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Electronic Health Record Professional Exam Content Outline According to Industry Standard Needs Study

	DOMAIN AREAS (I –V)	CHECK
哥	R Software and Its Application Contents Domain I of V	
1.	Following Electronic Health Record Standards	
8	1.1. The clinic administration	
	1.2. The patient's chart	
	1.3. The office visit	
	1.4. Clinical tools	
	1.5. Electronic recording of medical records (CCHIT)	
2	Transitioning to an Electronic Howlth Descript	
2.	Transitioning to an Electronic Health Record 2.1. Implementation of EHR	
	2.2. Harmful events	
	2.3. Medical errors	
	2.4. Conversion of data	
	2.4.1.Incremental conversion	
	2.4.2.Total conversion	
	2.4.3.Hybrid conversion	
-	2.4.4.Partial Conversion	
	2.4.4.1 Uttul Collycision	
3.	Use of Abbreviation & Acronyms in EHR Software (system)	
<u>J.</u>	Ose of Abbieviation & Actorynis in Link Software (system)	
4.	EHR Software Policy	
	4.1. Amendments	
	4.2. Corrections	
	4.3. Deletions	
5.	EHR Templates	
	5.1. Uses & advantages	
	5.2. Customization	
6.	Patient Flow	
7.	Pre-visit Pre-visit	
8.	Post-visit	
9.	EMAR	
	9.1. Objectives	
	9.2. Use	
10	Order Set	
10.	10.1. Objectives of using	
	10.1. Objectives of using 10.2. Benefits	
	TO.2. Delicito	
11	. Eprescribing	
11	триезинину	



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12. Role of IOM (Institute of Medicine) & HL7 in EHR	
Electronic Health Records in the Ambulatory & Inpatient Setting Domain II	of V
EHR AMBULATORY SETTING	
Category with Criteria	
Criteria's set for Manage patient demographics category	
Criteria's set for Identify and maintain patient records category	
Criteria's set for Manage problem list category	
Criteria's set for Manage medication list category	
Criteria's set for Manage patient history category	
Criteria's set for Health record output category	
Criteria's set for Manage clinical documents and notes category	
Criteria's set for Manage results category	
Criteria's set for Manage consents and authorizations category	
Criteria's set for Access control category	
Criteria's set for Encounter management category	
Criteria's set for Health record output category	
Criteria's set for Report generation category	
Criteria's set for Enforcement of confidentiality category	
Criteria's set for Audit category	
Criteria's set for Medications / eprescribing category	
Criteria's set for Order medication category	
EHR INPATIENT SETTING	
Category with Criteria	
Criteria's set for Patient demographics and administrative information category	
Criteria's set for Provider information category	
Criteria's set for Problem list category	
Criteria's set for Allergy information category	
Criteria's set for Medication list category	
Criteria's set for Order sets category	
Criteria's set for Medication administration category	
Criteria's set for Health record management category	
EHR Integration with Medical Billing/Coding & Healthcare Insurance Domain III	ofV
1. Tests, Procedures, and Diagnosis Codes	
1.1. ICD 9 cm (ICD 10 cm starting October 1st 2014)	
1.2. CPT	
1.3. HCPCS level II	
2. Insurance	
2.1. Medicare	
2.2. Medicaid	
2.3. Tricare	
2.4. Blue cross blue shield	



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3.	Medical Necessity
4.	Relative Value Scale
Th	Privacy and Security of Electronic Health Information Domain IV of V
1.	HIPAA
	1.1. Security rule
	1.2. Privacy rule
	1.3. EHR regulations
	1.4. Administrative simplification process
	1.5. Covered entitled
2	LUDA A TITU C
2.	HIPAA TITILE 2.1. Title 1
	2.2. Title 2
	2.3. Title 3
	2.4. Title 4
	2.5. Title 5
	Zio. Traco
3.	Access Features
	3.1. Password
	3.1.1.Requirements
	3.2. Administrator account
	3.3. User account
4.	Objectives of Using
	4.1. Patient tracker
	4.2. Time stamp
74 - 6	
5.	Security Features 5.1. Unique user identification
	5.1. Unique user identification 5.2. Emergency access procedure
	5.3. Automatic logoff
	5.4. Encryption and decryption
	5.5. Audit trail
	oler radia dan
6.	Preventable Medical Error
7.	Paper vs Electronic Health Records
8.	Protected Health Information
9.	Personal Health Records
11	R Reports & Documents Domain V of V
1.	Super bill
2.	Ageing report
3.	Remainder statement



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4.	Standard st	atement	*		
5.	Face sheet				
	W. W				
6.	Informed consent				
7.	Incident report				
8.	Aging report				
9.	Day sheet				
10.	O. Preauthorization				
	10.1.	Meaning full use			
	10.2.	Importance			
11.	11. Medical history				
	11.1.	Past			
	11.2.	Present			
	11.3.	Social			
	11.4.	Occupational			
12.	. SOAP				
	12.1.	Subjective			
	12.2.	Objective			
	12.3.	Assessment			
	12.4.	Plan of treatment			

For additional information about the exam content outline Email info@nccanow.com