Content of the Health Record—the Care Provider’s Responsibility

Learning Outcomes

At the end of this chapter, the student should be able to:

5.1 Explain each element of a SOAP note.
5.2 Identify elements of the history of present illness (HPI).
5.3 Identify elements of the Review of Systems (ROS).
5.4 Identify elements of the physical exam (PE).
5.5 Describe the process of traditional dictation and transcription.
5.6 Illustrate the advantages of speech recognition technology.
5.7 Outline the benefits of ePrescribing.
5.8 Evaluate the benefits of computerized physician order entry (CPOE).
5.9 Support the necessity to track physicians’ orders.
5.10 Examine the benefits of a Problem List.

Key Terms

Assessment
Care provider
Chief complaint
Computerized Physician Order Entry (CPOE)
Discharge summary
ePrescribing
History of present illness (HPI)
History and Physical report (H&P)
Interface
Objective
Physical exam (PE)
Plan (of care)
Point of care (POC)
Problem list
Review of systems (ROS)
SOAP note
Subjective
Speech recognition technology
Voice recognition technology
What You Need to Know and Why You Need to Know It

In this chapter, the EHR is assessed from the care provider’s perspective. In the PrimeSUITE demonstrations we will illustrate how a care provider captures clinical information, but in the exercises you will not be entering any information because only a physician, physician’s assistant, nurse practitioner, or perhaps a midwife, all of whom are care providers, would be entering clinical data.

Knowing where in the record certain information resides is important because it is often necessary for the medical assistant, biller, or other healthcare professional to access a care provider’s documentation to answer a question for another care provider or for an insurance company, or to complete forms.

5.1 The SOAP Note

SOAP stands for Subjective, Objective, Assessment, and Plan. It is a format for documentation that reflects a patient’s visit (typically an office visit) in an orderly fashion—from the time the visit begins to the time it ends. The four areas are:

Subjective (S): This is the information the care provider learns from the patient. The subjective findings are the patient’s description of his or her symptoms. For instance, Philip James is seen in Dr. Connors’ office today; he tells the doctor that he has had a cold and terrible headache for three days.

Objective (O): Objective findings include information the care provider gathers from performing a physical exam. For example, upon conducting a physical exam on Philip James, he notes the patient has tenderness above the eyebrows and just beneath the cheek bones when touched and a green nasal discharge.

Assessment (A): At this assessment stage, the care provider assesses the patient’s signs and symptoms and results of his physical exam in order to make a diagnosis or diagnoses. The documented diagnosis for Philip James is acute sinusitis.

Plan (P): The plan is also known as the plan of care. The care provider will order any tests he feels are medically necessary, prescribe medications or recommend over-the-counter medications, order consultations with other care providers if necessary, educate the patient about his condition, and advise the patient of follow-up instructions. So, in Mr. James’ case, Dr. Connors wrote an order for a CT scan of the sinuses. His instructions to Mr. James included drinking plenty of fluids and taking the next two days off from work. A prescription for a Z-Pak was ordered and he was given printed educational material about sinusitis (from the EHR software). He was told to schedule a follow-up appointment for 10 days from now.
An example of an instruction screen for a patient is found in Figure 5.1. In a paper record, the physician would handwriting the patient’s record as seen in Figure 5.2.

In an electronic health record, these elements are documented, but rather than being handwritten, a combination of free-text writing and use of drop-down menus and standard text make documentation more thorough, consistent, easily retrievable, and legible. As you complete the following exercises, you will see that the SOAP elements described above are present in the EHR.

When a patient is admitted to a hospital, the care provider documents the subjective and objective findings, along with the results of a physical exam, in the History and Physical report, otherwise known as an H&P. The assessment and plan, as well as a recap of the patient’s course in the hospital, would be documented in a discharge summary (or note).

