RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Community Health Aide/Practitioner Getting Started Guide

Version 1.9 Draft
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Office of Information Technology (OIT)
Division of Information Resource Management
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Table of Contents

Preface

The Indian Health Service (IHS) Office of Information Technology (OIT) National Electronic Health Record (EHR) Training and Deployment Program Community Health Aide and Village Clinic workgroup worked diligently to prepare the necessary deployment and training documents to facilitate the deployment of EHR within the Village Clinic setting. We hope that you find these documents helpful.

The Office of Information Technology conveys its sincere thanks all the members and guests of this workgroup. They spent long hours preparing and updating these documents and even longer documenting their experience; they deserve our appreciation. Without these dedicated workgroup members this would not be possible. A special thanks to Mary Wachacha, Chief IHS Health Education Program for her vision and resources.

We also give special recognition to the Community Health Aide Directors and Clinical Application Coordinators from (a) Tanana Chiefs Conference, (b) Bristol Bay Area Health Corporation, (c) Maniilaq Health Center, (d) Eastern Aleutian Tribes, (e) Aleutian Pribilof Island Association, and (f) Kodiak Area Native Association for their dedication in both deploying EHR within the Village Clinic setting and serving as subject matter experts (SMEs) for this project. Finally, we are indebted to our colleagues in the Indian Health Service and Community Health Aide Program for their support, encouragement, and input.

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1.0 Introduction

This guide instructs Alaska Community Health Aides and Practitioners (CHA/P) in retrieving patient data and creating electronic records using the Resource and Patient Management System (RPMS) Electronic Health Record (EHR) software. This guide is to be used in conjunction with the Alaska Community Health Aide/Practitioner Manual (CHAM). CHA/Ps are required to follow the steps in the CHAM for patient encounters.

Refer to organizational policy regarding use of reporting documentation. In emergency situations, a paper Patient Encounter Form (PEF) may be used instead of the EHR. This guide is not meant to replace the information in the CHAM.

1.1 Electronic Health Record

Healthcare providers use the EHR to document patient care, review and update patient charts across multiple locations, and access information without relying on potentially out-of-date paper records. The patient information entered into the EHR can be used to support patient care decisions and for trending specific health-related issues for health promotion and quality improvement initiatives.

1.2 Security

Features of this application contain confidential patient information that is subject to Privacy Act protection.

- The EHR software does not impose any additional legal requirements on the user, nor does it relieve the user of any legal requirements.
- Names, numbers, and demographic information used in the examples presented herein are fictitious.

1.3 Using this Guide

This guide is organized to meet the following objectives:

- Introduce the EHR to the reader (Section 1.0).
- Familiarize the reader with EHR features, functions, and screen objects (Section 2.0).
- Instruct the reader in how to log on to the EHR and to locate a patient (Sections 3.0 and 5.0).
- Guide the reader in using EHR to support and record patient encounters (Sections 6.0 through 23.0).

The appendixes contain supplementary information that the reader may find useful:

- Appendix A: is a quick-start reference for following the steps outlined in this guide.
- Appendix B: cross-references each part of the PEF to its appropriate EHR tab.
- Appendix C: lists the acceptable range of each measurement value that may be entered into the EHR.
- Appendix F: lists useful Windows keyboard shortcuts that work with the EHR.

2.0 General Terms

This section defines terms and concepts that are required to get started using the EHR and to understand this guide. Users should be comfortable using the mouse or touchpad on a laptop (including right-clicking, double-clicking, clicking and dragging, and selecting items on the screen), and should be able to type text into fields and templates in a Windows-based computer program such as the EHR.

2.1 Computer Input Devices

- **Keyboard**: Figure 2-1 shows an example of a standard keyboard.

Figure 2-1: Example of a standard 104-key keyboard

- **Mouse**: Figure 2-2 shows an example of a mouse. The appearance and extra features of a mouse may differ depending upon the manufacturer.

Figure 2-2: Example of a mouse

2.2 Terminology

This guide uses specific text styles, annotations, and backgrounds to convey information and call the reader's attention to statements that will assist in understanding the contents. The following subsections describe and define these visual cues.

2.2.1 Bold Type

Bold type is used to denote:

- Labels (names) of items displayed on the screen. This includes the names of fields, controls, and buttons, as well as the names of windows, panes, and dialogs.
- Specific user input (typing in a field).

An instruction containing both usages follows:

"Type **exempt** in the **License** field."

2.2.2 Bulleted List

A list of two or more items is often displayed as a bulleted list following an introductory paragraph. Here is an example of a bulleted list:

- This is an example of a first bullet. Note that the bullet is aligned with the left edge of the introductory paragraph.
  - When necessary, a bullet is divided into two or more sub-bullets (represented by a dash).
  - Note that the dashes are aligned with the text of the 'parent' bullet and that the text is further indented.
- This is an example of a second bullet. Note that the text is indented.

A bulleted list aids comprehension and can make it easier for the reader to find specific content when skimming through the guide.

2.2.3 Figures

Throughout this guide, graphics or 'pictures' are included to aid comprehension and to make it easy for the reader to correlate the presented information with the screens displayed by the EHR software.

- A Screenshot is an *exact* copy of all or part of an EHR window or dialog. An example of a screenshot is in Figure 2-3:

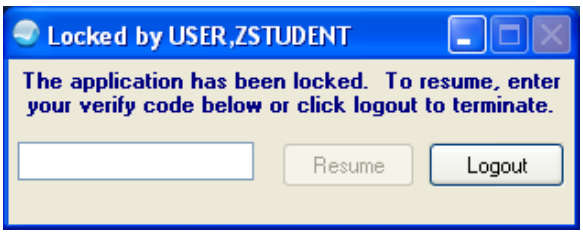


Figure 2-3: Example of a Screenshot

- An Illustration is a *representative* copy of the referenced item and may not exactly match what the reader has on hand. For example, Figure 2-4 shows the appearance and relative position of a keyboard key without attempting to exactly match the size, shape, and color of the corresponding key on the reader's keyboard:

Figure 2-4: Example of an Illustration

Each figure is labeled and includes a figure number made up of the section number, a dash, and the figure's sequence number within the section.

2.2.4 Notes

> Note: A routine note is displayed within a box on a light gray background.

2.2.5 Procedure Steps

Steps of a procedure are numbered:

1. This is an example of a first step. A procedure always has at least two steps.
   - Two or more bullets after a numbered step indicate that distinct conditions or considerations apply when executing that step.
   - This is an example of a second condition pertaining to Step 1.
2. This is an example of a second step. When a step includes two or more options:
   a. Each option is indented and marked with a lower-case letter.
   b. This is an example of a second option incorporated within Step 2.

2.2.6 User Interaction

To interact with the EHR software, use the workstation's *keyboard* and *pointing device* (mouse, trackball, touch pad, or other specialized hardware). The following verbs are used throughout this guide to describe the interaction:

- Click: The act of gently striking a button on the pointing device. When click is used alone, it means to press and quickly release the primary button, usually the left one. Other combinations of this verb are:
  – Click and hold: Gently strike the indicated button and hold it down.

  - Double-click: Gently strike and quickly release the indicated button twice in rapid succession.
  - Drag: The act of moving a screen object or manipulating a control (such as a scroll bar) after executing a 'click and hold' action with the pointer positioned over the object or control.
  - Release: Lift the finger to allow the button to return to its natural position.
  - Right-click: Gently strike the secondary button, usually the right one.
- Press: The act of gently striking and releasing a key on the keyboard. Other combinations of this verb are:
  - Press and hold: Gently strike the indicated key and hold it down.
  - Release: Lift the finger to allow the key to return to its natural position.
- Scroll: The act of manipulating the view of the contents of a window or field when the contents are greater than the available space. When this situation occurs, the EHR displays one or two scroll bars (along the right edge and/or along the bottom edge of the window or field – see Section 2.3.1.3) that can be manipulated to display the entire contents. Scrolling methods depend on the type of window or field:
  - Keyboard: With the cursor set in an editable field, use the arrow keys (Figure 2-5) to move the cursor; if there is unseen content beyond a boundary of the field, the view should scroll as the cursor is moved against the boundary.

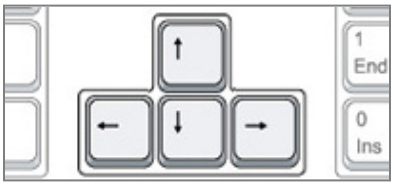


Figure 2-5: Arrow Keys (one variation)

  - Pointing Device: Place the pointer over the scroll bar control and click (or click and drag).

Note:	Some windows and fields may respond to the scrolling wheel present on some pointing devices; however, such behavior is not to be expected.

- Select: The act of choosing an option presented on the screen. The available options may be in various forms (radio button set, check box, menu, list box, etc.) however the form is not included as part of the instruction. An option is referred to by its label only ("Select **All**" not "Select the **All** checkbox").

Note:	The verb 'select' as used in this guide is generic and does not dictate the method (***pointing device*** or ***keyboard***) used.

- Type: The act of placing text into a field by sequentially pressing the appropriate keys on the keyboard. Text typically consists of alphabetic letters (A-Z and a-z), numerals (0-9), punctuation, and the space ( ); the properties of a field may also allow the use of the Tab key to position text horizontally and the Return (Enter key) to create a new line of text.

2.2.7 Warnings and Cautions

> Warnings, cautions, and other important information are displayed within a box on a yellow background.

2.3 Composition of the EHR Window

The EHR Window, shown in Figure 2-6, is composed of many standard Graphical User Interface (GUI) *objects*. These objects should be familiar in both look and function to anyone who has used a modern computer workstation. This section describes the various objects by type and explains the typical functionality of each.

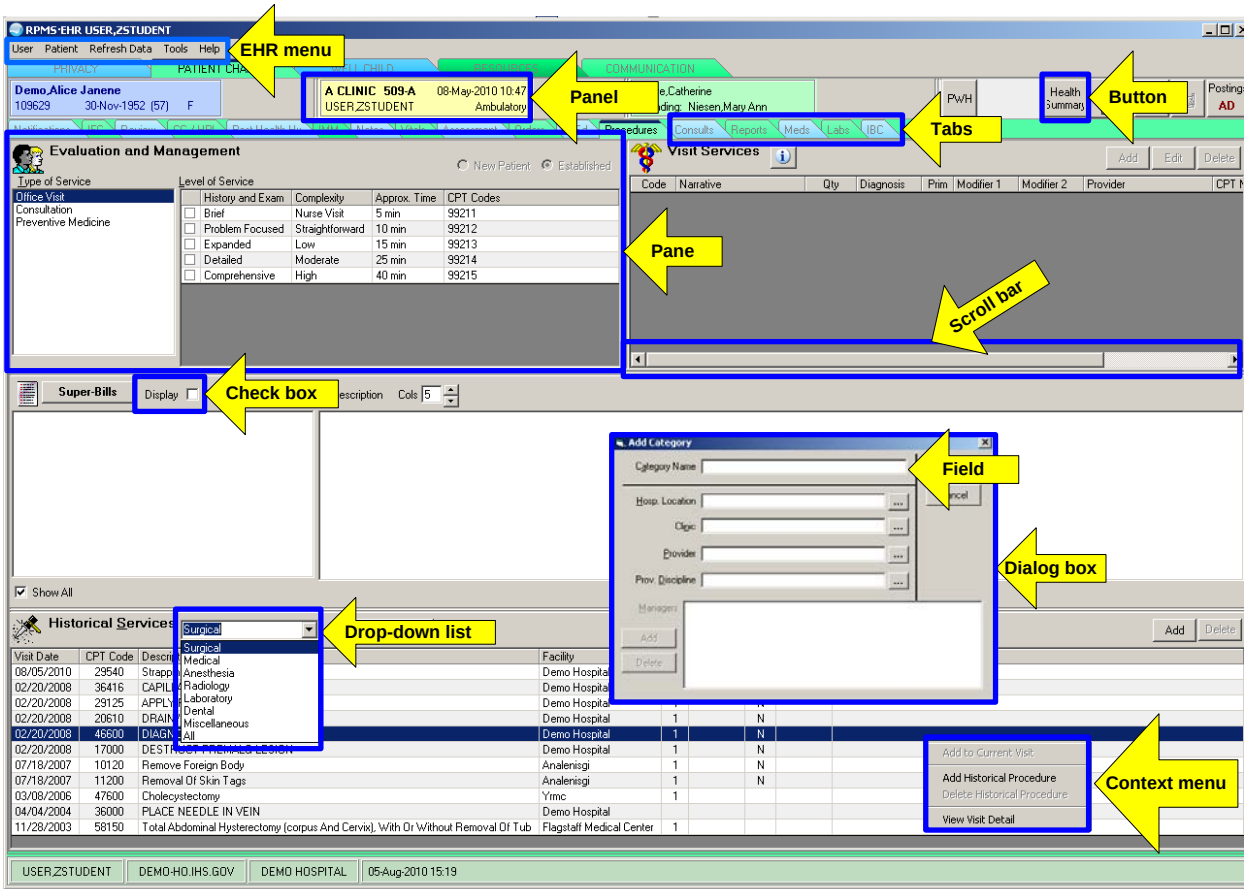


Figure 2-6: Controls and components of the EHR window

Some of the components shown in Figure 2-6 are defined in the following sections.

The EHR window can be modified by the site manager. Therefore, features of the reader's EHR window may not appear exactly as they are shown in this guide.

2.3.1 Display Objects

The EHR uses standard display objects to display and gather information. The appearance and behavior of these objects will be familiar to anyone who has used a personal computer and they function in much the same manner as in other software. The appearance and use of each display object is discussed in the following subsections.

2.3.1.1 Check Box

A check box provides the ability to select the item described by the check box's label. When the item is selected, a check mark is displayed in the box; when not selected, the box is empty.

- The presence of a check mark indicates an answer of **Yes**.
- The absence of a check mark indicates an answer of **No**.

Note: Check boxes are also found in templates on the **Notes** tab. In this case, clicking a check box opens a field where information specific to a template can be entered. See the example in Figure 2-7

Figure 2-7: Example of a Check Box

2.3.1.2 Drop-down List

A drop-down list is a field similar to that shown in Figure 2-8, which allows one item to be chosen from a list of items. Clicking the arrow to the right of the field displays a list of available items. When one item is selected from the list, the selected item is displayed in the field:

Figure 2-8: Example of a Drop-down List (list contents displayed but no choice made)

2.3.1.3 Radio Button Set

A radio button set allows the selection of one among a group of related labeled choices as shown in Figure 2-9. When a choice is made, a black dot is displayed in the selected control and all others in the set are cleared; only one choice can be made.

Figure 2-9: Example of a Radio Button set

2.3.1.4 Text Field

A text field is an area that displays freeform text. It may be restricted to a single line of text or it may 'wrap' text to multiple lines. A multi-line text field may display scroll bars that can be manipulated to allow all of the text to be viewed. A text field may be editable or it may be view-only.

Editable Text Field

An editable text field is an area where information in the form of characters, numbers, and punctuation can be typed; Figure 2-10 provides an example. In addition, information previously saved can be deleted or edited (depending on programmatic rules).

Figure 2-10: Example of a Text Field

View-only Text Field

A view-only text field is an area where information in the form of characters, numbers, and punctuation are displayed, but cannot be deleted or edited.

2.3.2 Control Objects

The EHR uses custom control objects to launch processes (retrieve, save, open a new window, etc.). The behavior of these objects should be familiar to anyone who has used a personal computer.

2.3.2.1 Context Menu

A context menu is displayed when the right mouse button is clicked while the cursor is positioned over a window object (click the right mouse button once), as shown in Figure 2-11. A context menu offers a limited set of choices for the current window, tab, pane, or the selected item:

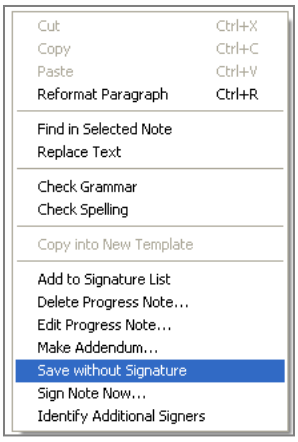


Figure 2-11: Example of a context menu

If a mouse is not available, the PC keyboard usually has a key for this option, as shown in Figure 2-12. The Context Menu key has an image of a cursor and menu and is typically located next to the right-hand Ctrl key:

Figure 2-12: Context Menu key on keyboard

To use the Context Menu key:

1. Position the cursor over the window object for which a context menu is sought.
2. Press the Context Menu key to display the context menu.
3. Use the up or down arrow key to step through the menu choices.
4. Press Enter to select a menu choice. To close the menu without choosing, press Esc (top left corner of the keyboard).

Note:	Template options in the **Notes** tab require the use of context menus.

2.3.2.2 Dialog

A dialog is a separate window that typically provides information and requires a response. Figure 2-13 shows an example of a dialog.

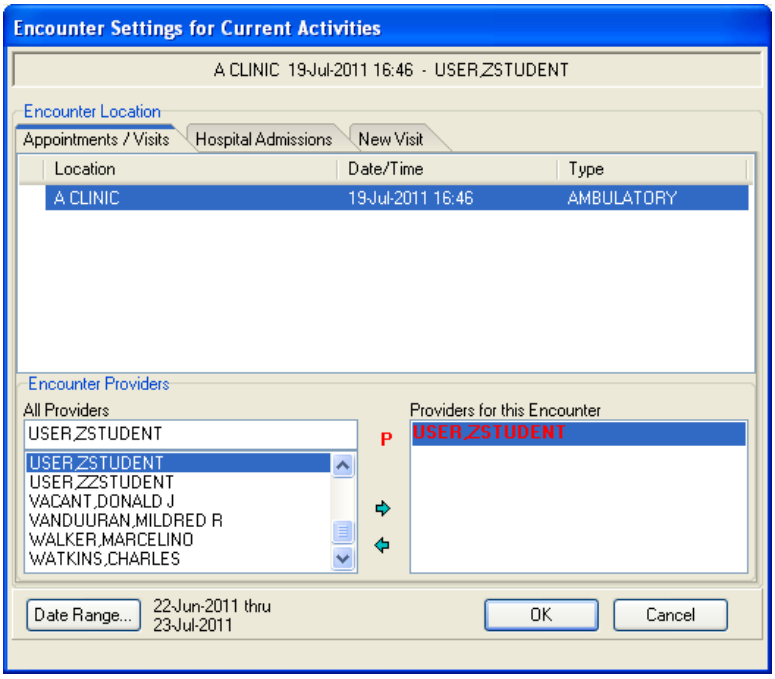


Figure 2-13: Example of a dialog

A dialog 'floats' over the EHR window and can be moved by clicking and holding the bar at the top of the dialog, and then dragging it to another place on the screen.

> Note: Usually a visible dialog must be responded to before work on the EHR window can resume.

2.3.2.3 Panel

The EHR toolbar contains three panels, as shown in Figure 2-14. The Patient panel is blue, the Visit panel is yellow, and the Primary Care Team panel is green. Panels can be clicked like buttons, but they also display information for the current patient whose encounter is being recorded. For example, the patient's name, Health Record Number (HRN), date of birth, age (in parentheses), and gender appear on the blue Patient panel.

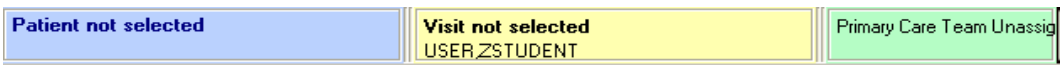


Figure 2-14: Patient panel, Visit panel, and Primary Care Team panel in the EHR toolbar

2.3.2.4 Pane

A pane refers to a distinct area within an EHR window, as shown in Figure 2-15. A window may contain several panes that are used for review, entering details regarding a patient encounter, or entering new patient data. In the example below, the **Problem List** pane is highlighted.

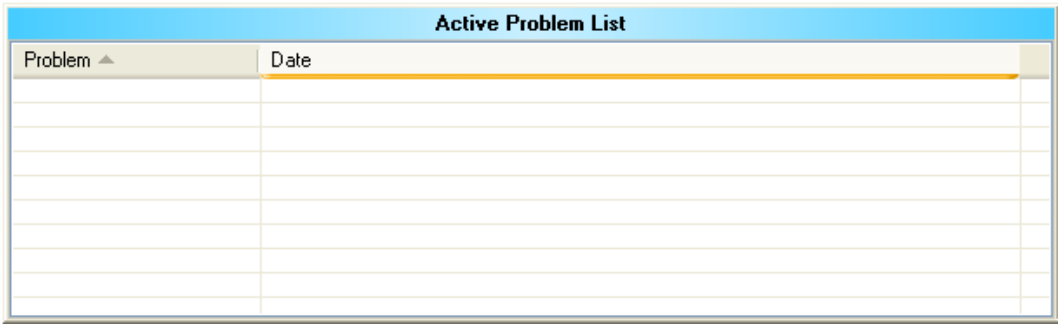


Figure 2-15: Example of a pane in the EHR

> **Note:** See the Glossary for more information regarding specific terms.

2.3.2.5 Refresh

To update recently changed patient information, select Refresh from the context menu or press F5 on the keyboard. Figure 2-16 shows an example of a context menu used to select **Refresh**.

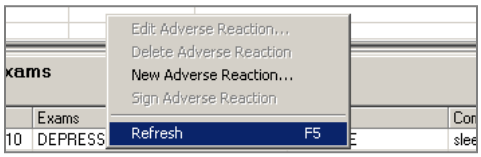


Figure 2-16: Selecting **Refresh** from a context menu

2.3.2.6 Scroll Bar

The scroll bar is a narrow rectangular control on the side or bottom of a window or pane that allows the display of parts of a document or screen when it is too large to fit in the window. To view different parts of the contents, drag the bar along the track or click the arrow at either end of the track to make precise adjustments.

Figure 2-17: Example of a Scroll Bar

2.3.2.7 Tab

EHR tabs look like traditional card tabs inserted in paper files or card indexes. The EHR application has several main tabs at the top of the window.

> **Note:** Most of the work performed in the EHR is done on the **PATIENT CHART** tab.

When the **PATIENT CHART** tab is selected, a row of smaller tabs is displayed, as shown in Figure 2-18. To chart a patient encounter, use the smaller tabs. The quantity and names of the tabs may vary by site.

Figure 2-18: Smaller tabs in the PATIENT CHART tab

2.3.2.8 Toolbar

In the EHR application, the toolbar is in the region below the main EHR tabs, as shown in Figure 2-19 and contains panels and buttons.

Figure 2-19: Toolbar panels and buttons

3.0 Log on to EHR

This section describes how to log on to the EHR application.

> **Note**: Access and verify codes, which are required to log on to the EHR application, are assigned by the site manager.

To log on to EHR:

1. Double-click the EHR application icon on the desktop (Figure 3-1) to open the **RPMS-EHR Logon** dialog (Figure 3-2).

Figure 3-1: EHR application icon

> **Note:** The EHR icon may look different from the one shown in Figure 3-1.

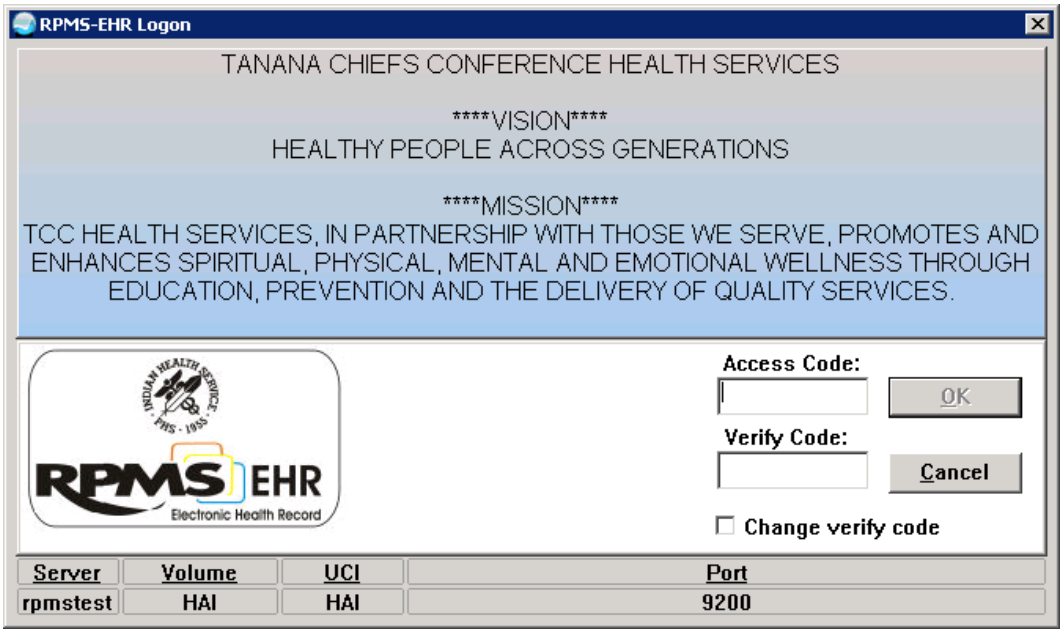


Figure 3-2: **RPMS-EHR Logon** dialog

2. Type the access code in the **Access Code** field.
3. Press Enter or Tab to move to the **Verify Code** field.
4. Type the verify code.
5. Click **OK** or press Enter.

> **Note:** To protect privacy, dots appear in the **Access Code** and **Verify Code** fields instead of the actual characters typed. If a mistake is made in typing either of these codes, press the Backspace key to erase the mistake and retype the code.

6. If necessary, select a different division and click **OK**.

> **Note:** A CHA/P who is working at a site other than his or her normal clinic must select the correct division based upon the site where patient care is being provided.

Typically, the EHR window opens to the **PATIENT CHART** EHR tab, **IFC** (Inside Front Cover) tab (Figure 3-3), which displays reference information from the inside front cover of the CHAM. However, the site manager may have disabled this default behavior and also may have removed the **IFC** tab entirely.

> **Note**: The **IFC** tab is for reference only. Text cannot be typed on this tab.

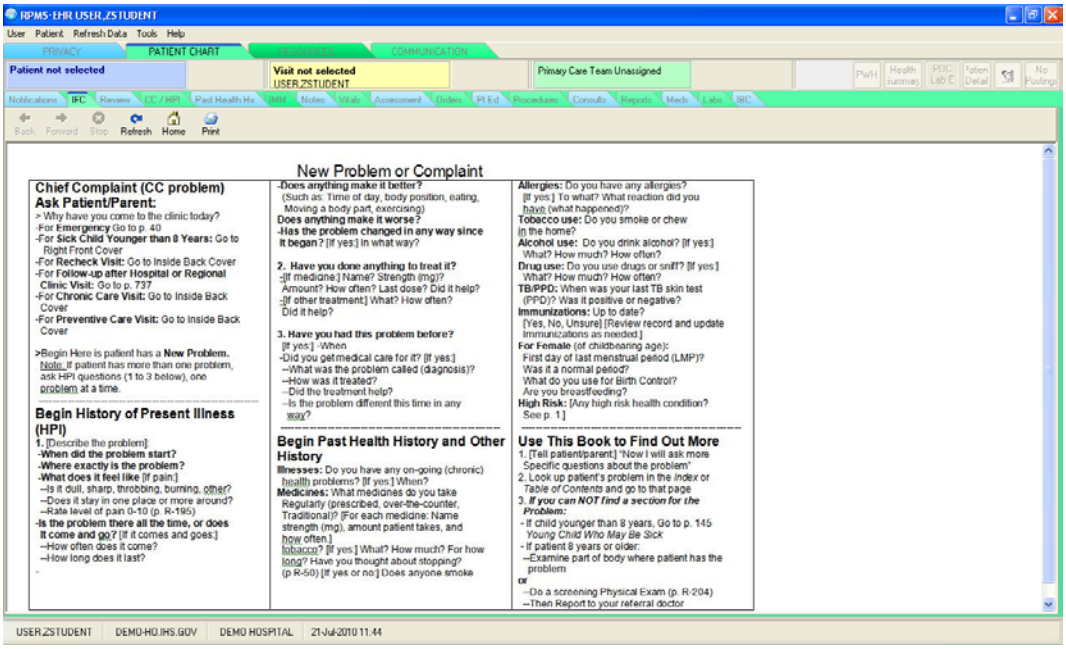


Figure 3-3: **IFC** tab

> **Note**: The position, order, and colors of the tabs in the EHR window may be different from the ones that are shown in the figures in this guide. For example, some sites set up the tabs to appear on the side or bottom of the window.

3.1 The Inactivity Limit Message

If the EHR application has not been used for a period of time, the Inactivity Limit warning message is displayed:

Figure 3-4: Inactivity Limit warning message

- To resume the session and return to the application, click anywhere on the circle.
- If no action is taken before the time limit has passed, the **Locked by** dialog, shown in Figure 3-5, is displayed:

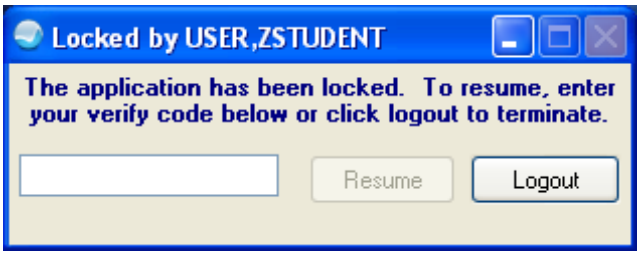


Figure 3-5: **Locked by** dialog

Note:	The next section describes the EHR window and its many features. To continue working in the EHR, skip forward to Section 5.0, "Select a Patient and a Visit."

3.2 Log off of EHR

1. To log off of EHR, do one of the following:
   - Select **Exit** from the **User** menu (Section 4.1.1).
   - Click the **X** in the upper right corner of the EHR window.

2. The **Confirm** dialog displays:

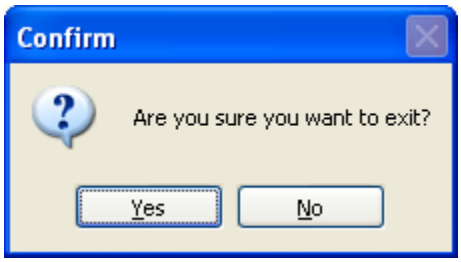


Figure 3-6: Confirm dialog

3. Click **Yes** to exit; **No** to return to the EHR.

4.0 The EHR Window

The **RPMS-EHR** window contains various panes, labels, controls, and fields used to access the functionality provided by the EHR software. This section contains a top-to-bottom description of each window and its features and functions.

4.1 EHR Main Menu

The EHR menu appears at the top of the EHR window. The following sections explain the use of the options available (if any) under each menu item.

Figure 4-1: EHR main menu

> Note: The individual menus on the menu bar may be customized by a system administrator. Consequently, the choices presented in this guide may not match those available at the site.

4.1.1 User Menu

The User menu, as seen in Figure 4-2, is typically the first (leftmost) option on the EHR Main Menu. Click **User** to expand the menu.

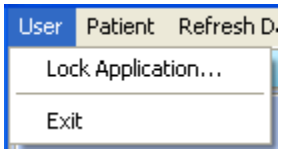


Figure 4-2: User menu

Lock Application option

Select the **Lock Application** option to temporarily hide and lock the EHR window to protect the privacy of patient data. The **Locked by** dialog is displayed (Figure 3-5):

- To return to the EHR, enter the verify code (the same code used to log on to the EHR) and click **Resume**.
- To leave the EHR, click **Logout**.

Exit option

Select the **Exit** option to log off of and close the EHR application.

4.1.2 Patient Menu

The Patient menu, shown in Figure 4-3, provides access to patient dialogs. Click **Patient** to expand the menu.

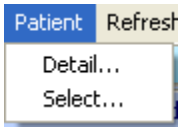


Figure 4-3: Patient menu

Detail option

With a patient selected, select **Detail** from the **Patient** menu to open the **Patient Detail** dialog and see the patient's demographic information (see Figure 5-7).

> **Note**: The **Patient Detail** button in the **Patient Selection** dialog can be used to view patient details. The **Detail** menu option is an alternate method for viewing a patient's demographic information.

Select option

Select **Select** from the **Patient** menu to open the **Patient Selection** dialog (see Figure 5-2).

> **Note:** The **Patient** panel on the toolbar can be used to select a patient. The **Select** menu option is an alternate method for selecting a patient.

4.1.3 Refresh Data Option

Select the **Refresh Data** option to refresh the data in the open tab.

Figure 4-4: Refresh Data option

This is useful to display updates that may have been made by another user. For example, if lab results are pending, using this option displays any new data that has been entered for a patient encounter.

4.1.4 Clear and Lock Option

Select the **Clear and Lock** option to clear the patient's information and lock the EHR window.

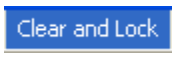


Figure 4-5: Clear and Lock option

The **Locked by** dialog is displayed (Figure 3-5):

- To return to the EHR, enter the verify code (the same code used to log on to the EHR) and click **Resume**.
- To leave the EHR, click **Logout**.

4.1.5 Tools Menu

Click **Tools** to expand the menu.

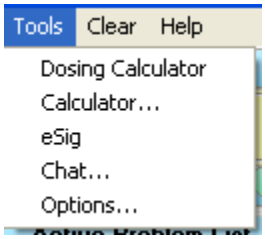


Figure 4-6: Tools menu

Calculator option

Select the **Calculator** option to open a standard Windows calculator, as shown in Figure 4-7.

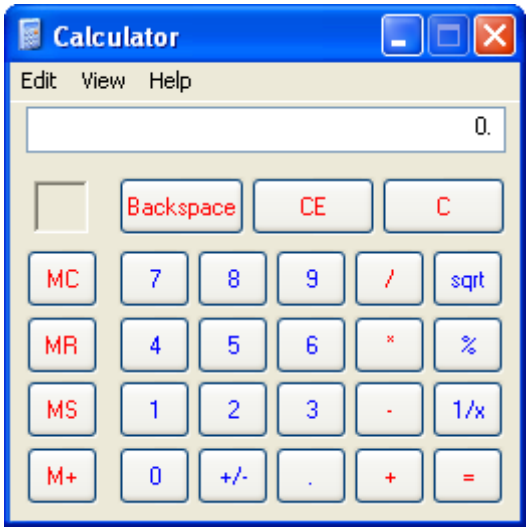


Figure 4-7: Calculator

e-Sig Option

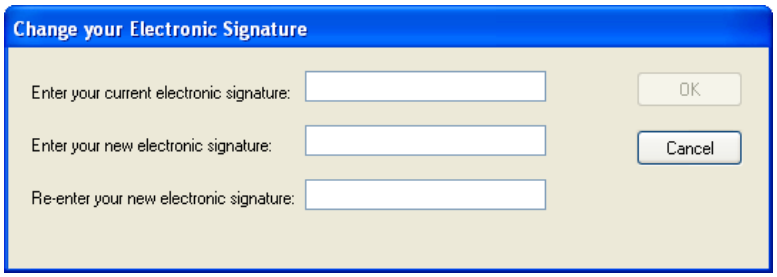


Figure 4-8: Change your Electronic Signature dialog

Chat option

Refer to regional policy regarding the use of this option.

Options option

Select the **Options** option to open the **Options** dialog, as shown in Figure 4-9.

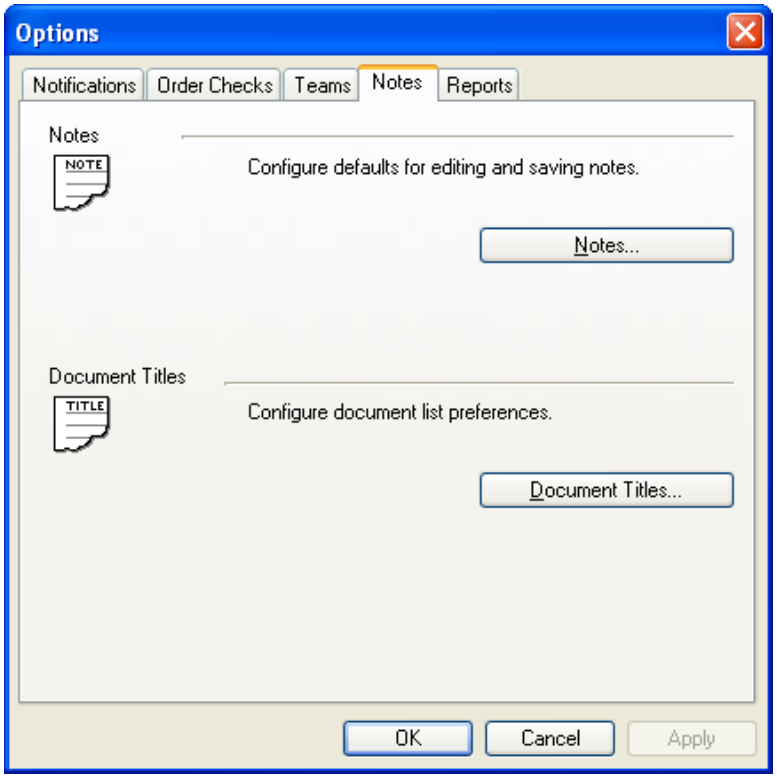


Figure 4-9: **Notes** tab of the **Options** dialog

The **Notes** tab of the **Options** dialog is used to specify the default document title. Refer to regional policy regarding other uses of this dialog.

1. Click the **Notes** tab in the **Options** dialog.
2. Click **Document Titles** to open the Document Titles dialog, as shown in Figure 4-10.

