***CMA 111 Documentation in the Medical Office***

Course Information Sheet

Instructor: Rick or Kathy Durling Email: durlinr@linnbenton.edu or durlink@linnbenton.edu Office: Upstairs in Health Occupations Center

Required Text: None [Rick’s Office Hours](https://docs.google.com/spreadsheets/d/1buaMdFl5HVV5NdcnlwI6htpCt7vJ6GmCXRwTo4R45Mk/edit?usp=sharing) CRN 32559

Class Time & Location: M/W 1200-1320, Health Occupations Center - Room 251

[Student Schedule of Responsibilities](https://docs.google.com/spreadsheets/d/1RDx4K4gFeA9wkp2FLjM8W-_C2Govs5w9oqJCyCgfLgM/edit?usp=sharing)

***Description***

This course is designed to teach the successful student how to properly document medical office activity, focusing on clinical (patient care) documentation.

***Outcomes***

Upon successful completion of this course, the student will have demonstrated competency in the following required Medical Assistant and Coding/Reimbursement Programs standards and by the AAMA and AAPC:

Course Outcomes I:

P1 - Student will produce a professional clinical note POMR style (with SOAP notes).

P2 - Student will produce a professional clinical note SOMR style

P3 - Student will produce a professional clinical note using electronic medical records

P4 - Student will demonstrate the ability to develop a History of Present Illness

P5 - Student will demonstrate the ability to develop a Review of Systems

P6 - Student will demonstrate the ability to accurately document a Patient Exam

P7 - Student will demonstrate the ability to accurately document Medical Decision Making

P8 - Student will demonstrate the ability to accurately document Past, Fam, Soc History

P9 - Student will demonstrate the ability to accurately scribe a medical office visit

MAERB Standards (Course Outcomes II)

|  |  |
| --- | --- |
| V.C.16 | Differentiate between subjective and objective information |
| V.C.8 | Discuss applications of electronic technology in professional communication |
| V.P.6 | Demonstrate professional telephone techniques |
| V.P.7 | Document telephone messages accurately |
| V.P.9 | Develop a current list of community resources related to patients' healthcare needs |
| VI.C.4 | Define types of information contained in the patient’s medical record |
| VI.C.5.a | Identify methods of organizing the patient’s medical record based on: problem-oriented medical record (POMR) |
| VI.C.5.b | Identify methods of organizing the patient’s medical record based on: source-oriented medical record (SOMR) |

**Assessment**

1. 10 Competencies 10 pts each (except CA10 is 20 pts)
2. 9 Activities 5 pts each (last one EC)
3. 10 Module Quizzes 10 points each
4. 1 Written Final Exam Worth 50 points
5. Total Points in this course: 300
6. A= 270 pt, B= 240 pt, C= 210 pt, D= 180 pt, F=< 180 pts

***Information about Assignments***

This course requires the competent use of [GOOGLE DOCS](https://www.youtube.com/watch?v=OBh8bMC7XEU). ALL assignments will be turned in using google docs. If you need additional instruction using google docs please see your instructor.

Competency Assessments and Activities - There will be one competency assessment and one activity for each week (module). Each assignment will be worth 10 points and will be due according to the [student schedule of course responsibilities](https://docs.google.com/spreadsheets/d/17L-32deVjWLc8WE019s2ZEFfLAGMPhEvKssfbfyIReM/edit?usp=sharing). Assignments are due by the scheduled due date at 8:00 AM and must be submitted through moodle. Assignments submitted by email will not be accepted or graded. Follow the specific assignment instructions in your moodle links and take a look at the grading rubric before submitting your assignment. *From time to time it may become necessary to understand what one “page” of writing might be. MLA standard would by 450-500 words per page. Google Docs has a word count feature listed under the tools menu to help guide you.*

From time to time you may have questions about the grading of assignments or other course material. Please email your instructor or come in during office hours. Your instructor will not discuss these items during class time. Please reference the course and assignment name when you do this.

While Competency Assessments are generally completed outside of class time, Activities are designed to be completed within a work group during class time. Activities can ONLY be turned in if you are in Attendance on Thursday and are designed to be collaborative with a group. You should team up to better cover the topic.