The history of present illness, or HPI, was introduced in Chapter 4; it is the patient’s depiction of his or her current illness as told to the healthcare professional or care provider. The typical elements of an HPI are:

• Location of the condition (abdomen, arm, leg, head, etc.).
• Quality: pain is sharp, dull, or an ache, for example.
• Severity: rating of pain/itch/cough/nausea, etc. Often, patients are asked to rate their symptoms on a scale of one to 10 with one being

Figure 5.1 Example of patient instructions from PrimeSUITE

Look up the Patient’s Plan of Care

In this exercise, it is necessary to access the plan of care Dr. Ingram ordered for Juan Ortega. Dr. Ingram is on the phone and has asked you to look up the treatment plan for Juan Ortega, since he has to return a call to Mr. Ortega quickly and is not at a computer. Once the information is accessed, then you would read the documentation to Dr. Ingram.

Follow these steps to complete the exercise on your own once you have watched the demonstration and tried the steps with helpful prompts.

From the PrimeSUITE desktop, the patient’s Facesheet is accessed and then the steps below are followed.

1. The Documents link is clicked on.
2. The entry for 06/07/2010 is clicked on.
3. Click the scroll button.
4. Note the information in the Plan section.

You have completed Exercise 5.1

EXERCISE 5.1

Go to http://connect.mcgraw-hill.com to complete this exercise.
barely noticeable and 10 being intolerable. This may also mean the severity in terms of bleeding, vomiting, or diarrhea—for instance, profuse bleeding from a laceration versus a small amount of bleeding.

- **Timing/duration**: how long the condition has been present—hours, days, weeks, months, for example.
- **Modifying factors**: alternating ice and heat on a painful area; affect of pain medication, etc.
- **Associated signs and symptoms**: for instance, the cold symptoms described by Philip James in Figure 5.2.

Read Philip James’ **SOAP note** in Figure 5.2 again. Match the information listed in the subjective portion of the note to the typical elements of an **HPI**. Not all elements are collected on all visits—only those that are necessary based on the patient’s **chief complaint** would be documented.

<table>
<thead>
<tr>
<th>Patient: Philip James</th>
<th>DOB: July 31, 1991</th>
<th>Date of Service: 05/11/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S</strong></td>
<td>Mr. James presented today because he has had a headache for the past three days. He has not received any relief from OTC decongestants or antihistamines. He describes the pain as more of an ache, though when he pushes on his forehead, it is painful. He has had cold symptoms for about a week, but his symptoms are getting worse, and on a scale of 1 to 10, he says that his pain is an 8. He has also noted that he has had two minor nose bleeds in the past two days.</td>
<td></td>
</tr>
<tr>
<td><strong>O</strong></td>
<td>Vital signs noted in his chart. All within normal limits. Head and face: physical exam of nasal passages reveals a moderate amount of green discharge from both nares. The patient is tender to the touch above each eyebrow and cheek bone. Chest is clear to percussion and auscultation. Heart: Regular rate and rhythm. Abdomen: Non-tender. This is the third time Mr. James has been diagnosed with a sinus infection in the past 18 months.</td>
<td></td>
</tr>
<tr>
<td><strong>A</strong></td>
<td>Acute sinusitis.</td>
<td></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>CT scan of sinuses to be done today or tomorrow at Memorial Hospital (order given to patient). Instructed to drink plenty of fluids and bedrest for two days. To return to office in 10 days for follow-up. Z-Pak single-dose pack was sent to The Corner Pharmacy via ePrescribe. Patient was given sinusitis literature.</td>
<td></td>
</tr>
</tbody>
</table>

**Jared Connors, MD 5/11/2011**

**Figure 5.2 Handwritten SOAP note**

**Locate Juan Ortega’s Blood Pressure**

In this exercise, Juan Ortega stopped by the office and wants to know what his blood pressure was on his last visit. To look this up, you will access Juan Ortega’s chart.

You will start by going to Juan X. Ortega’s Facesheet. The Vital Signs are found there, and you do not need to leave the Facesheet to find his blood pressure readings.