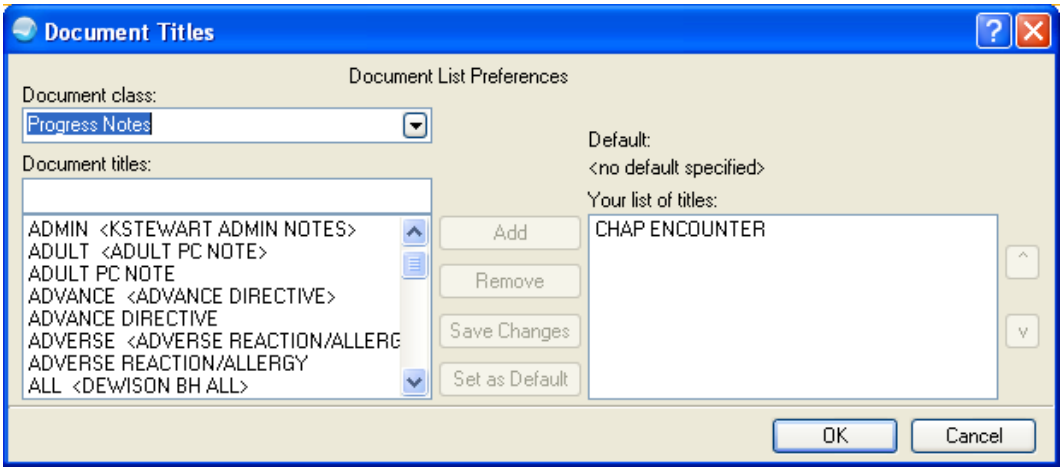


Figure 4-10: Setting CHAP ENCOUNTER as the default title in the **Document Titles** dialog

3. In the **Document Titles** dialog, select "CHAP ENCOUNTER" from the list of document titles, then click **Set as Default**. Click **OK** to close the **Document Titles** dialog.
4. In the **Options** dialog, click **OK**.

4.1.6 Clear Option

Select the **Clear** option to clear the patient's information from the EHR window.

Figure 4-11: Clear option

4.1.7 Help Menu

Click **Help** to expand the menu.

Figure 4-12: Help menu

The **Help** menu is another resource for information about using the EHR.

Contents option

The **Contents** option launches Help for the EHR configuration typically found at hospitals and large clinics. This option is not recommended for use by CHA/Ps; instead, select the **Help On** option.

Help On option

Select the **Help On** option to get help for specific EHR topics. This displays a submenu, shown in Figure 4-13, listing the available help topics.

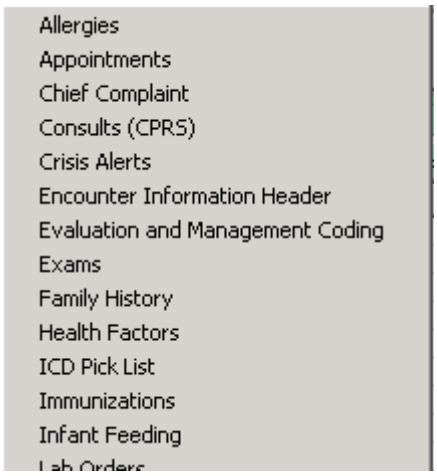


Figure 4-13: **Help on** submenu (partial)

- Click any item in the submenu to open that specific help topic. In the example of Figure 4-14, "Chief Complaint" was picked from the **Help on sub**menu:

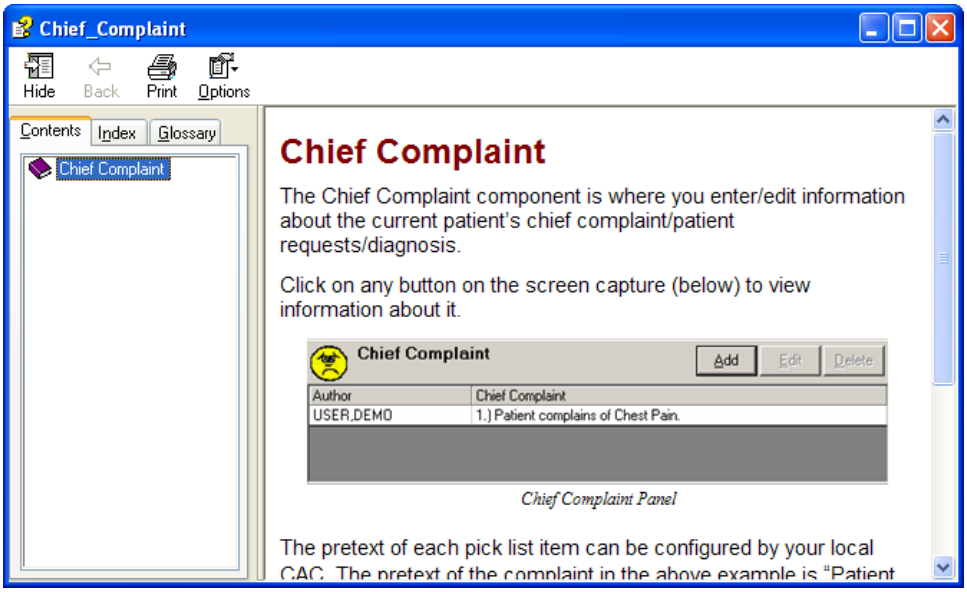


Figure 4-14: "Chief Complaint" help topic selected from the **Help on** menu

4.2 EHR Tab Set

The following tabs appear near the top of the EHR window:

- **PRIVACY** (see Section 4.2.1)
- **PATIENT CHART** (see Section 4.2.2)
- **WELL CHILD** (see Section 4.2.3)
- **RESOURCES** (see Section 4.2.4)
- **COMMUNICATION** (see Section 4.2.5)

> **Note:** Most of the work documenting a patient encounter in the EHR is done on the **PATIENT CHART** tab.

4.2.1 PRIVACY Tab

Use the **PRIVACY** tab to hide patient information. This tab looks different at different sites:

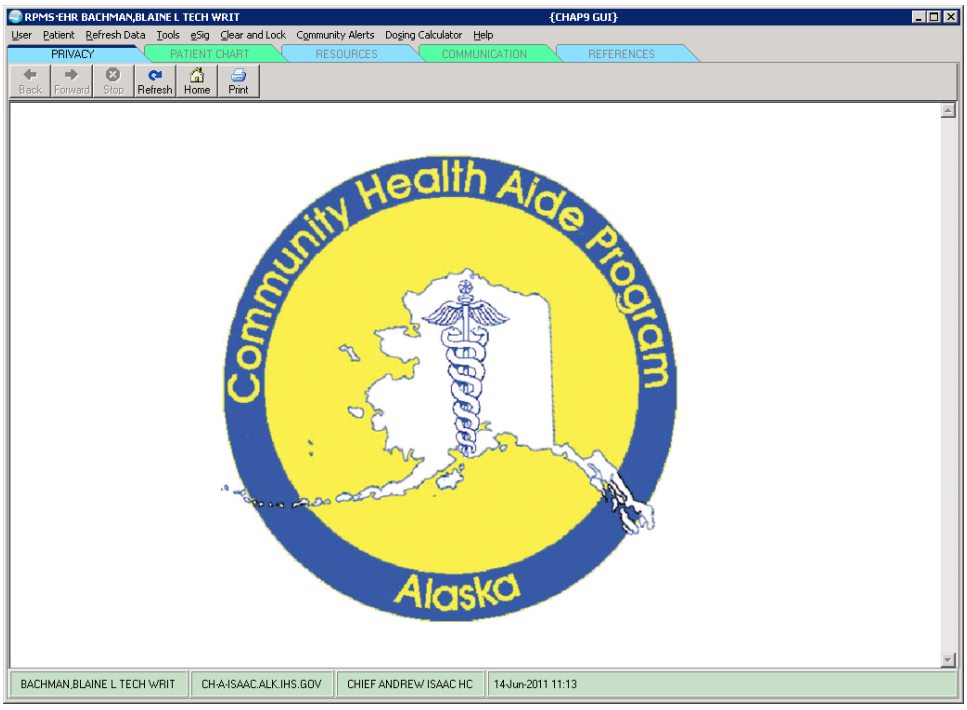


Figure 4-15: EHR **PRIVACY** tab

4.2.2 PATIENT CHART Tab

Most of the work in EHR involves entering patient encounter data on the **PATIENT CHART** tab. A row of smaller tabs appears on the **PATIENT CHART** tab:

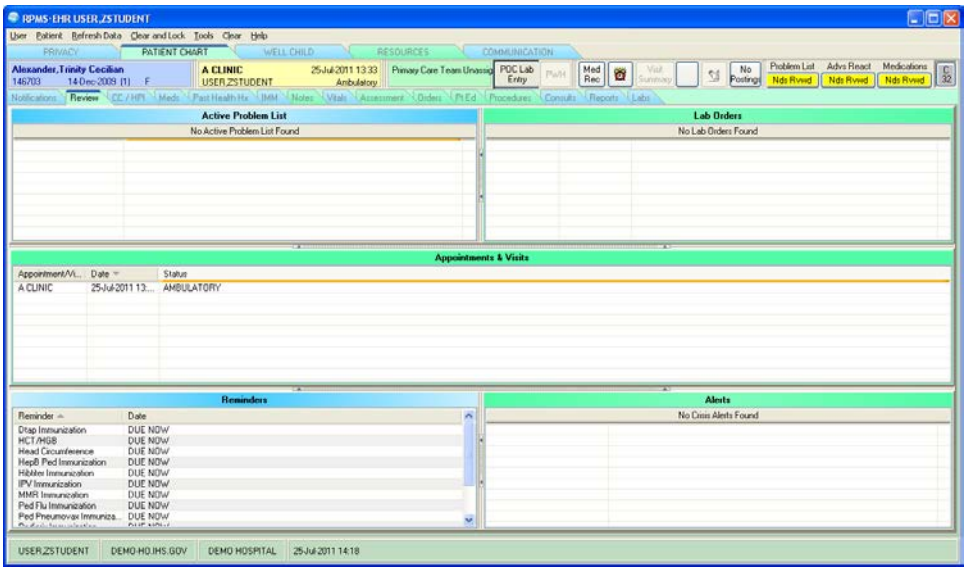


Figure 4-16: EHR **PATIENT CHART** tab showing the **Review** tab

To chart a patient encounter, use each of the smaller tabs on the **PATIENT CHART** tab in the order described in this guide.

4.2.3 WELL CHILD Tab

The **WELL CHILD** tab displays information for a patient of up to five years old:

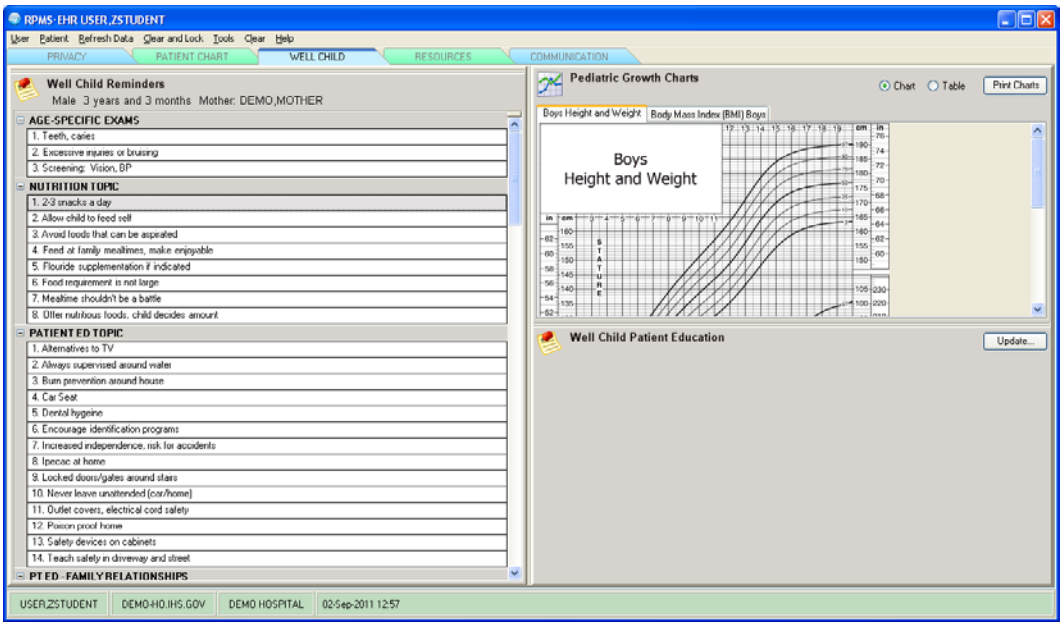


Figure 4-17: EHR **WELL CHILD** tab

The **WELL CHILD** tab contains three panes:

- **Well Child Reminders** pane contains a list of exams, topics, and questions that might be addressed during a Well Child visit.
- **Pediatric Growth Charts** pane displays standard growth charts using data entered in the Vital Signs tab. If no data exists, this pane will be blank.
- **Well Child Patient Education** pane lists any patient education provided to the patient at the time of the encounter. Age-specific patient education topics are presented to the provider at the time of encounter.

4.2.3.1 Print Pediatric Growth Charts

1. In the Pediatric Growth Charts pane (Figure 4-18), click **Print Charts** to open a new window displaying the charts in PDF format.

Figure 4-18: Pediatric Growth Charts pane header

2. Use the controls available on the PDF viewer to print or save the file.

4.2.3.2 Update Well Child Patient Education

Use of this tab is dependent upon site policy.

1. Click **Update** to display the **Well Child Patient Education Update** dialog (Figure 4-19).

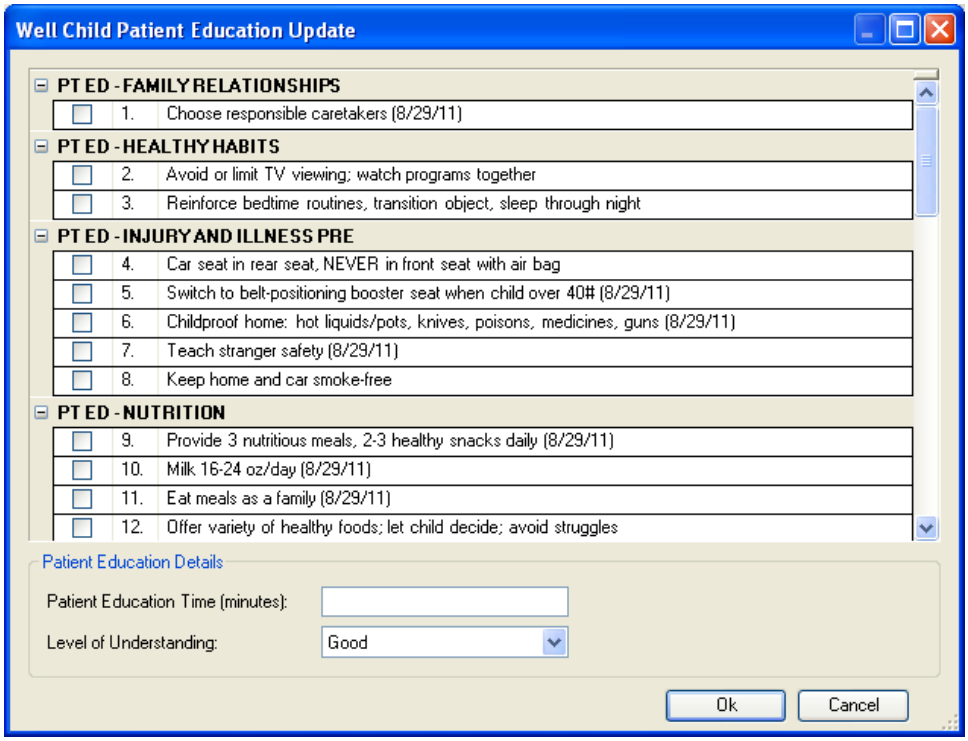


Figure 4-19: Example Well Child Patient Education Update

2. Select one or more education topics.
3. Type a number in the **Patient Education Time** field representing the total number of minutes spent providing patient education.
4. Select the appropriate response from the **Level of Understanding** list.
5. Click **OK** to display the Update Status dialog

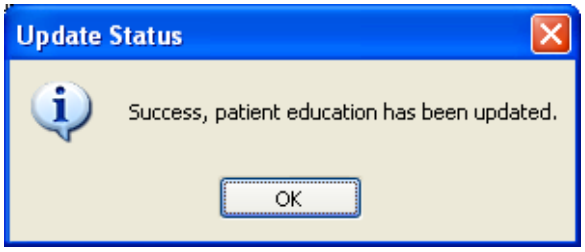


Figure 4-20: Update Status dialog

6. Click **OK**.

4.2.4 RESOURCES Tab

The **RESOURCES** tab displays different information at each site, such as links to items for RPMS access, Provider Portal access, and decision-making support tools such as IHS Comprehensive Guidelines:

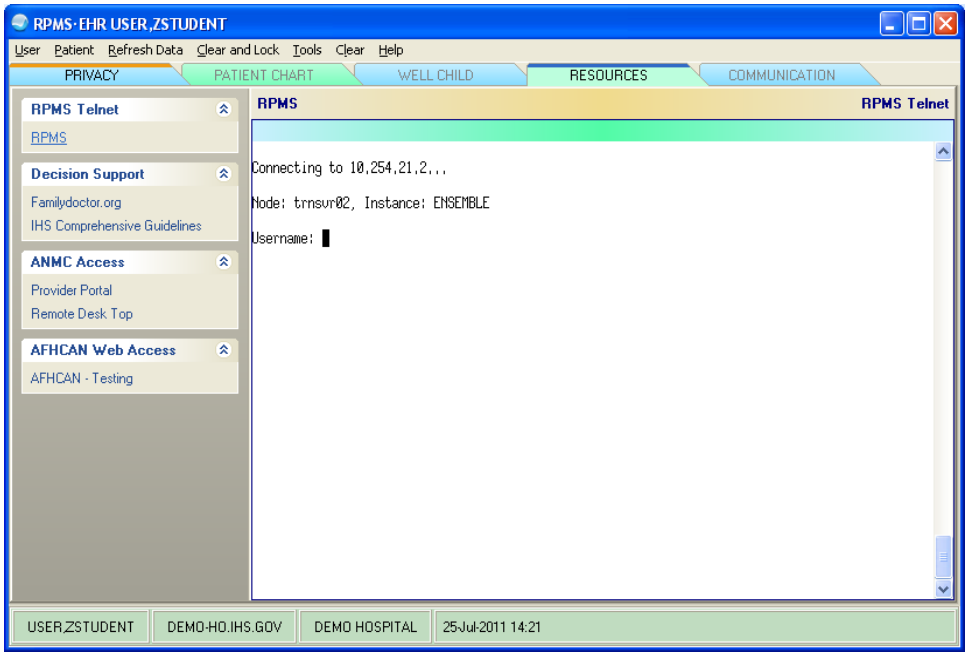


Figure 4-21: EHR **RESOURCES** tab

4.2.5 COMMUNICATION Tab

Use the **COMMUNICATION** tab to send a message to other EHR users in a division. This tab includes a pane to type messages and a list of users that can be selected to receive the message. Only users who are logged in to the EHR are in the User list:

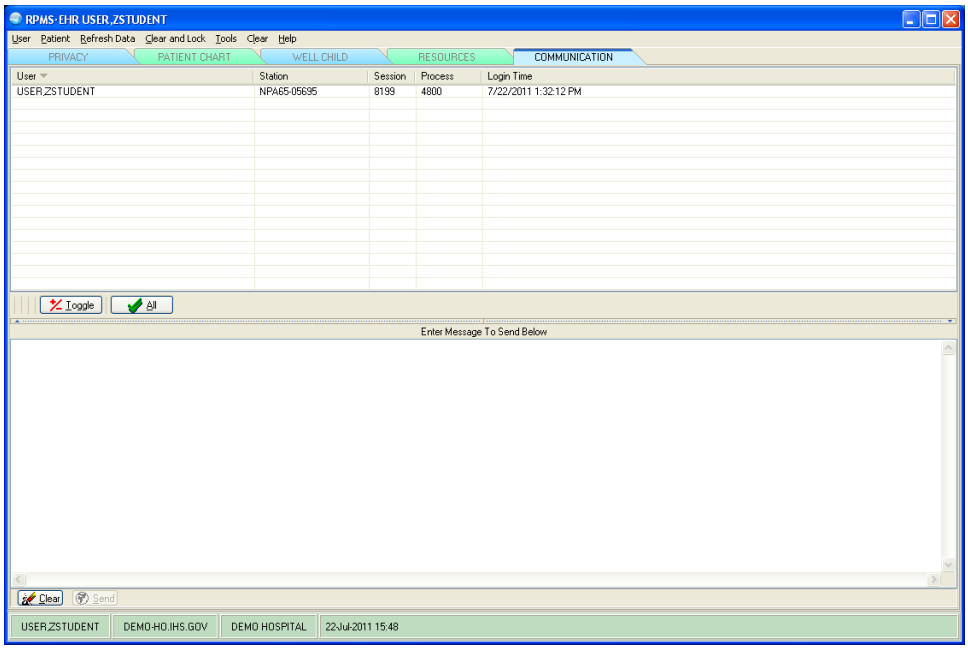


Figure 4-22: EHR **COMMUNICATION** tab

> Do not overuse the **COMMUNICATION** tab.
> Messages are displayed on the recipient's workstation immediately after clicking **Send**, as shown in Figure 4-23. Use this feature wisely; too many messages can disrupt the recipient's workflow.
>
> Refer to regional policy regarding the use of the **COMMUNICATION** tab.

Figure 4-23: Example of a message sent from the **COMMUNICATION** tab

This message is displayed in front of *all* EHR windows until the recipient closes it.

To close the message, click the red "X" in the upper right corner.

> **Note:** The **Send** button on the **COMMUNICATION** tab is not active if there is no message in the **Enter Message to Send Below** box. See Figure 4-22 for an example of an inactive **Send** button, and see Figure 4-24 for an example of an active **Send** button.

Sending a message using the COMMUNICATION tab

1. Type a message in the **Enter Message to Send Below** pane:

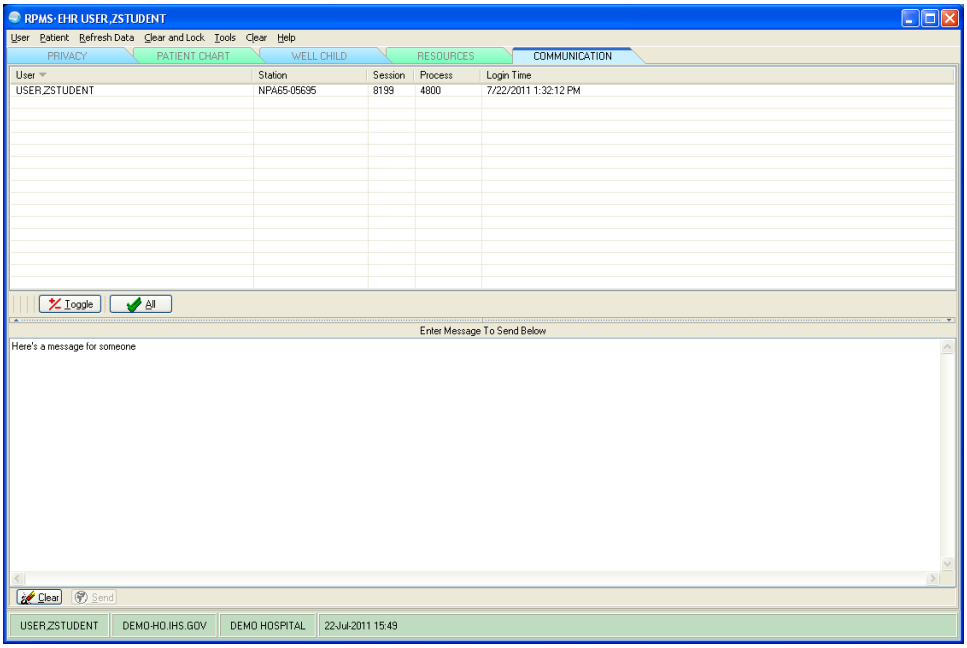


Figure 4-24: Example of a note typed in the **Enter Message To Send Below** pane

2. Click the name of the user or users to send the message to, as shown in Figure 4-25.

   - To choose more than one user, press and hold the Ctrl key while clicking each user's name.
   - To choose all users in the list, click **All**. This option should seldom, if ever, be used.

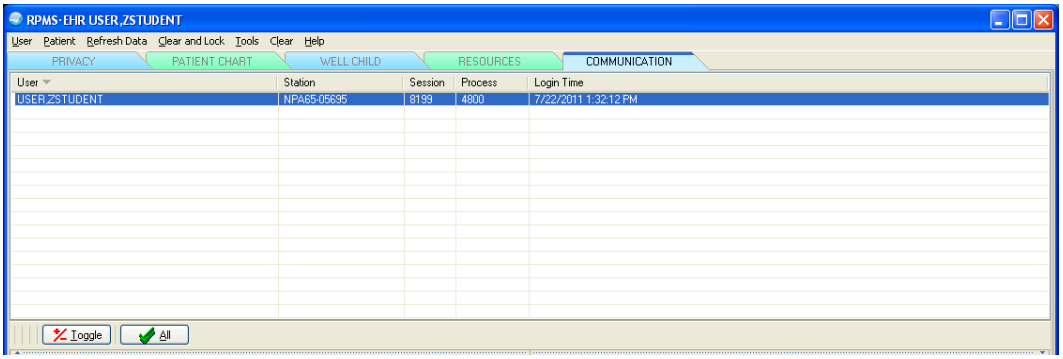


Figure 4-25: Selecting a recipient for a message

3. Click **Send**.

4.3 Patient Toolbar

Figure 4-26: Patient toolbar at the top of the EHR window

The Patient toolbar contains the panels and buttons necessary to use the EHR and document a new visit (a new patient encounter). The EHR toolbar always appears on the **PATIENT CHART** tab, regardless of which small tab is being used.

> **Note**: The colors of the panels and buttons on the toolbar may be different at different sites.

4.3.1 Patient Panel

Figure 4-27: Patient panel

The Patient panel, shown in Figure 4-28, is at the left side of the EHR toolbar. The EHR toolbar always appears at the top of the **PATIENT CHART** tab.

When a patient has been selected, the Patient panel displays the current patient's name (Last name, First name), Social Security Number (SSN), Health Record Number (HRN) or chart number, date of birth, age (in parenthesis), and gender (M or F).

> **Note:** For detailed information about selecting a patient when documenting an encounter, see Section 0.

- To select a patient, click the Patient panel to open the **Patient Selection** dialog, as shown in Figure 4-28.

  The **Patient Selection** dialog contains a list of patients, as well as demographic information for a selected patient.

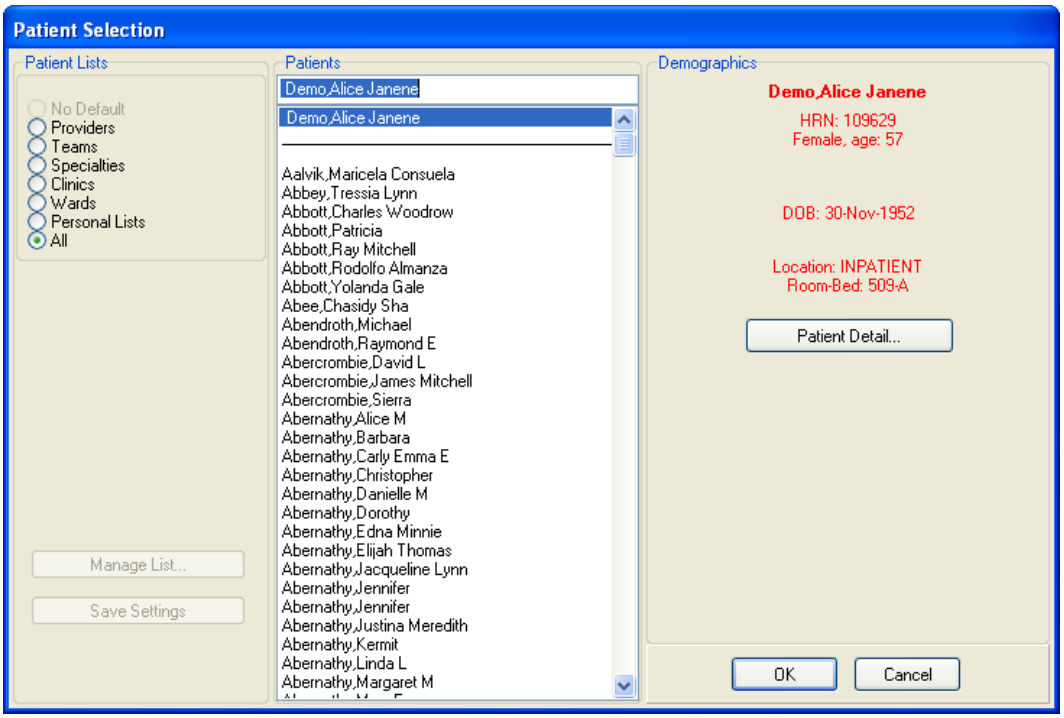


Figure 4-28: **Patient Selection** dialog

- To see basic patient information in the **Demographics** pane of the **Patient Selection** dialog, click the patient's name in the **Patients** list. An example of basic patient information in the **Demographics** pane is shown in Figure 4-28.

  Basic information shown in the **Demographics** pane includes the patient name, HRN, gender and age, and date of birth.

- To see detailed patient information, click **Patient Detail** in the **Demographics** pane to open the **Patient Detail** dialog.

  The **Patient Detail** dialog, shown in Figure 4-29, shows additional patient information, such as mailing address, telephone numbers, admission information, and other information that has already been entered in the database.

  - To make the information easier to read, increase or decrease the font size by clicking the arrows to the right of the **Font Size** field.
  - To print the information shown in the **Patient Detail** dialog, click **Print**.
  - To close the **Patient Detail** dialog, click **Close** or click the x located in the upper right corner of the dialog.

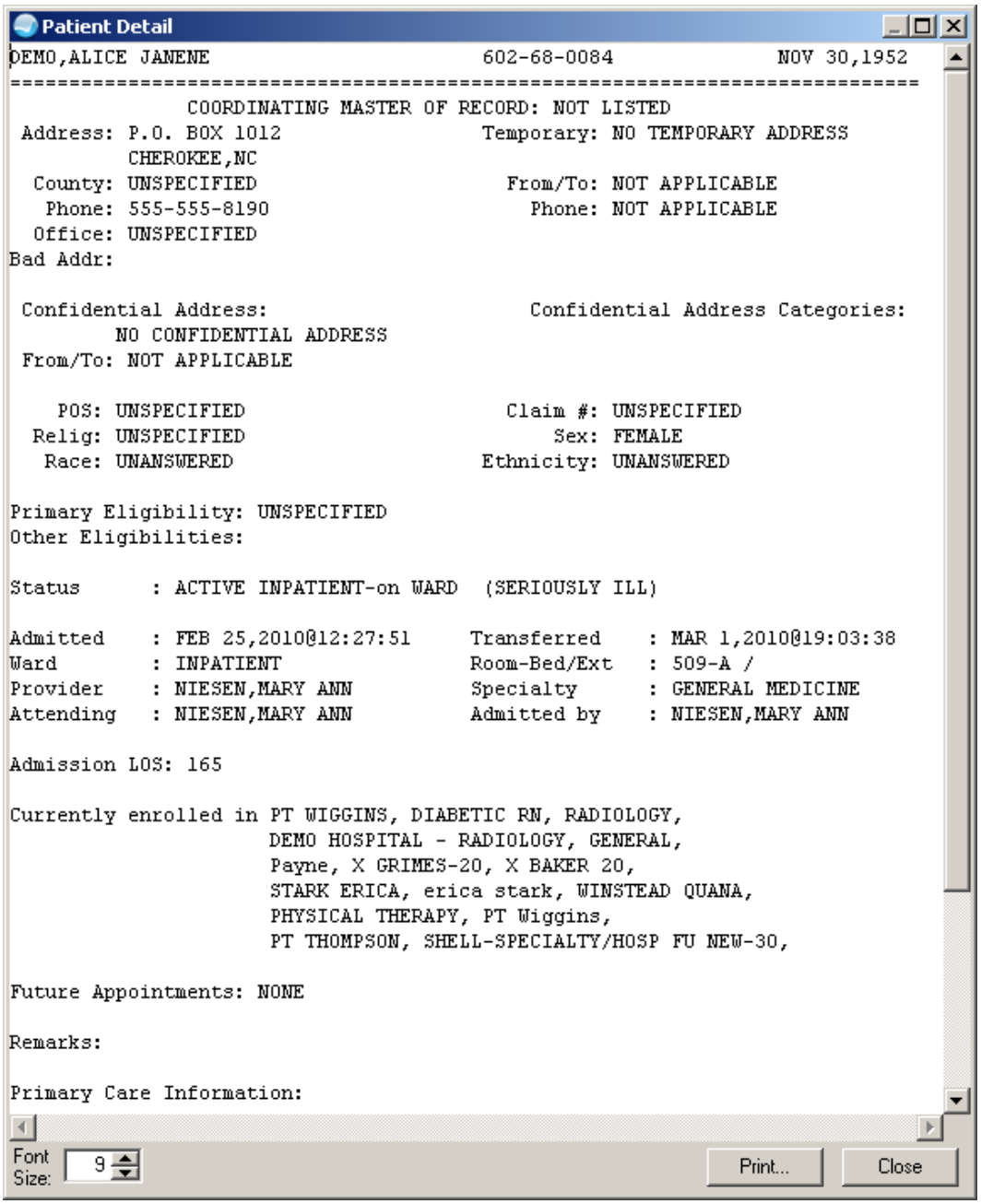


Figure 4-29: **Patient Detail** dialog

4.3.2 Visit Panel

Figure 4-30: Visit panel

The Visit panel, shown in yellow in Figure 4-30, is the middle panel on the EHR toolbar. The EHR toolbar always appears at the top of the **PATIENT CHART** tab.

When a patient has been selected, the Visit panel shows the patient's encounter provider (the patient's primary care provider) and the location for the visit, as well as the date and time of the visit.

> **Note:** For detailed information about creating a visit when documenting an encounter, see Section 5.2.

- To assign an encounter provider or location, click the Visit panel to open the **Encounter Settings for Current Activities** dialog.

  If an encounter provider or location has not been assigned, EHR prompts for this information by opening the **Encounter Settings for Current Activities** dialog when entering progress notes, creating orders, and performing other tasks.

4.3.3 Primary Care Team Panel

Figure 4-31: Primary Care Team panel

The Primary Care Team panel is for reference only.

4.3.4 Toolbar Buttons

Figure 4-32: Toolbar Buttons

> Note: The individual buttons on the toolbar may be customized. Consequently, the choices presented in this guide may not match those available at the site.

4.3.4.1 POC Lab Entry Button

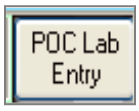


Figure 4-33: **POC Lab Entry** button

Use the **POC Lab Entry** button to order and result CLIA waived testing done on site in the **Lab Point of Care Data Entry Form** dialog. See Figure 4-34 for an example of this dialog.

> **Note**: CLIA and Test Controls
> The Clinical Laboratory Improvement Act, (Amendments of 1988) established quality standards for all lab testing involving humans. This ensures the accuracy, reliability, and timeliness of patient test results, *regardless of where the test is performed*. These rules apply to large commercial labs, hospitals, and CHAP clinics. For more information: http://www.cms.hhs.gov/clia

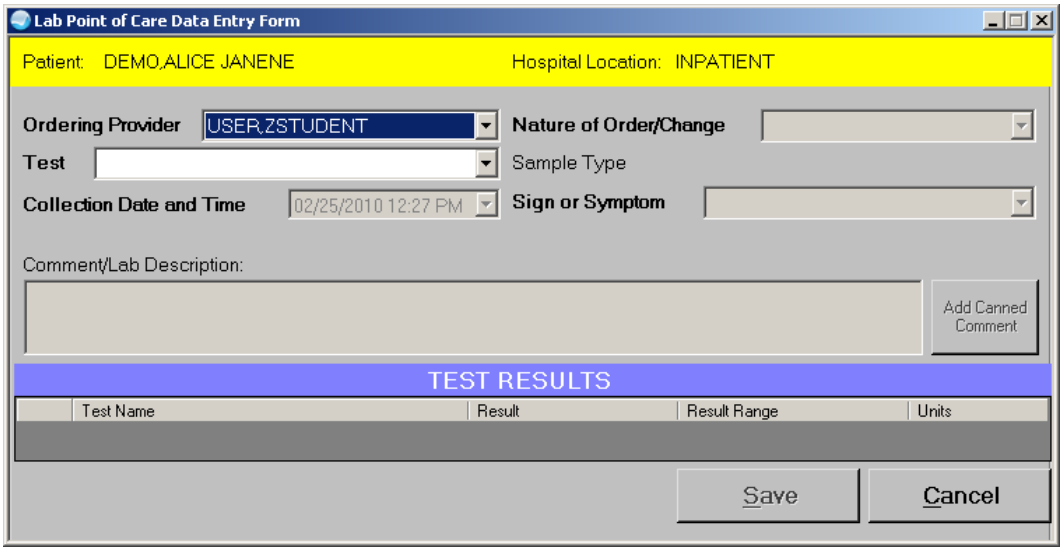


Figure 4-34: **Lab Point of Care Data Entry Form** dialog

- To open the **Lab Point of Care Data Entry Form** dialog, click **POC Lab Entry**. The current patient's name and hospital location appear at the top of the form.
- The default selection in the **Ordering Provider** field is the name of the CHA/P who created the visit. Select the test, the collection date and time, the nature of order or change, and the sign or symptom from the other fields.
- If desired, type a comment or lab description in the **Comment/Lab Description** field. To use a canned comment, click **Add Canned Comment**.