Assignment submissions should be hyperlinked with the assignment name, i.e. “CA1” or “A2”, etc. If you need help learning to do this please ask a team member or your instructor. Also, submitted documents should be properly headed. For example:

Sally Student\*

CMA 111

January 14, 2018

CA1

*(this would be in the top left hand corner of Sally’s submitted document)*

*(\*Additionally group submissions should include the names of the group members in the header)*

Quizzes - Quizzes will be due weekly on the topic material. According to department policy, quizzes cannot be made up or retaken (you may petition the department chair if you feel you have a valid reason to retake or make up a quiz). Quizzes will each be worth 10 points and will be timed for one hour. Students are expected to follow the department [academic honesty policy](https://docs.google.com/document/d/1nEogRRc18XxTGP1lwO8AtEhPUsqcJ6-r_FVPabAqtq0/edit?usp=sharing). This means you need to take the quiz yourself. Outside materials are permitted during test.

**Course Academic Dishonesty Policy**Any student caught cheating, duplicating another student’s work, or other form of academic dishonesty, will be counseled by the instructor. The first offense will result in a “zero” grade for that assignment/assessment, a lowering of the final course grade by one full grade, and the student’s name and offense may be sent to the Dean of Students for LBCC depending upon student response. A second offense will result in an automatic “fail” for the course and the student will be referred to the Dean of Students for LBCC to determine further disciplinary action and to gain approval before returning to class.

**LBCC Comprehensive Statement of Nondiscrimination**LBCC prohibits unlawful discrimination based on race, color, religion, ethnicity, use of native language, national origin, sex, sexual orientation, marital status, disability, veteran status, age, or any other status protected under applicable federal, state, or local laws.(for further information<http://po.linnbenton.edu/BPsandARs/> ***For Students with Disabilities***

LBCC is committed to inclusiveness and equal access to higher education. If you have approved accommodations through the Center for Accessibility Resources (CFAR) and would like to use your accommodations in this class, please talk to your instructor as soon as possible to discuss your needs. If you believe you may need accommodations, but are not yet registered with CFAR, please go to <http://linnbenton.edu/cfar> for steps on how to apply for services or call 541-917-4789.

***Text and Lecture Companion for CMA 111 by Rick Durling***

This Text and Lecture Companion is designed to accompany the course CMA 111 - Medical Documentation

*Please copy this document to your Google Drive to be used as a lecture outline during class. You can edit, add to, or delete any material as you choose once you have added a copy of this to your DRIVE.*

[MOODLE](http://elearning.linnbenton.edu/course/view.php?id=960#section-0) is the course management program for this course.

The Competencies students will achieve by successful completion of this course are as follows:

Program Competencies - CRS Students

P1 - Student will produce a professional clinical note POMR style (with SOAP notes).

P2 - Student will produce a professional clinical note SOAP (SOMR) style

P3 - Student will produce a professional clinical note using electronic medical records

P4 - Student will demonstrate the ability to develop a History of Present Illness

P5 - Student will demonstrate the ability to develop a Review of Systems

P6 - Student will demonstrate the ability to accurately document a Patient Exam

P7 - Student will demonstrate documentation of Medical Decision Making

P8 - Student will accurately document Past, Family, and Social History

P9 - Student will demonstrate the ability to accurately scribe for an office visit

AAMA Competencies - MA Students

|  |  |
| --- | --- |
| V.C.16 | Differentiate between subjective and objective information |
| V.C.8 | Discuss applications of electronic technology in professional communication |
| V.P.6 | Demonstrate professional telephone techniques |
| V.P.7 | Document telephone messages accurately |
| V.P.9 | Develop a current list of community resources related to patients' healthcare needs |
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| VI.C.5.a | Identify methods of organizing the patient’s medical record based on: problem-oriented medical record (POMR) |
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Medical Documentation and Screening

Lesson 1 (M1)

1. Course Introduction and Orientation

 A. Syllabus and Schedule

 B. Moodle

 C. Documents, Formats, Browsers

 D. Grading

2. General Note Structure

 A. SOAP

 B. POMR

 C. SOMR (paper)

3. EMR and PMR - (LBCC’s program)

4. Patient Screening

 A. Demographics

 B. Chief Complaint

 C. Symptoms

5. Importance of Documentation - Cardinal Rule of Coders: Not documented Not done

 A. Financial

 B. Legal

 C. Efficient Care

 D. Appropriate Care

 E. Same Importance

6. Evaluation and Management

 A. Evaluation - Finding out what is wrong

 B. Management - Fixing the problem

7. Documenting E&M

 A. Most common coding task

 B. Most common MA structured task

 C. History

 D. Exam

 E. MDM

8. Community Healthcare Resources

 A. [Samaritan](http://www.samhealth.org/Pages/default.aspx)

 B. [Corvallis Clinic](https://www.corvallisclinic.com/clinic_information/)

 C. [Peace Health](https://www.peacehealth.org/sacred-heart-university-district/Pages/default.aspx)

 D. [Salem Clinic](http://www.salemclinic.org/)

 E. [Independent Physicians](http://www.corvallisinternalmedicine.com/)

 F. Other Important Health Care Contacts

1. County Health Department: Linn Benton
2. Albany, Lebanon, Newport, Corvallis, Lincoln City Police Department
3. Linn, Benton, Lincoln County Sheriff Departments
4. [CDC](http://www.cdc.gov/)
5. [CARDVA](http://cardv.org/)