Follow these steps to complete the exercise on your own once you have watched the demonstration and tried the steps with helpful prompts.

From the PrimeSUITE desktop, the patient’s Facesheet is accessed and then the steps below are followed.

1. Click **Vital Signs**.
The review of systems (ROS) is a body system by body system assessment of any signs or symptoms the patient is experiencing that may or may not be related to the reason for his visit. The ROS is not the same as a physical exam, because the ROS refers to the patient’s own responses, not an objective assessment by the care provider. Often, the ROS is accomplished by the patient completing the medical history form that we discussed in Chapter 3. Or, the care provider may use that as a starting point and ask questions based on the patient’s responses given on the form. The completion (or review) of the ROS is an integral component in assessing the patient’s overall health as well as gaining a better picture of any additional signs or symptoms that may be related to the patient’s chief complaint. In addition, the ROS plays a role in how much the patient will be charged for the visit, since it takes into account the care provider’s time and medical expertise during an office visit. Regardless of whether the history form is already completed and the care provider reviews it or whether the care provider completes the form herself during an office visit, there must be some form of documentation to show that the ROS was done or reviewed in order to receive reimbursement for it. The particulars of procedure coding, charging, and reimbursement will be covered in another course.

Usually, a care provider will start at the head and work down through the body to the lower extremities. Listed below are the typical organs and/or body systems that may be reviewed as well as examples of questions that may be asked for each:

- General, also referred to as Constitutional (how the patient is feeling in general, any complaints or concerns, and a recap of vital signs)
- Skin (any rashes or wounds that will not heal, any unusual moles or markings that have appeared, etc.)
- Head, Eyes, Ears, Nose, and Mouth (headaches, double vision, blurring of vision, ringing of ears, earache, nosebleeds, dry mouth, dental issues)
- Throat (persistent sore throat, difficulty swallowing)
- Breasts (whether monthly self-exams are done, any changes, lumps, nipple discharge)
- Respiratory (difficulty breathing, shortness of breath)
- Cardiovascular (any chest pain, palpitations, or fluttering)
- Gastrointestinal (any problems with stomach pain, constipation, diarrhea; any changes in stool, signs of blood in stool)
• Genitourinary (any problems voiding, cloudiness of urine, changes in color or odor of urine, difficulty starting to urinate, nighttime urination, signs of blood in urine)
• Musculoskeletal (any pain in joints or extremities, difficulty walking)
• Neurologic (any dizziness, lightheadedness, difficulty with memory, cognition, coordination, or severe headaches)
• Endocrine (if female, any problems with menses, any swelling of the thyroid)
• Psychological (depression, changes in mood)
• Hematologic/Lymphatic (any unexplained or profuse bleeding, any swelling of lymph glands)
• Allergies (problems with environmental allergies; any known allergies or reactions to medications)

In PrimeSUITE and most EHR software, the ROS choices are determined by the patient’s chief complaint or the body system it relates to. Not every ailment requires a thorough ROS. For instance, for a patient being seen with cold symptoms, the care provider may just review the head, eyes, ears, nose and throat (HEENT) and the chest (which essentially makes up the respiratory system) and would typically have no need to review the breasts, neurological, psychological, or reproductive systems. Figure 5.3 shows how the constitutional ROS looks in PrimeSUITE and Figure 5.4 shows the full ROS.
The **physical exam** (PE) is performed by the care provider. As we discussed earlier, in a physician’s office that would be the physician, physician’s assistant, nurse practitioner, or nurse midwife. The extent of the physical exam is typically driven by the patient’s chief complaint, or the reason the patient is being seen today. If a patient is being seen for an annual physical exam, then it will be more extensive than the PE performed for a patient who is being seen with a chief complaint of a splinter in the right ring finger.

The care provider will also determine the extent of the PE based on the patient’s responses to the ROS questions. If the patient with the splinter in the right ring finger has also been falling more than usual, then the PE will be more extensive and may also include the musculoskeletal and neurologic systems.

