NHA Certified Electronic Health Records Specialist (CEHRS)

Test Plan for the CEHRS Exam

100 Scored Items/25 Pretest Items
Exam Time: 125 minutes

**Based on The Results of a Job Analysis Completed in 2019*

This document provides both a summary and detailed outline of the topics that may be covered on the CEHRS Certification Examination along with their associated weighting. The summary examination outline specifies domains that are covered on the examination and the number of test items per domain.

The detailed outline adds to the summary outline by including tasks and knowledge statements associated with each domain on the test plan. Task statements reflect the duties that a candidate will need to know how to properly perform. Knowledge statements reflect information that a candidate will need to know and are in support of task statements. Items on the examination might require recall and critical thinking pertaining to a knowledge statement, a task statement, or both.

CEHRS Summary Examination Outline

DOMAIN	# of Items on Examination
1. Non-Clinical Operations	28
2. Clinical Operations	32
3. Revenue Cycle/Finance	15
4. Regulatory Compliance	15
5. Reporting	10
Total	**100**

CEHRS Detailed Examination Outline

	Domain 1: Non-Clinical Operations	28 Items
1.A.	Verify patient identifiers before documenting in the EHR to ensure information is recorded in the correct chart.	
1.B.	Collect, record, and continuously update patient information (e.g., demographic information, clinical data, coverages/financial/insurance, guarantors, patient preferences).	
1.C.	Generate encounter documentation (e.g., admission/face sheet, labels, armbands).	
1.D.	Retrieve patient information from internal databases (e.g., provider database, financial database) to integrate into a patient's EHR.	
1.E.	Acquire patient data from external sources (e.g., diagnostic laboratories, ancillary facilities, other health care providers, other EHR systems).	
1.F.	Import information into the EHR from integrated devices (e.g., scanners, fax machines, e-signature pads, cameras).	
1.G.	Maintain inventory of EHR-related hardware (e.g., e-signature pads, cameras, tablets, mobile devices).	
1.H.	Coordinate patient flow within the facility (e.g., scheduling, patient registration and verification, check-in/check-out, patient referrals).	
1.I.	Provide initial and ongoing end-user training of EHR software to maintain competency (e.g., for new hires, upgrades and deployments).	
1.J.	Share information about updates to EHR software and the implications for workflow.	
1.K.	Identify data discrepancies within and among multiple EHRs, practice management systems, and other software systems.	
1.L.	Report or reconcile data discrepancies within and among multiple EHRs, practice management systems, and other software systems.	
1.M.	Provide support to patients regarding their use of patient portals (e.g., basic introduction, explain utility, grant access, navigation help).	
	Domain 1: Associated Knowledge Statements:	
1.K1.	Categories of patient information to be included in the EHR (e.g., demographic information, clinical data, coverages/financial/insurance, guarantors, patient preferences)	
1.K2.	Patient identifiers (e.g., Medical Record Number [MRN], EHR number, billing number)	
1.K3.	Search techniques to prevent duplicate Medical Record Numbers (MRNs)	
1.K4.	External information sources (e.g., diagnostic laboratories, ancillary facilities, other health care providers, other EHR systems)	
1.K5.	General office skills (e.g., copying, faxing, scanning, data entry)	
1K6.	Basic computer knowledge (e.g., word processing, hardware and software concepts, spreadsheets, basic networking)	
1.K7.	Procedures to transmit (e.g., import/export) data between devices	
1.K8.	Methods to inventory EHR-related hardware (e.g., e-signature pads, cameras, tablets, mobile devices) and implications for accurate and inaccurate inventory lists	

1.K9.	Provider schedules	
1.K10.	Scheduling templates and techniques	
1.K11.	Check-in/check-out procedures	
1.K12.	Credit card charging procedures	
1.K13.	Acceptable forms of identification	
1.K14.	Considerations for remote/virtual training and support	
1.K15.	Coaching and mentoring techniques	
1.K16.	EHR training documentation requirements (e.g., who needs training, scheduling needed training, training performed)	
1.K17.	Available EHR training material	
1.K18	Resources for developing new EHR training materials (e.g., frequently asked questions [FAQs], curriculum)	
1.K19.	Procedures to disseminate updated information to staff and others	
1.K20.	Basic IT troubleshooting techniques (e.g., making sure components are connected, where to find computer name/IP address, screenshot capture)	
1.K21.	IT escalation procedures	
1.K22.	EHR software reference library	
1.K23.	Data validation techniques and procedures	
1.K24.	Provider databases, specialties, and National Provider Identifiers (NPIs)	
1.K25.	Patient portal support (e.g., basic introduction, explain utility, grant access, navigation help)	