Medical Documentation and Screening

Lesson 2 (M2)

1. SOMR

This charting method still exists aplenty in acute care settings. Any of you who have been hospitalized or visited the ER recently may have observed this yourself. Most of you will be working in the outpatient, clinic-style environment and for this reason, SOMR will not be studied to the same extent as POMR and SOAP. My suggestion is to simply understand the acronym, know that it is subject specific with tabs at the tops of the chart folder. Usually the chart itself is a metal, top-down folder; and within each subject tab (labs, visits, imaging, etc…) the data is organized chronologically. Also remember that the nice “story telling” feel that you get with POMR and SOAP styles of charting is absent in SOMR. Rather it appears and feels more like a quick-hitting barrage of data points and mostly objective information.

 A. Source Oriented Medical Record

 B. Mostly restricted to paper charts/acute care settings

 C. Physician/Clinician notes written in narrative

 D. Notes are usually reverse chronology

 E. Limited value in EMR

II. [POMR](https://www.fortherecordmag.com/archives/0516p24.shtml)

To summarize our lecture discussion on POMR, I would say that we extolled the virtues of POMR as the most appropriate form of documentation for recording our management of chronic disease, multiple problem encounters, and managing patients whose medical record becomes more complex due to data from multiple sources.

We also spent some time in discussion talking about the components of POMR charting style. Each specific POMR encounter documentation includes a demographic section, usually in the masthead or a fixed (non-scrollable) part of the note on your screen. This section contains much of the patient identification data such as name, age, address, insurance, phone, email, etc. Often this portion of the note, the demographic portion, also contains information about current medications and the patients next and last appointment dates. All of this is excellent because you can refer to this information while working in a patient’s chart without leaving the screen/file you are working on. The second important component of the POMR style note is the problem list itself. The problem list should only contain chronic problems. Acute problems such as injuries, infections, etc. should not be on the problem list. Each entry on the problem list creates an additional “file” in the patient database which can be accessed and searched separately. Due to this feature, I can reference a specific problem, say…. diabetes, and then look at only the notes, data, labs, imaging, etc that pertain to the patient’s diabetes. Which brings us to the third component of a POMR style note, separate, problem-specific SOAP notes for all the complaints addressed during the encounter. Again, the purpose of this is to allow problem-specific searching and data use. Finally we “Plans of Action” as a final piece of the POMR style note. Plans of action are fairly simple as they just display and pull out the specific P: section data listed on each specific SOAP note. So it really becomes a plan summary, often addressing multiple problems.

A. Problem Oriented Medical Record

 B. Most adaptable to EMR

 C. All Information tied to Problem List

 D. Most efficient for chronic disease

 E. Extends concept to individual notes

 F. POMR Note

1. Demographics (sometimes called the “database” often contained in a page or note header)
2. Problem List
3. Plans of Action
4. Progress Notes

 1. SOAP Style

 2. One SOAP note for Each Problem

 3. *Vitals may be separate but part of the progress note\**

III. [SOAP](https://www.nurseone.ca/~/media/nurseone/page-content/pdf-en/soap_documentation_e.pdf?la=en)

SOAP charting, on the other hand, was found to be a more effective documentation style and easier to follow for single problem encounters, managing acute problems, and resolving less complex patient problems. In addition, every POMR style note also contains at least one SOAP style note, and usually multiple SOAP notes. So understanding this important charting style is vitally important to both documenters and documentation evaluators such as coders. We will dig deeper into the content of the four SOAP components in the coming weeks. For now, comprehending the documentation structure with a vague awareness of what goes in each component is our learning objective.