Let’s look at an example of a patient being seen for an annual physical exam (which will be in written form). (And, in Figure 5.6 you can see the PE of a patient, Ian Mikeals, in PrimeSUITE.)

The healthcare professional who needs to know the results of a patient’s physical exam to answer questions, complete forms, or handle insurance issues will need to access the patient’s physical exam, but will never have to actually enter information in this part of the patient’s chart.
Alexis Shaw is a 25-year-old African American female being seen today for her annual physical. Her ROS has been reviewed; and is unremarkable.

HEENT: Scalp clear; eyes and ears within normal limits; Nose: Some congestion noted; throat: post-nasal drip noted. Chest: Lungs clear to auscultation, no wheezes or rales. Cardio: Heart rate and rhythm normal; no murmurs. Abdomen: Soft, non-tender, no guarding or rebound noted. Skin: No rashes, broken skin, or open wounds. Nails: bites her nails, but otherwise unremarkable. Breasts & Genitalia: Deferred – she has an appointment with her GYN in two months. Her LMP was April 15 of this year. Periods are normal. Extremities: Range of motion intact; no swelling. Neuro: Within normal limits.

**Figure 5.5** Written PE

**Figure 5.6** PE as seen in PrimeSUITE

### 5.5 Medical Dictation and Transcription

With a manual record system, most care providers choose to handwrite their charts. That’s often been problematic since handwriting is often illegible. A chart that is not legible could cause safety concerns and negative patient outcomes, and wastes time for the healthcare professional who cannot read the writing and has to track down the care provider so that his or her writing can be deciphered. You have no doubt read or heard horror stories of wrong medications or wrong dosages being given to patients because of illegible handwriting. Health Insurance companies may also deny payment based on illegible handwriting.
Over the past 15 years or so, voice (speech) recognition technology has replaced traditional dictation to a great degree. Voice recognition technology is software that “learns” as it is used. In other words, it learns the voice and tone inflections of the dictator, and accuracy improves with time. Speech recognition technology, on the other hand, does not recognize individual voices. Many of you may already be using speech recognition technology and do not even realize it. For instance, your cell phone has a feature that allows you to voice dial; or you call your local cable company and have to go through a series of questions that you can respond to by “saying or pushing 3.” Both are forms of voice recognition. In these two examples, a command is carried out based on your speech response. With voice recognition used in the medical environment, as the care provider dictates, the words appear on the computer screen. In true voice recognition systems, the software “learns” the dictator’s voice. The words that end up on screen are not perfect; for instance, “there” may be typed rather than “their” or Xanax may be heard as Zantac. But, since medicine requires accurate information, the transcriptionist’s role has become more of editor than transcriber. The transcriptionist may listen to the entire piece of dictation and compare it against what appears on the screen, or, once the system learns that physician’s voice and becomes more accurate, the transcriptionist may only read what is on the screen to look for obvious errors.
The quality of transcription is higher with voice recognition (if the software recognizes the words correctly). Once physicians are comfortable with the use of voice recognition software, it may be less time consuming than dictation, and long-term costs are lower since in most instances the transcription costs are lower (especially if a transcription service has been utilized in the past). The greatest advantage, though, is speed of documentation. With traditional transcription, days could pass between the time a chart note was dictated and transcribed (known as turnaround time). With voice recognition, the documentation is instant—as the words are spoken, they are documented in the chart simultaneously. Of course, the chart should be reviewed and edited before the care provider authorizes (signs) the note, but the fact that there is a draft copy in the record so quickly is a strong benefit.

Most EMR/EHR software solutions have a voice recognition component.