> **Note**: Refer to regional policy regarding the use of the **Comment/Lab Description** field.

- If test results are available, add the results in the **TEST RESULTS** pane.

4.3.4.2 Patient Wellness Handout (PWH) Button

Figure 4-35: **Patient Wellness Handout** button

Use the **PWH** button to view or print the patient wellness handout, which is to be given to the patient.

- To open a dialog showing the Patient Wellness Handout Summary report, click **PWH**. This summary includes patient information such as height, weight, BMI, current medication, blood pressure, HIV screen, allergies, immunization records, cholesterol, diabetes care, diabetes kidney assessment, diabetes eye exam, diabetes foot exam, Pap smear or colon health screen, quality of care report card, and health care goals.

  See Figure 4-36 for an example of the Patient Wellness Handout Summary report. Different items may be shown in this summary for different patients.

- To print the Confidential Patient Wellness Handout Summary, click **Print** (located at the bottom of the dialog).

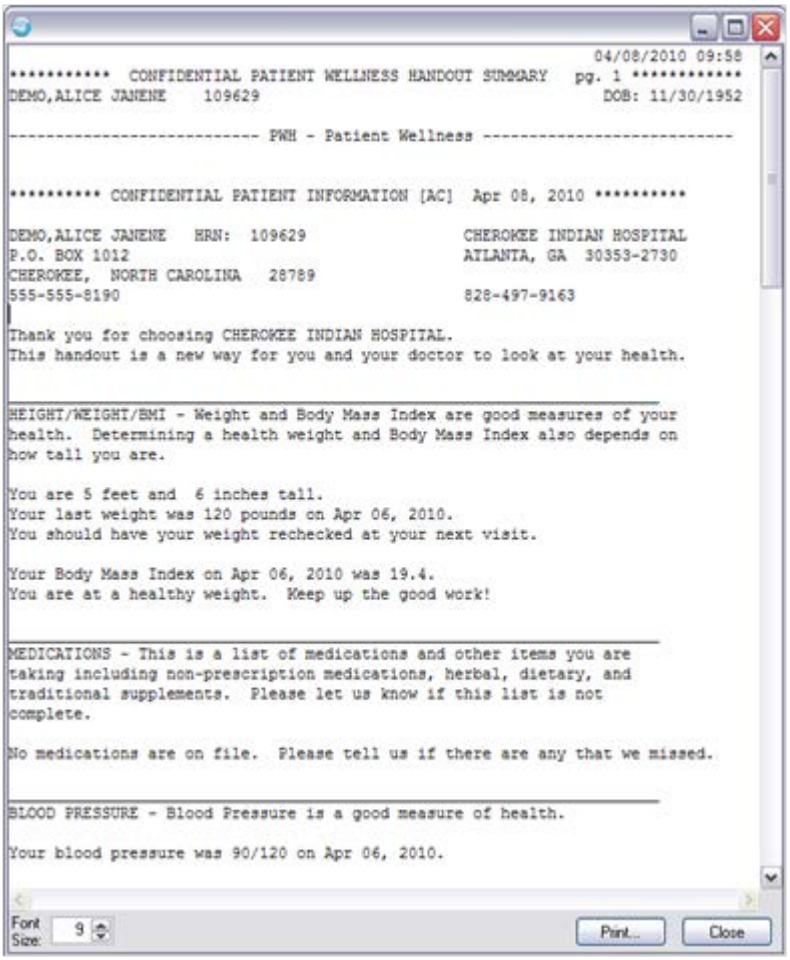


Figure 4-36: Confidential Patient Wellness Handout Summary

> **Note**: Refer to regional policy regarding requirements for release of information for a patient chart when providing the Patient Wellness Handout Summary.

4.3.4.3 Med Rec Button

Use the **Med Rec** button to display the selected patent's medical record.

Figure 4-37: Med Rec button

4.3.4.4 Reminders Button

Use the Reminders button to display the **Available Reminders** dialog (Figure 4-39) which lists reminders that have been set for the selected patient.

Figure 4-38: Reminders button

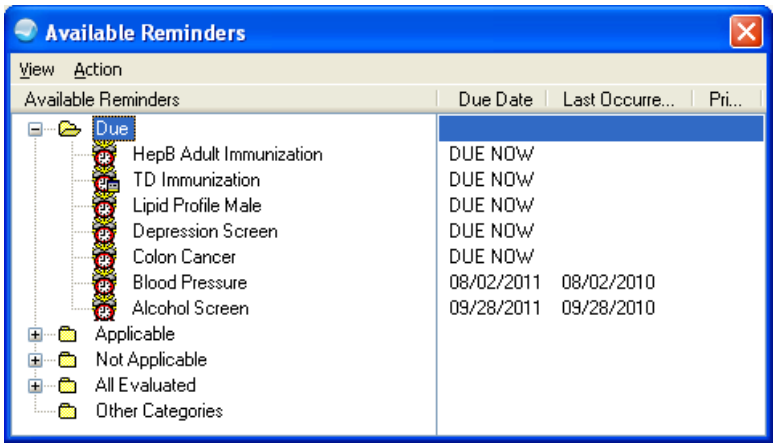


Figure 4-39: **Available Reminders** dialog

4.3.4.5 Visit Summary Button

Figure 4-40: Visit Summary button

4.3.4.6 Patient Detail Button

Use the **Patient Details** button to view detailed information about the current patient in the **Detail for <Patient Name>** dialog, as shown in Figure 4-42.

Figure 4-41: **Patient Detail** button

- To open the **Detail for <Patient Name>** dialog, click **Patient Details**.

  This dialog shows patient information such as the patient's name, social security number, birth date, address, phone number, religion, race, sex, ethnicity, eligibility, status, future appointments, remarks, and disabilities.

  Different items may be displayed in the **Detail for <Patient Name>** dialog at different sites.

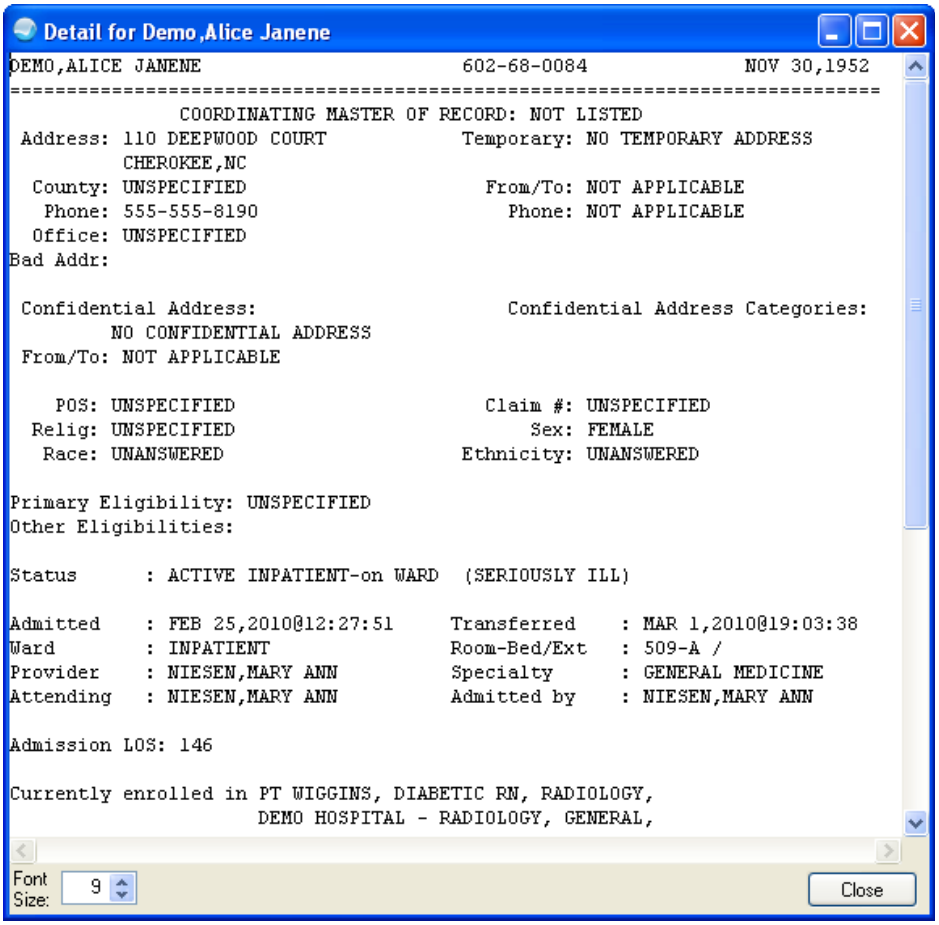


Figure 4-42: **Detail for <Patient Name>** dialog

4.3.4.7 Awaiting Review/Signature Button

Figure 4-43: Awaiting Review/Signature button

Most orders or documents, such as medications, labs, progress notes, reports, or health summaries, require an electronic signature. Generally, orders that require a signature are not released to services or activated until they are signed.

Use the Awaiting Review/Signature button to sign orders in the **Review/Sign Changes** dialog, as shown in Figure 4-44. If the Awaiting Review/Signature button is unavailable (dimmed), there are no orders to sign.

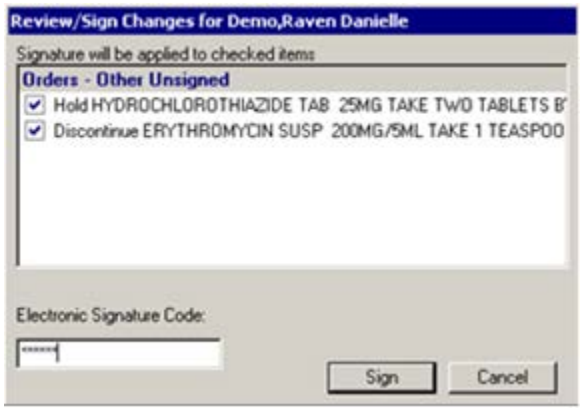


Figure 4-44: **Review/Sign Changes** dialog

- To open the **Review/Sign Changes** dialog, click the Awaiting Review/Signature button.

  A check box appears before each item that requires a signature.

- To sign specific items in the list, click the check box in front of each item. A check mark appears in each check box that was selected.

  To uncheck a checked item in the list, click the item's check box again. Items without a check mark will not be signed.

  In Figure 4-44, both the "Hold HYDROCHLOROTHIAZIDE" line and the "Discontinue ERYTHROMYCIN" line have been selected to be signed.

- To electronically sign the checked items, type the code used for the electronic signature in the **Electronic Signature Code** field and click **Sign**.

  To electronically sign an order or a document, an electronic signature code is required. If lacking a signature code, create one or contact the site manager. Electronic signature codes should be kept confidential, and are subject to the same rules as any other login or access code.

4.3.4.8 Patient Postings Button

Figure 4-45: **Postings** button

Use the **Postings** button to view a patient's allergies, crisis notes, warning notes, and directives in the **Patient Postings** dialog, as shown in Figure 4-46.

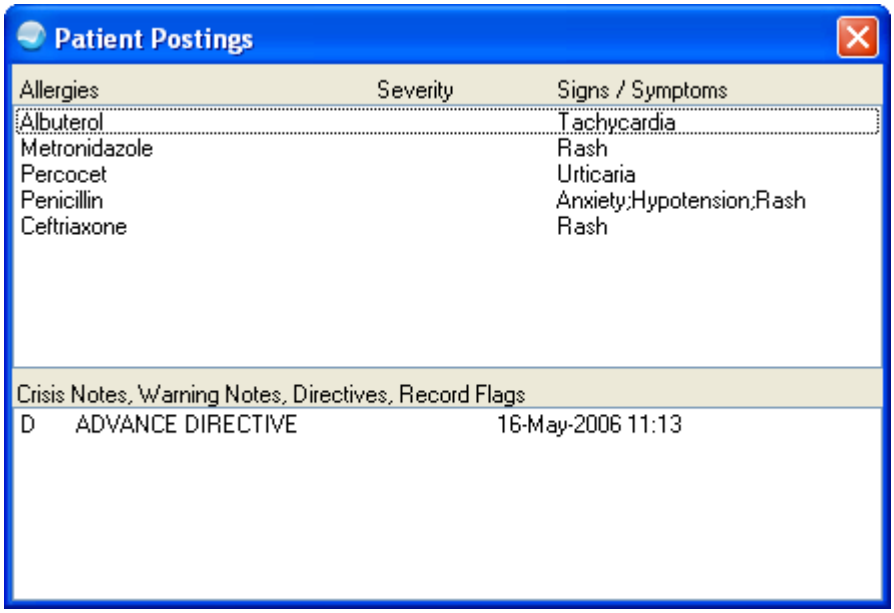


Figure 4-46: **Patient Postings** dialog

One or more code letters (**C**, **W**, **A**, or **D**) may appear on the **Postings** button beneath the word "Postings." Refer to Table 4-1 for definitions of these codes.

> **Note:** The codes for crisis notes, directive notes, and clinical warnings are based on the title selected by the clinician when the note was created. For example, select the title "Crisis Note" to create a progress note classified as a crisis note.

Table 4-1: Code definitions for Postings button

Code	Meaning
A	Allergies have been posted for this patient. This code displays if Adverse Reaction entries exist.
C	Crisis notes have been posted for this patient.
D	Directive Notes have been posted for this patient.

Code	Meaning
W	Clinical Warnings have been posted for this patient.
(No code)	A dialog containing important patient information may display when a patient name is selected.

If no allergies, notes, warnings, or directives have been entered for a patient, no code letters will appear on the **Postings** button, and the **Patient Postings** dialog will be empty.

Click the Patient Postings button to open the **Patient Postings** dialog:

- If any allergies have been posted for a patient, the top pane of the **Patient Postings** dialog lists each allergy, its severity, and its signs and/or symptoms.
- If any crisis notes, clinical warnings, or directive notes have been posted for a patient, they are displayed in the bottom pane of the dialog.

4.3.4.9 Review Buttons

Three review buttons, seen in Figure 4-47, indicate the need to review specific portions of the patient's chart and provide the ability to change the indication.

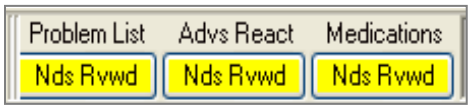


Figure 4-47: Review buttons

4.3.4.10 C32 Button

Figure 4-48:C32 button

4.4 Encounter Tab Set and Workspace

The Encounter tab set controls the configuration and contents of the Patient workspace

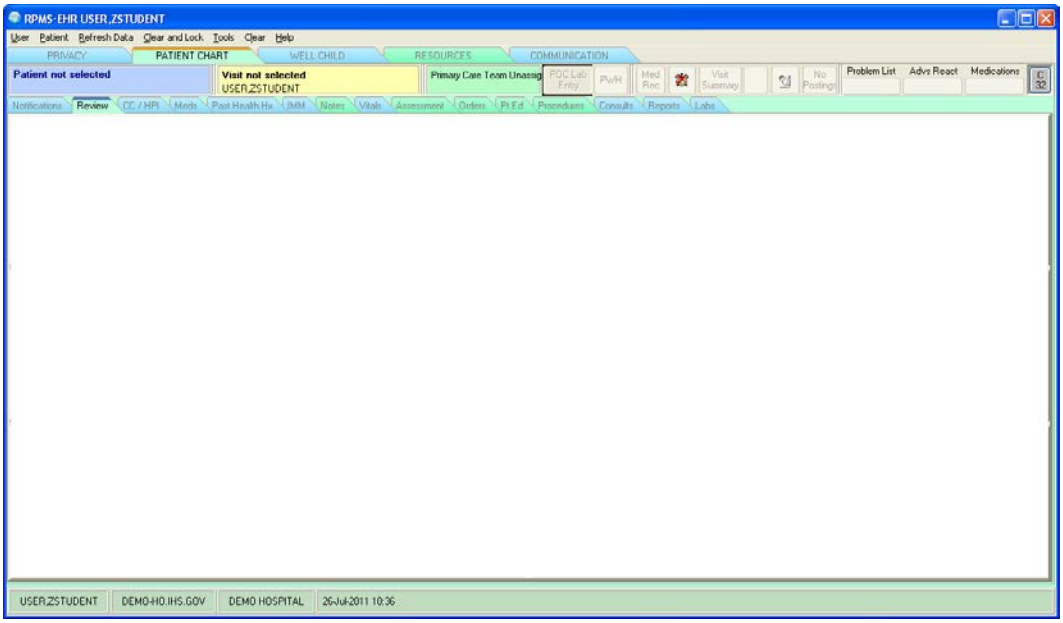


Figure 4-49: Encounter tab set and workspace (contents blank)

Click a tab to display a specific pane in the Patient workspace:

- **Notifications**: see Section 23.0.
- **Review**: see Section 6.0.
- **CC/HPI (**Chief Complaint and History of Present Illness**)**: see Section 7.0.
- **Meds**: see Section 8.0.
- **Past Health Hx**: see Section 9.0.
- **IMM** (Immunizations): see Section 10.0.
- **Notes**: see Sections 11.0, 13.0, and 18.0.
- **Vitals**: see Section 12.0.
- **Assessment**: see Section 15.0.
- **Orders**: see Section 16.0.
- **Pt Ed** (Patient Education): see Section 17.0.
- **Procedures**: see Section 19.0.
- **Consults**: see Section 20.0.
- **Reports**: see Section 21.0.

- **Labs**: see Section 22.0.

4.5 Status Bar

The Status bar displays information about the current EHR session including:

- User name
- Site Domain name
- Site Facility name
- Today's date

Figure 4-50: Status bar

Additional status information is sometimes displayed to the right of Today's date.

4.6 Common Features

This section describes standard RPMS-EHR GUI features that are available while working in the EHR.

4.6.1 Windows Clipboard

The contents of a text field can usually be copied to the Clipboard. Additionally, text previously copied to the Clipboard (from Windows-based application including RPMS-EHR) can be pasted to an editable text field.

- Click and drag to highlight text, then hold **Ctrl** and press **C** to copy it to the Clipboard.
- Click to place the cursor in an editable field, then hold **Ctrl** and press **V** to paste the contents of the Clipboard to the field.
- Occasionally, RPMS-EHR provides a distinctive button or a right-click menu selection to copy non-editable text to the Clipboard.

4.6.2 Table Data

RPMS-EHR displays lists of data in rows and columns, typically referred to as *table format*. Tables are divided into horizontal *rows* and vertical *columns* and each intersection of a row and a column is called a *cell*. Usually, each column has a *column heading*; a label at the top of the column describing the content of the cells below it.

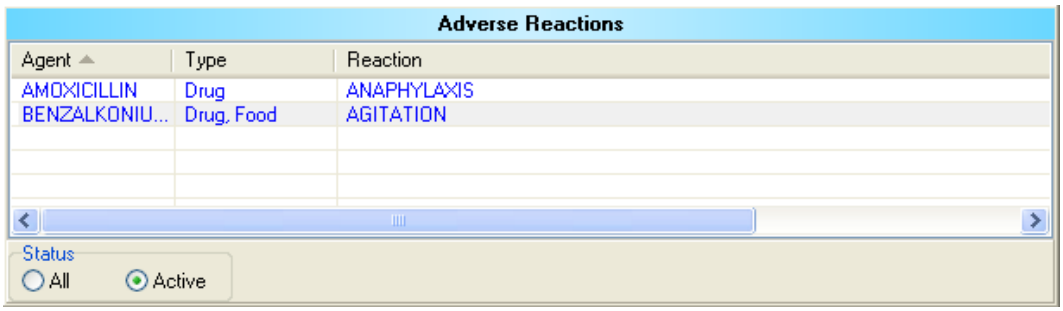


Figure 4-51: Data displayed in Table format

The following subsections describe the features and functionality typically (but not always) available when data is displayed in Table format. Refer to Figure 4-51 while reading these instructions.

4.6.2.1 Adjust Column Width

Data longer than the width of its column is truncated to fit and is followed by ellipses (…).

- Click and drag the faint vertical bar between two column headings to change the width of the column to the left of the bar.
- Double-click the vertical bar to automatically force the column width to equal that of its longest entry.

4.6.2.2 Scroll Vertically

A list longer than the pane that contains it displays a scroll bar along its right edge.

- Click and drag the scroll bar or click the vertical scroll bar's up and down arrows to scroll through the list.

4.6.2.3 Scroll Horizontally

A list wider than the pane that contains it displays a scroll bar along its bottom edge.

- Click and drag the scroll bar or click the horizontal scroll bar's left and right arrows to move the view to the left or right.

4.6.2.4 Sort by Column

The column by which a list is sorted displays a small triangle in the column heading. If the triangle's point is up the sort order is low to high (for dates, oldest first); if the point is down the order is high to low (newest date first).

- Click the column heading once to sort a table by any column.
- Click the heading a second time to reverse the sort order.

4.6.2.5 Reorder Columns

Displayed column order may be changed to arrange information in whatever order is deemed most useful. To move a column:

1. Click and hold its column heading.
2. Drag the column left or right to its new position.
3. Release the mouse button.

4.6.3 Refresh Data

Changes made by another user may make displayed data out of date. To refresh data:

1. Right-click within the pane.
2. Select **Refresh** from the right-click menu.

> **Note:** To refresh the entire EHR, click **Refresh Data** on the Menu bar.

4.6.4 Select Date/Time dialog

As an alternative to typing the date or a date and time in the correct format, the **Select Date/Time** dialog provides an easy method for entering the date and time in most date/time fields. Both versions of the dialog contain a standard calendar ***widget***; the second version also contains a tool used to select the time (in five-minute increments):

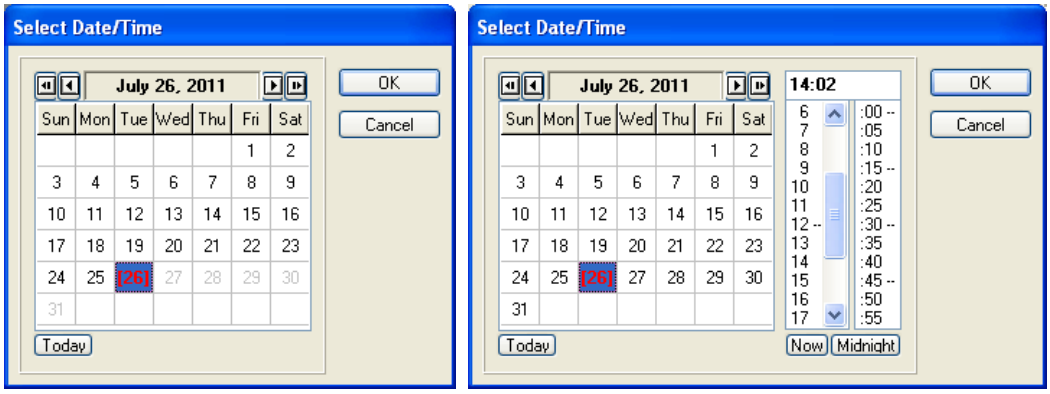


Figure 4-52: Select Date/Time dialogs

To open the dialog, click ellipses (…) at the end of a date/time field.

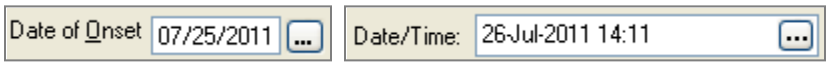


Figure 4-53: Sample Date/Time fields

Features of the dialog include:

- Four calendar navigation buttons, two on either side of the month name, allow navigation through the calendars:
  - Single arrowhead buttons step through the calendars one month at a time.
  - Double arrowhead buttons step through the calendars one year at a time.
- Today's date on the current month calendar is displayed in bold red text and enclosed in square brackets.
- The date selected is highlighted.
- Click **Today** to select today's date.
- On dialogs containing the time selection tool:
  - Click **Now** to select the current time.
  - Click **Midnight** to set the clock to 12:00 AM.
- Click **OK** to close the dialog and save the selected date and time; **Cancel** to discard the selection.

4.6.5 Print to a Local Printer

RPMS-EHR can print to any printer installed on the workstation, whether directly connected to the workstation or configured on the connected network. Printing is available wherever a Print button is displayed:

1. Click **Print** to open the **Printer Selection** dialog:

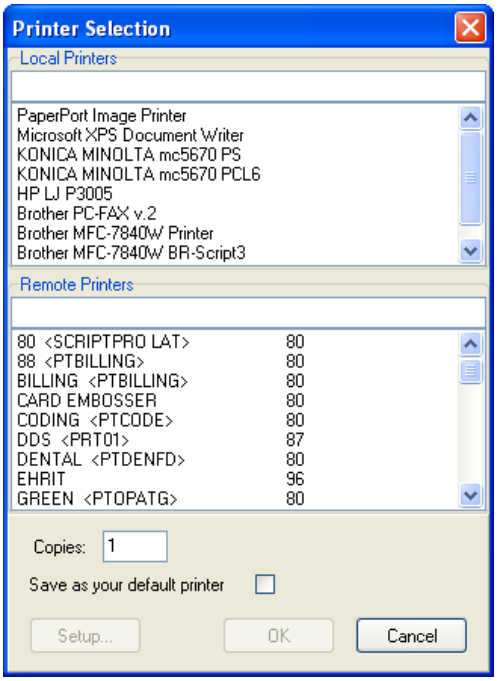


Figure 4-54: Printer Selection dialog

2. Select a printer
3. Click **Setup** to perform any needed setup.
4. Click **OK** to close the dialog and to begin printing.

4.6.6 Web Reference Search

The Info button appears in several locations in the EHR.

Figure 4-55: Info button

When clicked, the Info button uses search keywords associated with the current EHR page to find pertinent information on the Internet and display it in the default browser window.

5.0 Select a Patient and a Visit

At logon, "Patient not selected" appears on the Patient panel and "Visit not selected" appears on the Visit panel:

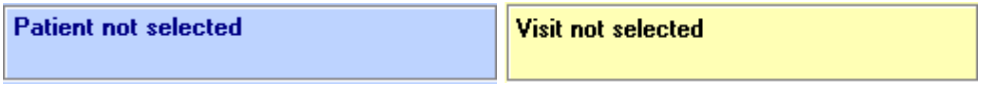


Figure 5-1: Patient panel and Visit panel at logon

Prior Steps

Before selecting a patient, log on to the EHR (see Section 3.0)

5.1 Select a Patient

1. Click the Patient panel (Figure 5-1) to open the **Patient Selection** dialog:

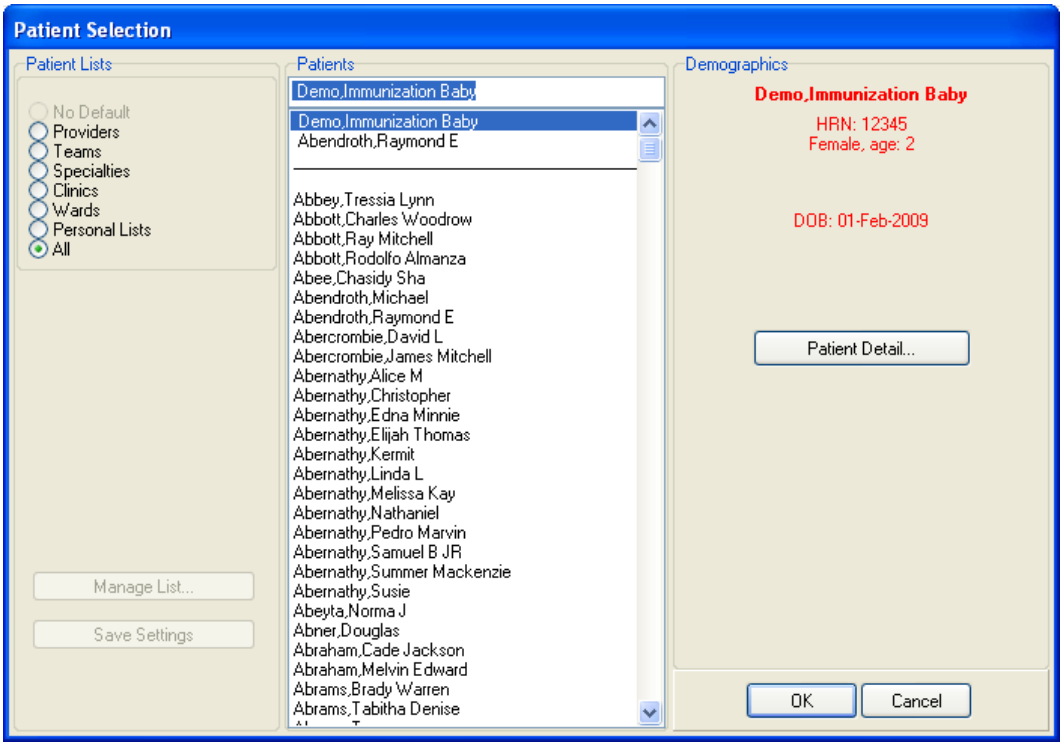


Figure 5-2: **Patient Selection** dialog

Note: Another way to open the **Patient Selection** dialog is to click **Select** on the **Patient** menu (see Section 4.1.2)

Opening the **Patient Selection** dialog is like opening a file drawer filled with patient charts, and selecting a patient in the dialog is like taking a patient's chart out of the file drawer. The names of the patients whose charts are in the "drawer" are listed in the **Patients** pane. This dialog includes three panes:

- **Patient Lists**: This pane contains a set of radio buttons used to filter the contents of the dialog.

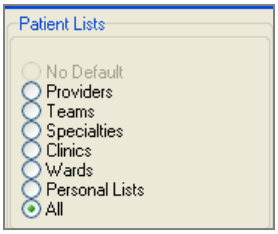


Figure 5-3: **Patient Selection** dialog, **Patient Lists** pane

Each selection causes other changes on the dialog, adding or removing fields and enabling or disabling buttons. The functionalities provided by these changes will be discussed further on in this document.

- **Patients**: This pane contains a search box and a list of selectable patients:

Figure 5-4: **Patients** pane showing a short list and a long list

This list is divided into two parts by a horizontal line:

– Above the line, the content of the 'short list' changes depending on the list type selected in the **Patient Lists** pane.

  - Below the line; the 'long list' contains an alphabetical list of all patients in the database.
- **Demographics**: This pane displays summary information about the currently highlighted patient.

Figure 5-5: **Patient Selection** dialog, **Demographics** pane

Red text indicates that this is also the currently selected patient, otherwise the text is black. Besides basic demographic information, a patient photograph is displayed (if available and if this feature is enabled) and a **Patient Detail** button is available for additional information.

2. Select **All** in the **Patient Lists** pane to view all patients.
   - The 'long list' includes all patients registered at the facility to which the CHA/P is logged on.
   - The 'short list' contains names of patients who were previously selected during the current EHR session.
3. To find a specific patient, do one of the following:
   - Scroll through the list to locate the patient by name.
   - Type one of the following in the search field at the top of the **Patients** pane:
     - The patient's name ("Lastname,Firstname," with no space between the comma and the first name); for example, to search for a patient named "John Smith," type **Smith,John**.

- The HRN or SSN (the HRN must be a minimum of four digits in length; for shorter numbers, add zeros at the beginning of the number); for example, to search for HRN "38," type **0038**.
- The Date of birth beginning with the letter **B** followed by the date in 6- or 8-digit numeric format; for example, to search for the date "July 1, 1961," type **B070161** or **B07011961** in the text box

If the patient for this encounter is not in the list of patients, it may be necessary to log off and log back on to the correct division. If the patient's name still does not appear in the list of patients, follow regional protocols.

4. Select the patient's name in the list. The patient's information appears in red in the **Demographics** pane.

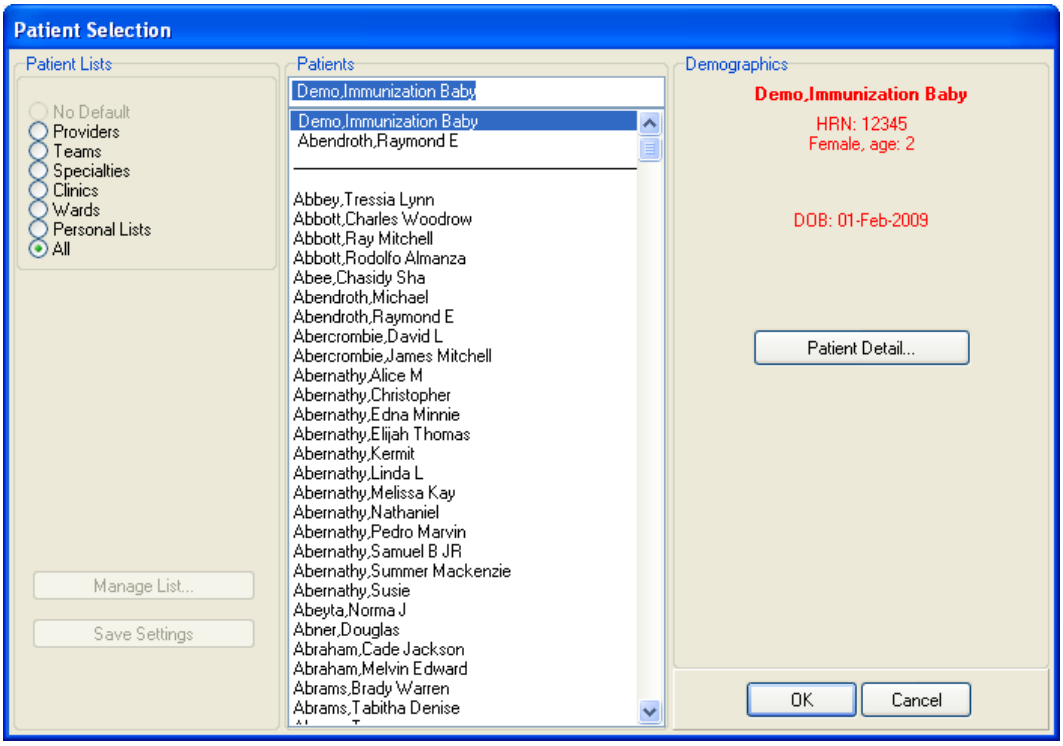


Figure 5-6: **Patient Selection** dialog showing demographic information in red for the selected patient

5. Carefully examine the patient's information in the **Demographics** pane to be sure the correct patient name has been selected. To view additional information about the selected patient, click **Patient Detail** to open the **Detail** dialog, as shown in Figure 5-7.

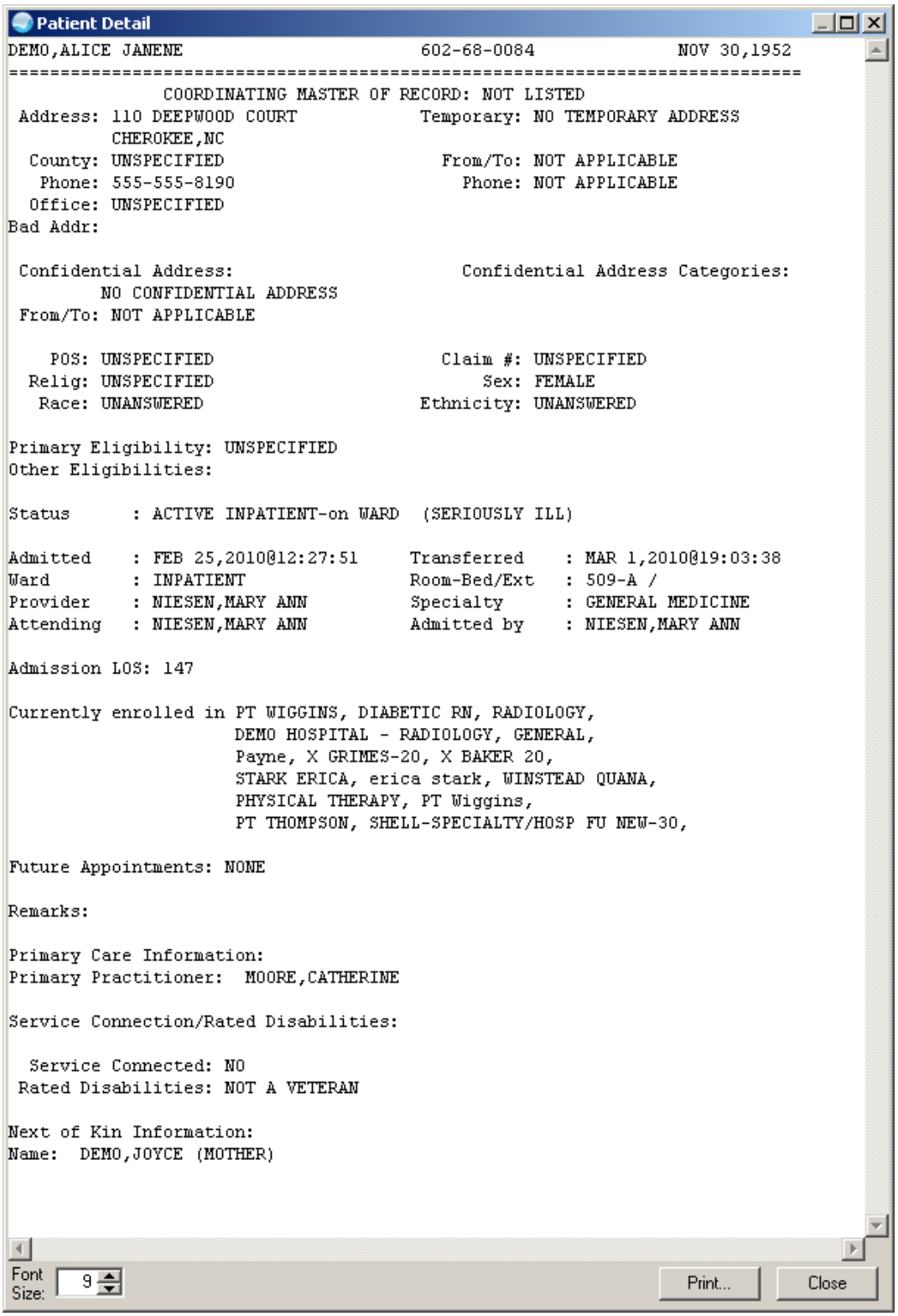


Figure 5-7: **Patient Detail** dialog

Important:Verify that the correct patient has been selected by double-checking the DOB, HRN, and other data in the **Patient Detail** dialog.