 A. Subjective

 B. Objective

 C. Assessment

 D. Plan

Medical Documentation and Screening

Lesson 3 (M3)

Lessons from last module…

1. When we do a soap note, it needs to stand alone….
2. When we do a soap note for multiple problems, each should be represented in each element of soap.
3. POMR notes were great…. Few problems, especially with assessment but that will come….
4. Great job overall!
5. Telephone/Direct Messages

 A. Information Taken

 1. Name of Caller

 2. Patient, Family, Relationship

 3. Allied Clinicians directly to MA

 4. Physician calls directly to provider

 5. Date/Time

 6. Message Body

 7. Urgency

 B. Usually an EMR message today

 C. Most providers prefer all messages screened by MA

II. Telephone Etiquette/Technique

1. Telephone Etiquette: Thirty-Six Tips

1. Turn away from your computer, desk or other work.

2. Have pens, pencils and note-paper or the proper electronic form up on your screen and handy. If messages through EMR have that function open on your desktop at all times.

In answering the phone:

3. Answer calls promptly, by the second or third ring.

***4. Smile as you pick up the phone.***

5. Assume your "telephone" voice, controlling your volume and speed. Remember to speak clearly and slowly when speaking to older patients or hearing impaired.

6. Project a tone that is enthusiastic, natural, attentive and respectful.

7. Greet the caller and identify yourself and your company/department/unit. 8. Ask, "To whom am I speaking?"

9. Ask, "How may I help you?"

In the course of the conversation:

10. Focus your entire attention on the caller.

11. Enunciate/articulate clearly. Speak distinctly.

12. Use Plain English and avoid unnecessary jargon, technical language and acronyms unless talking to another medical professional.

13. Use action specific words and directions.

**14. Use the caller's name during the conversation.**

15. Always speak calmly and choose your words naturally.

16. Use all of your listening skills:

a. Focus your full attention on the caller and the conversation.

b. Listen "between" the words.

c. Use reflective/active listening to clarify and check for understanding.

17. If there is a problem, project a tone that is concerned, empathetic, and apologetic.

18. Avoid the Five Forbidden Phrases.

a. The worst is….."I don't know" Instead, say: "That is a good question; let me find out for you" or offer to connect the caller with someone who could provide the answer. If a call involves some research, assure the person that you will call back by a specific time. If you do not have an answer by the deadline, call back to say, “I don’t have an answer yet, but I’m still researching it.” **There is no excuse for not returning calls. This really makes patients upset… perhaps more than anything.**

b. "I/we can't do that." Instead say: "This is what I/we can do."

c. "You'll have to" Instead say: "You will need to" or "I need you to" or “Here’s how we can help you.”

d. "Just a second" Instead: Give a more honest estimate of how long it will take you and/or let them know what you are doing.

e. "No." Instead: Find a way to state the situation positively.

19. Use "LEAPS" with the emotional caller to vent.

**L Listen; allow the caller to vent.**

**E Empathize; acknowledge the person's feelings**

**A Apologize when appropriate, even if the problem is not your fault, you can say, "I am really sorry this has happened" and mean it.**

**P (Be) Positive**

**S Solve; suggest/generate solutions that you can both agree on** and/or ask what you can do to help and, if reasonable, do it! If not, find a compromise.

In concluding the call:

20. End the conversation with agreement on what is to happen next; if you are to follow-up, do so immediately.

21. Thank the caller for calling; invite the caller to call again.

In transferring calls:

22. Transfer ONLY when necessary; get the information yourself.

23. If you must transfer, avoid the use of the word "transfer." Say instead: "I am going to connect you with".

24. Explain why you are "transferring" the call.

25. Give the caller the person's name and direct number

26. Stay on the line and introduce the caller.

In taking messages:

27. Identify yourself and for whom you are answering the phone.

28. Practice political sensitivity.

~~29. Indicate the period of time the person will be unavailable.~~ see above

30. Write down all the important information given: a. The name of the caller. Ask for spelling if unclear. b. The (correct) telephone number of the caller. c. The message. Ask for clarification if necessary.

31. Read back what you've written to be sure you've understood the message correctly.

32. Always assure the person that you will deliver the message promptly. 33. Deliver the message in a timely fashion. Do not begin another task until the message is delivered.

The Complaint Call

Complaint callers who are irate are really saying, "I rate." They have bought into society's "the squeaky wheel gets the grease" mentality. When that happens, try the EAR method:

**Empathize** with the caller.

**Apologize** and acknowledge the problem.

*Accept* **Responsibility**. (You'll do something.)

Empathize with the caller. This is different from sympathy, where you take on someone else's problem. Try to understand how the person is feeling.

Apologize and acknowledge the problem. You don't have to agree with the caller, but express regret that there is a problem. People want to be heard, and no one's complaint is trivial. Each deserves prompt handling, so do not deal with it in a trivial manner.

