository. This will be discussed further in Chapter 5. Coding & Billing have services rendered must be reimbursed. This will be discussed further in Chapter 6.

Recurring Features in SCMO

Buttons are found throughout, with some having graphics and others with text labels. Most use a single click and are only clickable if they're in full color. If unclickable, the button will be grayed. In the *default* settings when dialog boxes are opened the options are already preselected, much like in a word processor document with fonts and margins. The info panel is found on the left of the screen and will change based which module (Front Office, Clinical Care, Coding & Billing) is being used. Unstructured data entry uses voice dictation or free text typing into text fields and is most similar to paper charting. Structured data entry uses drops down menus, default settings, templates, and check boxes to enter patient information. Structured data provides more consistent documentation and is easier to share among computer systems. It's important to become familiar with both types of data entry and the SCMO has both types for your experience. The *find patient* tool allows for entry of the first few letters of a last name to display matching names to more easily locate a patient than scrolling through lists of names.

Establishing and Maintaining a Patient Registry

Active patients have been seen by a provider in the clinic within three years, *inactive patients* haven't been seen in three years, and *closed patients* are those patients that have terminated their relationship due to moving away, discharge from the practice for bad debts, or missing appointments, or patients that are deceased. Closed patient records must be kept for a certain amount of time, which is set forth by law that varies from each state, and this is called the *retention period*.

Internet Use in the Medical Office

Professional use of the internet occurs as most EHRs, including SCMO, need the internet in order to run. Other uses of the internet in the medical office include looking up information about other testing sites, medications, support groups, and patient education material. Caution should be taken with various sites, as not all internet sites are reliable. Personal use of the internet shouldn't occur while at work and includes use of social media sites, online shopping, playing games, checking bank account information, or paying bills. The internet should be used solely for tasks related to one's job.

Discover More: Assistance and SimChart in EHR

Complete the key term review in the Chapter Review Activities found at the end of Chapter 2.

Discover More Answer Key:

Discover More: Assistance and SimChart in EHR

1. c
2. d
3. b
4. a
5. e
6. f

1.3 Describe HIPAA, the Security Rule, the Privacy Rule, and confidentiality and its effect on patient care

Assignment 3: Privacy, Confidentiality, And Security

READING ASSIGNMENT

Read this assignment. Then read Chapter 3 in your textbook.

Health Insurance Portability and Accountability Act (HIPAA)

Health Insurance Portability and Accountability Act (HIPAA) is a mandatory measure in place to protect privacy, confidentiality, and security in healthcare. HIPAA began due to the easier and more abundant access to patient information with electronic transmission of patient information. The portability portion protects patients from being denied insurance due to preexisting conditions and allows employees

to keep insurability when moving from one job to another. The accountability portion protects patient information.

Confidentiality versus Privacy

Confidentiality and privacy can be used interchangeably in casual speech, but with relation to HIPAA and healthcare, they have different meanings. *Confidentiality* is the right of an individual to have all of his or her information kept private. Only those directly involved in the patient's care should view their healthcare information. There are certain things to implement to stay confidential in the work place, such as protected computer screens, screen locked when away from the computer, avoidance of posting schedules around the office, and patient cases shouldn't be discussed where others may overhear the conversation.

Privacy is the patient's right to control how his or her healthcare information is used and shared with others. Before information can be given to a third party, there must be written permission, such as when a provider wants to use patient information for research or writing a journal article. HIPAA states that if the patient information is being used for treatment, payment, or operations, the patient doesn't need to give permission. A patient has a right to know who has accessed their health record and who has received information from the health record. All of this is tracked within EHR.

Confidential versus Anonymous

The notion of *confidential* information is that the healthcare information isn't shared. However, there are multiple instances that information is shared such as in sexual assault cases, child protective services cases, and sexually transmitted diseases. All of these are reported to a specific agency, usually public health and law enforcement. Insurance companies also may receive results, as patient's sign a document permitting access to healthcare records when they sign up for insurance. *Anonymity* means that the patient's information wouldn't be attached to specific testing, therefore the testing couldn't be traced back to the patient.