	Domain 2: Clinical Operations	**32 Items**
2.A.	Develop clinical templates for data capture (e.g., by diagnosis, by procedure, by practice).	
2.B.	Securely transmit and exchange patient data internally and externally (e.g., to pharmacies, other health care providers, other agencies) for research, analytics, and continuity of care.	
2.C.	Review and monitor clinical documentation to ensure completeness and accuracy (e.g., self-review, peer-to-peer).	
2.D.	Provide point-of-care EHR support (e.g., at-the-elbow, remote) for clinical documentation.	
2.E.	Input real-time clinical data into the EHR.	
2.F.	Document patient historic clinical data in the EHR (e.g., medications, immunizations, surgeries).	
2.G.	Provide support for computerized provider order entry (CPOE).	
2.H.	Locate and provide patient education materials available within the EHR.	
2.I.	Navigate the EHR system to retrieve requested patient data.	
	Domain 2: Associated Knowledge Statements	
2.K1.	Content included in clinical templates (e.g., diagnoses, procedures)	
2.K2.	Types of information required for specific templates	
2.K3.	Common uses of clinical templates	
2.K4.	Telehealth/telemedicine workflows	
2.K5.	Requirements and procedures to securely transmit data	
2.K6.	Types of data that must be encrypted and the encryption processes	

2.K7.	Types of information that can be shared externally	
2.K8.	Considerations (e.g., purpose, audience) for transmitting data	
2.K9.	Common errors in documentation (e.g., directional terms, misspelling of names, conflicting information, duplicate charting)	
2.K10.	Charting requirements (e.g., primary and secondary diagnosis codes)	
2.K11.	Charting formats and methods (e.g., problem-oriented medical records [POMR], Subjective, Objective, Assessment, Plan [SOAP], Subjective, Objective, Assessment, Planning, Implementing, Evaluating, Reassessing [SOAPIER]	
2.K12.	Patient alerts and quality indicators	
2.K13.	Types of clinical data to be entered during a patient visit	
2.K14.	Procedures and treatments performed by health care professionals	
2.K15.	Types of historic data that must be entered into the EHR (e.g., medications, immunizations, allergies, surgeries)	
2.K16.	Scope of practice regarding computerized provider order entry (CPOE)	
2.K17.	Patient education materials available in the EHR (e.g., smoking cessation, wound care, prenatal care) and how to access them (e.g., applicable search terms, how to navigate)	
2.K18.	Scope of practice regarding patient education	
2.K19.	Location of specific patient data in the medical record (e.g., vital signs, medication list, lot number, blood glucose)	

	Domain 3: Revenue Cycle/Finance	**15 Items**
3.A.	Find codes in databases (e.g., International Statistical Classification of Diseases and Related Health Problems [ICD], Current Procedural Terminology [CPT], and Healthcare Common Procedure Coding System [HCPCS]).	
3.B.	Navigate the EHR to create a superbill, encounter forms, fee slips, or charge forms.	
3.C.	Enter the diagnosis and procedure codes billing information (e.g., from a superbill) into the EHR system for claims processing.	
3.D.	Verify that all diagnoses and procedural descriptions for reimbursement are accurately documented in the EHR.	
3.E.	Verify insurance and eligibility in the EHR.	
3.F.	Obtain and document authorizations in the EHR.	
3.G.	Provide estimated patient costs.	
3.H.	Navigate the EHR to provide patient statements.	
3.I.	Collect and post payments to a patient's account.	
	Domain 3: Associated Knowledge Statements	
3.K1.	The link between documentation accuracy and reimbursement	
3.K2.	Types of codes (e.g., Current Procedure Terminology [CPT], International Classification of Diseases [ICD], Healthcare Common Procedure Coding System [HCPCS])	
3.K3.	Search and look-up procedures within classification codes	
3.K4.	The structure of coding and classification systems	

3.K5.	Clinical vocabularies associated with various classification systems	
3.K6.	Structure of a patient chart	
3.K7.	Medical necessity and code linkage	
3.K8.	Methods and procedures to optimize reimbursement	
3.K9.	National Correct Coding Initiative (NCCI) standards	
3.K10.	Real-time eligibility for services and supplies	
3.K11.	Reimbursement systems and processes (e.g., Medicare, Medicaid, workers' compensation, third-party payer insurance)	
3.K12.	Guarantors	
3.K13.	Fee schedules	
3.K14.	Explanation of Benefits (EOB) and Remittance Advice (RA)	
3.K15.	Procedures to obtain and document prior authorizations and pre-authorizations (e.g., pharmacological, referral, medical equipment, health care services)	
3.K16.	Payers' policies regarding authorizations	
3.K17.	Procedures to obtain estimated costs	
3.K18.	Payment methods (e.g., credit card charging procedures, cash application)	
3.K19.	Balance reconciliation (e.g., between the EHR and receipts)	
3.K20.	Documentation for both payment and non-payment	
3.K21.	Health insurance terminology	
3.K22.	Health care revenue cycle	
3.K23.	Claims submission procedures	
3.K24.	Electronic Data Interchange (EDI)	