Accept responsibility. Make sure something is done. Take it upon yourself to DO something. Many times, that's all that people want: the reassurance that something will be done. People want to be helped. They want to know that you care. Use these phrases to get that sentiment across: "How can I help you?" "What can I do for you?" "I'll make sure this message/information gets to the right person." The acceptance of responsibility may be as simple as forwarding the call to the appropriate individual or sending the caller more information. If you do forward the caller to someone else on your staff, follow up with that person to make sure the caller was taken care of.

If you get an irate caller, or even one who is calm, cool, and collected, here are some more methods to handle complaint calls:

First, don't overreact, especially if the caller starts using "trigger" words or phrases, such as: "I want to talk to someone who knows something." Most people respond by getting defensive when their "hot-button words" are pressed. Remember, a positive attitude is the most important asset you have.

Second, listen completely to the complaint. Allow the caller the opportunity to vent some frustration. When you listen, don't try to apply logic to the situation. Many people are beyond logic if they are angry, so accept the feelings being expressed. Avoid argument and criticism.

Third, do not blame anyone -- the caller, yourself, or someone on your staff -- even if you know who is to blame for a problem. This information should not be shared with the caller.

Fourth, paraphrase the caller's comments, and ask questions if you do not understand the information being presented to you. Restate the problem as you understand it.

Fifth, offer solutions and, if appropriate, offer alternatives. Providing alternatives empowers callers. It gives callers a feeling that they were not dictated to and that they were part of the solution.

Finally, confirm the solution with the caller. Make sure the caller agrees with what has been decided. Of course, not everyone will be happy, no matter what you do. These people will not be content; they just like being grumpy. Usually, these are the people who want to talk to the person "above you." If that is what it takes to lessen their anger, then do so. By the time they have been transferred to a supervisor, they usually have become calmer and less demanding. It seems that they just needed to vent their anger at someone: you. Just remember that most people are not that way and keep a firm grip on that positive attitude of yours. It is contagious!

When does a message need to be documented in the patient chart? That may depend on many things, but the critical nature of a message that needs patient chart documentation when it is defined as “clinical”. Any information regarding the patient’s health in any way must be documented in the chart. For instance, a patient may need help clarifying the directions for a particular medication; or they may need clarification on a specific patient instruction; or they may need a refill.

When can a message NOT be documented in the patient chart? When it is administrative ONLY in nature. If the call is regarding scheduling, billing, or any other administrative concern, a message may be taken for the appropriate person; but a clinical documentation in the chart is not necessary.

Medical Documentation and Screening Lesson 4 (M4)

I. Subjective

1. Despite what literature may tell you - VERY VALUABLE
2. [Definition](http://dictionary.reference.com/browse/subjective)- short version: who said it? (answer - patient - subjective)
3. Is the most directly related to the patient or problem
4. Is very often the *ONLY* information you have to assess
5. Is the most effective way to assess progress
6. Speaks to the *ART* of medicine rather than the technical practice
7. More often correct than wrong

II. Objective

 A. [Definition](http://dictionary.reference.com/browse/objective?s=t)- or: who said it?(answer -provider- objective)

 B. Should only be viewed through the subjective lens of the patient

 C. Should never overrule subjective, only confirm it

 D. Should be used as a guide or map to determine route of care

 E. Should be used as a *general* indicator of progress

 F. Tends to be more valued by younger providers and patients

 G. Very often inaccurate or misleading

III. HPI

1. History of Present Illness
2. Seeks to provide SUBJECTIVE information concerning the chief complaint(s) that are the focus of the visit.

 1. Chief Complaint

 2. Often Multiple

 C. Is measured in 8 general categories (memorize these)

 1. Location

 2. Duration

 3. Severity

 4. Context

 5. Quality

 6. Timing

 7. Modifying Factors

 8. Associated Signs and Symptoms (ASS)

D. [E/M University Info](http://emuniversity.com/HistoryofPresentIllness.html)

E. Learn to ask these questions

F. Learn to recognize these answers in documentation

G. Remember that all of this information must come ***FROM the PATIENT***

*Example of a complete HPI*

Sloan Thomas, a 32 yo F who works as a grade school teacher, comes in today with complaints of back, abdominal, and chest/breast discomfort. She does not exactly call it pain; but when asked, she stated the pain level was about a 4 out of 10. Sloan stated that this “discomfort” began approximately two weeks ago; and is more prominent at the end of the day than when she gets up in the morning. Sloan states that she has been taking Motrin, 400 mg tid without any noticeable relief.