6. After confirming that the correct patient has been selected, click **OK**. The patient's information appears in the **Patient** panel in the toolbar, as shown in Figure 5-8.

Figure 5-8: Patient information in the Patient panel

5.2 Create a Visit

Use the Visit panel to create a new visit for this patient encounter.

Prior Steps

Before creating a new visit, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)

The correct patient's name and demographic information must appear on the Patient panel (as in Figure 5-8).

A visit lists the date, time, and location of the visit, as well as the patient's encounter provider (the CHA/P).

5.2.1 Create a new visit

1. Click the yellow Visit panel on the EHR toolbar to open the **Encounter Settings for Current Activities** dialog.

2. Select the **New Visit** tab.

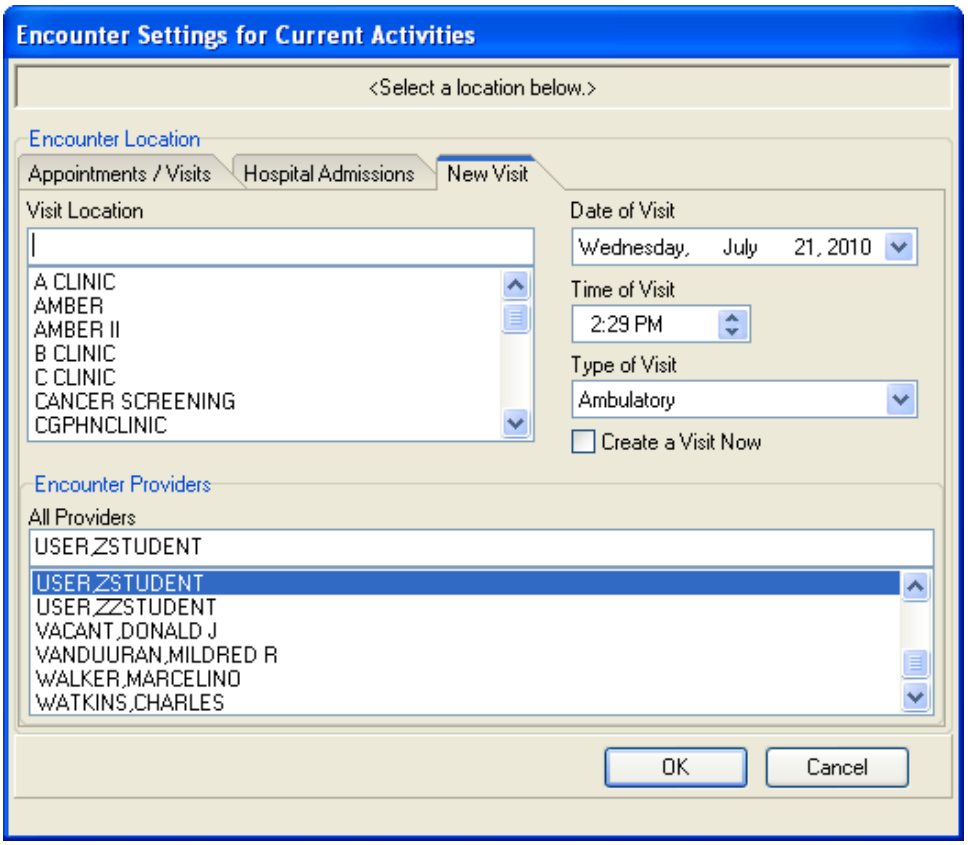


Figure 5-9: **Encounter Settings for Current Activities** dialog with the **New Visit** tab selected

The **Visit Location** pane shows the location, date, time, and type of visit for this encounter.

The **Encounter Providers** pane (in the lower half of the **New Visit** tab) shows available providers in the **All Providers** list.

3. Click the location name in the **Visit Location** list.

4. Verify the correct date and time for the encounter is in the **Date of Visit** and **Time of Visit** fields. If these items are incorrect, use the arrows and drop-down menu to the right of the field to correct an incorrect date or time.

> If documenting an encounter after-the-fact, be sure to set the Date and Time to match the date and time of the encounter.

5. Choose the correct visit type in the **Type of Visit** field. See Figure 5-10:

   - **Ambulatory**: Used for face-to-face visits with a healthcare provider or for visits involving medication ordering or refills.

- **Historical**: Used for documenting historical services or services provided at another location.
- **Telephonic**: Used for telephone calls.
- **Chart Review**: Used for documenting information in the patient's record that is not historical and did not involve another type of visit (examples: case management, follow-up on a test results that did not require intervention).
- **Not Found**: Used for home visits to document that the patient was to have a home visit but the patient was not there.

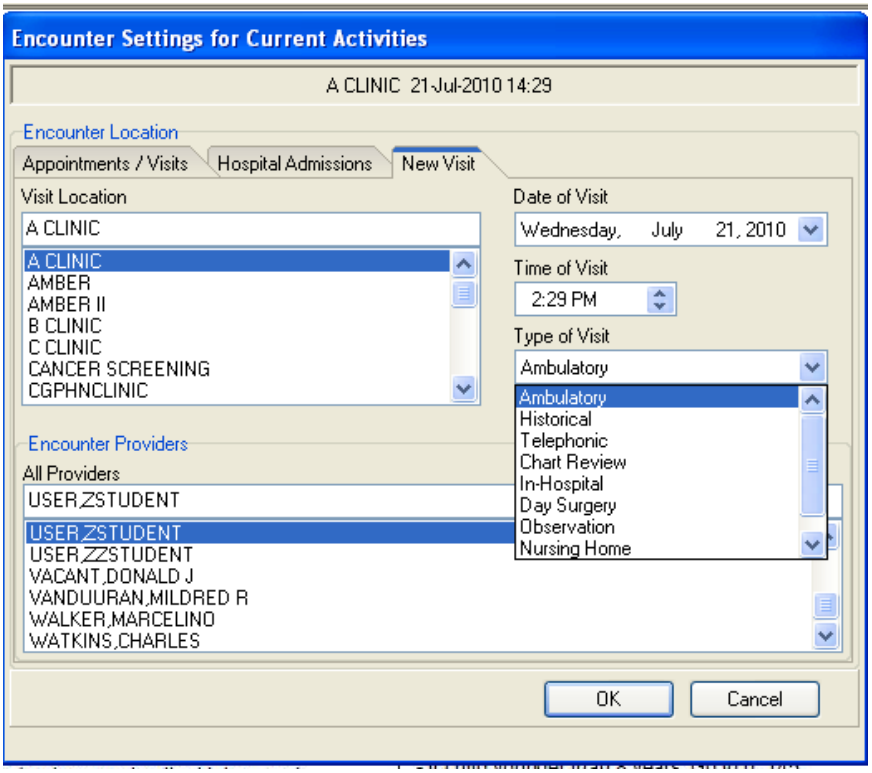


Figure 5-10: Choosing the type of visit in the **Encounter Settings for Current Activities** dialog

6. Select the **Create a Visit Now** check box to view the **Providers for this Encounter** field, as shown in Figure 5-11.

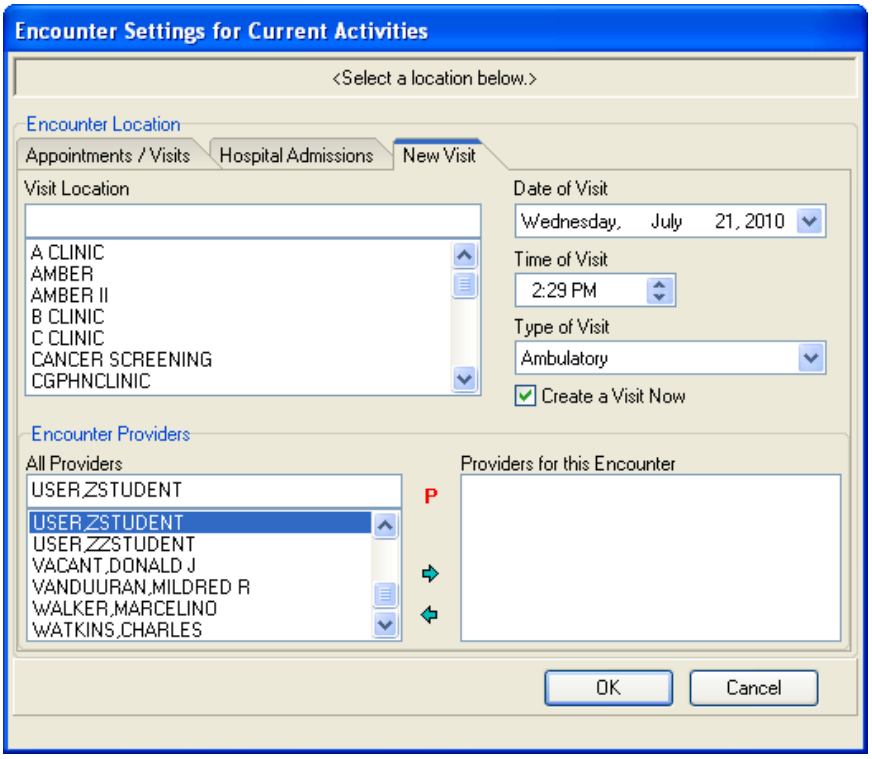


Figure 5-11: **Create a Visit Now** check box selected in the **Encounter Settings for Current Activities** dialog

7. To be listed as the primary provider for this visit, follow these steps:

   a. Find your name in the **All Provider**s list and click on it.

   b. Click the green arrow that points to the right (toward the **Providers for this Encounter** list) to move your name to that list.

   c. If a provider name was mistakenly added to the **Providers for this Encounter** list, click the incorrect name in the list to select it, and then click the green arrow that points to the left (toward the **All Providers** list) to remove it from the list.

   Listing yourself as the primary provider is the same as putting your name and level of training at the bottom of the PEF.

> **Note**: The first time the EHR is used, the CHA/P must locate his or her name in the **Encounter Providers** list. For subsequent uses of the EHR, the CHA/Ps name will be at the top of the list by default.
>
> If the CHA/Ps name is not in the **Encounter Providers** list, contact the Clinical Applications Coordinator (CAC).

8. After entering the visit location, visit date, and encounter provider, the dialog should look like the example in Figure 5-12.

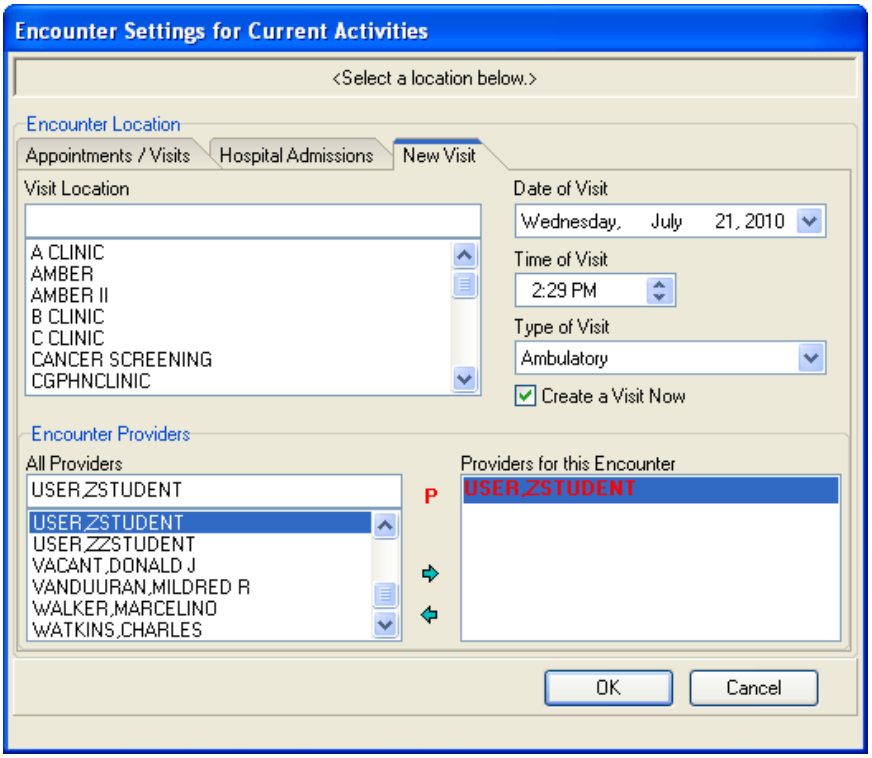


Figure 5-12: **Encounter Settings for Current Activities** dialog with the date of visit, the visit location, and the provider filled in

9. Click **OK** to save the information in the **Encounter Settings for Current Activities** dialog and return to the PATIENT CHART tab.

5.2.2 Select from Similar Visits

If a second visit for a patient occurs in one day, the **Similar Visits** dialog is displayed, as shown in Figure 5-13.

It is uncommon for one CHA/P to see the same patient more than once in a day, so the EHR treats a second visit in a single day as a possible mistake and allows the CHA/P to confirm or reject the second visit.

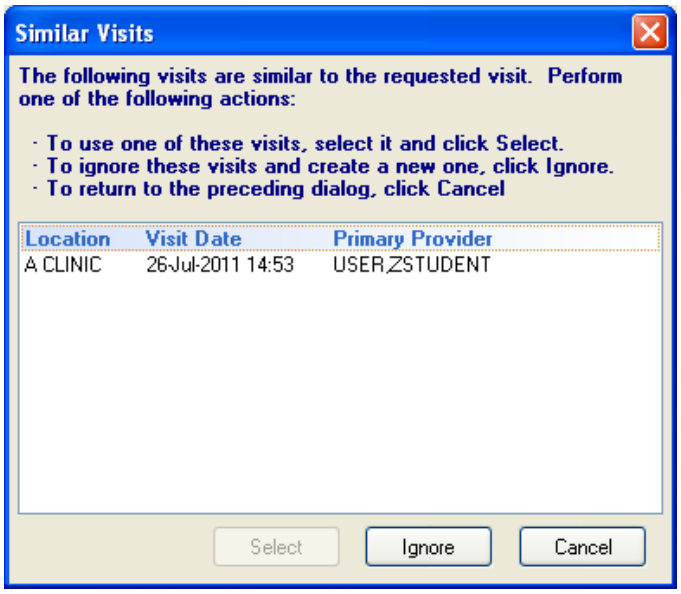


Figure 5-13: **Similar Visits** dialog

- To create a second visit on the same day for this patient, click **Ignore**.
- To use one of the existing visits shown in the dialog, select the visit and click **Select**.
- To close this dialog and return to the **Encounter Settings for Current Activities** dialog, click **Cancel**.

> **Important**:If the site has ancillary staff that checks patients in and creates the visit in the EHR, refer to regional policy on how to select the correct visit and proceed with the patient encounter.

6.0 The Review Tab

The **Review** tab contains panes that display the following information about a patient, as shown in Figure 6-1:

- The patient's active problems (the **Active Problems** pane)
- Recent lab orders (the **Lab Orders** pane)
- Recent appointments and visits (the **Appointments and Visits** pane)
- Any alerts that have been posted for the patient (the **Alerts** pane)
- The **Reminders** pane is not currently used.

> **Note:** It may take the application time to update information for the panes in the **Review** tab**.** The messages "Retrieving Active Problem List…" or "Retrieving Lab Orders…" indicate that the application is updating this information.

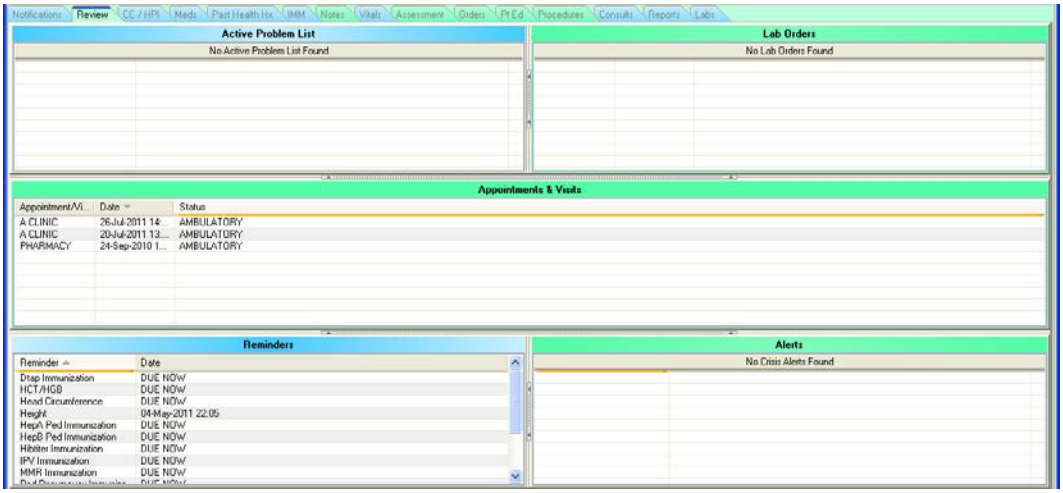


Figure 6-1: **Review** tab

- To see more information about an item shown in the **Review** tab, click the item to open a **Detail** dialog.

  The **Details** dialogs for each pane are described in the following sections.

> **Note**: The **Review** tab is *only* used for reviewing information. No information can be entered in any pane on the **Review** tab.

6.1 Active Problem List Pane

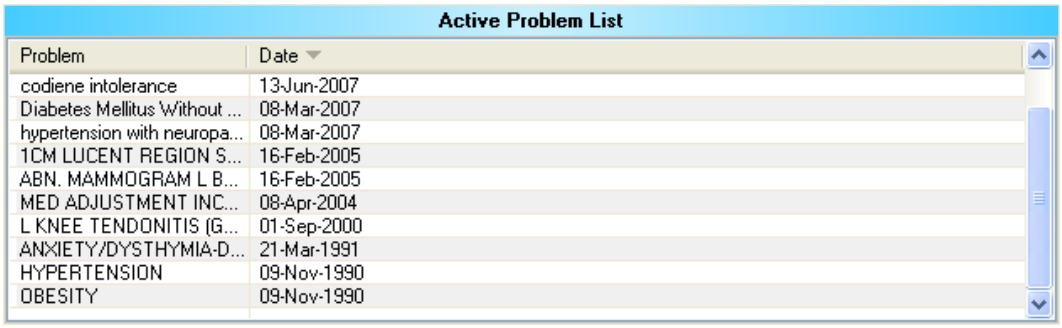


Figure 6-2: **Active Problem List** pane

The **Active Problem List** pane contains a list of the patient's problems with the date that each problem was last updated.

- To see detailed information about a specific problem, click the problem's name in the **Problem** column to open the **Problem Detail** dialog.

  In Figure 6-3, the problem named "Unspecified Otitis Media" was selected.

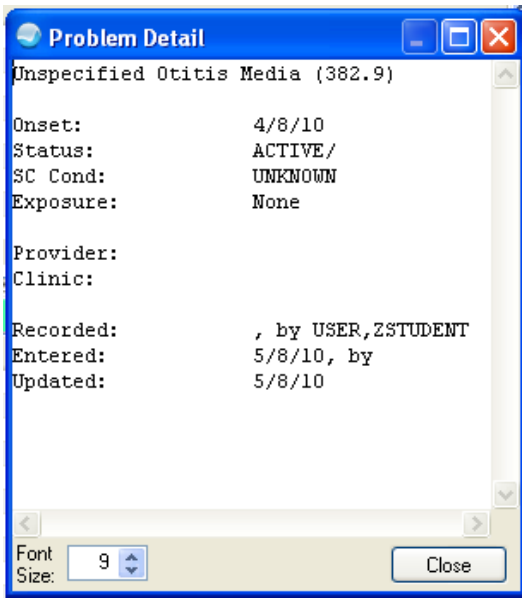


Figure 6-3: **Problem Detail** dialog

The **Problem Detail** dialog shows additional information about the problem in the following fields:

- Onset
- Status
- SC Cond
- Exposure

- Provider
- Clinic
- Recorded
- Entered
- Updated

6.2 Lab Orders Pane

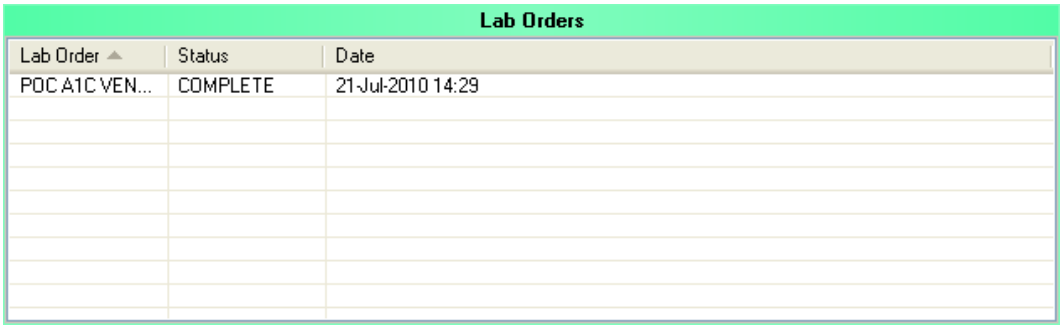


Figure 6-4: **Lab Orders** pane

The **Lab Orders** pane contains a list of the patient's lab orders with the status of each order and the date that it was last updated.

- To see detailed information about a specific lab order, click the order in the **Lab Order** column to open the **Lab Order Detail** dialog.

  In Figure 6-5, the order "POC AIC BLOOD WC LD" was selected.

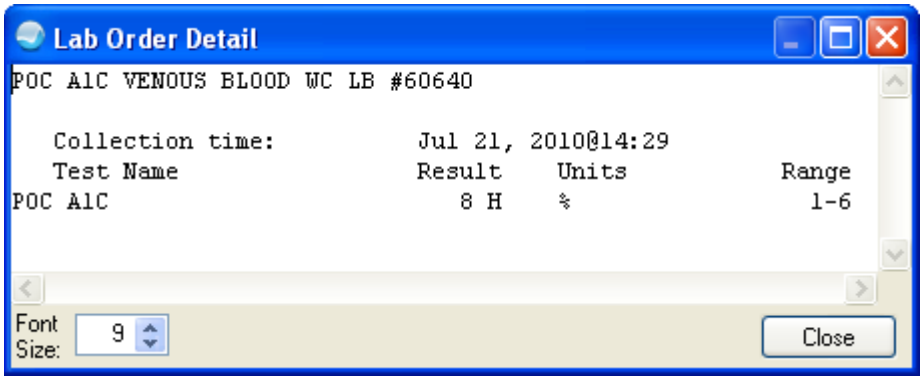


Figure 6-5: **Lab Order Detail** dialog

The **Lab Order Detail** dialog shows additional information about the order in the following fields:

- Collection time
- Test Name

- Result
- Units
- Range

6.3 Appointments & Visits Pane

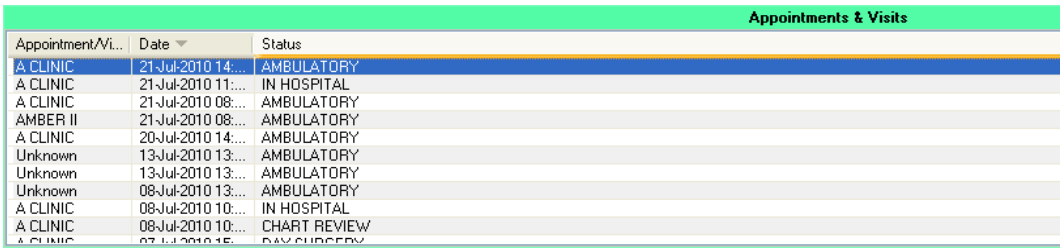


Figure 6-6: **Appointments & Visits** pane

The **Appointments & Visits** pane contains a list of the patient's future and past appointments and visits with the date and status of each encounter.

- To sort the appointments by date, click the **Date** column header.
- To see detailed information about a specific appointment or visit, click the encounter in the **Appointment/Visit** column to open the **Appointment/Visit Detail** dialog.

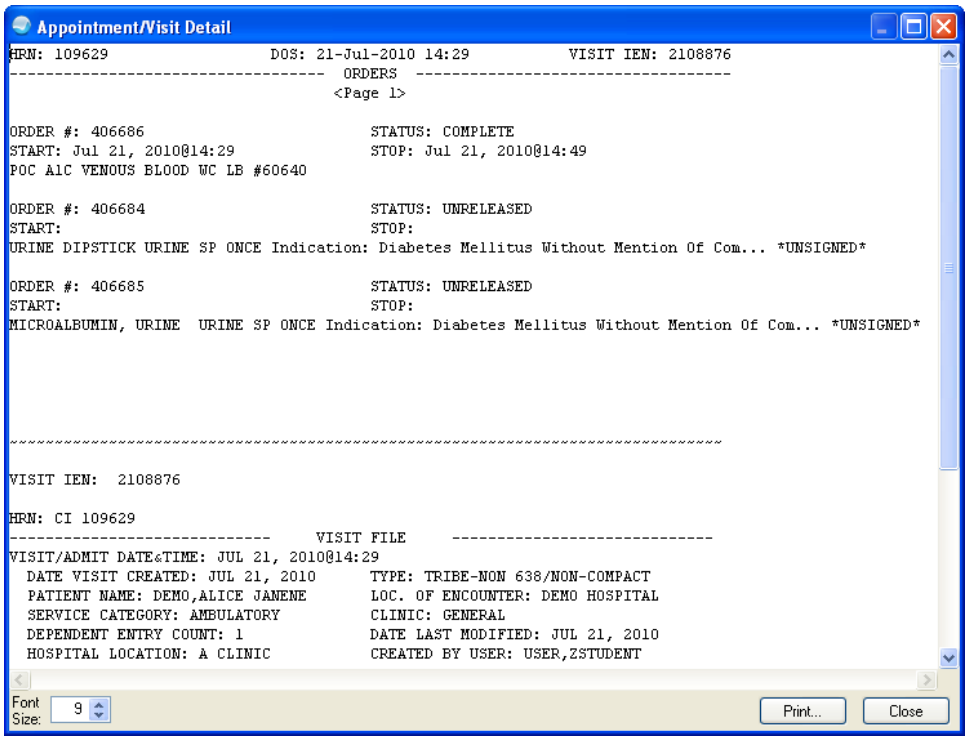


Figure 6-7: **Appointment/Visit Detail** dialog

6.4 Reminders Pane

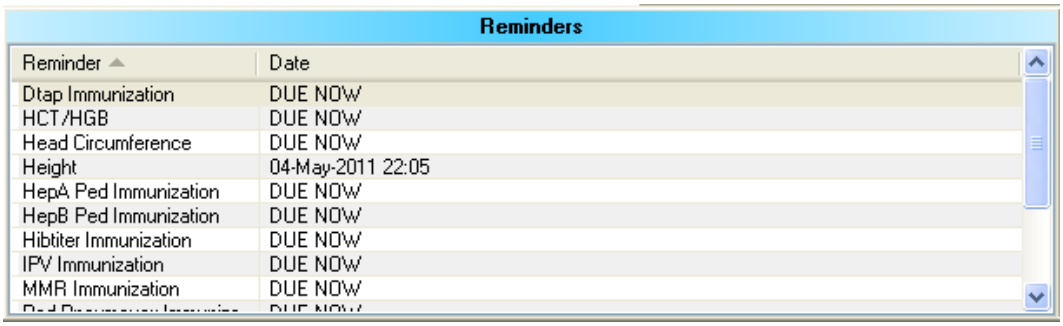


Figure 6-8: **Reminders** pane

Click the **Reminder** or **Date** column headings to sort items in the list in either ascending or descending order by reminder name or date.

Click on a reminder to open the **Reminder Detail** dialog and view additional information. See Figure 6-9.

Items in the reminders list that are historical display lab test results and dates. Items that are due now display details about when the test or immunization should be administered, problem diagnosis, and provider narrative.

To increase or decrease the font size in the **Reminder Detail** dialog, use the up or down arrows to the right of the **Font Size** field.

To print the reminder, click **Print**.

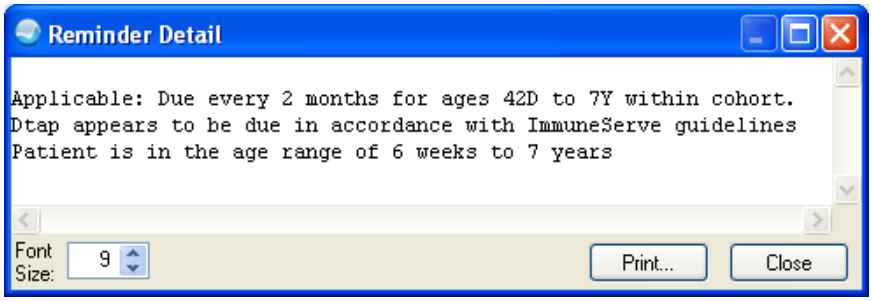


Figure 6-9: Reminder **Detail** dialog

6.5 Alerts Pane

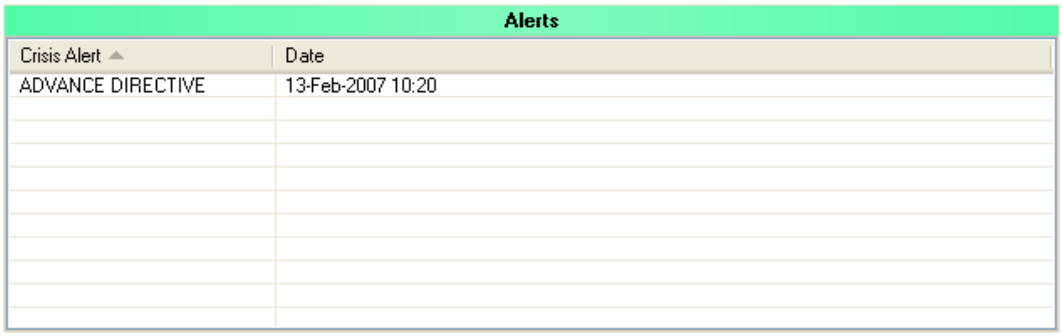


Figure 6-10: **Alerts** pane

The **Alerts** pane contains a list of clinical warnings, advance directives, and crisis notes that have been posted for the patient, with the date that each alert was posted.

- To sort the alerts by date, click the **Date** column header.
- To see more detailed information about a specific alert, click the alert in the **Crisis Alert** column to open the **Crisis Detail** dialog.

  In Figure 6-11, the "Crisis Note" alert was selected.

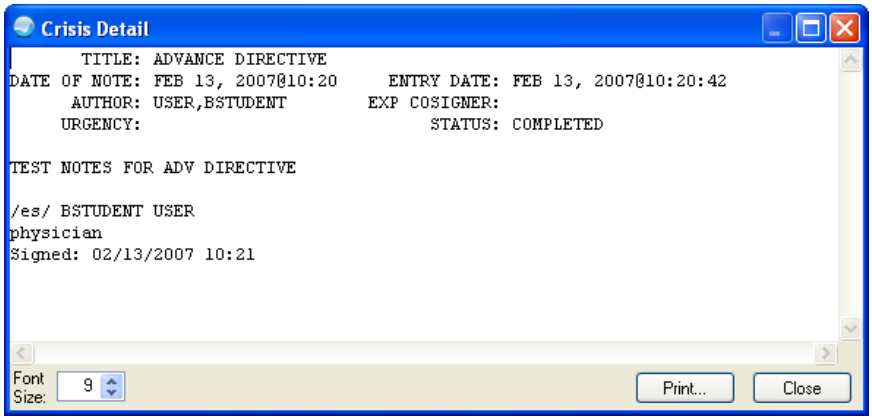


Figure 6-11: **Crisis Detail** dialog

The **Crisis Detail** dialog shows the text of the alert, as well as additional information about the alert in the following fields:

- Title
- Date of Note
- Entry Date
- Author
- Exp Cosigner
- Urgency

- Status
- Notes
- Electronic signature and title of the signer
- Signed date and time

7.0 Record the CC/HPI

(Chief Complaint and History of Present Illness – CC/HPI Tab)

Use the **CC/HPI** tab to enter the patient's chief complaint (CC) and history of present illness(HPI). Entering the patient's chief complaint and history of the present illness in the EHR is similar to writing this information on the PEF.

Use the questions from the inside front cover (IFC) of the CHAM to enter CC, problem, and HPI information into the EHR.

Prior Steps

Before entering the patient's chief complaint and history of present illness information, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 7-1: Example of EHR toolbar showing patient name and encounter information

7.1 The CC/HPI Tab

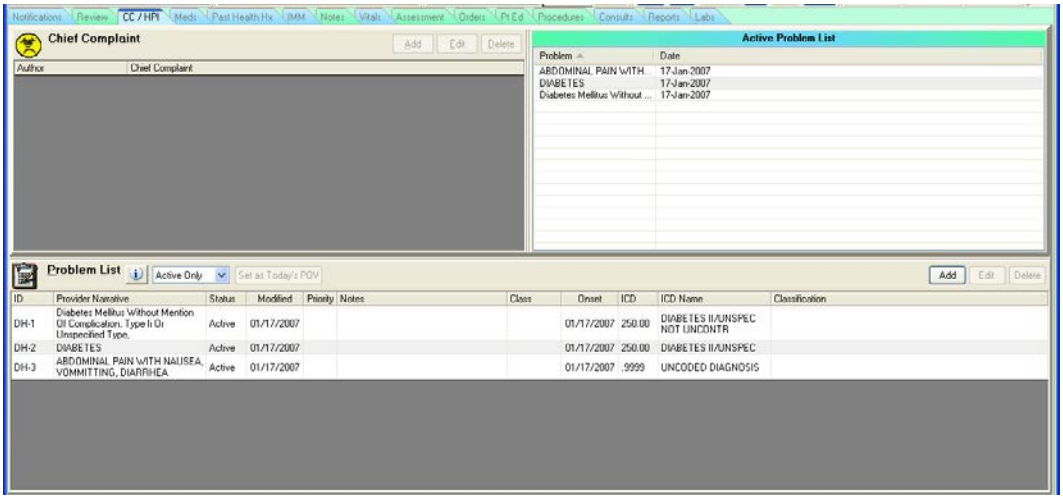


Figure 7-2: **CC/HPI** Tab

The **CC/HPI** tab contains panes that display the following information about a patient, as shown in Figure 7-2:

- The reason the patient has come to the clinic today (the **Chief Complaint** pane). Use the **Chief Complaint** pane to enter the patient's complaints at today's visit, using the questions from the IFC of the CHAM as a guide.
- The list of problems already entered by the medical staff for this patient (the **Problem List** pane). Use the problems listed in the **Problem List** pane to help answer health history questions from the CHAM about the patient's illnesses and risk factors, and to compare with the answers the patient gives to these questions during the current visit.

7.2 Enter the CC/HPI

1. Click the **CC/HPI** tab.

2. Click **Add** on the right side of the **Chief Complaint** pane to open the **Chief Complaint** dialog, as shown in Figure 7-3.

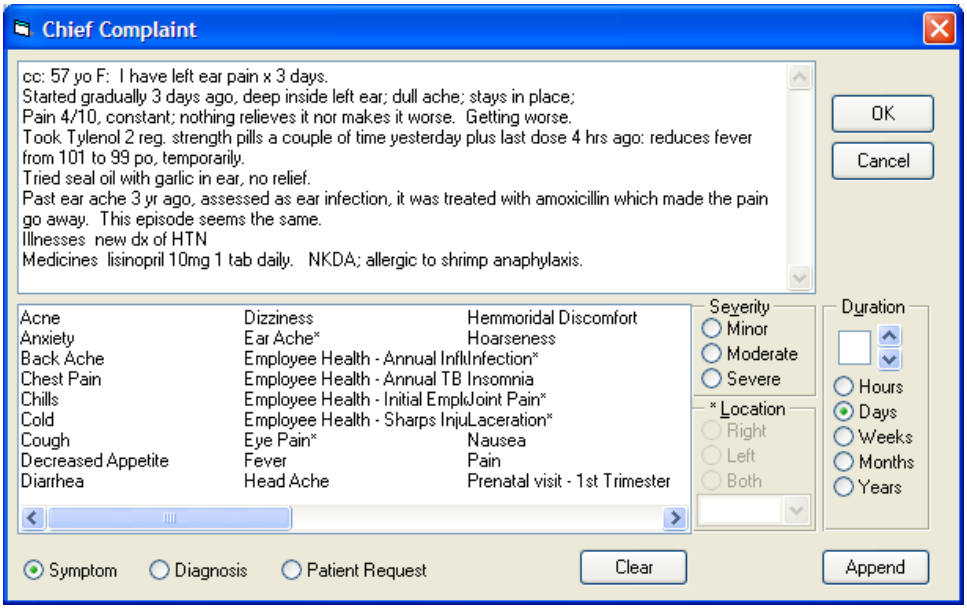


Figure 7-3: **Chief Complaint** dialog

3. Click once in the empty field at the top of the **Chief Complaint** dialog to type a description of the patient's chief complaint. The information entered here answers the CC and HPI questions on the IFC of the CHAM.