Privacy Rule

The *HIPAA Privacy Rule* establishes standards for the use and *disclosure* of individually identifiable health information, promotes patients' understanding of their privacy rights, and helps patient control ways in which their health information is used and disclosed. This applies to all health information in any form, such as conversation, paper, or electronic. *Protected Health Information (PHI)* is any identifiable health information that may include demographic information, diagnosis, or billing information that's stored, maintained, or transmitted electronically. If PHI is released for any reason other than healthcare operations, this must be documented and kept in a log for six years. There are multiple contents that must be included with each disclosure, which is explained in Chapter 3. If PHI is needed for research purposes, all of the information must be de-identified appropriately, removing anything that may identify the patient, such as

telephone number, serial numbers of implanted devices, medical record numbers, health insurance ID, and so on to keep the health record confidential.

Covered entities include any medical provider (businesses within the healthcare industry that transmit claims, including laboratories and accounting firms that process medical billing claims), health plan (any payer of medical cost, except law enforcement, worker's compensation, or vehicle insurance policies), or healthcare clearinghouse (information processing company that allows healthcare services and billing companies with compatible platforms to share information) that transmits health information electronically. *Business associates* are any person or entity that performs certain functions or activities that involve use or disclosure of PHI. A contract is written from the covered entities for the business associates that outlines the privacy and security requirements of the PHI.

Minimum necessary standard is the minimum amount of information that should be included when a covered entity makes an allowed disclosure to accomplish the task, therefore each employee in the healthcare facility has different access to patient information. Patients may sign an authorization form in order to give permission for PHI to be discussed with others, such as a spouse. Patient's must also sign consent for their health information to be used for treatment, payment, and operations.

Watch this video <https://www.youtube.com/watch?v=gzh80m0r7k4> for

further understanding of HIPAA and the privacy rule.

Security Rule

The security rule protects PHI from natural disaster or hacking, and only those can have access when it's in line with their job function. Both the security and privacy rules are closely bound. Essentially the privacy rule is a statement of principles and the security rule is the plan for applying them.

Security Safeguards in the Medical Practice

Safeguards are put into place to avert security breaches and fall into three areas. *Administrative safeguards* mean that covered entities must adopt processes that prevent, detect, contain, and correct security violations. *Physical safeguards* protect the facility where the EHR is housed. This can include locks, security guards, badges, and video monitoring. Equipment, such as computers, should also be protected and this can be done with password protection and screen savers. There must be a plan in place in the event of a natural disaster or power outage, so that PHI is backed up and saved in a different location. Lastly, if the EHR is to go down, there must be a plan in place to continue with routine patient care and documenting. Each employee will have a username and password to log into the EHR. The amount of access is determined by the security officer, and in general, providers will have full access. Passwords should have a minimum of eight alphanumeric characters and should be changed periodically, at least every 90 days.

Technical safeguards grant users the minimum amount of access necessary to perform their job duties. For the purposes of learning, the SCMO is designed to allow full access to you as the user. There must be termination of access for those no longer authorized to use the EHR, such as an employee that has been terminated. An *access trail* shows which patient records have been accessed and which functions have occurred within the patient record. Periodically, the access trail for each user will be audited to determine correctness and completeness. Users can be added to the specific patient record, so that unauthorized users would be unable to search for that specific patient.

Patients' Rights Under HIPAA

HIPAA has been amended many times since it was first introduced in 1996, which has led to misunderstandings. There are several patient rights under HIPAA. A patient can view or receive copies of health records, which is guaranteed by law and some medical clinics may charge a copying or mailing fee. A patient can have inaccurate health information corrected. If there's an agreement between patient and provider that information is wrong, an amendment may be completed within 60 days, without the previous information removed, but rather clearly documented that this information is incorrect. The provider doesn't have to make an amendment if they don't agree with the inaccuracy of the information, but a statement of disagreement can be filed by the patient and placed in EHR to give their rationale behind what's inaccurate and why. A patient can receive a notice of privacy

practices which explains how the PHI can be disclosed, to whom, and under what circumstances. A patient can opt out of sharing certain information with certain people such as with specific family members, but not others, choose to have their room number unavailable at the hospital switchboard, and other privacy requests.

A patient can have certain information withheld from certain third parties, such as health information withheld from patient's employer, direct marketers, and others, unless the patient signs an authorization form for release. A patient can receive a list of disclosures of health information for who, when, and why health information has been accessed. A patient can file a complaint, if it's believed that any of their providers have violated their provisions, they're able to file a complaint with the Office for Civil Rights (OCR) of the US Department of Health and Human Services (HHS).