Medical Documentation and Screening

Lesson 5 (M5)

I. ROS - A review of systems is an inventory of information gathered, beyond the HPI, that has specific implication to actual body systems. The ROS is a way of categorizing and compartmentalizing, or even refocusing the entire encounter being documented. ROS is separate, and additional to, the HPI; although the questions asked in ROS should be at least loosely informed by the HPI. Ultimately, value is given towards the perceived quality of the visit according to how the ROS is conducted and documented.

 Please be aware that the ROS is considered to be one of the more difficult to understand portions of the documented EM visit, particularly for non clinical folks. But to the clinician, this portion of documentation is their opportunity to first use their knowledge to begin sorting through the patient’s complaints, the attributes of their stated concerns, and begin to focus the visit on the important data that will lead to accurate diagnosis and effective treatment.

1. [Review of Systems](http://emuniversity.com/ReviewofSystems.html)
2. Distinguished from the exam by its source
3. From the patient
4. Subjective

 C. Is a subjective account of the problem, progress, or complication solely based on patient prospective

 D. Is intended to inventory clinical symptoms (or lack thereof) within problematic or related body systems which patients may not indicate on their own

 E. It is designed, along with the HPI and PFSH to illuminate the diagnosis

 F. Consistently covers one or more of these body systems:

 1. Integumentary System

 2. Digestive/GI System

 3. Nervous System

 4. Cardiovascular System

 5. Respiratory System

 6. Endocrine System

 7. Genitourinary System

 8. ENMT

 9. Eyes

 10. Hematologic/Lymphatic System

 11. Musculoskeletal

 12. Psychiatric

 13. Allergic/Immunologic System

 14. Constitutional

 G. Provider’s clinical judgement will inform them of which systems to review. Typically that includes the focused body system in which the chief complaint(s) reside; however it often contains one or two *related* body systems and sometimes more. Additionally, there are some offices that, by protocol, require that the MA and/or Patient review ALL body systems either in the exam room or while in the waiting room.

 I. How is it documented? Usually as a list with each system documented if ROS was performed. Make sure you understand what is required to count a “complete” ROS; and what documentation allows for this.

II. PFSH

1. Past, Family, Social History
2. Designed to get a complete picture of the “person” of the patient
3. Wholistic
4. Past
5. This refers to the patient’s relevant personal medical history including surgeries, illnesses, preventative care history, etc
6. Often clarifies the route to diagnosis
7. Does not include past history on the current complaints or presenting problem

 E. Family

1. Relevant family history leads to probable cause (etiology)
2. Usually this is filtered by genetic reliability
3. Usually patients have a better memory for this than their own personal medical history

 F. Social

1. Completes the picture of lifestyle, coping mechanisms, general activity, patient involvement, etc
2. Can often illuminate social or psychiatric symptoms
3. Highlights negative health influences in lifestyle, self-destructive habits, neglect, substance problems, or even abuse
4. Illuminates important sexual behaviors (and history) or problems associated with general well-being

E. How is it documented? Usually by separate notes for each type or portion of PFSH. For example, you could document:

“Penny Patient is a cigarette smoker with 22 pack years. Penny drinks alcohol occasionally, about 1 time each week in various quantities. Penny does not use any illegal drugs and currently uses marijuana tincture and skin cream. Penny’s mother died from diabetic complications at the age of 41. Penny has no significant past medical history related to the current complaints.”



Medical Documentation and Screening

Lesson 6 (M6)

The Exam ([*The Physical Exam*](http://emuniversity.com/PhysicalExam.html))

I. Objective

1. All of it
2. What makes an exam?
3. Includes testing data
4. labs
5. imaging
6. diagnostic testing

 C. Each individual exam + or -

 D. Organized by Organ System or Body Area

 E. Organ Systems (12)

1. Constitution (vitals x 3, general appearance)
2. Eyes
3. ENMT
4. Cardiovascular
5. Respiratory
6. GI
7. Genitourinary
8. Musculoskeletal
9. Skin
10. Neurologic
11. Psychiatric
12. Hematologic/Lymphatic/Immunologic

 F. Body Areas (7)(10 with each ext.)

1. Head
2. Neck
3. Thoracic/chest
4. Abdomen
5. Genitals
6. Back
7. Each Extremity

II. [Methods of Exam](http://www.ncbi.nlm.nih.gov/books/NBK420/) (should be noted with location and positive or negative - if positive provide explanation) (this is not a comprehensive list)

1. palpation
2. auscultation
3. observation
4. percussion
5. inspection
6. hearing
7. feeling
8. smelling
9. manipulating