> **Note**: The list of complaints at the bottom of the dialog and the buttons under **Severity** and **Duration** are not used at this time.

4. Finish typing information about the patient's chief complaint.

5. Click **OK**.

7.2.1 Edit the Chief Complaint

To make changes to the chief complaint after it has been saved:

1. Click the chief complaint in the **Chief Complaint** pane.

2. Click **Edit**.

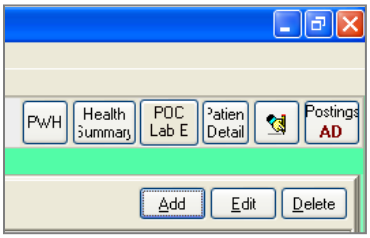


Figure 7-4: **Edit** button in the **CC/HPI** tab

3. To add information to the chief complaint, click once in the field at the top of the **Chief Complaint** dialog and type the additional information.

4. After completing the edits, click **OK** in the **Chief Complaint** dialog to save the edits and close the dialog.

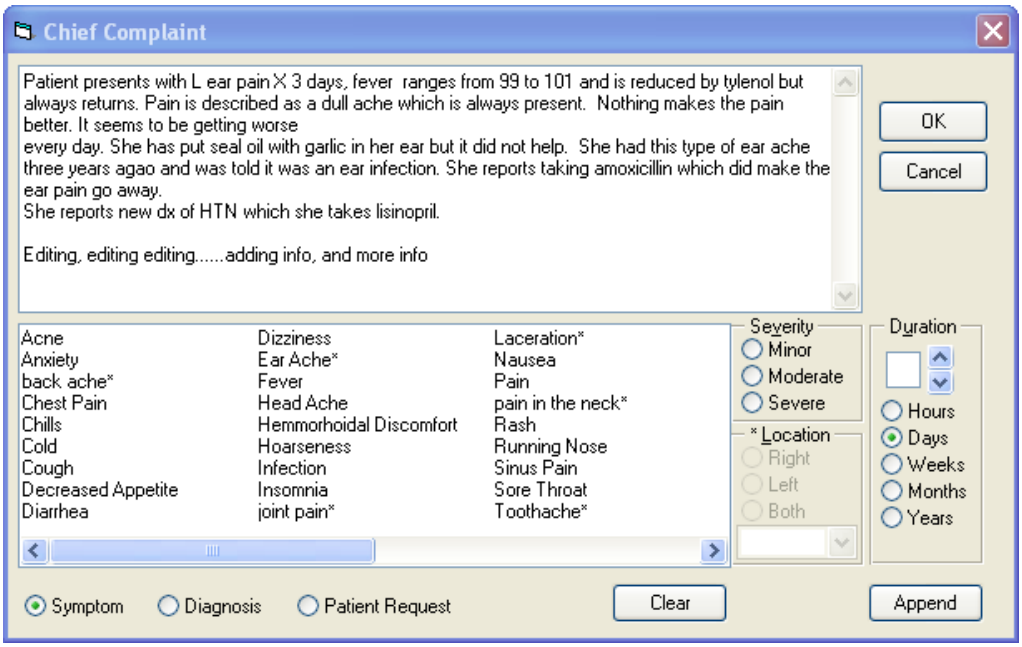


Figure 7-5: Editing the chief complaint

7.2.2 Delete a Chief Complaint

To delete a chief complaint that has already been saved:

1. Select the complaint.

2. Click **Delete**, as shown in Figure 7-6.

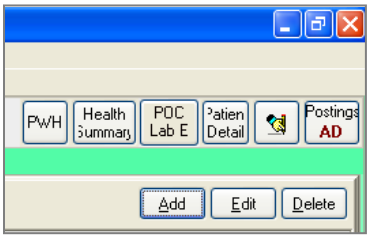


Figure 7-6: Deleting a chief complaint on the **CC/HPI** tab

3. In the **Delete Chief Complaint** dialog, click **Yes** to delete the chief complaint.

   - To cancel the "Delete" operation and keep the chief complaint, click **No**.

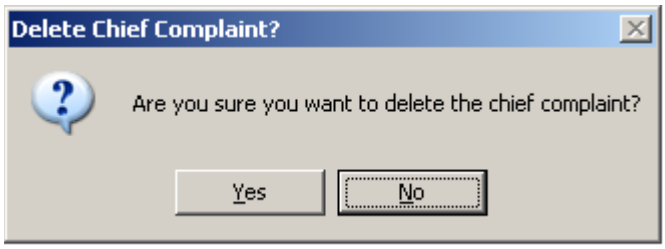
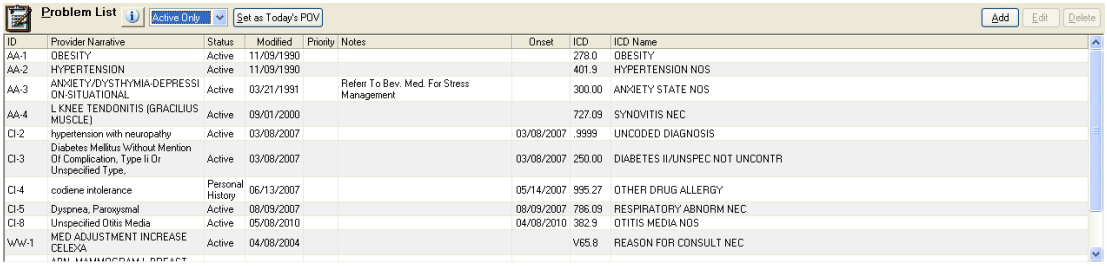


Figure 7-7: **Delete Chief Complaint** dialog

7.3 Review Problems in the Problem List Pane



ID	Provider Narrative	Status	Modified	Priority	Notes	Onset	ICD	ICD Name
AA-1	OBESITY	Active	11/09/1990				278.0	OBESITY
AA-2	HYPERTENSION	Active	11/09/1990				401.9	HYPERTENSION NOS
AA-3	ANXIETY/DYSTHYMIA-DEPRESSION-SITUATIONAL	Active	03/21/1991		Refer To Bev. Med. For Stress Management		300.00	ANXIETY STATE NOS
AA-4	L KNEE TENDONITIS (GRACILIUS MUSCLE)	Active	09/01/2000				727.09	SYNOVITIS NEC
CI-2	hypertension with neuropathy	Active	03/08/2007			03/08/2007	.9999	UNCODED DIAGNOSIS
CI-3	Diabetes Mellitus Without Mention Of Complication, Type Ii Or Unspecified Type,	Active	03/08/2007			03/08/2007	250.00	DIABETES II/UNSPEC NOT UNCONTR
CI-4	codiene intolerance	Personal History	06/13/2007			05/14/2007	995.27	OTHER DRUG ALLERGY
CI-5	Dyspnea, Paroxysmal	Active	08/09/2007			08/09/2007	786.09	RESPIRATORY ABNORM NEC
CI-8	Unspecified Otitis Media	Active	05/08/2010			04/08/2010	382.9	OTITIS MEDIA NOS
WW-1	MED ADJUSTMENT INCREASE CELEXA	Active	04/08/2004				V65.8	REASON FOR CONSULT NEC

Figure 7-8: **Problem List** pane

The **Problem List** pane appears in the lower portion of the **CC/HPI** tab. Physicians, PAs, and advance practice nurses determine what is added to or deleted from the problem list.

Use the problem list to answer Past Health History questions about illnesses and risk factors from the IFC of the CHAM.

1. Review the problem list.

2. Ask the patient if he or she has any ongoing health problems. Compare the patient's response to what is shown in the problem list.

3. If the patient has a chronic problem that is not in the problem list, enter the problem as a note in the **Notes** tab, and then talk to the patient's referral provider so that he or she can add the problem to the problem list.

> **Note**: Refer to Section 11.0 for instructions on entering the problem in the **Notes** tab. The chronic problem will be added to the **History Template** in the **Other Hx** field.

To see more information about a specific problem, click the problem to open the **Problem Maintenance** dialog, as shown in Figure 7-9 and Figure 7-10.

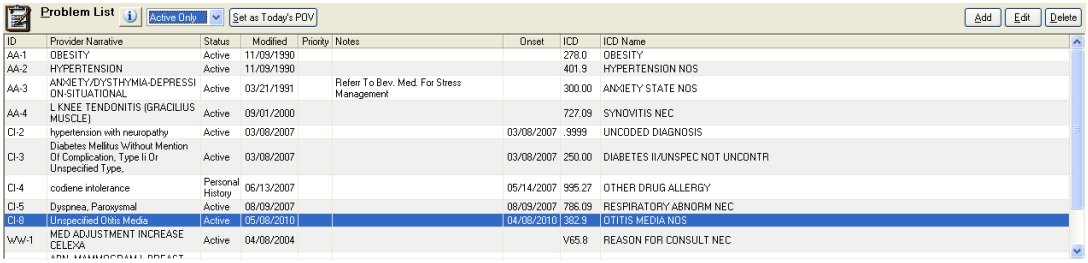


Figure 7-9: Selecting a problem in the **Problem List** pane

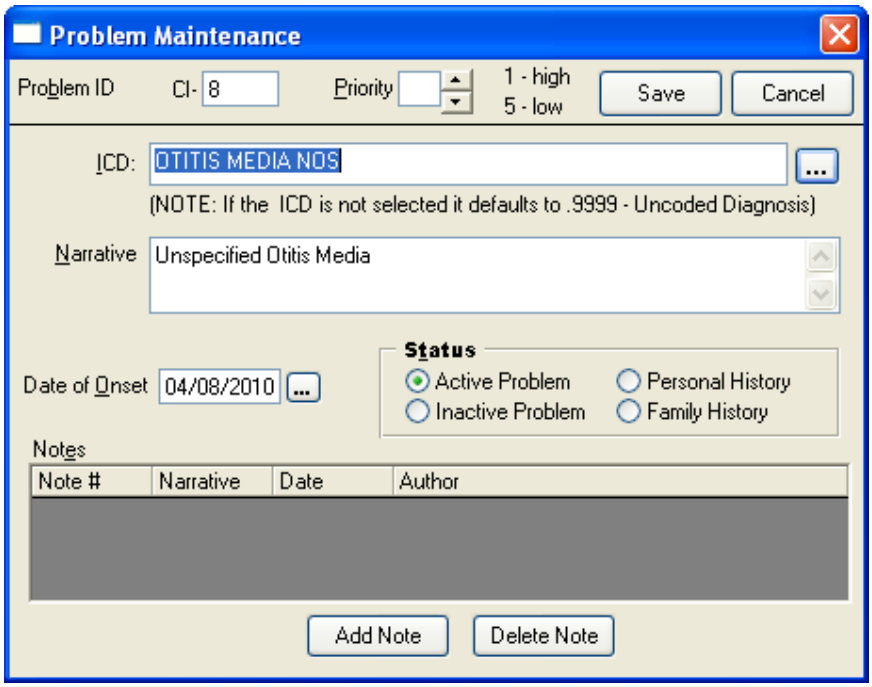


Figure 7-10: **Problem Maintenance** dialog

The **Problem Maintenance** dialog shows additional information about the problem in the following fields:

- ICD
- Narrative

- Date of Onset
- Status (Active Problem, Inactive Problem, Personal History, or Family History)
- Notes, if any, including the Note #, Narrative, Date, and Author for each note

The information in the problem list can be sorted by ID, Provider Narrative, Status, Modified, Priority, Notes, Onset, ICD, or ICD Name.

7.3.1 Sort problems by date last modified

To sort the list of problems by the date they were last modified, click the **Modified** column heading, as shown in Figure 7-11.

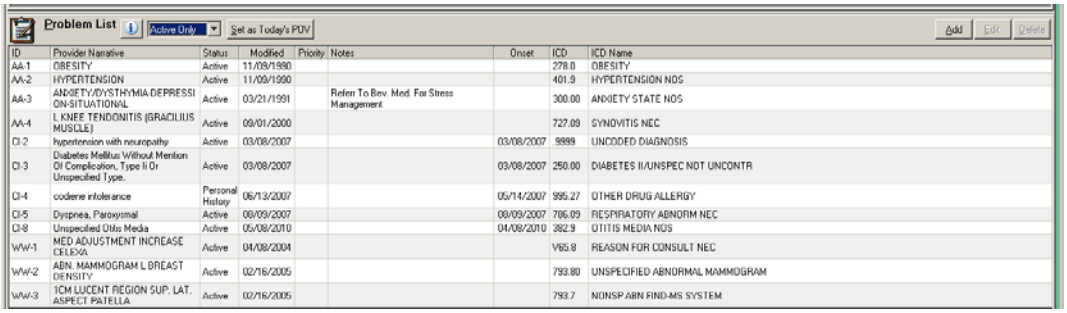


Figure 7-11: **Modified** column heading

7.3.2 Filter problems by status

Use the field to the left of the **Set as Today's POV** button to "filter" or display only a specific type of problem in the problem list.

The following types of problems can be shown in the list: All Problems, Active Only, Inactive Only, Personal History, or Family History.

> **Note**: The options in the field correspond to the buttons in the **Status** area of the **Problem Maintenance** dialog.
>
> For example, to display problems that have the **Active Problem** button selected in the **Problem List** pane, select "Active Only" from the field.

1. To filter the list of problems, click the arrow on the field to the left of the **Set as Today's POV** button to open the status list.

2. Click the problem status to be displayed.

   For example, to display only problems with a status of "Active Only," click the arrow on the field, and then click "Active Only", as shown in Figure 7-12.

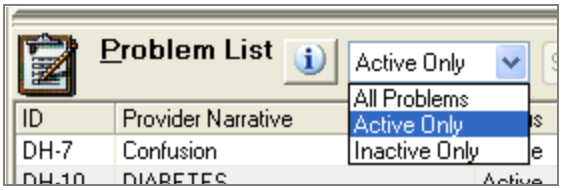


Figure 7-12: Problem status field with “Active Only” status selected

7.3.2.1 Filtering by status of “Active Problem”

Figure 7-13 shows the **Problem List** pane filtered to display only problems that have the **Active Problem** button selected in the **Problem Maintenance** dialog.

Click the “Active Only” option in the field to display problems with the “Active Problem” status.

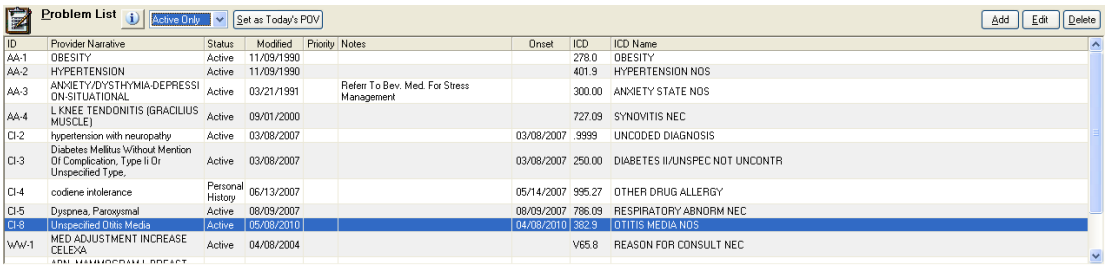


Figure 7-13: **Active Only** filter

7.3.2.2 Filtering by status of “Inactive Problem”

Figure 7-14 shows the **Problem List** pane filtered to display only problems that the **Inactive Problem** button selected in the **Problem Maintenance** dialog.

Click the “Inactive Only” option in the field to display problems with the “Inactive Problem” status.

Figure 7-14: **Inactive Only** filter

8.0 The Meds Tab

Use the **Meds** tab to review the current patient's medications. The **Meds** tab is for review only. No data can be entered on this tab.

Prior Steps

Before using the **Meds** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)
13. Record patient education information (Section 17.0)
14. Enter information on the Lab Assessment Plan template and sign the note and other items (Section 18.0)
16. Review information on the Consults tab (Section 20.0)
17. Print the patient's health summary (Section 21.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 8-1: Example of EHR toolbar showing patient name and encounter information

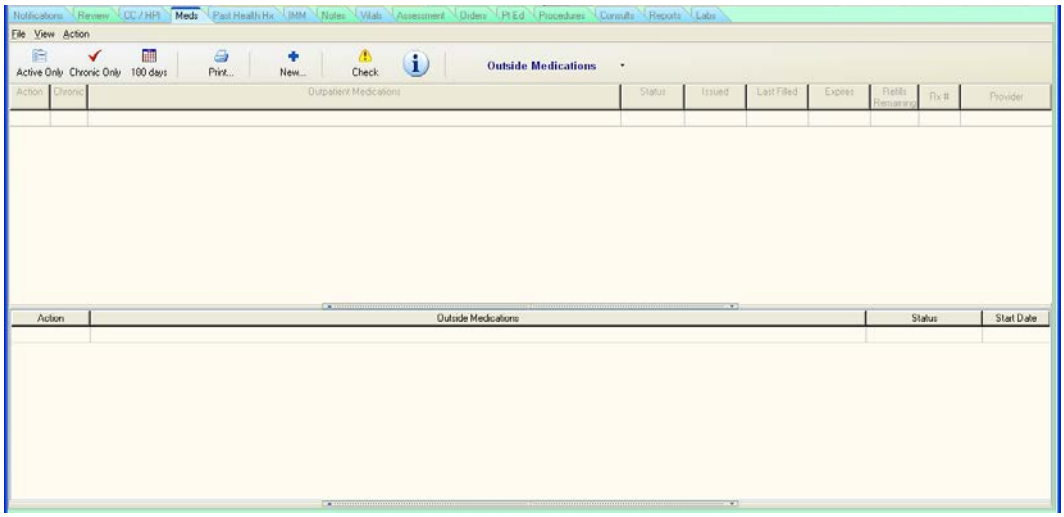


Figure 8-2: **Meds** tab showing buttons used to filter medications

1. Click within either of the two panes (**Outpatient Medications** or **Outside Medications**) to activate the desired list.

2. Use the buttons at the top of the **Meds** tab to filter the medications in the list. Buttons that may appear on the tab include **Active Only**, **Chronic Only**, **Days**, **Print**, **Process**, **New**, and **Check**.

3. Click a column header to sort the list of medications. For example, click the **Last Filled** column header to sort the list by the last filled date.

    - To sort in ascending order, click the column heading once.
    - To sort in descending order, click the column heading a second time.

9.0 Review and Update Past Health History

Reviewing and updating the patient's past health history in the EHR is similar to reviewing the patient's chart and filling out this information on the PEF.

Use the **Past Health Hx** tab to review and update information about the patient's allergies and adverse reactions, health factors, exams, and personal health data.

Prior Steps

Before entering the patient's past health history, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 9-1: Example of the EHR toolbar showing patient name and encounter information

The **Past Health Hx** tab contains panes that display the following information about a patient, as shown in Figure 9-2:

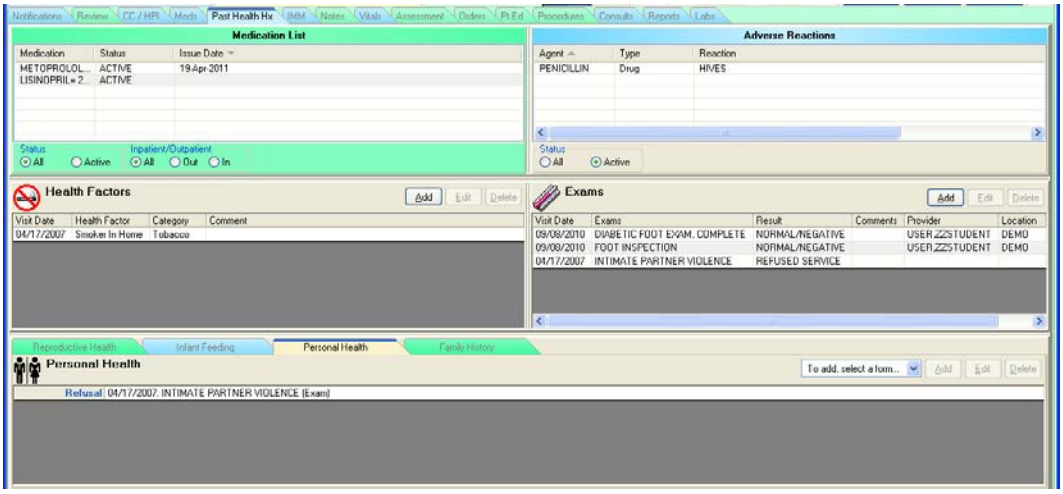


Figure 9-2: **Past Health Hx** tab

- A list of medications that have been prescribed (the **Medication List** pane): Compare the medications listed on the **Medication List** pane with the patient's answers to the questions on the IFC of the CHAM. See Section 9.1.
- The patient's known allergies and adverse reactions (the **Adverse Reactions** pane): Use the **Adverse Reactions** pane to review and update information about the patient's allergies and adverse reactions. See Section 9.2.
- A list of the patient's health factors (the **Health Factors** pane): Use the **Health Factors** pane to review and update the patient's current health factors. See Section 9.2.3.
- A list of exams and screenings that have been performed for the patient (the **Exams** pane): Use the **Exams** pane to enter the results of screenings performed during the visit, to enter a refusal if the patient refuses to answer the screening questions, or to enter historical information about drug or alcohol use provided by the patient. See Section 3.
- Data related to the patient's asthma status, reproductive status, functional status, treatment contract, etc., as well as infant feeding information and other pediatric data (the **Personal Health** pane): Use the **Personal Health** pane to record important personal health data about the patient. See Section 9.4.6.

9.1 Medication List Pane

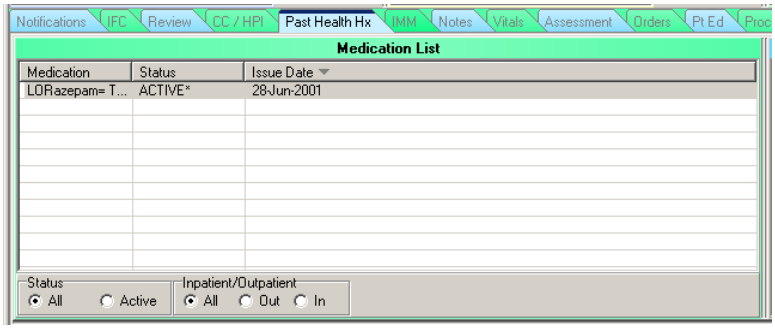


Figure 9-3: **Medication List** pane

The **Medication List** pane in the top left corner of the **Past Health Hx** tab lists medications that have been prescribed for the patient, including the date the prescription was issued and the current status of the prescription.

- To see all medications that have been prescribed, select **All** (located at the bottom of the **Medication List** pane).
- To see only medications that are currently active, select **Active** (located at the bottom of the **Medication List** pane).

Compare the patient's answers to the questions from the IFC of the CHAM with the information in the **Medication List** pane. If the patient reports a medication that is not in the **Medication List** pane, enter the medicine in the **Notes** tab as specified by the site.

9.2 Adverse Reactions Pane

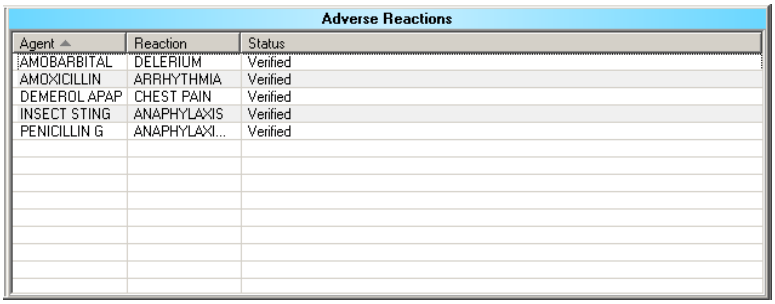


Figure 9-4: **Adverse Reactions** pane

The **Adverse Reactions** pane in the top right corner of the **Past Health Hx** tab shows a list of the patient's known allergies, including the causative agent, the signs or symptoms of the reaction, and the status of the allergy. Use the **Adverse Reactions** pane to review known allergies and adverse reactions, and to add new allergies and adverse reactions, if necessary:

- If the column heading displays the message, **No Allergy Assessment**, the patient has no adverse reactions listed and has not been assessed for allergies.

  Leaving the Adverse Reactions pane in this state counts against the site when statistics are compiled for Meaningful Use.

- If the column heading displays the message, **No Known Allergies**, the patient has been assessed for allergies and has reported or exhibited none.

9.2.1 Add a New Adverse Reaction

To add a new allergy or reaction to the **Adverse Reaction** pane:

1. In the **Adverse Reactions** pane, right-click anywhere in the pane to display the context menu.
2. Select **New Adverse Reaction** as shown in Figure 9-5.

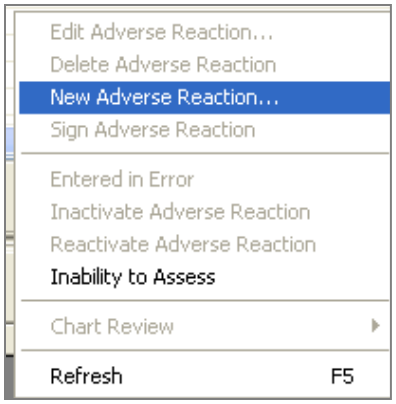


Figure 9-5: Selecting the **New Adverse Reaction** option in the context menu

3. The **Look up Causative Agent** dialog is displayed, as shown in Figure 9-6.

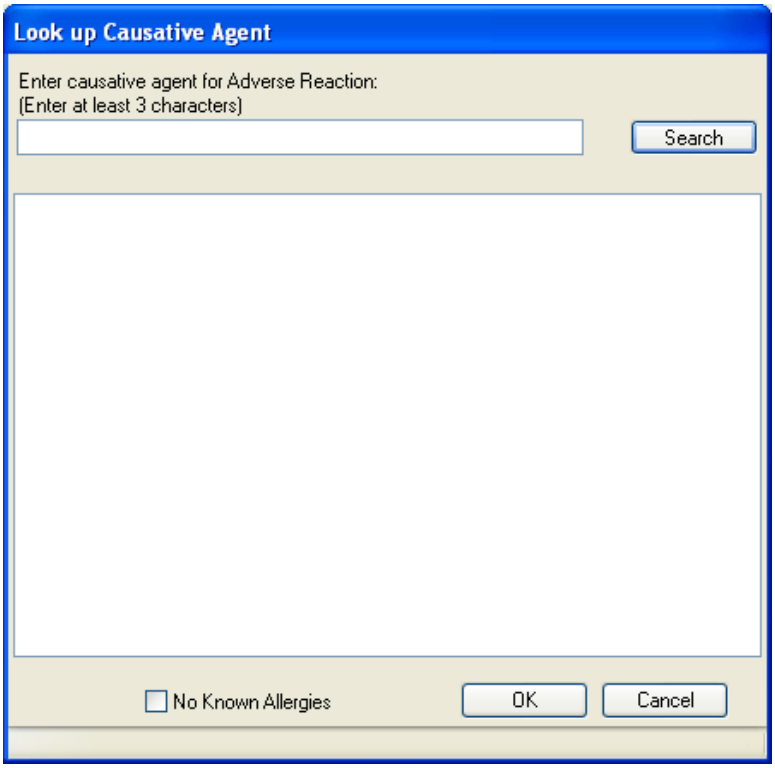


Figure 9-6: **Look up Causative Agent** dialog

4. To find a specific causative agent:

   a. Type a minimum of three characters in the field at the top of the **Look up Causative Agent** dialog.

   b. Click **Search**.

A list of causative agents starting with those characters is displayed, as shown in Figure 9-7.

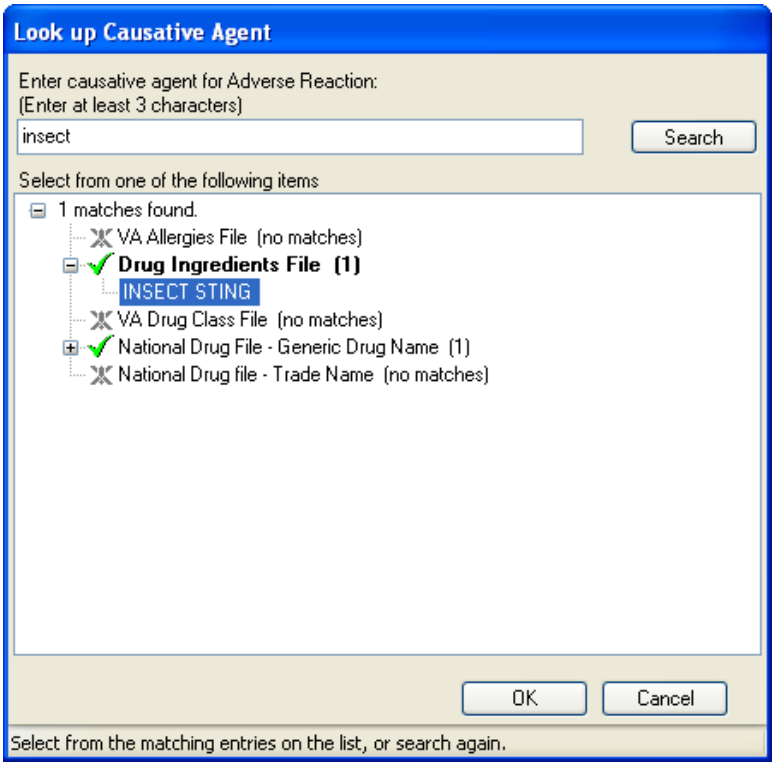


Figure 9-7: List of agents in the **Look up Causative Agents** dialog

5. Select the appropriate causative agent by clicking it in the list.
6. Click **OK** to return to the **Create Adverse Reaction** dialog.

In this example, the causative agent was an insect sting which is displayed in the **Causative agent** field.

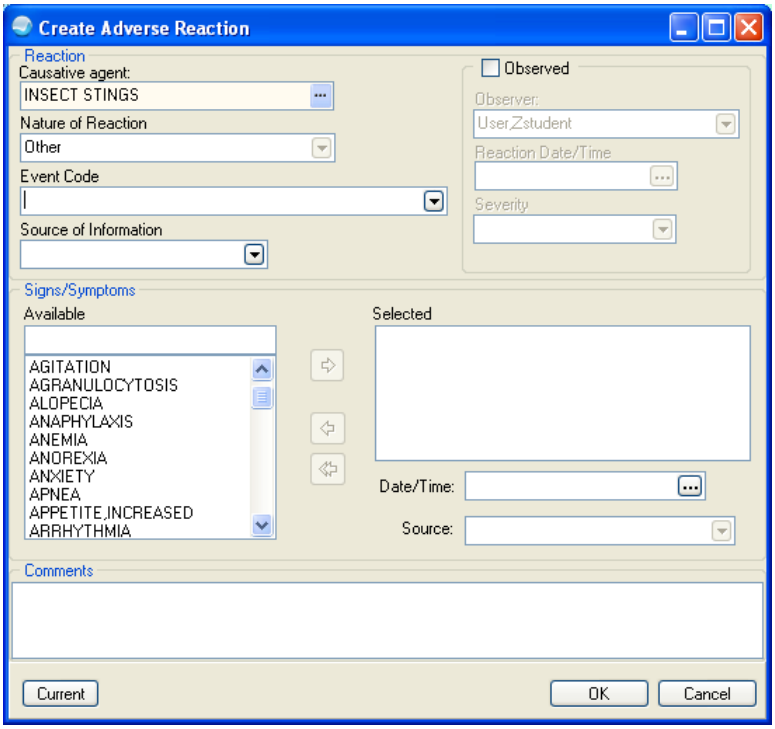


Figure 9-8: **Create Adverse Reaction** dialog

7. In the **Nature of Reaction** field select one of the following: Drug; Food; Other; Drug, Food; Drug, Other; or Food,Other. See Figure 9-8.

> **Note**: Many Causative agents are assigned a default Nature of Reaction; when this occurs (as shown in Figure 9-8), the Nature of Reaction cannot be changed.

8. If appropriate, select an **Event Code** and a **Source of Information**.
9. Select one or more **Signs/Symptoms** to associate with this adverse reaction. To find a sign or symptom in the list:
   a. Type the first few characters in the field at the top of the **Available** list.
   b. Select the correct sign or symptom.
   c. Click the right arrow (toward the **Selected** list) to add it to that list, as shown in Figure 9-10.

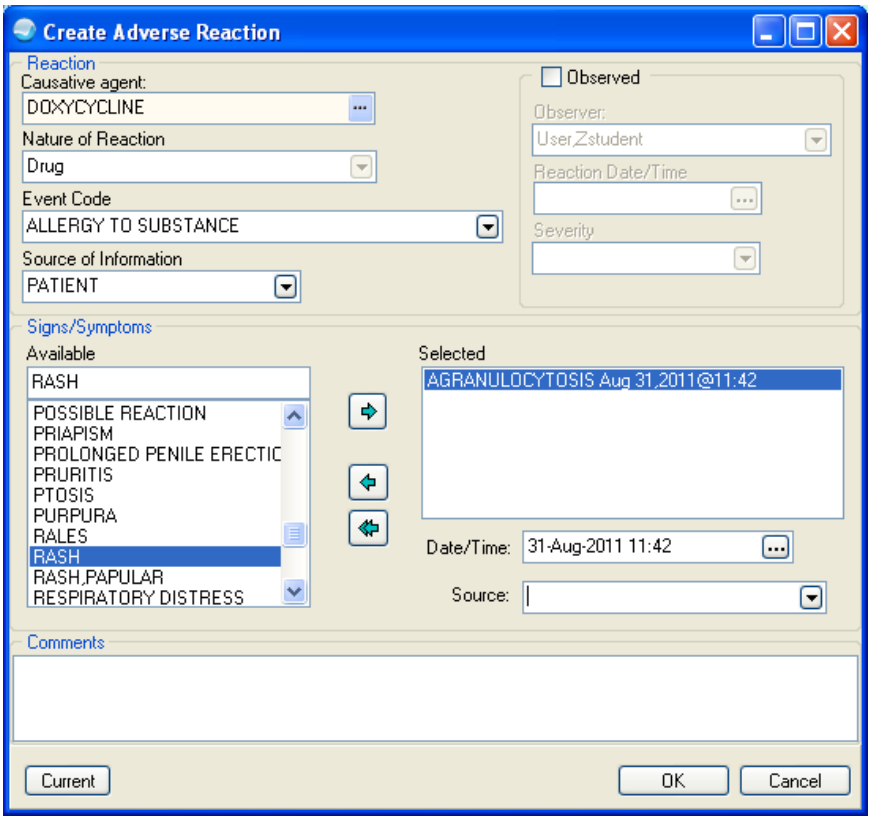


Figure 9-9: Moving the selected sign/symptom to **Selected**

10. To remove a sign or symptom from the **Selected** list.
    a. Click the sign or symptom.
    b. Click the left arrow (toward the **Available** list).
11. Add a comment in the **Comments** field, if necessary.

12. If appropriate, click the **Observed** check box and enter the reaction date, time, and severity. For example, click the **Observed** check box if a patient is stung by a bee while waiting for her/his appointment or a patient is receiving an immunization and a reaction is observed by the provider. See Figure 9-10.

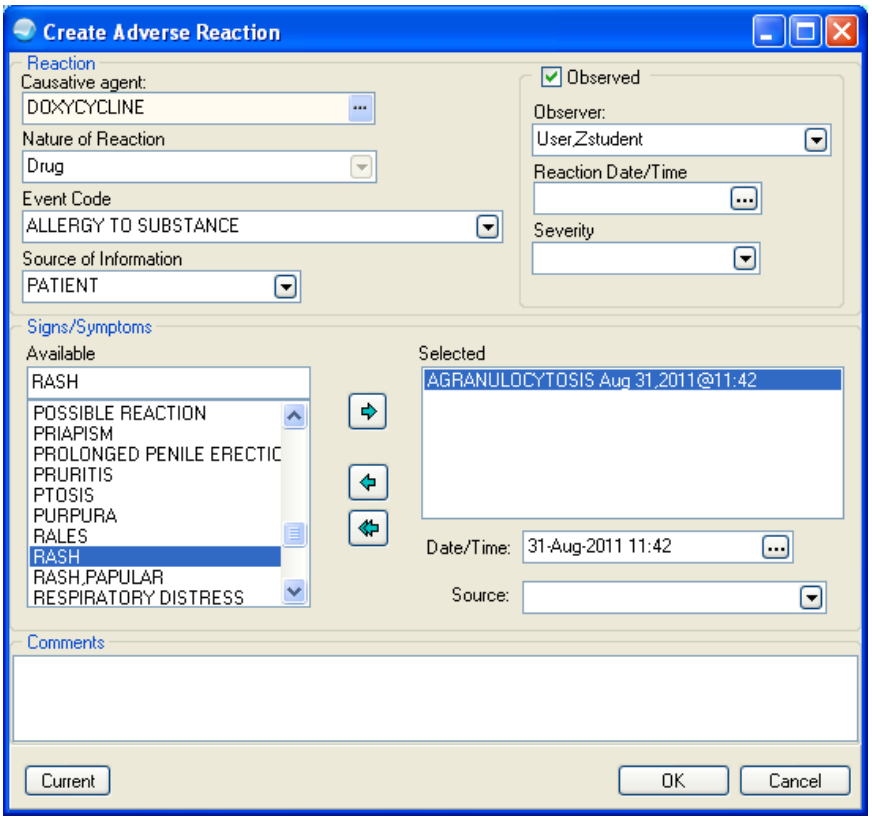


Figure 9-10: Selecting the **Observed** check box

Note: The **Observed** check box is only selected when the provider observes a reaction during the encounter.