Other Security Initiatives

Consolidated Health Informatics Initiative is a collaborative effort of 20 federal agencies, including the HHS, to have specific standards for health information exchange throughout the federal government. HITECH Act, which is part of the American Recovery and Reinvestment Act of 2009, has security elements to enforce penalties and requires breach-of-data notifications.

Access to Protected Health Information

Government agencies can have access to EHRs including correctional

institutions, military health plans, worker's compensation, and medical examiners. If a privacy complaint has been filed, the HHS has access to review patient records. Financial Institutions are governed under the Financial Services Modernization Act, which allows for banks, insurance agencies, check cashers, mortgage brokers, finance companies, and others to join as a single entity. Payments made to a pharmacy or medical practice may be freely shared. These institutions must disclose privacy practices to allow for customers to opt out. Only healthcare institutions and facilities are subject to HIPAA.

Consumer reporting agencies are used for potential lenders to check your payment history before providing a loan. Life, health, disability, and long-term care insurance rely on consumer agencies to find out about health and prescription drug history. These companies aren't subject to HIPAA. The Fair Credit Reporting Act (FCRA) is to protect the consumer's privacy and ensure accuracy of information. If rates increase or coverage is denied from information obtained from a consumer reporting agency, the customer must be given notice of this change and also has access to the report. The Medical Information Bureau (MIB) is a consumer report agency that's a nonprofit and maintains a database of medical information exchanged by the life, health, and disability insurers. Patients who have never filed a health insurance claim for serious injury or illness, won't have a file. Prescription database tools show drug purchasing history in a database, which can be sold for a low price to insurance companies. Prescription medication can give an indication for certain diagnosis,

but due to many medications being used *off-label*, that's used for other means other than the intended use, this can mislead that a particular medication is used for a specific diagnosis.

Employers with group health plans with 50 or more employees are subject to HIPAA and have access to review the summary of healthcare expenses for their employees. In many states, an employer may have an employee sign a waiver to authorize disclosure of information in their EHR systems. Many times, this may occur unknown to the employee when they're signing disclosure for background checks and so on.

Disclosure of patient information to family and friends of the patient must be specified by the patient. An exception is if the patient is incapacitated and it can be reasonably known that the patient wouldn't object, relevant health information can be disclosed, particularly if it's in the best interest of the patient.

Through the internet, many people post health updates on social media sites. Many of these sites capture, store, and sell this information without the patient's knowledge, which could potentially make it to insurance companies and marketers. A general rule is don't post it unless you want the whole world to see it.

Research is an important secondary use of healthcare information and many patients approve of disclosure of medical information for research purposes, barring that the information is personally deidentified. Direct marketing firms can be thought of as junk mail or

spam. There have been concerns that information in the EHR may be disclosed for purposes of invasive direct marketing to patients by competitors. For example, if a patient is prescribed a specific medication, a competitor that makes a similar medication may be able to obtain this information and directly attempt to market the product directly to the patient. HIPAA privacy rule prohibits disclosure of PHI from EHR unless it occurs face to face or the direct marketer offers a gift.

How Patients Can Protect Their Health Information

Patients should check records for inaccuracies that can be made by human error and may affect patient's health. A patient may review medical, dental, and prescription drug records and if there are any inaccuracies, a patient can request an amendment and this is to be completed within 60 days. A patient may request a disclosure log to determine who has been accessing their records. Patients may also request restrictions on disclosure of sensitive information for payment purposes. For instance, if someone is covered under their spouse's work insurance, she may restrict the insurance company from disclosing PHI to her husband. A patient may ask to receive correspondence at alternative locations as patients may choose where to receive telephone messages and medical bills. Patients may pay out of pocket for certain medical visits or for mental health or addiction medicine, keeping their information "off the grid" from insurance companies or private payers. A patient may opt for online versus paper statements and read them carefully as there are concerns for

EHR information that may be lost or stolen from medical institutions. In terms of identity theft, many still steal mail directly out of the mail box, so it's best to receive electronic statements.

Discover More: Medical Data Encryption

Complete the key terms review in the Chapter Review Activities found at the end of Chapter 3.