III. How is it Documented? Exam Method + Location + Finding (positive or negative)

Medical Documentation and Screening Lesson 7 (M7) Assessment

1. [Medical Decision Making](http://emuniversity.com/MedicalDecision-Making.html) in the coding phase
2. This is where diagnoses and management treatment options are documented
3. Diagnoses can only be made by MD, DO, PA, or NP. Diagnoses should be as SPECIFIC as possible
4. When not enough information exists, or the physician’s knowledge/skill level is not specific enough, a diagnosis may not be provided or documented. In these instances management treatment options might be substituted. A management treatment option could be put in place to:
	1. Manage symptoms
	2. Collect more data to help find a diagnosis
5. When no MTO’s or diagnoses are mentioned, the chief complaint(s) must be considered the dx.
6. The Assessment portion of the note documents and quantifies the CONCLUSION details of physician labor and patient analysis.
7. This is where prognoses are documented as well. An assessment of the problem might include an expected course for the disease, whether chronic or acute. This could be defined as how long until the pathology is resolved; or, how long until the pathology causes the patient to expire.
8. Diagnoses can be considered comparative, differential, or hopefully definitive
9. Nurses can provide diagnoses only by protocol under physician supervision. They can also proceed under assumed diagnoses by protocol. Depending on the clinical situation, this can be quite autonomous.
10. MA’s cannot establish a diagnosis. MA’s can only provide or assume diagnoses and proceed under assumed diagnoses as both directed and confirmed by supervising physician.
11. Diagnoses should be listed by relevance to the visit. First-listed, principal, and primary diagnoses defined, along with relevant associated signs and symptoms or comorbidities. How does all of this fit into a soap note? It all goes in the “A” portion of the note. Do not list diagnostic tests or medications…. They go in the plan or the “P” portion of SOAP. Finally, if you are wondering where the “risk” portion of MDM is documented, it is not. It is inferred.
12. When conducting the assessment portion of the visit, remember that it is not a discussion. This is the provider telling the patient what is what, carefully explaining the dx, mto’s, progress or status.

Medical Documentation and Screening

Lesson 8 (M8)

The Plan

1. In the coding phase this is part of Medical Decision Making: “What to do Now”
2. The plan(s) documented in the note should be based upon the listed diagnoses and management treatment options documented for the patient in list format.
3. The plan should include extended diagnostic information, such as tests (imaging, lab, etc), procedures, surgeries, consultations, etc for each listed diagnosis, whether ordered or reviewed.
4. The plan should include treatment information, such as patient education, pharmacotherapy, surgery, etc. for each listed diagnosis.
5. The plan should include the patient’s return to office (RTO), and when it should be scheduled. (The front desk should reference this when setting FU appts.)
6. The plan should include detailed instructions for patients to follow in their treatment. This may include specific exercise, stretching, OTC medications, cutting down on smoking, cutting down on salt, increasing water intake, etc.
7. Each component of the plan should include a goal if possible. For instance, if the plan is to cut down on smoking - the goal would be to avoid cancer risk and improve breathing competence or a specific target such as: cut down to 1 ppd over the next three months….. Or if the plan is to increase daily walking to 2 miles - the goal would be to increase stamina, endurance, strength, and active range of motion. A plan without a goal is empty and not likely to be taken seriously by the patient as there is zero motivation or reason compelling them to comply.

You have now received instruction on ALL phases of clinical documentation. All we have to do is put it all together….

PMR/EMR Orientation - Log In and orient yourself to our EMR software

**Campus students:** You may log in to PMR using any of the LBCC HOC campus desktop computers or laptops, including those in the library.

**Remote Students:** To log into PMR remotely (from off campus), you first must have your Single-Sign-On ID and password. If you have recently joined the program or have not claimed your single-sign-on, call the student help desk at **541-917-4360** or ask your instructor for assistance.

Once you have your SSO ID and PW, you can install the Horizon/VDI Client on your computer and begin logging into PMR.

Those who had established PMR PW’s may need to reset them. If so, your temporary password will be “PASSWORD”

Follow [THESE](https://docs.google.com/document/d/1Mk07URYp0AGLOuJMjHQxEXxQY-HS5wRBwwNPhGrTD6g/edit?usp=sharing) instructions to setup and login.