13. When finished, click **OK** to close the **Create Adverse Reaction** dialog. The new adverse reaction appears in the **Adverse Reaction** pane with a status of "Unsigned", as shown in Figure 9-11.

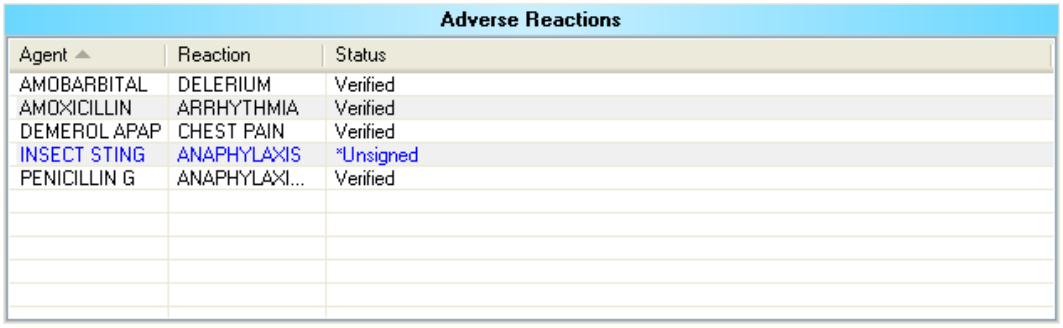


Figure 9-11: A new adverse reaction appears in blue in the **Adverse Reactions** pane

14. After adding one or more new adverse reactions, click **Awaiting Review/Signature** (shown in Figure 4-43) to open the **Review/Sign Changes** dialog, as shown in Figure 9-12. If any of the newly added items need to be signed, they will be listed in the dialog.

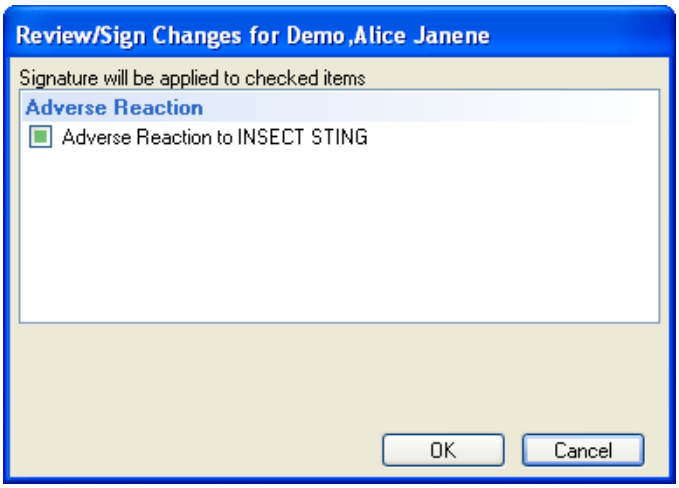


Figure 9-12: **Review/Sign Changes** dialog

In the example in Figure 9-12, there is a single item to be signed. The green button to its left indicates that it is selected.

15. Click **OK**.

9.2.2 Enter No Known Allergies in the Adverse Reactions Pane

To enter a "No Allergy Assessment" note in the **Adverse Reactions** pane, follow these steps:

1. In the **Adverse Reactions** pane, right-click to display the context menu.
2. Select **New Adverse Reaction** to open the **Look up Causative Agent** dialog.

3. Select the **No Known Allergies** check box at the bottom of the dialog, as shown in Figure 9-13.

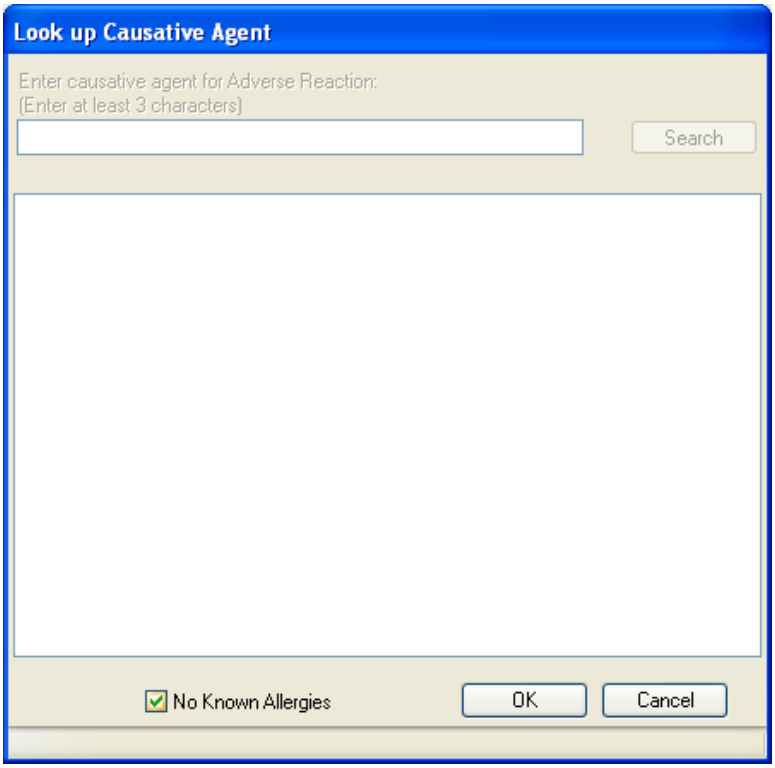


Figure 9-13: Selecting the No Known Allergies check box

4. Click **OK** to close the dialog.

5. Click the **Refresh Data** menu item at the top of the EHR window to see the "No Allergy Assessment" note in the **Adverse Reactions** pane.

9.2.3 Enter "Inability to Assess" in the Adverse Reactions Pane

To enter "Unassessable" in the **Adverse Reactions** pane, follow these steps:

1. In the **Adverse Reactions** pane, right-click to display the context menu. Select the **Inability to Assess** option to open the **Reason Prompt** dialog.

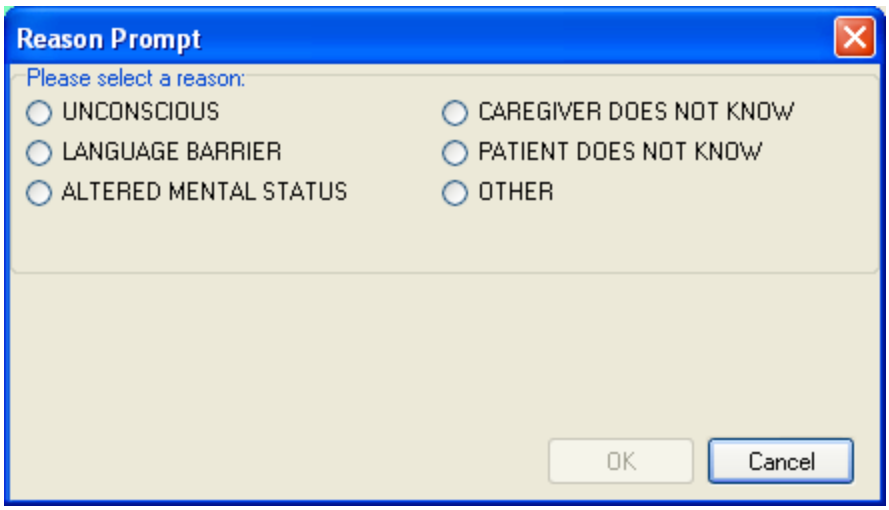


Figure 9-14: **Reason Prompt** dialog

2. Select a reason.
3. Click **OK** to close the dialog.
4. Click the **Refresh Data** menu item at the top of the EHR window to see the "Unassessable" note in the **Adverse Reactions** pane.

9.3 Health Factors Pane

The **Health Factors** pane in the **Past Health Hx** tab (located below the **Medication List** pane) shows the patient's current health factors. See Figure 9-15.

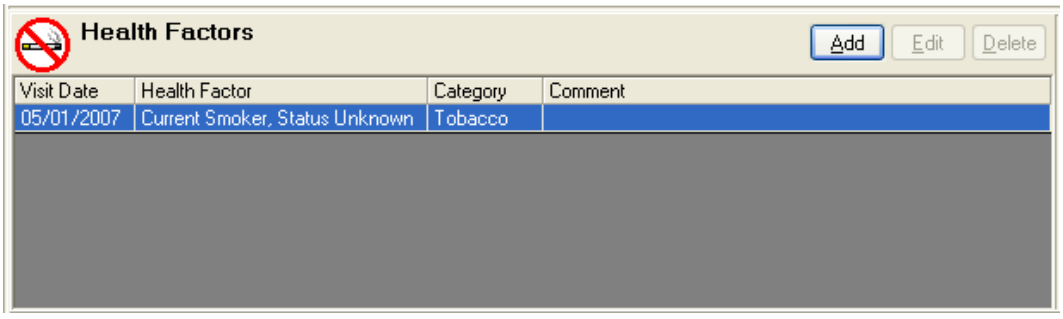


Figure 9-15: **Health Factors** pane in the **Past Health Hx** tab

9.3.1 Review Health Factors

Use the **Health Factors** pane to review the patient's health factors and to add new health factors when the patient answers the questions on the IFC of the CHAM.

Health Factors describe a component of the patient's health and wellness not documented elsewhere or as an ICD or CPT code. Health factors are not visit specific and relate to the patients overall health status.

Health Factors influence a person's health status and response to therapy. Some important patient education assessments can be considered health factors such as readiness to learn, barriers to learning, and learning preferences.

Why should health factors be entered?

- Health factors influence a person's health status and response to therapy.
- Health factors include tobacco use, alcohol use, and TB status.
- Some important patient education assessments can be made in health factors, such as readiness to learn, barriers to learning, and learning preferences.
- Patient health factors must be documented for reporting requirements under the Government Performance and Results Act (GPRA).

9.3.2 Add a New Health Factor

To add a new health factor for the patient follow these steps:

1. Click **Add** (located on the right side of the **Health Factors** pane) to open the **Add Health Factor** dialog, as shown in Figure 9-15.

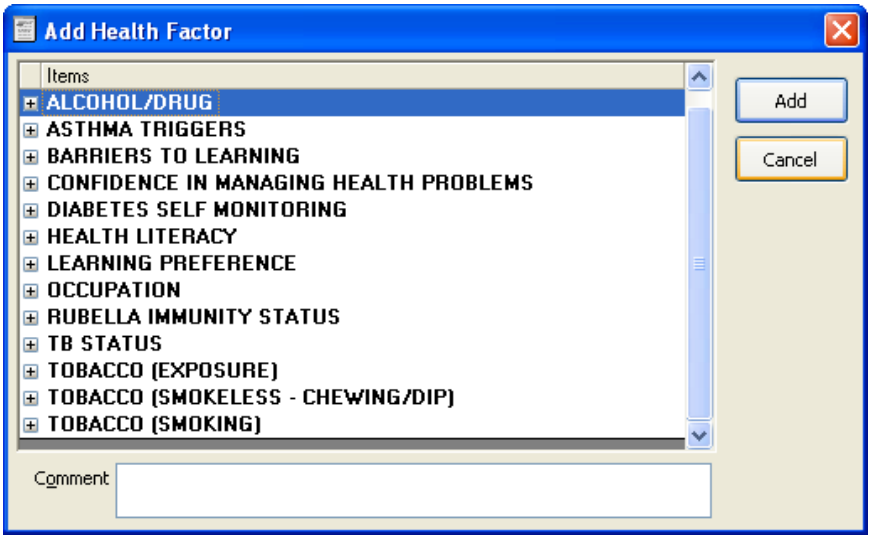


Figure 9-16: **Add Health Factor** dialog

2. To add answers to the tobacco-related questions from the IFC of the CHAM, click the plus sign (+) next to any of the three "TOBACCO" entries to open a list of possible answers to the questions, as shown in Figure 9-17.

To meet the requirements for Meaningful Use, select one answer from the **TOBACCO (SMOKING)** list.

Select the items that most closely describes the patient's tobacco use.

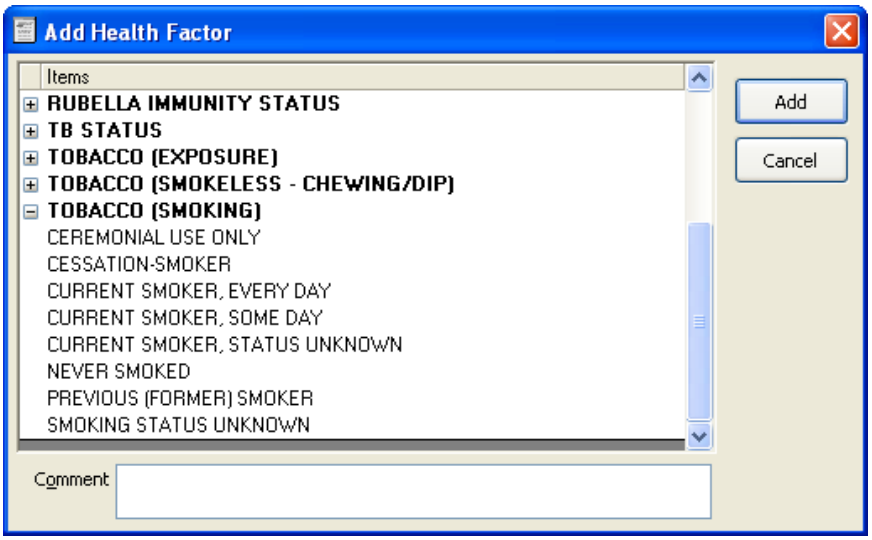


Figure 9-17: List of options for the "TOBACCO (SMOKING)" health factor

Tobacco health factors and their meanings:

- **TOBACCO (EXPOSURE)**:
  - **EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE**: is around tobacco smoke while at work or performing other activities.
  - **SMOKE FREE HOME**: no one smokes in the patient's home.
  - **SMOKER IN HOME**: someone smokes in the patient's home.
- **TOBACCO (SMOKELESS – CHEWING/DIP)**:
  - **CESSATION SMOKELESS**: currently in the process of quitting smokeless tobacco; has quit for less than 6 months.
  - **CURRENT SMOKELESS**: currently using chewing tobacco, dip, snuff, Igmik.
  - **NEVER USED SMOKELESS TOBACCO**: never used chewing tobacco, dip, snuff, Igmik.
  - **PREVIOUS (FORMER) SMOKELESS**: has quit using smokeless tobacco for longer than 6 months.
  - **SMOKELESS TOBACCO, STATUS UNKNOWN**: unknown if ever used smokeless tobaccl.
- **TOBACCO (SMOKING)**:
  - **CEREMONIAL USE ONLY**: uses tobacco for ceremonial or religious reasons only.
  - **CESSATION SMOKER**: currently in the process of quitting smoking tobacco; has quit for less than 6 months.
  - **CURRENT SMOKER, EVERY DAY**: currently smoking cigarettes, pipe, cigars.

- **CURRENT SMOKER, SOME DAY**: currently smoking cigarettes, pipe, cigars.
- **CURRENT SMOKER, STATUS UNKNOWN**: currently smoking cigarettes, pipe, cigars.
- **NEVER SMOKED**: never used cigarettes, pipe, cigars.
- **PREVIOUS (FORMER) SMOKER**: has quit smoking tobacco for longer than 6 months.
- **SMOKING STATUS UNKNOWN**: unknown if ever used smoking tobacco.

3. To add comments to the selected factor, click the **Comment** field and type the comment

4. Click **Add**.

9.4 Exams Pane

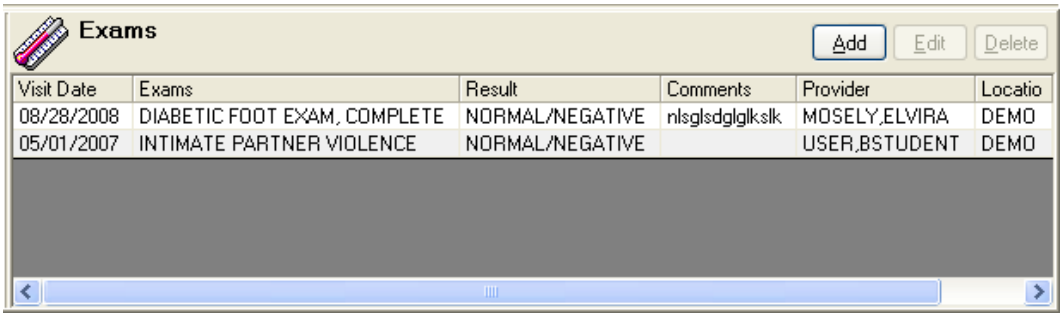


Figure 9-18: **Exams** pane

Use the **Exams** pane in the **Past Health Hx** tab, shown in Figure 9-18, to document the results of various screening exams, such as alcohol and drug screenings and depression screenings.

Document a patient's refusal to answer screening questions in the **Exams** pane. The refusal can also include other circumstances that prevent a screening from being performed, as well as prior history of alcohol or drug use and exams performed at other clinics.

9.4.1 Document a New Alcohol/Drug Screening

> **Note:** The **Exams** pane does not include a separate exam option for documenting drug use. Use the **Comment** field for the ALCOHOL SCREENING option to document the results of the drug screening.

1. In the **Exams** pane, click **Add** to open the **Exam Selection** dialog.

2. In the list of exams, select the "ALCOHOL SCREENING" option, as shown in Figure 9-19.

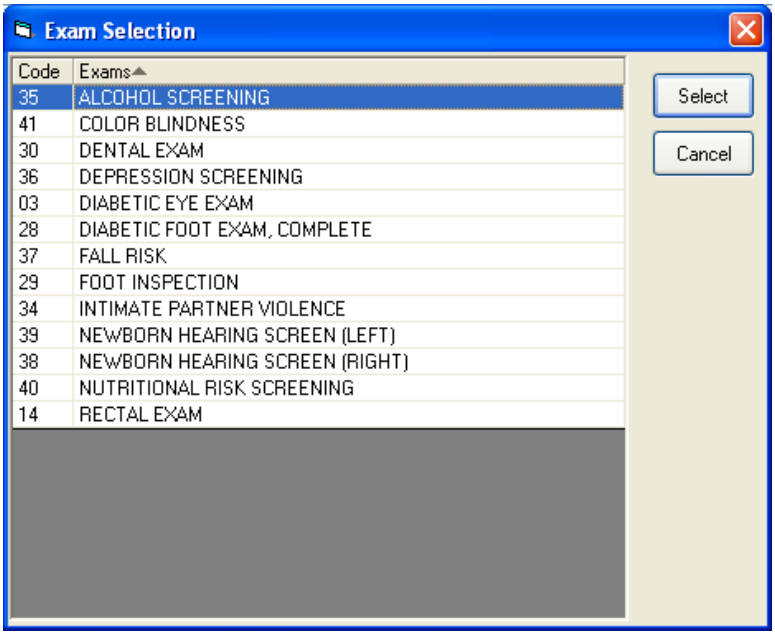


Figure 9-19: Selecting "ALCOHOL SCREENING" in the **Exam Selection** dialog

3. Click **Select** to open the **Document an Exam** dialog, as shown in Figure 9-20.

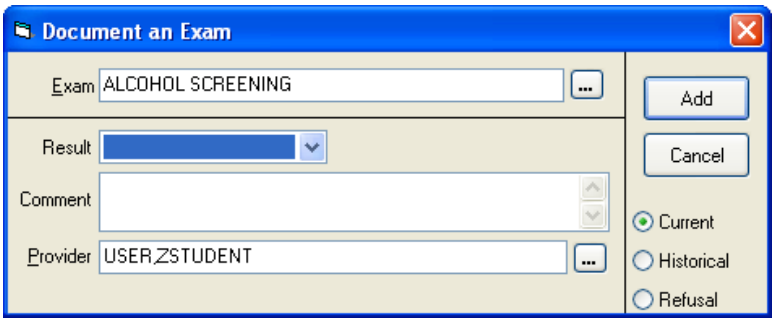


Figure 9-20: **Document an Exam** dialog

The **Exam** field at the top of the **Document an Exam** dialog contains the name of the selected exam. In Figure 9-20, the selected exam is ALCOHOL SCREENING.

4. Ask the patient the drug and alcohol screening questions from the IFC of the CHAM.

5. Click the arrow next to the **Result** field to select "POSITIVE" or "NEGATIVE" depending on the patient's answers, as shown in Figure 9-21.

> **Note**: For a patient that drinks alcohol or uses drugs, select "POSITIVE." For a patient that does not drink alcohol **and** does not use drugs, select "NEGATIVE."

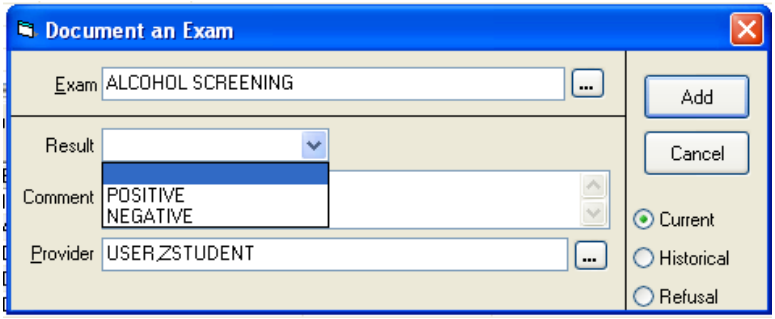


Figure 9-21: Selecting "POSITIVE" in the **Result** field

6. To enter comments about the type of alcohol and/or drugs used by the patient, click in the **Comment** field and type the comments, as shown in Figure 9-22.

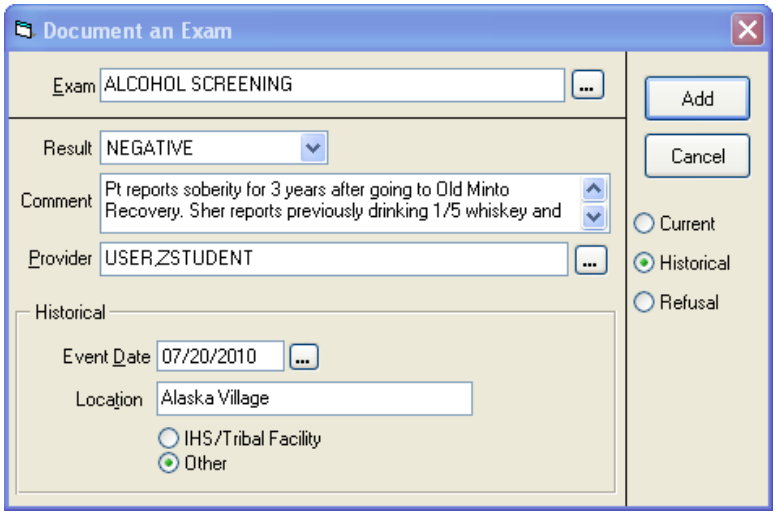


Figure 9-22: Entering comments about drug and alcohol use in the **Comment** field

> **Note**: Enter all drug screening results in the **Comment** field. There is currently no other place in the EHR to document drug screenings.

7. Click **Add** to close the dialog and return to the **Exam** pane in the **Past Health Hx** tab.

9.4.2 Document a Depression Screening

Ask the Mental Health Screening questions beginning on page 694 of the CHAM.

> **Note:** The screening exam must be performed before POSITIVE or NEGATIVE can be selected in the **Result** list.

1. In the **Exams** panel click **Add** to open the **Exam Selection** dialog, as shown in Figure 9-23.

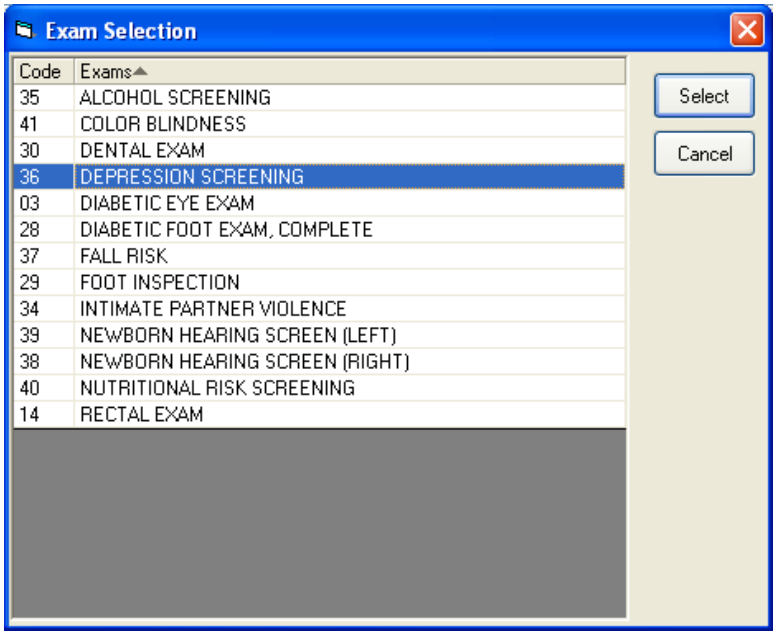


Figure 9-23: The **Exam Selection** dialog

2. Select the "**DEPRESSION SCREENING**" option.

3. Click **Select**.

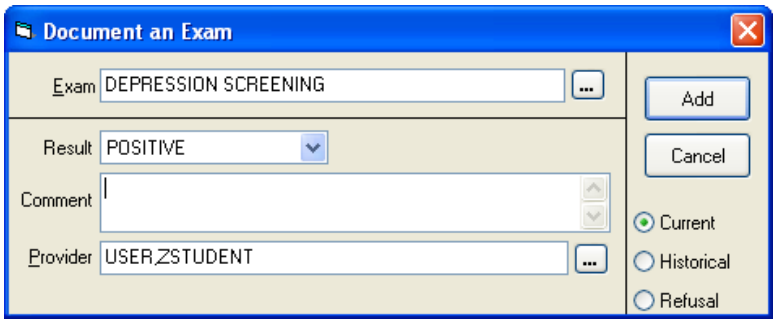


Figure 9-24: Documenting a positive depression screening

4. In the **Result** list, select "POSITIVE" or "NEGATIVE."

   - If the assessment and plan for Depression on page 699 of the CHAM is chosen, select "POSITIVE."

- If a different assessment and plan is chosen, select "NEGATIVE."

5. If "POSITIVE" was selected, type an explanation of this result in the **Comment** field.

6. Click **Add** to close the dialog and return to the **Exam** pane in the **Past Health Hx** tab.

9.4.3 Document "Unable to Screen" for Depression Screening

If a depression screening cannot be performed, follow these steps to document the situation:

1. In the **Document an Exam** dialog, select **Refusal** on the bottom right side of the dialog.

2. In the **Reason** list, click the arrow and choose "UNABLE TO SCREEN" from the list as shown in Figure 9-25.

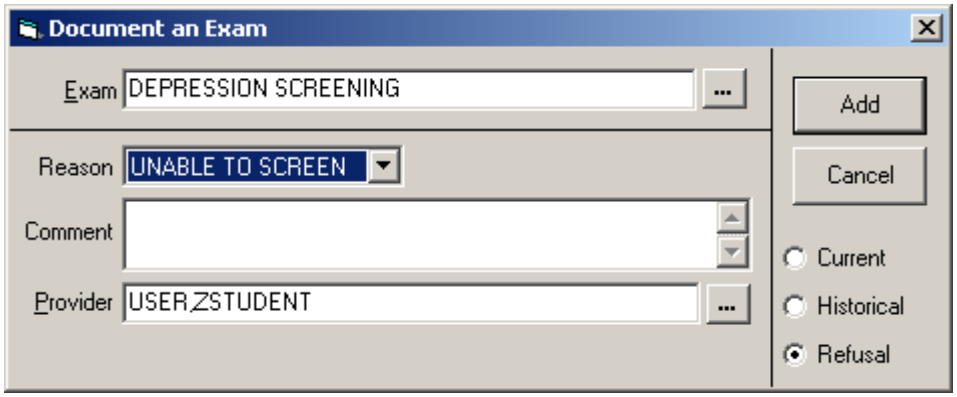


Figure 9-25: Selecting "UNABLE TO SCREEN"

3. In the **Comment** field, type a note about why a depression screening was not performed, as shown in the example in Figure 9-26:

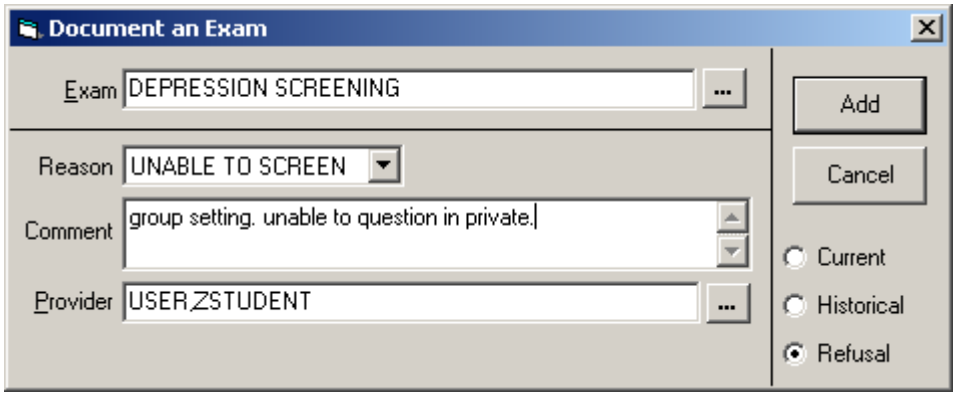


Figure 9-26: Comment entered to document "UNABLE TO SCREEN" for depression

4. Click **Add** to close the dialog and return to the **Exam** pane in the **Past Health Hx** tab.

9.4.4 Document a Refusal for Drug/Alcohol Screening

If the patient refuses to answer questions for a drug or alcohol screening, follow these steps to document the refusal:

1. In the **Exams** pane, click **Add** to open the **Exam Selection** dialog. Select "ALCOHOL SCREENING" from the list, as shown in Figure 9-27.

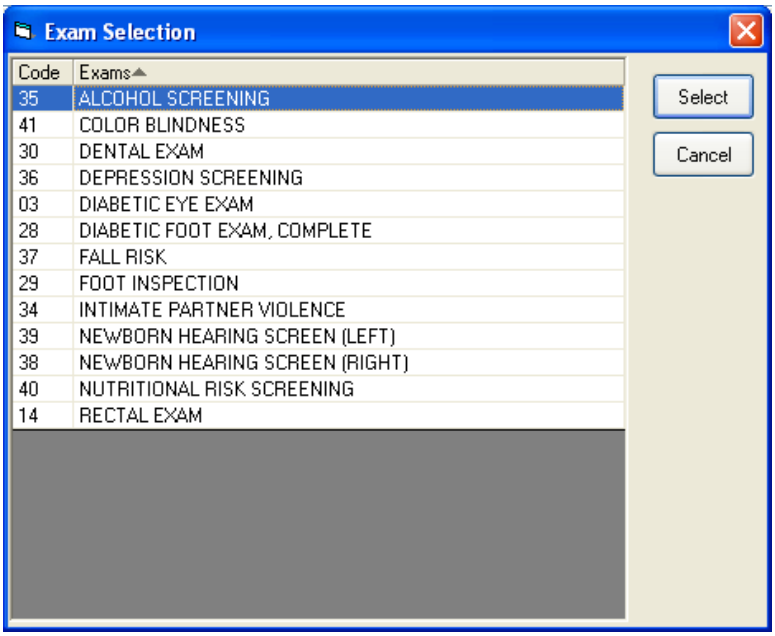


Figure 9-27: **Exam Selection** dialog

2. Click **Select** to open the **Document an Exam** dialog, as shown in Figure 9-28. The default is set to **Current**.

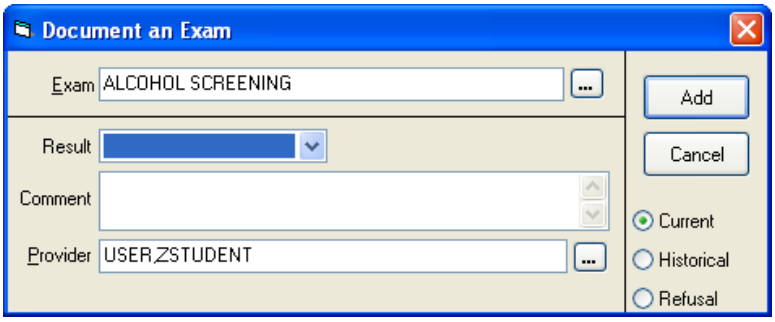


Figure 9-28: **Document an Exam** dialog

3. Select **Refusal** (located on the bottom right side of the dialog), as shown in Figure 9-29. The **Result** label changes to **Reason**.

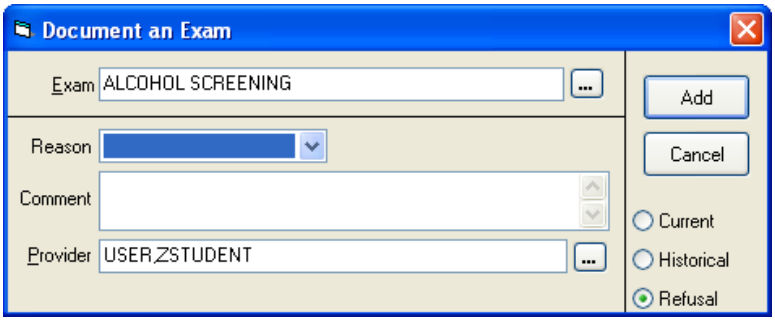


Figure 9-29: Documenting a refusal

4. In the **Reason** list, select "REFUSED SERVICE," as shown in Figure 9-30.

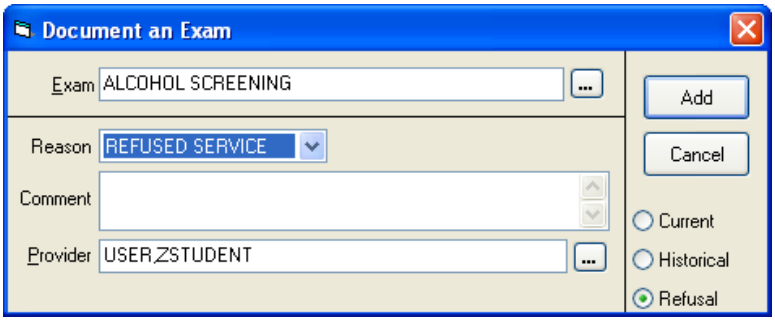


Figure 9-30: Selecting "REFUSED SERVICE" from the **Reason** field

5. If necessary, type an explanation of the patient's refusal in the **Comment** field.

6. Click **Add** to close the dialog and return to the **Exam** pane in the **Past Health Hx** tab.

9.4.5 Document a Diabetes Foot Exam

1. In the **Exams** pane, click **Add** to open the **Exam Selection** dialog.

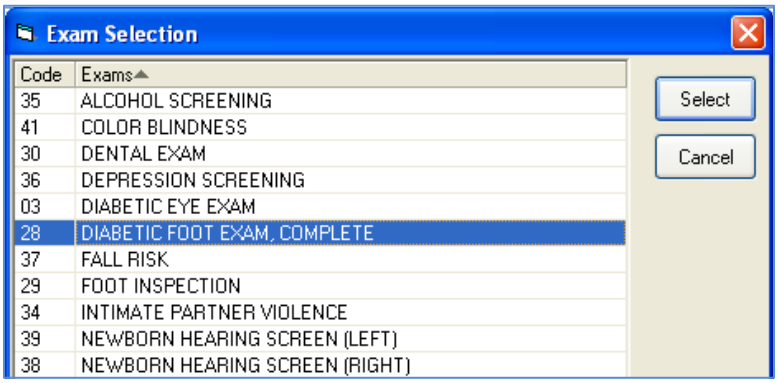


Figure 9-31: **Exam Selection** dialog

2. In the list of exams, select **DIABETIC FOOT EXAM, COMPLETE**, as shown in Figure 9-19.
3. Click **Select** to open the **Document an Exam** dialog, shown in Figure 9-20.

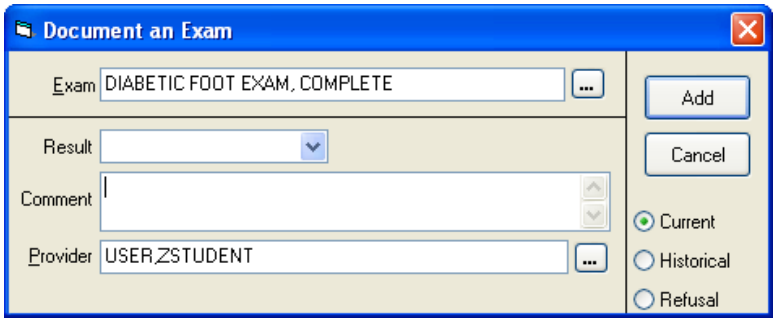


Figure 9-32: **Document an Exam** dialog

The **Exam** field at the top of the **Document an Exam** dialog contains the name of the selected exam.

4. Perform the Diabetic Foot Exam as described in the CHAM.
5. Record the results of the exam in the **Comment** field, as shown in Figure 9-22.

Leave the **Result** field blank; do not pick a result from the list.