Discover More Answer Key:

Discover More: Medical Data Encryption

1. c
2. d
3. i
4. g
5. j
6. a
7. l
8. f
9. b
10. h
11. n
12. m
13. k
14. o

15. e

Lesson 1 Review

Self-Check

1. Early medical documentation of present day post-traumatic stress syndrome was first seen in
 - a. the plagues of Europe.
 - b. 200 BCE China.
 - c. the Korean War.
 - d. the US Civil War.
2. Which of the following is not found in the patient medical record?
 - a. Operative reports
 - b. Living will
 - c. Immunization records
 - d. Patient statement
3. An example of a HIPAA form that's included in the medical record would be
 - a. informed consent forms acknowledgment.
 - b. a living will.
 - c. a Notice of Privacy Practices.
 - d. a patient information sheet.
4. Voice recognition software
 - a. will increase transcription costs for the medical office.

- b. has a quick implementation and requires very little training.
- c. may increase errors because there is no assistant to review the notation.
- d. automatically converts a documenter's spoken word into written words.

5. The receptionist would commonly document

- a. patient vital signs.
- b. patient no-shows.
- c. diagnosis of the patient condition.
- d. results of tests performed.

6. Owner of the physical medical record

- a. is the one who creates and maintains the record.
- b. is always the patient.
- c. is the hospital the provider admits to.
- d. is always the provider.

7. In SimChart for the Medical Office, a patient visit with a provider is called a(n)

- a. progress note.
- b. visit.
- c. interaction.
- d. encounter.

8. Which of the following professional organizations is made up of health information management professionals?

- a. AAPC
- b. AMT
- c. AHIMA

- d. AMA
- 9.** Which of the following professional organizations has identified the use of computers and electronic equipment in the medical office as one of its key competencies?
- a. AAPC
 - b. AMT
 - c. AAMA
 - d. AMA
- 10.** With the implementation of an EHR, it's helpful if employees can be _____ so that they're able to perform more than one duty within the EHR.
- a. team leaders
 - b. fully supported
 - c. cross-trained
 - d. out-sourced
- 11.** An individual who is responsible for recording data in the patient record is called a
- a. health records clerk.
 - b. data entry clerk.
 - c. transcriber.
 - d. documenter.
- 12.** Which of the following is *not* a documenter of the patient chart?
- a. Provider
 - b. Medical assistant
 - c. Patient
 - d. Medical billing specialist

13. What's an element of the user interface on which the user can click to execute a command, such as confirm, cancel, or exit?

- a. Icon
- b. Submenu
- c. Button
- d. Drop down box

14. What would the record of a patient who hasn't been seen by the provider in three or more years be considered?

- a. Closed record
- b. Terminated record
- c. New patient
- d. Inactive record

15. What's a preselected value or setting that will be used unless the user specifies a substitute by overriding the preselected choice?

- a. Context-specific feature
- b. Default
- c. Button
- d. Icon

16. An appropriate use of the Internet in a healthcare setting would be

- a. searching for a new apartment.
- b. viewing personal emails.
- c. finding links for community resources.
- d. posting pictures to Instagram.

17. In SimChart for the Medical Office, Front Office, Clinical Care, and Coding & Billing are known as

- a. offices.

- b. modules.
- c. clinic statuses.
- d. tabs.

18. Which of the following Student Resources will provide help with completing tasks in SimChart for the Medical Office?

- a. Simulation Playground
- b. Student FAQ
- c. Quick Tips for Students
- d. Medical Office Workflow

19. What should you click on in the assignment grid to open the assignment?

- a. Module
- b. Assignment title
- c. Status
- d. Estimated duration

20. What's the landing page for SimChart for the Medical Office assignments?

- a. Login
- b. Patient dashboard
- c. Calendar
- d. Billing and Coding Module

21. _____ is the term that describes the amount of time records must be kept in storage by a medical office.

- a. Restore
- b. Statute of limitations
- c. Retention period

d. Limitation period

22. When it's certain that a patient will no longer be returning to the practice, that patient's record is considered to be

- a. terminated.
- b. active.
- c. closed.
- d. inactive.