You login ID VMware is your SSO

Your login ID for PMR is the first three letters of your first name, followed by the first letter of your last name: My username is “ricd”

FYI….. here is the normal order for a clinical note in EMR (PMR)

Database

Problem List

Progress Note (or notes if multiple problems)

Plans of Action

And the med list should be ever-present in the right-hand pane of your software

Medical Documentation and Screening

Lesson 9 (M9)

1. Building the E&M Note in POMR (PMR too?)
2. Note Structure
3. Note Content
4. Note Closing and Signing
5. Meaningful Use (HITECH Act)
6. What is it?
7. Where is it?
8. When do we have to do it?
9. What happens if we don’t do it?
10. Resources: [Stage I](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MU_TableOfContents.pdf), [Stage II](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf), [Sample EMR-MU Checklist](http://www.practicefusion.com/wp-content/uploads/2014/06/2014-meaningful-use-attestation-checklist.pdf), [Penalties](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf), [2014 Final Ruling](http://www.gpo.gov/fdsys/pkg/FR-2014-09-04/pdf/2014-21021.pdf)

II. Using Electronic Records

1. Number 1 Thing - **Don’t go into your Own Chart Ever**
2. Do Not ever open a chart unless you have a need to know
3. Clinical
4. Administrative
5. Creating a new note in a chart: Use problem-oriented, individual SOAP notes as part of a POMR note style. This means starting a new note for each problem addressed.
6. New Note
7. Vitals
8. Med List
9. PFSH
10. HPI
11. ROS
12. Exam
13. Diagnosis
14. Data
15. Plan
	1. medications
	2. patient instructions
16. Added Procedures
17. Navigating through charts and notes within a chart, remember that each header contains demographic information, the PCP assigned, and is called the database.
18. Navigating to demographic information
19. Editing
20. Saving
21. Navigating to other clinical information, The CPOE is where medications, imaging, and labwork are ordered
22. Editing
23. Adding

Medical Documentation and Screening

Lesson 10 (M10)

1. Scribing 101
2. [What is a Scribe?](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049807.hcsp?dDocName=bok1_049807) - [ScribeAmerica](https://docs.google.com/document/d/1Xh9BkEhZ32yNOPBfN-d752f5IujpGhqE39RVRuroLUc/edit?usp=sharing), [Scribe-X Northwest](http://www.scribe-x.com/)
3. Basic Duties
4. Assist provider in navigating the EHR
5. Responding to clinical and administrative messages as directed by the provider
6. Locating information for the provider to review and consider including clinical research
7. And most importantly…. Entering information INTO the EHR as directed by the provider
8. Legal Considerations and Challenges
9. No verbal orders
10. [Access to CPOE is technically not allowed](http://www.himss.org/ResourceLibrary/InterviewDetail.aspx?ItemNumber=23850)
11. Note closing and signing must be done by provider
12. HIPAA, HITECH, ARRA (Stimulus Act-800 Billion) confidentiality, patients rights compliance
13. Employee/Contractor status for above
14. Who can do this job?
15. Who IS doing this job?
16. Certified Medical Assts
17. Med Students
18. Certified Coders
19. PA Students
20. Non-Certified Medical Assts
21. Who is hiring for this job?

 Samaritan - Officially only using scribes in ER. Scribe limitations with the CPOE is a major drawback. However, many of the new MA’s being hired are moving into positions which require some or all their job to be scribing.

 Corvallis Clinic - Officially still evaluating the idea, leary of the limitations on the CPOE. Will probably need to use MA’s in this role as they are the only legal method of completing the job as physicians would like it.

 Portland - The success of Scribe-x is a testimony to how fast the field is growing. Scribe-X has no real comment concerning whether or not their scribes are following the Medicare Directive for CPOE and licensed or certified use…. they do however refer to the ruling in favor of their scribes having legal access, so perhaps that is interpretation.

II. How do I scribe

1. Scribes are to be seen and not heard in the patient exam room
2. Scribes are to accurately document the entire proceeding of the office visit keeping up with both sides of the conversation and organizing everything into a proper clinical E&M note.
3. Scribes may be asked to produce orders, find data, and do on-the-spot research as directed by the physician. This ability to computer multi-task is critical and should be practiced. It is somewhat akin to being a court reporter.
4. Above all, you cannot panic. If you miss something or make a mistake, you must press on and continue to get as much as you can; then go back to the physician later and ask for help filling in the blanks.
5. This will feel like a lot of pressure to perform. You just need to practice and then relax the best you can during the visit while you focus on capturing the very fabric and essence of the visit in your documentation. You are about to give it a shot.

III. The Final Word - Scribing is an interesting, but difficult and fast-paced, job. It is very challenging, makes pretty good dough, but the legal environment for this career is a bit murky. Those betting on a positive resolution are already profiting. The career of scribing struggles for relevance in competition with coders and MA’s. Since they are not certified, and either MA’s or Coders can also do their job, they position one or two rungs lower than these two professions. But for offices that attain higher productivity by taking the documentation portion of the work out of physician/provider hands, scribes can be a godsend.