### 5.7 Electronic Prescribing (ePrescribing)

ePrescribing software is another component of the Meaningful Use requirements of HITECH. With ePrescribing, the care provider sends prescriptions to the patient’s pharmacy electronically, at point of care (occurring at the time the patient is being seen). Electronically sending prescriptions speeds up the process for the patient as opposed to the traditional method where the care provider hands the patient a written prescription, the patient takes it to the pharmacy, and then waits for it to be filled (or returns at a later time). Even if the prescription is called in by the office, the process takes longer than using ePrescribing.

Most importantly, quality of care is greatly improved with electronic prescribing; not only does the prescription itself go directly to the pharmacy, but also the patient demographics, insurance information, allergies, and medication history are sent as well. Care providers and pharmacists are alerted to possible food and drug interactions between medications that are currently prescribed or that the patient is already taking, and drug allergies and sensitivities are flagged. Also, medication dosing errors are avoided—for instance, if the care provider orders 250 mg of a particular drug for a 15-year-old patient, but the recommended dosage for that drug is 25 mg for a 15-year-old, an alert message would automatically appear, so that the care provider can make the correction before the prescription is sent through to the pharmacy. Prescription renewal requests are handled more efficiently too since they are received electronically and there is no need to manually update the patient’s chart. And of course, there are no more legibility issues—pharmacists do not have to make phone calls back to the office to ask what was written by the care provider; and the office staff does not have to take the time to track down the care provider or chart.
5.8 Computerized Physician Order Entry (CPOE)

No treatment, diagnostic test, or medication administration is performed on any patient without a care provider’s order. Using paper records, orders were traditionally either written by the care provider or given verbally and written in the patient’s record by a nurse. Orders may be in written form or may be electronically submitted. PrimeSUITE’s functionality is called Orders Requisition. Through this function, orders can be printed or electronically submitted to an outside laboratory, medical equipment company, or hospital with interface capabilities with PrimeSUITE. The interface capability means that one computer system (or component) can accept and receive data from another system. The interface could refer to systems at different locations or within the same facility. Your office may have PrimeSUITE software for PM and EHR, but your laboratory system...
Tracking Physicians’ Orders

If a test is important enough to order, then learning the results of that test is equally important. Tests that are not carried out and reported in a timely manner can delay necessary care and also cause inefficiency in the business processes of an office. Having this functionality in an EHR system prevents communication breakdowns and unnecessary rework.

When an order has been completed and the results are ready for the care provider’s review, she will receive notification on her Desktop. In Figure 5.7, note on the left side of the screen that the Lab Flow-sheet tab shows one resulted order and has a red star next to it,
meaning it is high priority. The care provider would click on the Orders tab to review the returned results.

Once the care provider clicks the Orders tab, all resulted orders will appear on the screen. In Figure 5.8 you can see that there is one order that has been resulted, and it is for a metabolic panel on Dr. Ingram’s patient, Tom Gunn.

Dr. Ingram will want to see the detailed results, and to do so he clicks on View/Edit and will see the complete report; at that time he will also click Sign Note on the report to document that he has reviewed the results. Figure 5.9 illustrates a detailed report.

If, based on the results of the lab test, Dr. Ingram wants to order additional tests, prescribe a particular medication, or follow up with the patient soon, he will give additional orders to the healthcare professional to handle the situation accordingly.

Figure 5.10 represents the final screen the care provider sees. From it he can note whether the results were normal, abnormal, or a specific assessment, and can also send a follow-up task to one of the healthcare professionals in the office or to another care provider in the practice for review. These tasks can be done directly from the Order screen without having to exit that function and find another.
Locate the Status of an Order

In this exercise, a lipid panel was ordered for Juan X. Ortega by Dr. Ingram. Dr. Ingram is asking the healthcare professional about the results. By going to the Facesheet and then looking at Orders Tracking History, the healthcare professional found that those results are still pending.

The results could be pending because Mr. Ortega did not go to the lab to have his blood drawn, or the results may not be ready yet. It is the healthcare professional's responsibility to follow up with the lab and/or Mr. Ortega. For instance, if Mr. Ortega has not gone to the lab to have his blood drawn, she should express to him the importance of doing so as soon as possible. If it is the laboratory that has not posted the result yet, then she should ask that it be done promptly because Dr. Ingram needs the results.