23. When entering the Clinical Care module, the _____ will be displayed.

- a. Patient Dashboard
- b. Patient Ledger
- c. Gradebook
- d. Calendar View

24. Which of the following is *not* an example of Student Resources in SimChart for the Medical Office?

- a. Gradebook Overview
- b. Job Readiness
- c. Submitting an Assignment
- d. Assignment Answer Key

25. ABC insurance has decided to discontinue Avery's insurance based on information it received from the local consumer reports agency. This falls under

- a. anonymity.
- b. statute of limitations.
- c. adverse action.
- d. preexisting condition.

26. The office manager reviews the staff _____ every six months to determine if any unauthorized information was accessed.

- a. audit trail
- b. authorization checks
- c. user name verification
- d. authentication trails

27. In order to release patient information for participation in a research study, a _____ form would be completed in SimChart for the Medical Office.

- a. Notice of Privacy Practices
- b. Disclosure Authorization
- c. Advance Directive
- d. Authentication Consent

28. Kim has an appointment with a specialist to discuss chronic syncopal episodes. She needs must provide _____ for a copy of her PMH to be sent to the specialist.

- a. consent
- b. authentication
- c. authorization
- d. contract

29. A consumer reporting agency is regulated under the _____ Act.

- a. Federal Trade Commission
- b. Fair Credit Reporting
- c. CMS
- d. HIPAA

30. Medical offices submitting claims electronically are called

- a. electronic carriers.
- b. HIPAA entities.
- c. covered entities.
- d. covered claims.

31. To locate and complete the Medical Records Release document, you would click on which icon in SimChart for the Medical Office?

- a. Coding and Billing
- b. Form Repository
- c. Patient Demographics
- d. Correspondence

32. Katie is going to an ENT specialist for seasonal allergies. Only those progress notes pertaining to treatment of rhinitis and copies of sinus x-rays are sent to the specialist's office. This is an example of

- a. laws.
- b. HIPAA release.
- c. consent.
- d. minimum necessary standard.

33. Implementation of user names, passwords, and screen savers are examples of _____.

- a. privacy
- b. protected health information
- c. codes
- d. safeguards

34. Which of the following is *not* an example of secondary use?

- a. Research of disease treatment
- b. Prescription sent to a pharmacy

- c. Monitoring and tracking disease incidence
- d. Marketing

35. The federal government agencies responsible for the Consolidated Health Informatics (CHI) initiative are

- a. Centers for Medicare and Medicaid Services (CMS) and the Department of Veterans Affairs (VA).
- b. Department of Veterans Affairs (VA) and the Office of the National Coordinator (ONC).
- c. Office of Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS).
- d. Department of Veterans Affairs (VA) and the Department of Health Human Services (HHS).

Self-Check Answer Key

1. the US Civil War.

Explanation: The Civil War era is when the first records were kept of what we today refer to as post-traumatic stress disorder.

Reference: Section 1.1

2. Patient statement

Explanation: A patient statement is not found within the patient's medical record. The contents of the medical record include clinical information, such as immunization records and operative reports, administrative information, and legal documents, which

include a living will.

Reference: Section 1.1

3. a Notice of Privacy Practices.

Explanation: A notice of privacy practice is a document that provides an explanation for how health information is used and shared, which is typically signed by the patient on the first visit to a medical practice.

Reference: Section 1.1

4. automatically converts a documenter's spoken word into written words.

Explanation: Voice recognition software uses a microphone to transmit spoken words into text, which may decrease the transcription cost and allows the user to make corrections if there are any errors.

Reference: Section 1.1

5. patient no-shows.

Explanation: The receptionist would be responsible for documenting patient no-shows within the chart, as this is a front office duty.

Reference: Section 1.1

6. is the one who creates and maintains the record.

Explanation: The one who creates and maintains the medical record is the owner of the medical record, which may vary by a provider working in a private practice, in which they own their own record, or a provider within an institution, for which the institution owns the record. The patient does not own the record but is able to control the information within the record.

Reference: Section 1.1

7. encounter.

Explanation: An encounter is the term used to describe the interaction between the provider and the patient within SimChart for the Medical Office.

Reference: Section 1.1

8. AHIMA

Explanation: AHIMA is an abbreviation for American Health Information Management Association, which is a professional organization made up of health information management professionals.