	Domain 4: Regulatory Compliance	**15 Items**
4.A.	Adhere to professional standards of care as they pertain to health records.	
4.B.	Maintain confidentiality and security of protected health information (PHI) in compliance with the HIPAA Privacy Rule, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and facility policy.	
4.C.	Educate others regarding compliance with best practices to safeguard electronic information and assist with enforcement of compliant behaviors.	
4.D.	Identify non-compliant behaviors (e.g., sharing passwords, unlocked room) that represent threats to the security of electronic information.	
4.E.	Allocate access controls within the EHR system based on user roles and predetermined privileges.	
4.F.	Verify and assist with compliance of access controls (i.e., privileges) within the EHR system.	
4.G.	De-identify protected health information (PHI).	
4.H.	Release protected health information (PHI) in accordance with the HIPAA Privacy Rule and facility policy.	
4.I.	Participate in internal audits of the EHR (e.g., consent forms, release of information forms, signature on file).	
4.J.	Comply with regulations regarding the use of abbreviations in the EHR system.	
4.K.	Initiate down-time procedures related to the EHR (e.g., data recovery).	

4.L.	Comply with the requirements of EHR incentive programs.	
	Domain 4: Associated Knowledge Statements	
4.K1.	Types of data considered protected health information (PHI) (e.g., email addresses, next of kin, phone numbers, social security numbers)	
4.K2.	Methods and procedures used to de-identify protected health information (PHI)	
4.K3.	HIPAA requirements	
4.K4.	Best practices to maintain the security of electronic information	
4.K5.	Legal ramifications related to inaccuracies in the EHR	
4.K6.	Legal requirements for sharing or transmitting data externally	
4.K7.	Potential security breaches	
4.K8.	Escalation procedures	
4.K9.	Federal guidelines on reporting breaches	
4.K10.	Procedures to safeguard data (e.g., screen savers, password rules, screen visors)	
4.K11.	Adult learning and education techniques	
4.K12.	Required IT controls	
4.K13.	Role-based privileges	
4.K14.	Acceptable abbreviation practices and policies	
4.K15.	Data backup and recovery methods	
4.K16.	Data storage guidelines	
4.K17.	Consequences of noncompliance to regulations (e.g., penalties, non-payment, sanctions)	
4.K18.	EHR incentive programs and their requirements	

	Domain 5: Reporting	**10 Items**
5.A.	Run and execute standardized financial reports (e.g., aging, carriers, financial guarantor, relative value, cost of procedures, prospective payment systems).	
5.B.	Run and execute standardized clinical reports to track patient outcomes (e.g., by diagnosis, by procedure, by provider) for the support of continuity of care.	
5.C.	Generate ad hoc financial reports using fields in the EHR system.	
5.D.	Generate ad hoc clinical reports using fields in the EHR system.	
5.E.	Generate statistical reports for quality improvement (QI) measures, productivity, metrics, and research.	
5.F.	Compile data from the EHR for external reporting (e.g., for Meaningful Use/Quality Payment Program [QPP]).	
5.G.	Verify the accuracy of generated reports prior to distribution (e.g., check for errors).	
	Domain 5: Associated Knowledge Statements	
5.K1.	Methods to generate reports (e.g., running queries, executing standardized reports, creating custom reports)	
5.K2.	Provider, diagnosis, and procedures reports	
5.K3.	Types and requirements of financial reports	
5.K4.	Types and requirements of clinical reports	

5.K5.	Data mining and extraction methods	
5.K6.	Quality improvement measures (e.g., average length of stay, patient outcomes, diagnoses, infection rates)	
5.K7.	Common reporting errors (e.g., missing fields, too much data on report)	

	Core/Foundational Knowledge **The following knowledge statements do not represent standalone domains on the CEHRS exam. Rather, these are fundamental skills and necessary knowledge for those who perform specialized tasks within in the electronic health record, which could be used in the context of an assessment item and are being provided for preparation and review purposes.**
CK1.	Health care regulatory agencies (e.g., Centers for Medicare and Medicaid Services [CMS], The Joint Commission [TJC], United States Department of Health and Human Services [HHS]) and their relevance to EHR practices
CK2.	Professional standards related to EHR practices (e.g., Centers for Medicare and Medicaid Services [CMS], Health Insurance Portability and Accountability Act [HIPAA], Health Information Technology for Economic and Clinical Health [HITECH] Act, Meaningful Use/Quality Payment Program [QPP], Systematized Nomenclature of Medicine – Clinical Terms [SNOMED CT])
CK3.	Medical terminology
CK4.	Basic health care finance terminology
CK5.	Health care systems, settings, and personnel (e.g., facility types, roles, credentials)
CK6.	Parts of the EHR (e.g., demographic information, clinical records, medication administration record, diagnoses, laboratory reports, orders, billing information)
CK7.	Protected health information (PHI)
CK8.	Types and implications for use of health records (e.g., paper or electronic [including app-based/mobile, computer-based, web-based/online])
CK9.	Types of health care documentation (e.g., Subjective, Objective, Assessment, Plan [SOAP] progress notes, laboratory reports, imaging, operative reports, orders)
CK10.	General function(s) and purpose of the EHR (e.g., continuity of care, streamlined care)
CK11.	Patient rights and responsibilities
CK12.	Interoperability concepts
CK13.	Population health concepts