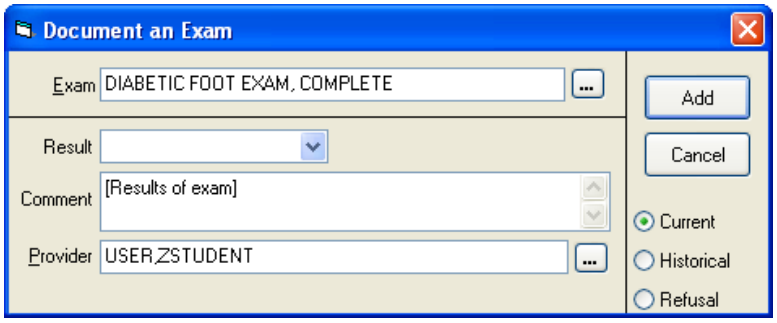


Figure 9-33: Entering comments about drug and alcohol use in the **Comment** field

6. Click **Add** to close the dialog and return to the **Exam** pane in the **Past Health Hx** tab.

9.4.6 Document an Historical Exam

Use the **Historical** button to document prior history of alcohol or drug use, or to document an exam performed at a different clinic. A historical exam that was performed at a different clinic will not typically be recorded.

If the patient has a history of drug use or alcohol use, click **Historical** to document this history.

1. In the **Exams** pane, click **Add** to open the **Exam Selection** dialog. Select "ALCOHOL SCREENING" from the list, as shown in Figure 9-34.

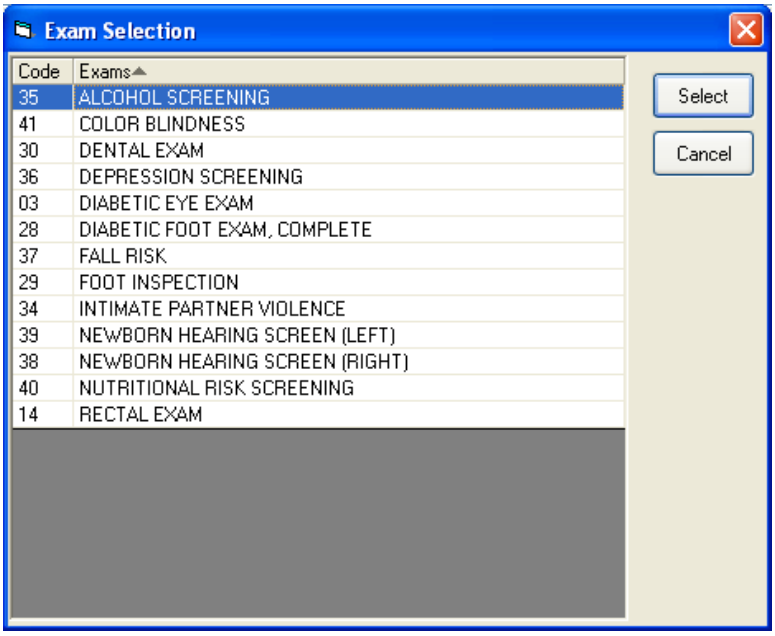


Figure 9-34: **Exam Selection** dialog

2. Click **Select** to open the **Document an Exam** dialog, and then click **Historical** to document past alcohol or drug use history, as shown in Figure 9-35.

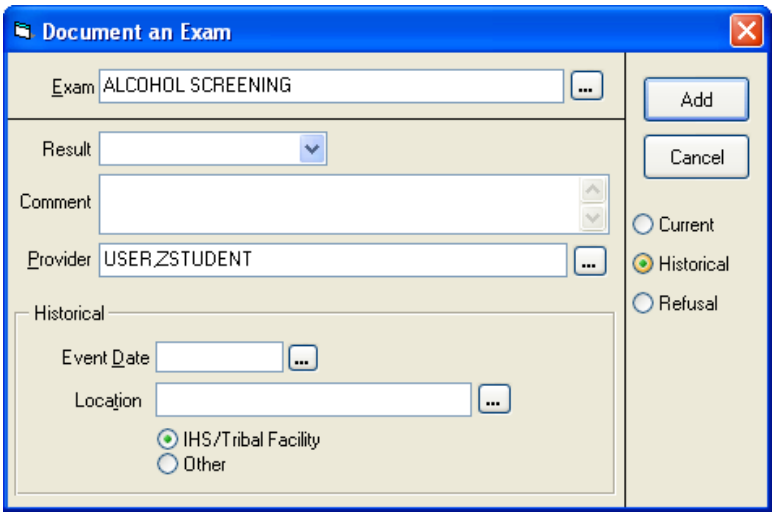


Figure 9-35: Documenting a historical exam

3. In the **Comment** field, type historical information about the patient's alcohol or drug use.

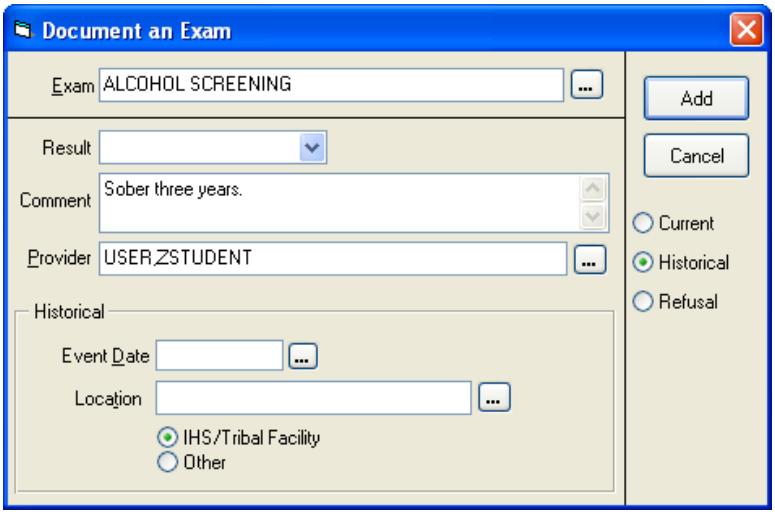


Figure 9-36: Documenting historical alcohol use

4. In the **Historical** panel, click the button beside the **Event Date** field to select a date from the Select Date/Time dialog (see Section 4.6.4).

When documenting an encounter after-the-fact, be sure to set the Date to match the date of the encounter.

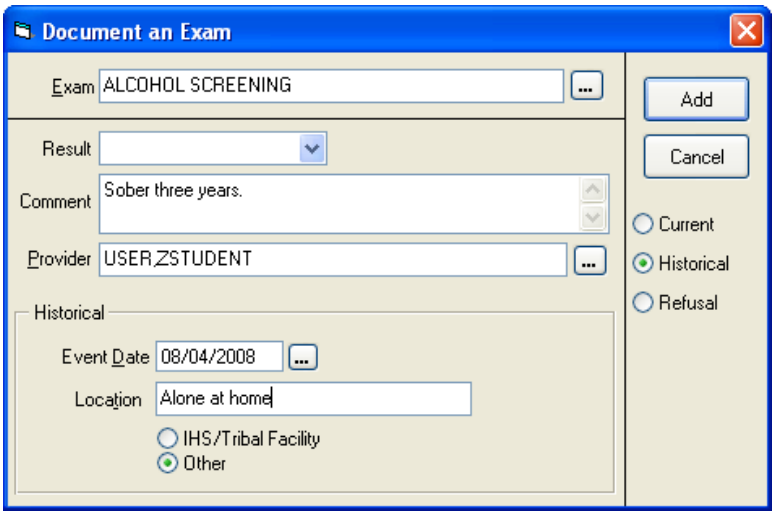


Figure 9-37: Entering location information into the **Location** field

5. Click **Other** and type the location of the patient's historical drug or alcohol use in the **Location** field.

6. Click **Add** to close the dialog and return to the **Exam** pane in the **Past Health Hx** tab.

9.5 Document Personal Health

Use the **Personal Health** pane to document a patient's patient refusal, treatment contract, and functional status (for elder care).

Figure 9-38: **Personal Health** pane of the **Past Health Hx** tab

9.6 Record Reproductive History

Use the **Reproductive History** to record important data regarding a female patient's reproductive history for the current visit. This option applies to females patients only.

1. Select the **Reproductive History** tab to display the **Reproductive Factors** pane as shown in Figure 9-39.

Figure 9-39: **Reproductive Factors** tab

Note: Though the fields on this page appear editable, they are not.

2. Click **Edit**. To display the **Update Reproductive Factors** dialog (Figure 9-40).

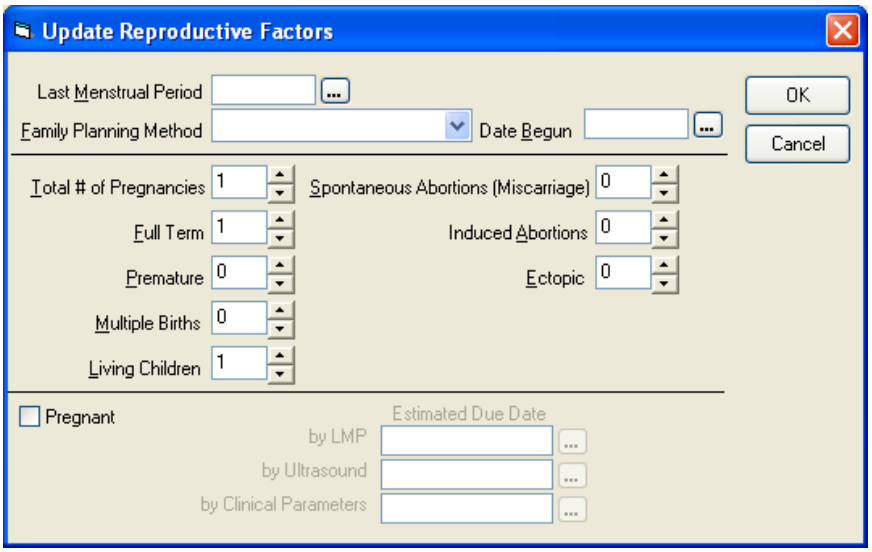


Figure 9-40: **Update Reproductive Factors** dialog

3. Fill in the fields that are applicable to the patient.

4. Select the **Pregnant** check box if the patient is pregnant. Selecting this check box activates the **Estimated Due Date** fields.

Note:	If the **Estimated Due Date** fields have been populated, and the **Pregnant** check box is unchecked, the data in the **Estimated Due Date** fields will disappear.

10.0 Update Immunization and Skin Test Records

(IMM Tab)

Use the **IMM** tab to review, edit, and add immunization information, and to update the patient's skin test history.

Prior Steps

Before reviewing and updating the patient's immunization record and skin test history, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 10-1: Example of EHR toolbar showing patient name and encounter information

The **IMM** tab contains two panes, as shown in Figure 10-2:

- The **Immunization Record** pane, which contains the **Forecast, Contraindications,** and **Vaccinations** panels**.**
- **The Skin Test History** pane.

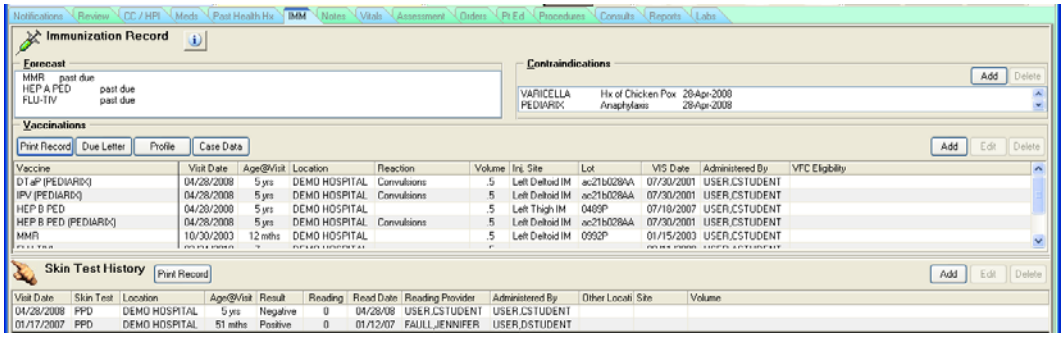


Figure 10-2: **IMM** tab

10.1 Immunization Record Pane

Use the **Immunization Record** pane to review and print the patient's immunization status and history, and to document new and historical vaccinations, refusals to be vaccinated, and any vaccine reactions and contraindications.

To review the patient's immunization status and history, click the **IMM** tab.

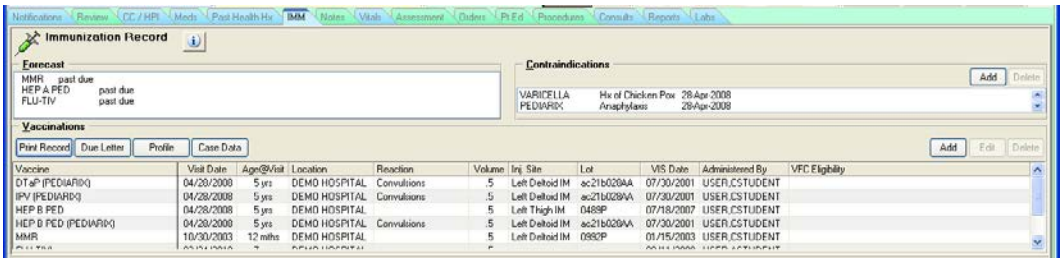


Figure 10-3: **Immunization Record** pane

The **Forecast** panel in the **Immunization Record** pane provides alerts for any vaccinations that are currently due for the patient.

- The **Forecast** panel shows a list of immunizations and skin tests that are due for the current patient.
- The **Contraindications** panel lists any known vaccine contraindications for the patient, and should be referred to prior to administering a vaccine.
- The **Vaccinations** panel lists the following information about the patient's vaccination history, as shown in Figure 10-4:
  - The name of the vaccine
  - The date of the visit at which the vaccine was administered
  - The patient's age at the time of the vaccination
  - The location of the visit at which the vaccine was administered
  - The patient's reaction to the vaccine, if any
  - The volume, injection site, and lot number of the vaccine
  - The Vaccine Information Statement (VIS) date
  - The name of the person administering the vaccination

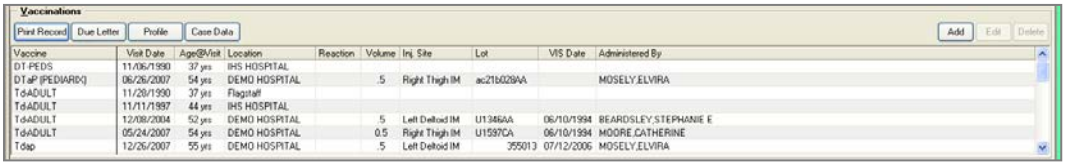


Figure 10-4: **Vaccinations** panel in the **Immunization Record** pane showing the vaccines received by a patient

10.1.1 Add a Contraindication

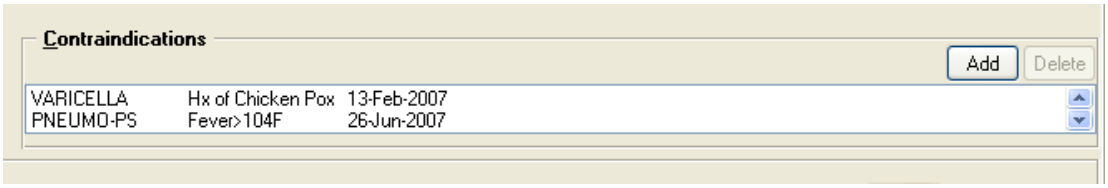


Figure 10-5: **Contraindications** panel

If the patient has a known contraindication to a vaccine, edit the patient's record to document the contraindication. All documented contraindications display in the **Contraindications** panel at the top of the **Immunization Record** pane.

1. To add a vaccine contraindication to the patient's record, click **Add** at the right of the **Contraindications** panel to display the **Enter Patient Contraindication** dialog.

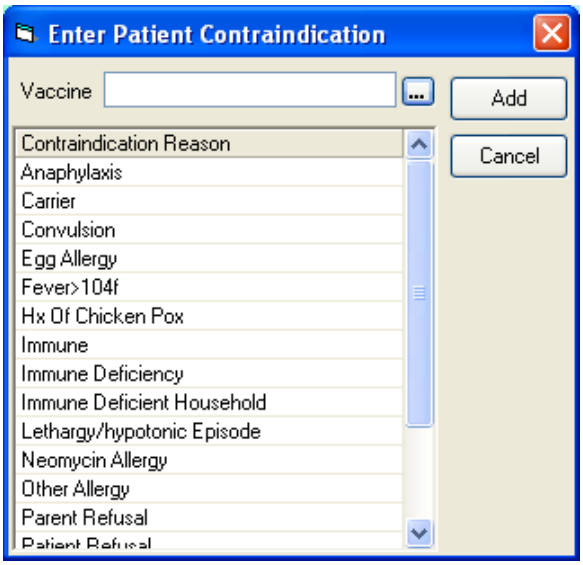


Figure 10-6: Entering a patient contraindication

2. Click the button to the right of the **Vaccine** field to display the **Immunizations** list.

3. Select a vaccine by clicking its name in the **Immunizations** list.

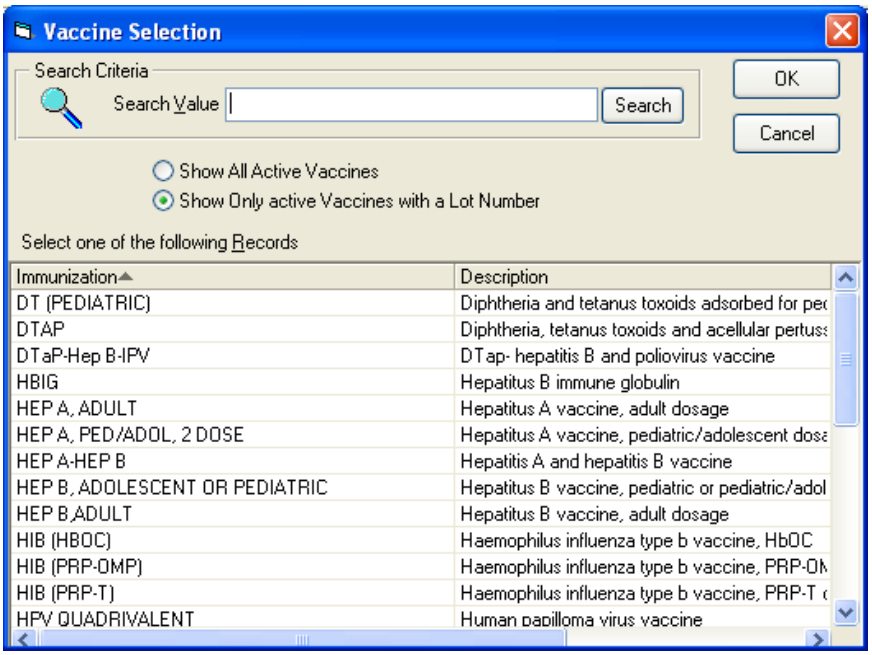


Figure 10-7: **Vaccine Selection** dialog

4. Click **OK** to return to the **Enter Patient Contraindication** dialog with the selected vaccine shown in the **Vaccine** field, as shown in Figure 10-8.

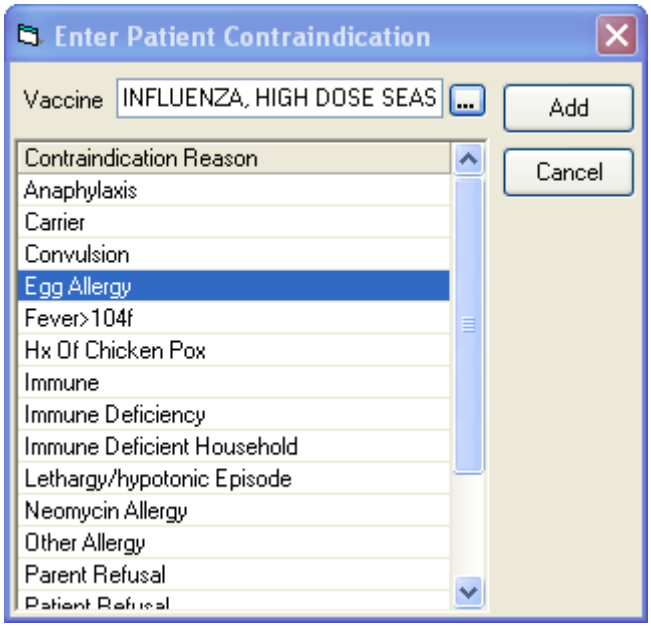


Figure 10-8: Selecting a vaccine in the **Enter Patient Contraindication** dialog

5. Select a contraindication in the **Contraindication Reason** list by clicking it.

6. Click **Add** to close the **Enter Patient Contraindication** dialog and return to the **IMM** tab.

   The new patient contraindication is displayed in the **Contraindications** panel of the **Immunization Record** pane, as shown in Figure 10-9.

Figure 10-9: A new patient contraindication in the **Contraindications** panel

> A vaccination reaction may turn into an emergency. If this is an emergency, refer to the CHAM.
>
> A severe reaction is considered an emergency. **Stop** entering data into the EHR and continue documenting the encounter on the paper PEF.

10.1.2 Document a New Immunization

10.1.2.1 From the IMM Tab

1. To add a new immunization at the IMM tab, click **Add** (located at the right of the **Vaccinations** panel) to open the **Vaccine Selection** dialog.

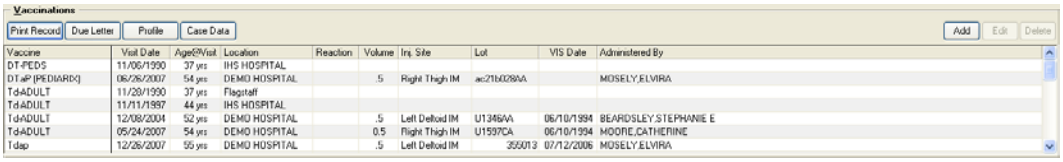


Figure 10-10: **Vaccinations** panel

2. Select a vaccine by clicking its name in the **Immunizations** list, as shown in Figure 10-11.

> **Note**: If a vaccine is absent from the vaccine list, follow procedures from the regional immunization coordinator or follow agency procedures to enter the vaccine into the system.

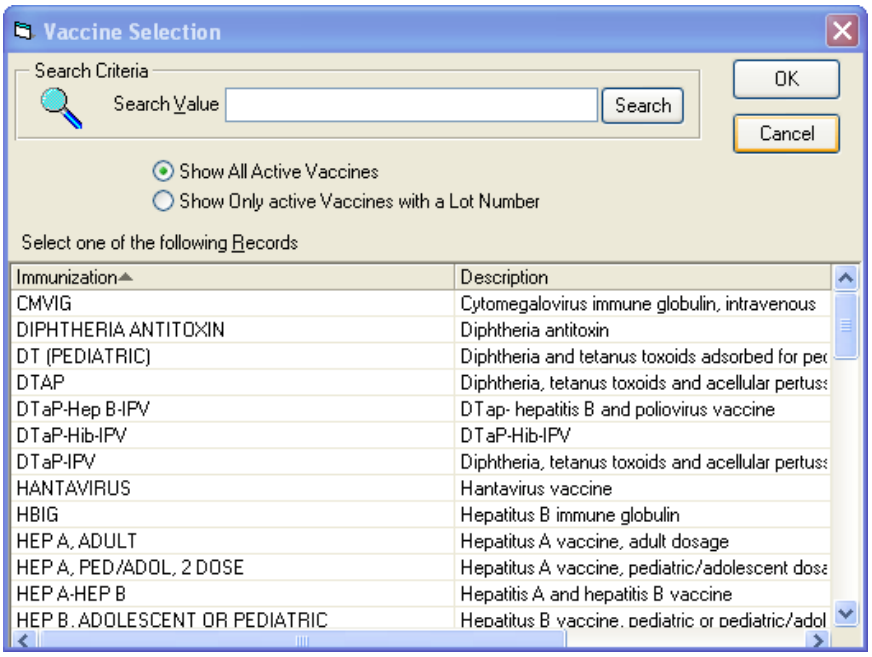


Figure 10-11: Selecting an immunization in the **Vaccine Selection** dialog

3. Click **OK** to open the **Add Immunization** dialog with the selected vaccine shown in the **Vaccine** field (See Figure 10-12).

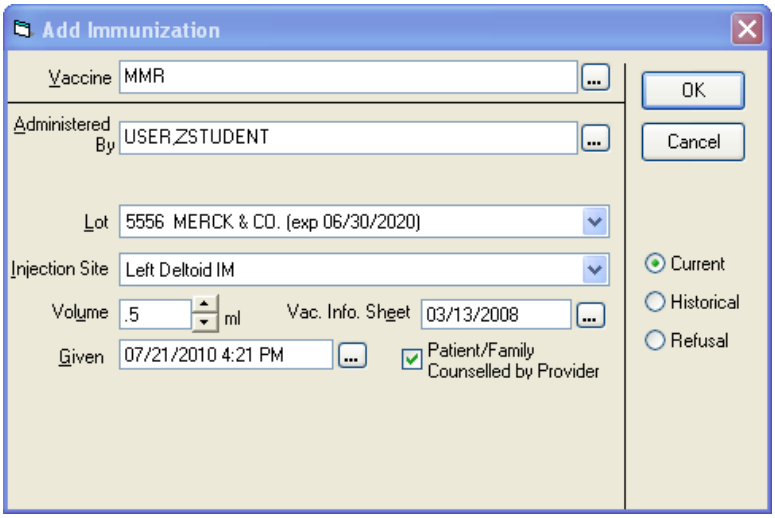


Figure 10-12: Selecting the lot number for a vaccine

Because the information in the **Add Immunization** dialog is reported to state agencies, these fields must be completed accurately.

4. To select a lot number for this vaccine, click the arrow to the right of the **Lot** field, as shown in Figure 10-12.
5. To select an injection site for this vaccine, click the arrow to the right of the **Injection Site** field, and then select the correct site from the list.
6. To specify the dose for this vaccine, click the up or down arrow next to the **Volume** field to adjust the volume in ml.
7. The date in the **Given** field automatically defaults to the current date.
    - To change the date, click **Date** (located to the right of the **Given** field) and select a new date.

When documenting an encounter after-the-fact, be sure to set the Date to match the date of the encounter.

8. Refer to the CHAM regarding patient counseling. Select the **Patient/Family Counseled by Provider** check box after following the instructions in the CHAM.
9. Click **OK** to close the dialog and save the new immunization to the patient's record.

Visit services codes (CPT codes) and procedure codes will be automatically added to their respective windows (Visit Services, and Visit Diagnoses, respectively).

10.1.2.2 From the Procedures tab

The site may document immunizations on the Procedures tab using a feature called Associations. This captures the immunization, the charge code for the vaccine and its administration, the procedure code for the vaccine, and the patient education codes defined for the procedure.

1. Select the Super-Bill that contains the immunization on the **Super-Bills** pane of the **Procedure** tab (Figure 10-13).

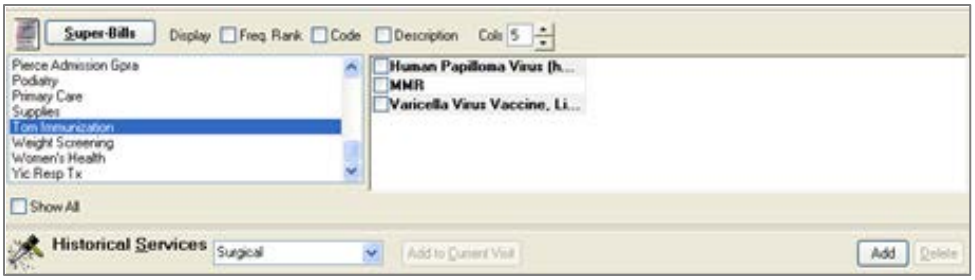


Figure 10-13: Super-Bills pane on the Procedures tab

2. Select the immunization (in the right-hand panel) to display the **Add Immunization** dialog (Figure 10-14).

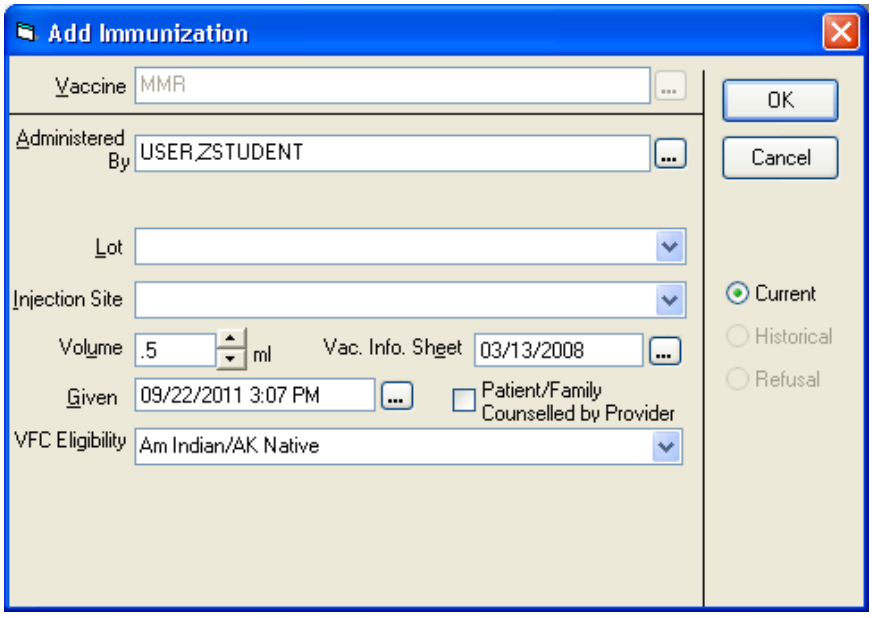


Figure 10-14: Add Immunization dialog

3. Select the **Lot** and the **Injection Site**.
4. Edit other information as necessary.
5. Click OK. The **Add Patient Education Event** dialog displays (Figure 10-15).

> **Note:** If no Patient Education Event is associated with the vaccine, this dialog is not displayed.

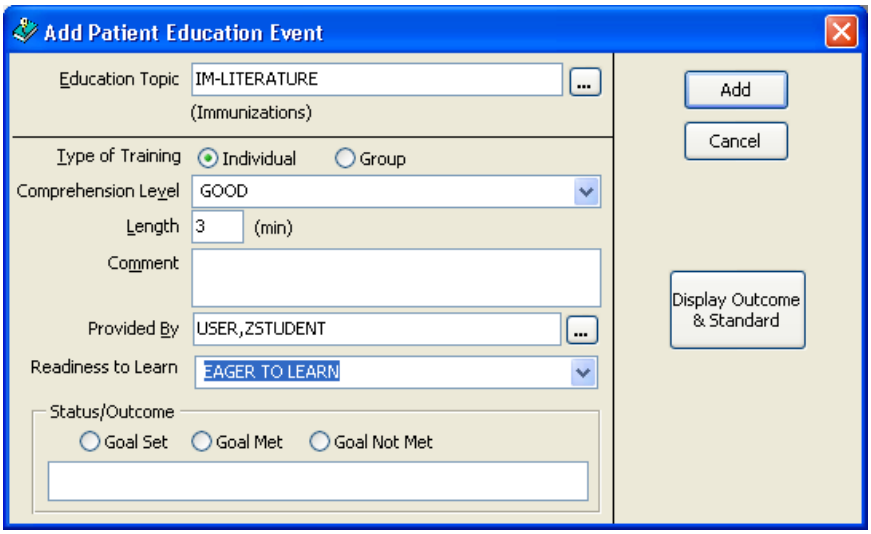


Figure 10-15: Add Patient Education Event dialog

6. Select the **Comprehension Level** and the **Readiness to Learn**.
7. Type a number indicating the **Length** of the Education Event in minutes.
8. Type a **Comment** if appropriate.
9. Click **Add**.

10.1.3 Document a Historical Vaccination

1. To add a historical immunization to the patient's record, click **Add** at the right of the **Vaccinations** panel to open the **Vaccine Selection** dialog, as shown in Figure 10-11.
2. Select a vaccine by clicking its name in the **Immunizations** list.

> **Note**: If a vaccine is absent from the vaccine list, follow procedures from the regional immunization coordinator or follow agency procedures to enter the vaccine into the system.

3. Click **OK** to open the **Add Immunization** dialog with the selected vaccine shown in the **Vaccine** field.
4. Click **Historical** to change the dialog to the **Add Historical Immunization** dialog, as shown in Figure 10-16.

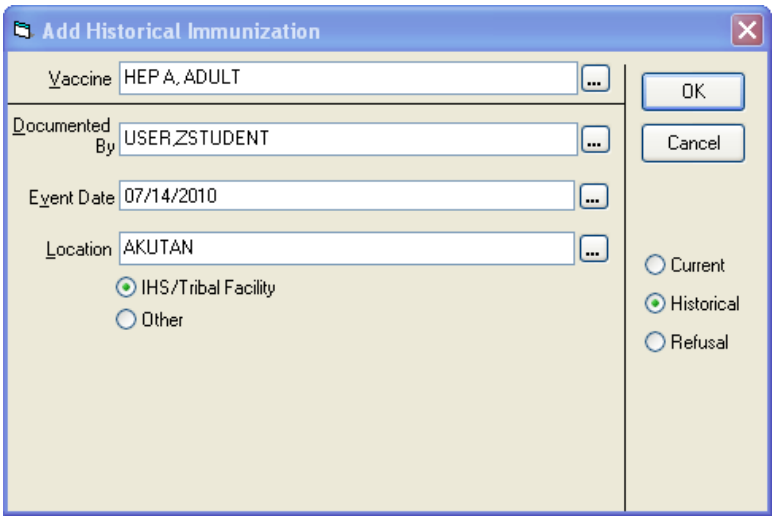


Figure 10-16: **Add Historical Immunization** dialog

5. To enter the date of the immunization, click the button to the right of the **Event Date** field and select the correct date.

> When documenting an encounter after-the-fact, be sure to set the Date to match the date of the encounter.

6. To enter the location where the immunization was given, click the button to the right of the **Location** field and select the location from the list.

7. Click **OK** to close the dialog and save the historical immunization to the patient's record.

Figure 10-17: Newly added vaccine appears in blue in the **Vaccinations** pane

10.1.4 Document a Refusal

If a vaccine was offered to a patient but the patient refused to receive it, the words "REFUSED SERVICE" appear with the vaccine's record in the **Vaccinations** panel.

1. To add a refusal to receive an immunization to the patient's record, click **Add** at the right of the **Vaccinations** panel to open the **Vaccine Selection** dialog, as shown in Figure 10-10.

2. Select a vaccine by clicking its name in the **Immunizations** list, as shown in Figure 10-11.

> **Note**: If a vaccine is absent from the vaccine list, follow procedures from the regional immunization coordinator or follow agency procedures to enter the vaccine into the system.

3. Click **OK** to open the **Add Immunization** dialog with the selected vaccine shown in the **Vaccine** field, as shown in Figure 10-18.

4. Click **Refusal** to change the dialog to the **Add Immunization Refusal** dialog, as shown in Figure 10-18.

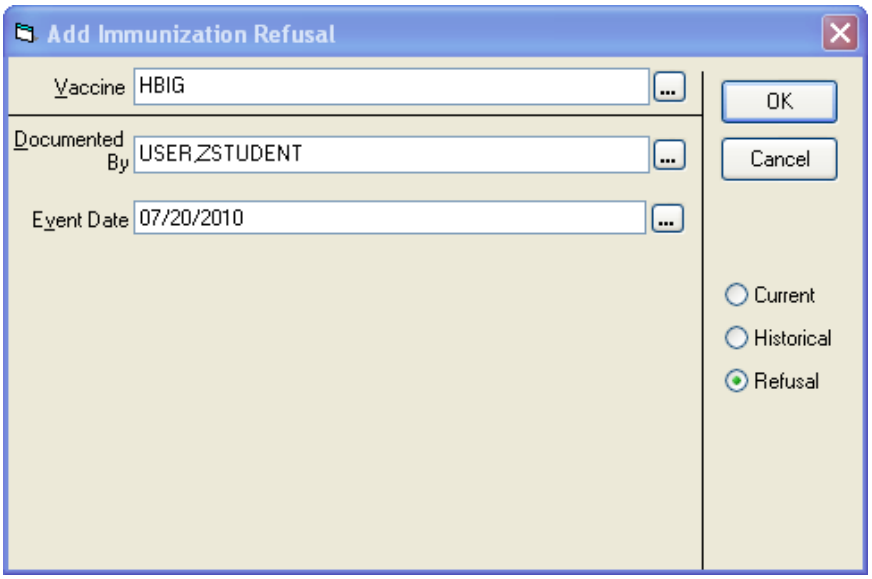


Figure 10-18: **Add Immunization Refusal** dialog

5. Click **OK** to close the dialog and save the refusal to be immunized to the patient's record, as shown in Figure 10-19.