Reference: Section 1.1

9. AAMA

Explanation: AAMA is an abbreviation for the American Association of Medical Assistants and is a professional organization that identifies with the competencies of use of computers and electronic equipment in the medical office.

Reference: Section 1.1

10. cross-trained

Explanation: As the EHR has multiple components, employees should be cross-trained in several areas to allow for multiple duties to be performed within the patient chart.

Reference: Section 1.1

11. documenter.

Explanation: Multiple users are able to document within the chart and any of these users are called documenters.

Reference: Section 1.1

12. Patient

Explanation: Medical assistants, providers, and medical billing specialists are all documenters within the chart, but patients do no document within the chart.

Reference: Section 1.1

13. Button

Explanation: A button is the element that allows a command to be performed with a click.

Reference: Section 1.2

14. Inactive record

Explanation: If a patient has not been seen by a provider within 3 years, this would be called an inactive record, as any current patient within 3 years is called an active record.

Reference: Section 1.2

15. Default

Explanation: If a user does not specify a preselected value, this will be set to a default. The user may also override the default to choose a preselected choice.

Reference: Section 1.2

16. finding links for community resources.

Explanation: Internet use in the office should only be used for job related duties and an example would be using the internet to find

links for community resources.

Reference: Section 1.2

17. modules.

Explanation: SimChart for the Medical Office contains four modules, which are Medical Office, Front Office, Clinic Care, and Coding & Billing.

Reference: Section 1.2

18. Medical Office Workflow

Explanation: Medical Office Work Flow is a student resource available in SimChart for the Medical Office to complete tasks.

Reference: Section 1.2

19. Assignment title

Explanation: Clicking on Assignment Title within the assignment grid will open the assignment.

Reference: Section 1.2

20. Calendar

Explanation: The calendar is the assignment landing page within SimChart for the Medical Office.

Reference: Section 1.2

21. Retention period

Explanation: Records must be kept for a set amount of time in storage by a medical office, called the retention period.

Reference: Section 1.2

22. closed.

Explanation: A closed record is the state of a record if it's certain the patient will never return (for example, if the patient is deceased).

Reference: Section 1.2

23. Patient Dashboard

Explanation: The patient dashboard is displayed upon entering the clinical care module.

Reference: Section 1.2

24. Assignment Answer Key

Explanation: Within SimChart for the Medical Office, the student resources available are submitting an assignment, job readiness, and gradebook overview. The assignment answer key is not

available.

Reference: Section 1.2

25. adverse action.

Explanation: Adverse action is a negative action reported to an insurance company that results in denial of insurance coverage.

Reference: Section 1.3

26. audit trail

Explanation: An audit trail is a detailed map of each user's clicks and which charts have been accessed by the user. This protects the patient's chart from inappropriate access and usage.

Reference: Section 1.3

27. Disclosure Authorization

Explanation: A disclosure authentication is a form for release of patient information to be included in a research study.

Reference: Section 1.3

28. authorization

Explanation: A patient must sign an authorization form in order for their patient information to be sent to a specialist for further care.

Reference: Section 1.3

29. Fair Credit Reporting

Explanation: The Fair Credit Reporting Act is responsible for regulating the consumer reporting agency to protect the consumer's privacy and ensure accurate information.

Reference: Section 1.3

30. covered entities.

Explanation: A covered entity is a medical office that submits insurance claims electronically.

Reference: Section 1.3

31. Form Repository

Explanation: The form repository icon within SimChart for the Medical Office in order to complete the Medical Records Release document.

Reference: Section 1.3

32. minimum necessary standard.

Explanation: The minimum necessary standard is the minimum amount of information that should be included when a covered

entity makes an allowed disclosure to complete a task.

Reference: Section 1.3

33. safeguards

Explanation: Security guards are put into place to prevent any security breaches, which include passwords, usernames, and screen savers.

Reference: Section 1.3

34. Prescription sent to a pharmacy

Explanation: Secondary use of medical information includes research of disease, marketing, and monitoring and tracking disease.

Reference: Section 1.3

35. Department of Veterans Affairs (VA) and the Department of Health Human Services (HHS).

Explanation: The Department of Health and Human Services (HHS) and Department of Veterans Affairs (VA) are responsible for the Consolidated Health Informatics (CHI) initiative.

Reference: Section 1.3