Once the Facesheet of the patient’s chart is accessed, follow these steps to complete the exercise on your own once you have watched the demonstration and tried the steps with helpful prompts.

1. Click Orders Tracking History.
2. Note the Status.

You have completed Exercise 5.4

5.10 The Problem List

Another requirement of Meaningful Use is an up-to-date **problem list** of current and active diagnoses. Providing quality care means that current diagnoses or conditions should be followed on an ongoing basis until the problem is resolved, or at least until it is stable. Of course, there are some medical conditions, such as asthma or coronary artery disease, that may never resolve completely, but the care provider must ensure that the patient is stable and that his or her condition is not worsening. With the use of a problem list, as long as it is kept current, necessary testing or assessment of the condition does not “fall through the cracks.” For instance, a patient may be seen today because of an upper respiratory infection, but has also been treated by the care provider for hypertension, and on today’s visit the care provider notes that the patient’s blood pressure is elevated. By clicking on Hypertension in the list of diagnoses included in the problem list, the care provider is able to quickly see the treatment history and prior blood pressure readings on that patient and then proceed accordingly.

Sometimes, the information included in the problem list is helpful to the patient as well as the care provider. The patient may have told the care provider something about his treatment or hospitalizations, and later forgets the details. By having this complete history, the medical office has the information readily available when needed.
Utilizing the Problem List

In the scenario we are about to view, Juan X. Ortega has been treated for angina over the past few years. He was first diagnosed in 2005 and has been hospitalized at Memorial Hospital twice for it—once on August 31, 2010, and once on June 17, 2009. Mr. Ortega has asked the office staff to complete a form that he needs for his employer. His employer needs to know if he has ever been hospitalized for angina and when. He does not recall the dates but does remember giving that information to Dr. Ingram on his last visit, so he hopes the information can be found in his record.

From the Facesheet of Juan X. Ortega, the healthcare professional will click on angina from the Problem List area in order to get Mr. Ortega the information he needs.

Once the Facesheet of the patient’s chart is accessed, follow these steps to complete the exercise on your own once you’ve watched the demonstration and tried the steps with helpful prompts.

1. Under Problem List, click on **Angina**.
2. Click **OK**.
3. Note the hospitalization dates.

✔ You have completed Exercise 5.5
## LEARNING OUTCOME CONCEPTS FOR REVIEW

### 5.1 Explain each element of a SOAP note.
- Subjective—the patient’s description of the problem
- Objective—the care provider’s results of physical examination
- Assessment—the diagnosis or diagnoses
- Plan—the diagnostic tests or treatment plan for the patient

### 5.2 Identify the elements of the history of present illness (HPI).
- Location of the condition (abdomen, arm, leg, head, etc.)
- Quality of the symptoms
- Severity of the symptoms
- Duration/timing of the symptoms
- Context under which symptoms occur
- Modifying factors
- Associated signs and symptoms

### 5.3 Identify elements of the review of systems (ROS).
- Body system by body system assessment of any signs or symptoms the patient is experiencing that may or may not be related to the reason for his or her visit
- Not the same as the physical exam

### 5.4 Identify the elements of the physical exam (PE).
- The extent of the exam is dependent on the patient’s presenting symptoms (the chief complaint)
- The physical exam relates to the findings of the care provider, not the patient, as in the ROS; for example, the patient complains of pain in the right lower abdomen, yet when the care provider presses on the right lower abdomen, the patient does not express feelings of pain

### 5.5 Describe the process of traditional dictation and transcription.
- Physician dictates medical notes into a recording device
- Transcriptionist types the words using word processing software
- Often takes days for the transcribed report to be filed in the patient’s record

### 5.6 Illustrate the advantages of speech recognition technology.
- The provider’s documentation immediately appears in the patient’s record; no lag time between dictation and transcription
- In the long term, may be less expensive than traditional dictation and transcription
- Quality is higher than with traditional transcription (in most cases)
<table>
<thead>
<tr>
<th>LEARNING OUTCOME</th>
<th>CONCEPTS FOR REVIEW</th>
</tr>
</thead>
</table>
| **5.7** Outline the benefits of ePrescribing. pp. 90–91 | - Less chance for medication errors  
- Potential food/drug interactions are identified  
- Fewer man-hours to complete the process  
- More convenient and less wait time for patients  
- Overall, better-quality care |
| **5.8** Evaluate the benefits of computerized physician order entry (CPOE). pp. 91–92 | - Fewer errors in carrying out orders because they are no longer handwritten  
- Orders can be sent directly from the office to the laboratory or hospital  
- Safer for the patient—the order is sent by the care provider rather than verbally given to another healthcare professional to send on to the laboratory or hospital  
- If an interface exists, the results automatically come back to the ordering physician. |
| **5.9** Support the necessity to track physicians’ orders. pp. 92–94 | - Patient care—knowing the results of the test in a timely manner, proper treatment can be started quickly |
| **5.10** Examine the benefits of a problem list. pp. 94–95 | - Timely follow-up of conditions  
- Serves as a reminder to the care provider to address problems on the patient’s problem list  
- Information about each problem is located in one place |
MATCHING QUESTIONS

Match the terms on the left with the definitions on the right.

1. [LO 5.1] objective
   a. patient’s description of her current illness
2. [LO 5.8] interface
   b. EMR feature that is part of HITECH’s Meaningful Use requirements
3. [LO 5.4] physical exam
   c. comprehensive inventory of patient symptoms such as headaches, vision, heart palpitations, swelling of joints, etc.
4. [LO 5.6] voice recognition
   d. staff member responsible for creating typed documentation of a doctor’s spoken notes
5. [LO 5.9] order tracking
   e. comprehensive record of a patient’s complaints and conditions
6. [LO 5.2] history of present illness
   f. section of a SOAP note that contains information gathered during a physician’s exam
7. [LO 5.5] transcriptionist
   g. the ability to access and use another provider’s practice management software
8. [LO 5.10] problem list
   h. set of steps performed by a medical provider to assess a patient
9. [LO 5.7] ePrescribing
   i. software that automatically turns spoken words into text
10. [LO 5.3] review of systems
    j. periodically checking the status of procedures requested by a provider

MULTIPLE-CHOICE QUESTIONS

Select the letter that best completes the statement or answers the question:

1. [LO 5.2] Which of the following is an element of the history of present illness?
   a. Duration
   b. Prevention
   c. Medication
   d. Treatment

2. [LO 5.3] Which of the following would most likely require a complete review of systems?
   a. Annual exam
   b. Headache
   c. Mole on back
   d. Sore throat
3. **[LO 5.1]** Notes about a prescription ordered for a patient would appear in the ______ section of a SOAP note.
   a. subjective
   b. objective
   c. assessment
   d. plan

4. **[LO 5.3]** An ROS covers information likely documented in the:
   a. history of present illness.
   b. medical history form.
   c. physical exam.
   d. SOAP note.

5. **[LO 5.9]** PrimeSUITE has the capability to ______ the status of an order.
   a. assign
   b. generate
   c. query
   d. track

6. **[LO 5.6]** The biggest advantage of voice recognition software over manual transcription is:
   a. clarity.
   b. cost.
   c. ease.
   d. speed of turn-around-time.

7. **[LO 5.1]** Creating an electronic SOAP note in an EHR makes use of:
   a. drop-down menus.
   b. free-text fields.
   c. standard text.
   d. all of the above.

8. **[LO 5.1]** Information gathered during a provider’s physical exam would appear in the ______ section of a SOAP note.
   a. subjective
   b. objective
   c. assessment
   d. plan

9. **[LO 5.6]** The more voice recognition software is used, the:
   a. faster it corrects mistakes.
   b. quicker it gets.
   c. more it learns voice inflections.
   d. slower it gets.
10. **[LO 5.8]** There must be a ______ to perform any tests or treatments.
   a. diagnosis  
   b. referral  
   c. order by the care provider  
   d. SOAP note

11. **[LO 5.5]** A person hired to manually record a physician’s spoken words is known as a:
   a. dictator.  
   b. recorder.  
   c. stenographer.  
   d. transcriptionist.

12. **[LO 5.2]** Which of the following elements of an HPI are collected at a visit?
   a. All of them  
   b. Duration, quality, and severity  
   c. Location and severity  
   d. Only those that apply to the patient’s chief complaint

13. **[LO 5.4]** The extent of a physical exam largely depends upon which of the following?
   a. Age of patient  
   b. Amount of time available  
   c. Patient’s chief complaint  
   d. Patient’s medical history

14. **[LO 5.10]** Meaningful Use regulations require the keeping of an up-to-date:
   a. exam registry.  
   b. order queue.  
   c. problem list.  
   d. provider note.

15. **[LO 5.7]** The use of ePrescribing is part of the requirements for:
   a. HIPAA  
   b. HITECH  
   c. HIM  
   d. HPI

**SHORT ANSWER QUESTIONS**

1. **[LO 5.2]** List the typical elements of a History of Present Illness.

2. **[LO 5.5]** List at least three drawbacks of handwritten patient charts.

3. **[LO 5.7]** List five benefits of using ePrescribing.

4. **[LO 5.3]** In order for a practice to receive reimbursement for an ROS, what must happen?

5. **[LO 5.4]** Explain the factors that might influence the extent of a physical exam.
6. [LO 5.1] List the four sections of a SOAP note and give an example of each.

7. [LOs 5.5, 5.6] Why is there still a need for medical transcriptionists in an age of voice-recognition software?

8. [LO 5.3] List the typical organs and body systems that would be covered in a complete review of systems.

9. [LO 5.10] List one reason a provider might use a patient’s problem list.

10. [LOs 5.3, 5.4] Contrast an ROS with a PE.

11. [LO 5.4] List four types of medical providers who might perform a physical exam.

12. [LO 5.8] Explain what it means to have interface capabilities with PrimeSUITE. What benefits does interfacing have?

13. [LO 5.9] List three benefits of PrimeSUITE’s order tracking capabilities.

14. [LO 5.4] Based on Alexis Shaw’s physical exam as documented in the text, what is her chief complaint?


**APPLYING YOUR KNOWLEDGE**

1. [LOs 5.1, 5.2, 5.3, 5.4] Patient James Frank presents for his appointment. He is complaining of fatigue and headaches. When Dr. Ingram examines him, he finds that James has an enlarged lymph node on the right side of his throat; his lungs are clear; his blood pressure is a little low at 100/68. Dr. Ingram suspects anemia or an underactive thyroid as the causes of James’s fatigue, so he orders a comprehensive blood panel be done. Create a SOAP note that properly documents each piece of James Frank’s visit with Dr. Ingram.

2. [LO 5.6] Your office is preparing to implement new voice recognition technology, and you have been tasked with creating some talking points and benefits to share with your peers. How could you go about explaining the benefits of voice recognition software?

3. [LOs 5.7, 5.10] Why would ePrescribing and an up-to-date problem list be addressed under Meaningful Use requirements?

4. [LOs 5.7, 5.8, 5.9, 5.10] Of the following PrimeSUITE capabilities—ePrescribing, CPOE, order tracking, and the problem list—which do you think is the most beneficial? Explain your answer.

5. [LO 5.7] Create two flowcharts: one that shows the progression of a manually written prescription, and one that shows the progression of a prescription entered using ePrescribing.