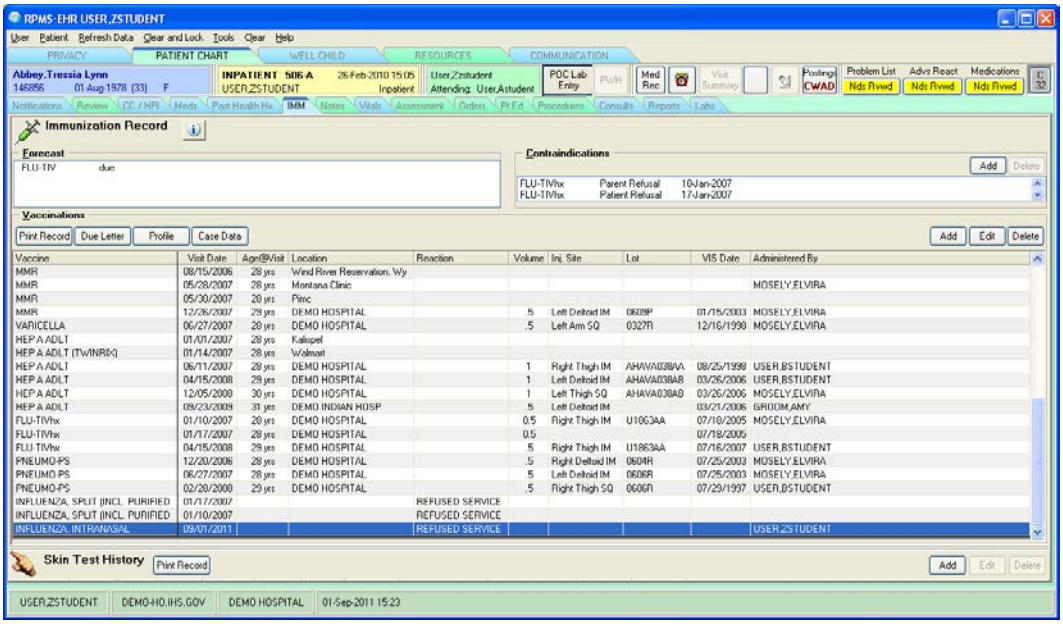


Figure 10-19: Refusal in the **Vaccinations** panel (highlighted in bottom of list)

10.1.5 Print a Vaccination Record

- To print a copy of the patient's vaccination record, click **Print Record** in the **Vaccinations** pane, to display the **Print Record** dialog, as shown in Figure 10-20.

> **Note**: Before printing a vaccination record from the EHR, the printer list must be set up by the site manager.

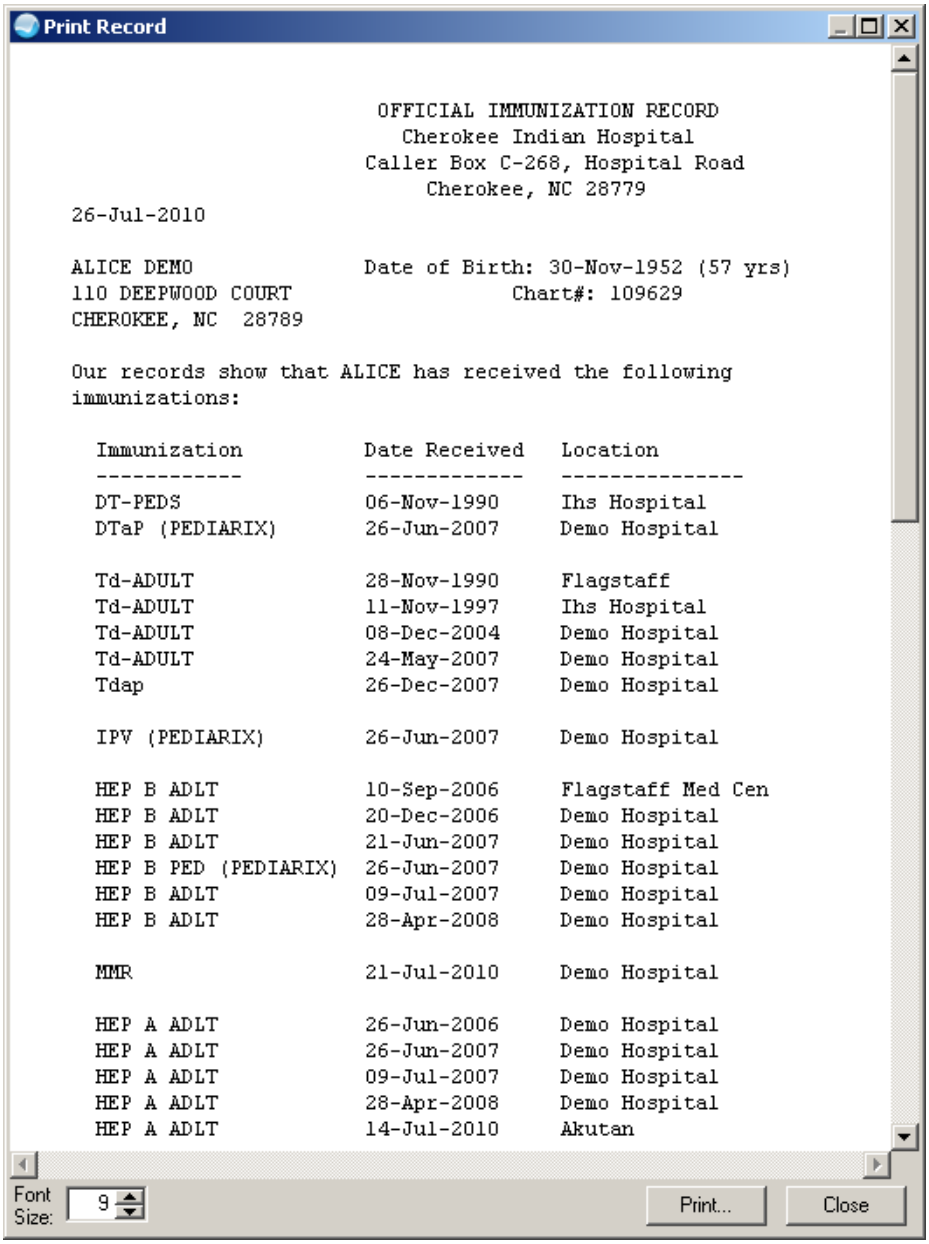


Figure 10-20: **Print Record** dialog

10.1.6 Edit a Vaccination

Vaccination records can be edited to add or update the information that was previously recorded.

Figure 10-21: **Edit** button in the **Vaccinations** panel

1. To edit a vaccine, select it by clicking its name in the **Vaccine** column, and then click **Edit** (located at the right side of the **Vaccinations** panel).
2. Edit the fields in the **Edit Immunization** dialog as required.
3. Click **OK** to close the dialog and save the edited information to the patient's record.

10.1.7 Document a Reaction to a Vaccine

If the patient has a reaction to a vaccine, edit the vaccination record to document the reaction.

1. To document a reaction to a vaccine, select the vaccine in the **Vaccinations** panel. Click **Edit** (Figure 10-21) to open the **Edit Immunization** dialog, as shown in Figure 10-22.

> **Important**:If the patient has a severe reaction, refer to the CHAM. A severe reaction is considered an emergency. **Stop** entering data into the EHR and continue documenting the encounter on the paper PEF.

2. Click the arrow to the right of the **Reaction** field, as shown in Figure 10-22.

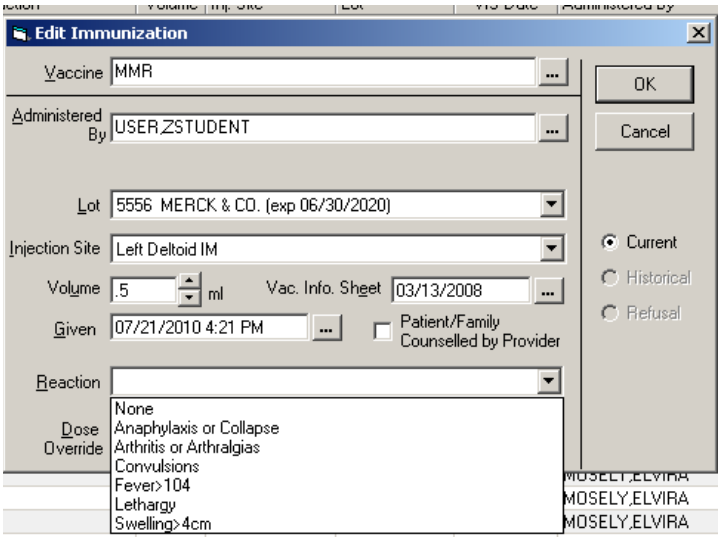


Figure 10-22: Selecting a reaction in the **Edit Immunization** dialog

3. Select the reaction from the list.

4. Click **OK** to close the dialog and save the reaction to the patient's record, as shown in Figure 10-23.

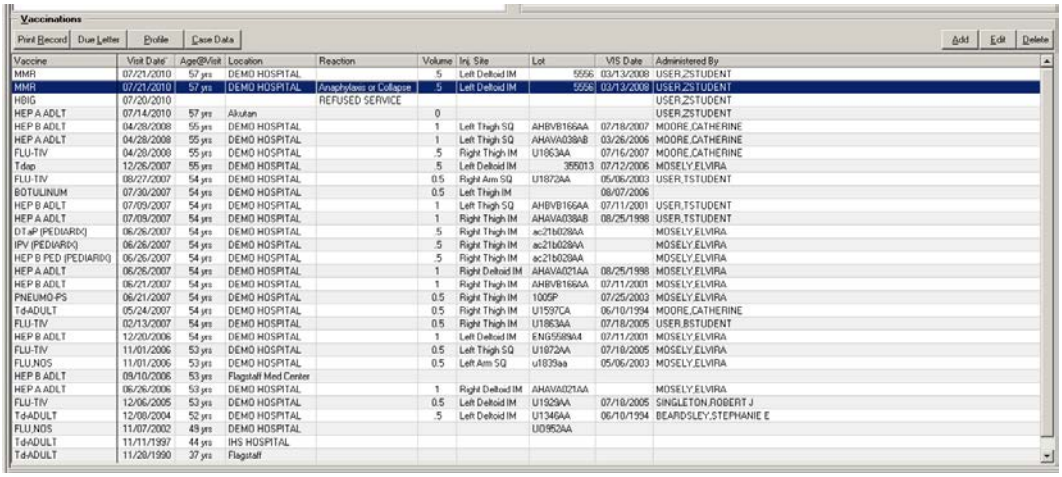


Figure 10-23: Reaction entered in the **Vaccinations** panel

10.2 Skin Test History Pane

Use the **Skin Test History** pane in the **IMM** tab to review the patient's skin test history and to document new and historical skin tests, the results of new tests, and refusals to be tested.

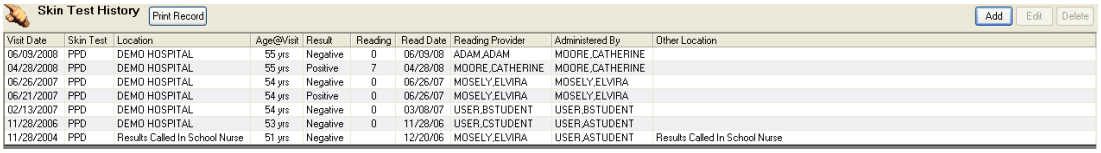


Figure 10-24: **Skin Test History** pane on the **IMM** tab

The **Skin Test History** pane lists the following information about the patient's skin test history:

- Visit Date
- Skin Test
- Location
- Age at Visit
- Result
- Reading
- Read Date
- Reading Provider

- Administered By
- Other Location

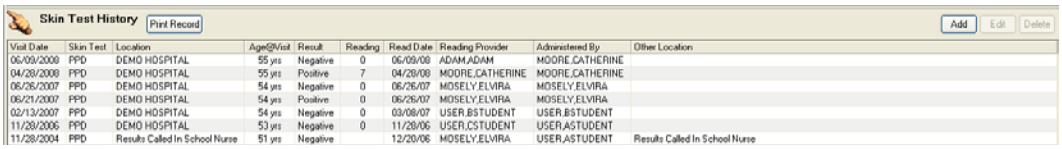


Figure 10-25: **Skin Test History** pane

10.2.1 Document a New Skin Test

1. To add a new skin test, click **Add** (located at the right in the **Skin Test History** pane) to open the **Lookup Skin Test** dialog, as shown in Figure 10-26.

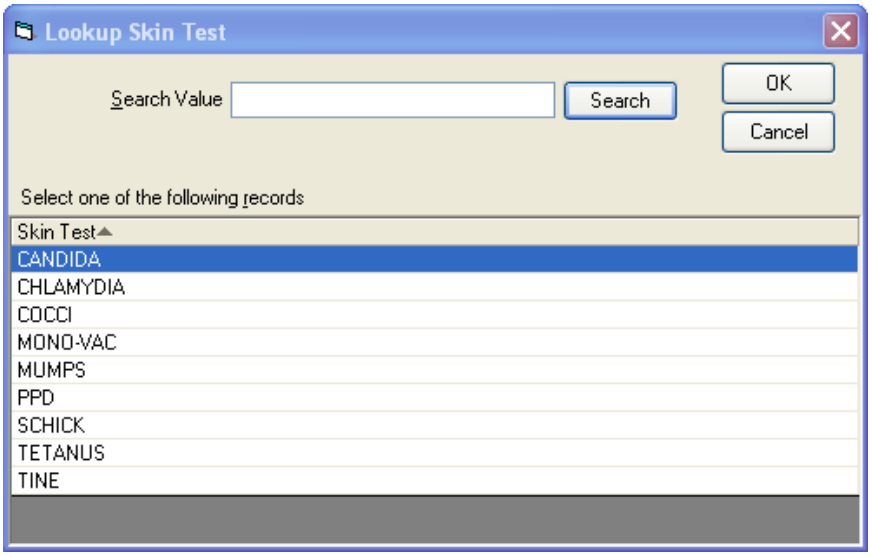


Figure 10-26: **Lookup Skin Test** dialog

2. Select the appropriate skin test by clicking it in the **Skin Test** list.
   - To find a skin test in the list, type the first few letters of the name of the test in the **Search Value** field, and then click **Search**.
   - To select the skin test, click its name.

3. Click **OK** to close the **Lookup Skin Test** dialog and open the **Add Skin Test** dialog, as shown in Figure 10-27.

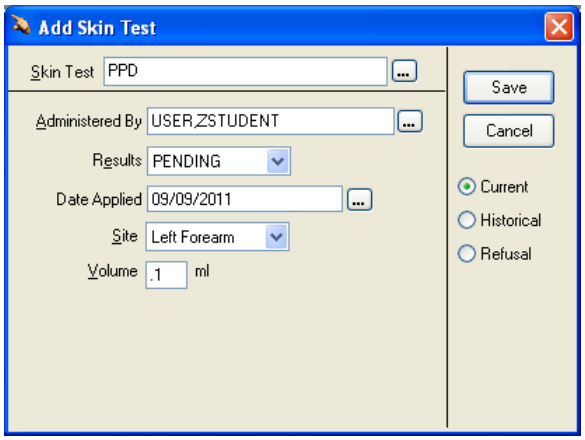


Figure 10-27: **Add Skin Test** dialog

4. Select the skin test **Site**.

5. Click **Save**.

Note: In 72 hours, edit the new skin test to record the results.

10.2.2 Record the Results of an Existing Skin Test

1. To edit an existing skin test and record the results, click on the skin test to highlight it in the **Skin Test History** pane.

2. Click **Edit** (located at the right side of the **Skin Test History** pane) to open the **Edit Skin Test** dialog, as shown in Figure 10-28.

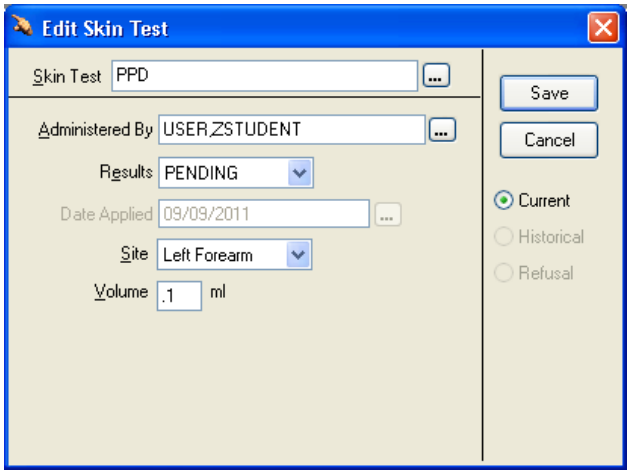


Figure 10-28: Editing a skin test

3. Select one of the **Results**. The contents of the dialog may change depending on the selection made.

4. Set the **Reading** value by clicking the arrows to the right of the **Reading** field:

   a. If the result was positive, select the size of the reaction, as shown in Figure 10-29.

   b. If the result was negative, set the value to "0".

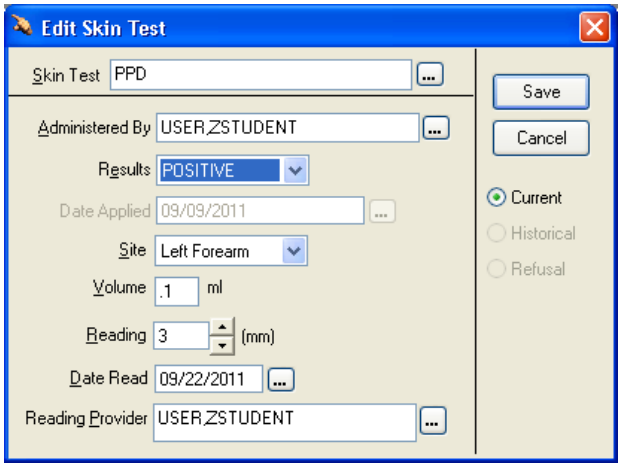


Figure 10-29: Documenting the size of a skin test reaction

5. Click **Save** to close the **Edit Skin Test** dialog and return to the **IMM** tab.

10.2.3 Document a Historical Skin Test

1. To add a historical skin test, click **Add** (located at the right of the **Skin Test History** pane) to open the **Lookup Skin Test** dialog, as shown in Figure 10-26.

2. Select the appropriate skin test by clicking it in the **Skin Test** list, as shown in Figure 10-26.

   - To find a skin test in the list, type the first few letters of the name of the test in the **Search Value** field, and then click **Search**.
   - Find the test in the list, and click its name to select it.

3. Click **OK** to close the **Lookup Skin Test** dialog and open the **Add Skin Test** dialog, as shown in Figure 10-27.

4. On the bottom right of the dialog click **Historical** to change the dialog name to **Add Historical Skin Test**, as shown in Figure 10-30.

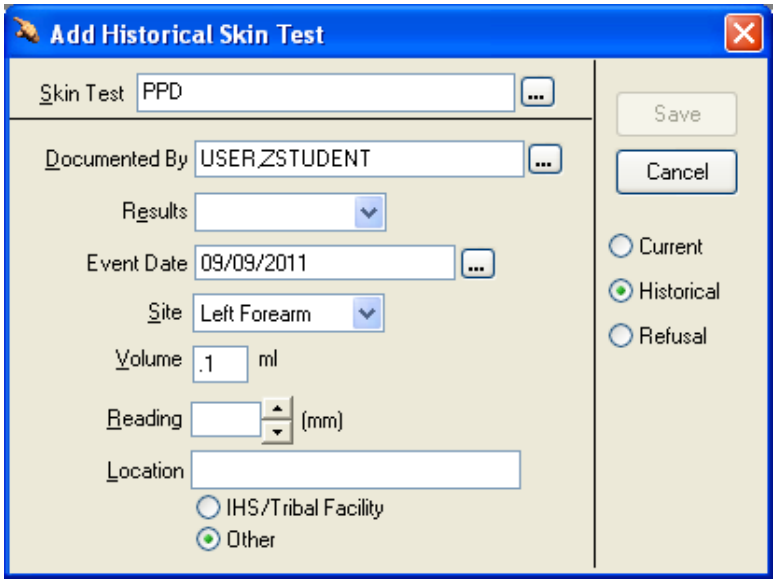


Figure 10-30: **Add Historical Skin Test** dialog

5. To select the result of the historical skin test, click the arrow to the right of the **Results** field and select the correct result from the list.

6. To enter the date of the historical skin test, click the button to the right of the **Event Date** field and select the correct date.

> When documenting an encounter after-the-fact, be sure to set the Date to match the date of the encounter.

7. Set the **Reading** value by clicking the arrows to the right of the **Reading** field:

   a. If the result was positive, select the size of the reaction.

   b. If the result was negative, set the value to "0".

8. To enter the location of the historical skin test, click the button to the right of the **Location** field and select the location from the list.

   - To search for the location where the skin test was given, click **IHS/Tribal Facility**.

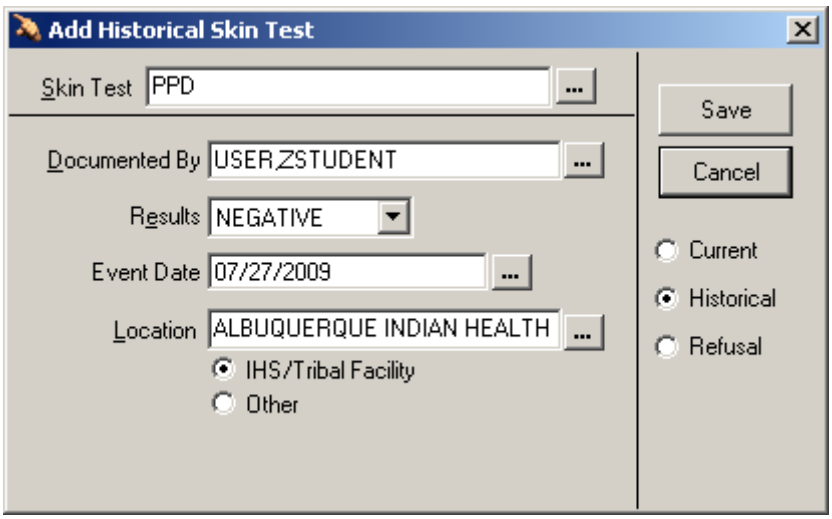


Figure 10-31: Results, date, and location added to a historical skin test

9. Click **Save** to close the **Add Historical Skin Test** dialog and return to the **Skin Test History** pane in the **IMM** tab.

10.2.4 Document a Refusal

If a skin test was offered to a patient but the patient refused to receive it, the words "REFUSED SERVICE" are displayed with the test's record in the **Skin Test History** panel.

1. To add a refusal to be tested, click **Add** (located at the right of the **Skin Test History** pane) to open the **Lookup Skin Test** dialog, as shown in Figure 10-26.
2. Select the appropriate skin test by clicking it in the **Skin Test** list, as shown in Figure 10-26.
   - To find a skin test in the list, type the first few letters of the name of the test in the **Search Value** field, and then click **Search**. Find the test in the list, and click its name to select it.
3. Click **OK** to close the **Lookup Skin Test** dialog and open the **Add Skin Test** dialog, as shown in Figure 10-27.
4. On the bottom right of the dialog click **Refusal** to change the dialog to the **Add Skin Test Refusal** dialog. The **Results** field is automatically set to "REFUSED," as shown in Figure 10-32.

When documenting an encounter after-the-fact, be sure to set the Date to match the date of the encounter.

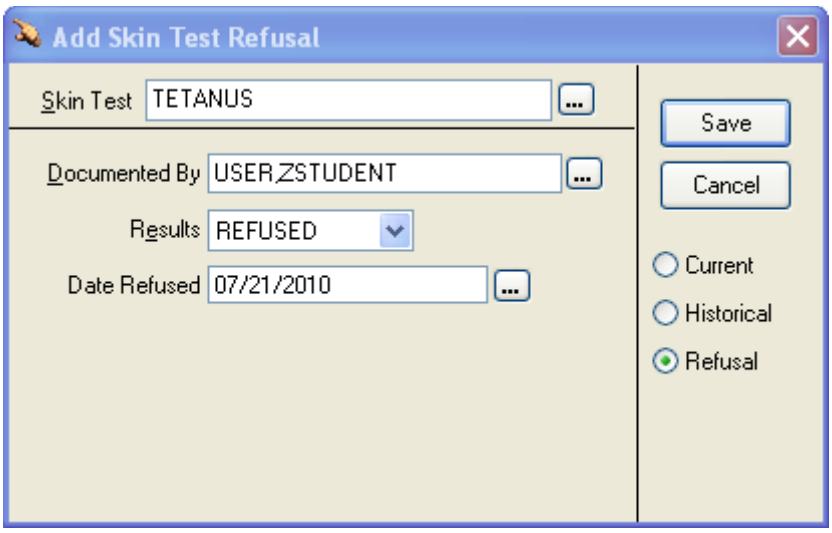


Figure 10-32: Adding a skin test refusal

5. Click **Save** to close the dialog and document that the patient refused the skin test.

11.0 Record Patient History

(Notes Tab /History Template)

11.1 About Notes and Templates

The **Notes** tab (Figure 11-1), where narrative of the care provided to the patient is documented, is similar to the Notes section on the PEF.

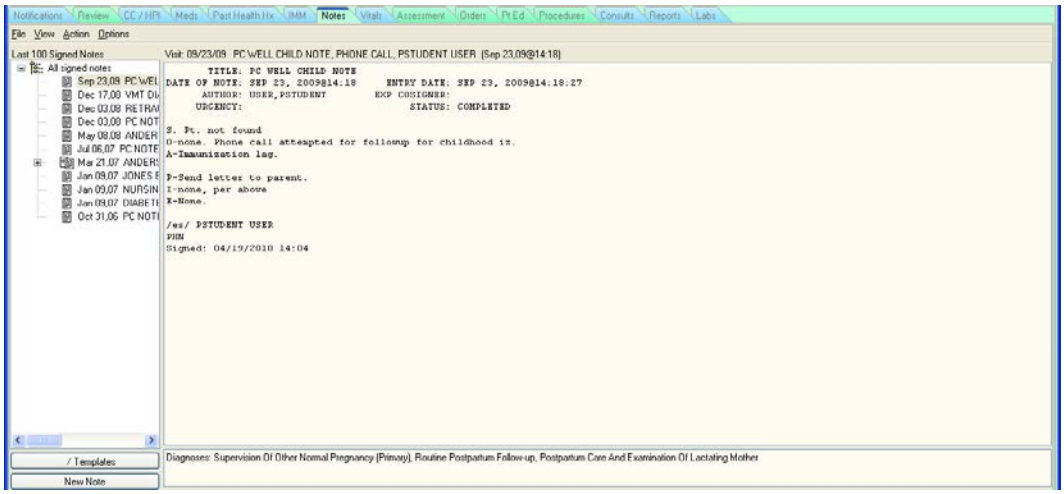


Figure 11-1: **Notes** tab

In the EHR, notes are created by filling in fields in templates. Templates are not notes, but they contain predefined text that standardizes note content. A single template can make up the entire content of a note, or sections of several different templates can be inserted into a note. One or more templates can be used when creating new notes and when editing existing notes.

11.2 The History Template

The **History** template is the first template used in the **Notes** tab. In Figure 11-2, a sample **History** template is open.

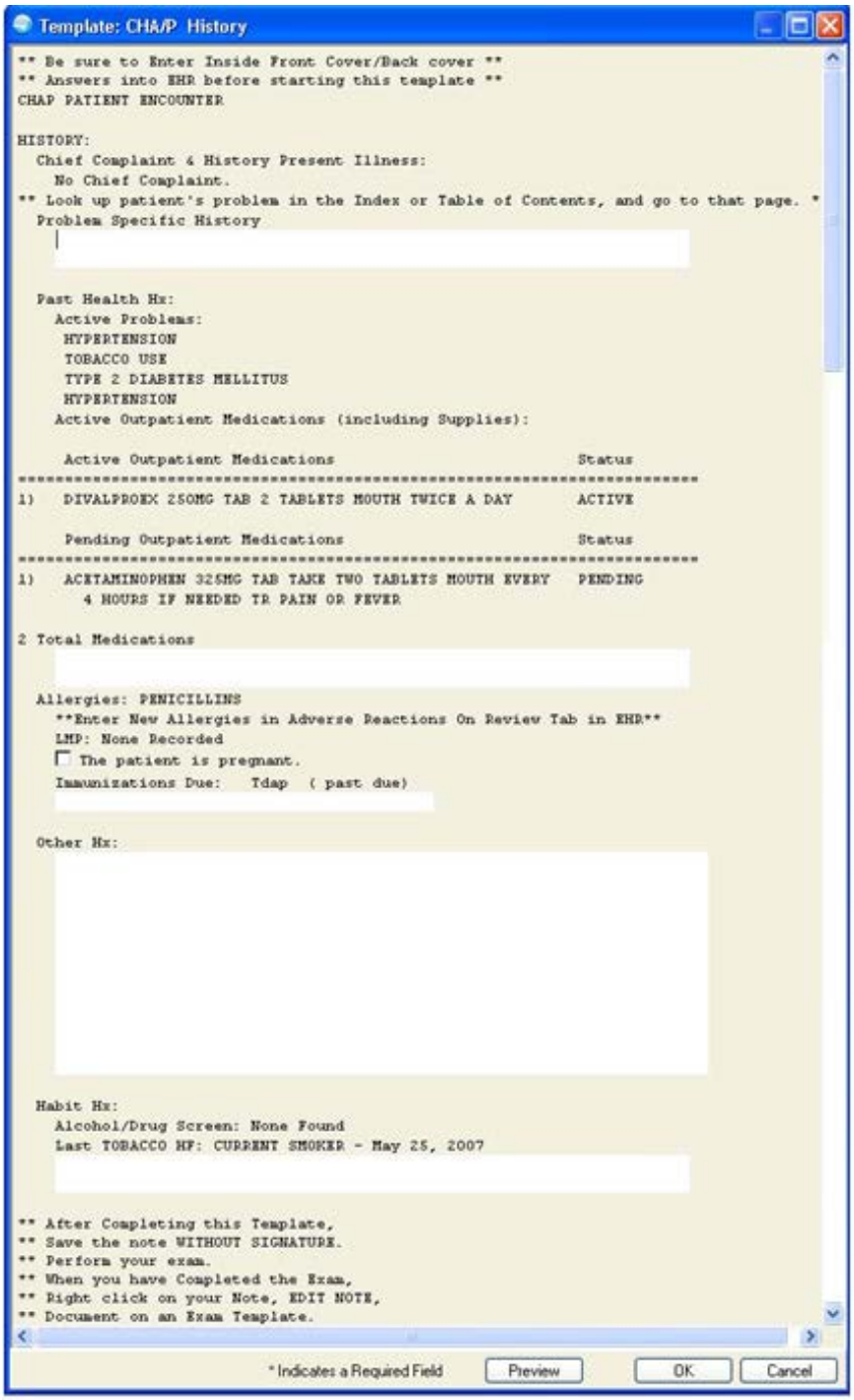


Figure 11-2: **CHA/P History** template with important instructions noted

Prior Steps

Before using the **History** template in the **Notes** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 11-3: Example of EHR toolbar showing patient name and encounter information

Ask questions from the IFC and Inside Back Cover (IBC) of the CHAM and enter the answers into the previous tabs in the EHR, then information can be entered in the **History** template in the **Notes** tab.

When the patient's history is entered into the **History** template, the information appears in the main area of the **Notes** tab. Every time information is entered and saved in a subsequent template, the new information appears at the bottom of the note in the main area of the **Notes** tab.

- To create a new note, follow the steps in Section 11.3.
- To select the **History** template for a note, follow the steps in Section 11.4.
- To fill in the fields in the **History** template, follow the steps in Section 11.5.

11.3 Create a New Note

1. In the **Notes** tab, click **New Note** at the bottom of the left column (Figure 11-4) to open the **Progress Note Properties** dialog, as shown in Figure 11-5.

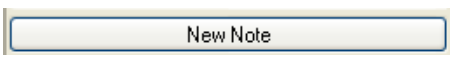


Figure 11-4: **New Note** button

2. In the **Progress Note Title** field, select **CHAP ENCOUNTER**. The **Date/Time of Note** field and the **Author** field are automatically filled with the correct information, as shown in Figure 11-5.

When documenting an encounter after-the-fact, be sure to set the Date and Time to match the date and time of the encounter.

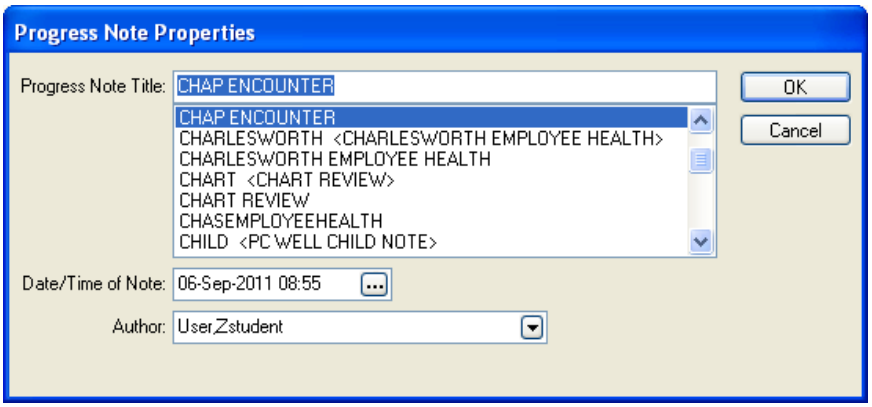


Figure 11-5: Selecting **CHAP ENCOUNTER** in the **Progress Note Title** field

3. Click **OK** to close the dialog and return to the **Notes** tab with a new CHAP ENCOUNTER note open, as shown in Figure 11-6.

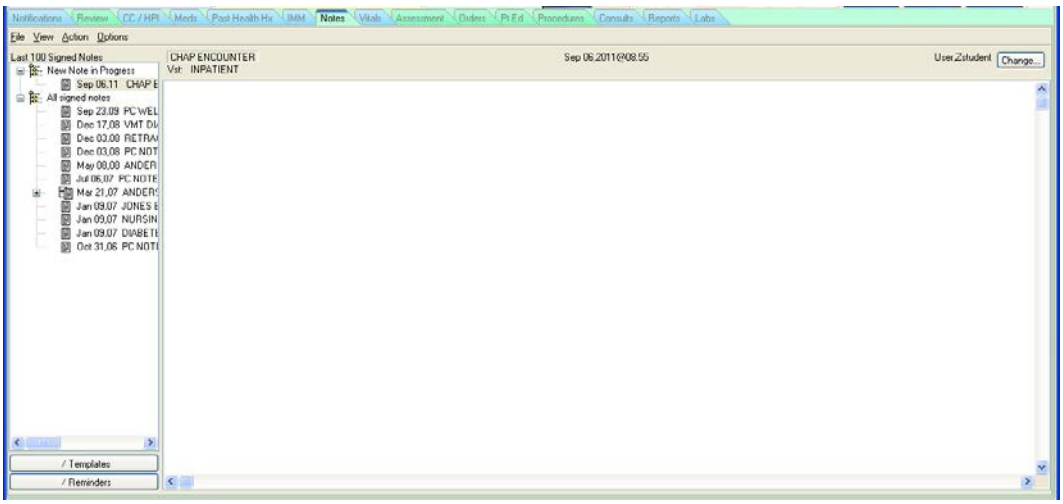


Figure 11-6: Example of a new note in progress

If an error was made when entering information into a note and the note needs to be deleted, follow the instructions in Section 11.7.

11.4 Select a Template in the Templates Drawer

The **Notes** tab contains a number of templates that can be used to create or add to notes about patient care. The templates are grouped in folders and stored in a "drawer" in the **Notes** tab, which is opened by clicking **Templates**.

> **Note:** For new EHR users, typically only the templates stored in the **General** folder in the **Templates** drawer will be used. Advanced users may be using other templates.

1. Follow the steps in Section 11.3 to create a new note. The **Templates** button appears at the bottom left corner of the **Notes** tab, as shown in Figure 11-7.

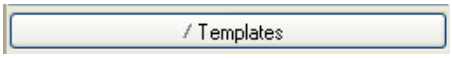


Figure 11-7: **Templates** button

2. Click **Templates** to open the **Templates** drawer, as shown in Figure 11-8.

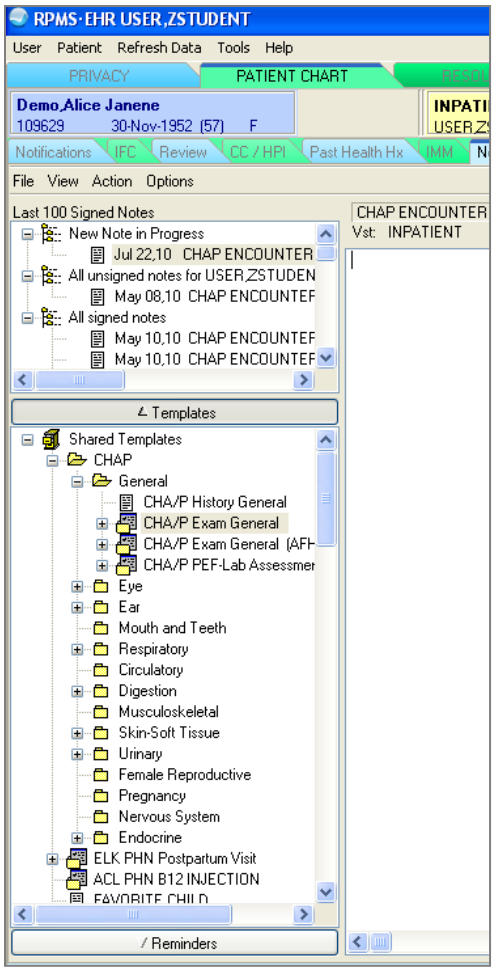


Figure 11-8: Open **Templates** drawer

The **Template** drawer contains a list of folders and templates. Folders may contain subfolders as well as individual templates. Each folder contains History, Exam, and Lab Assessment Plan templates that are specific to chapters in the CHAM.

Each template in the **Templates** drawer has an icon that looks like a piece of paper to the left of the template name.

- To see the contents of a folder, click the plus sign (+) to "expand" the folder and display the list of templates and subfolders within it.
- To hide the contents of a folder, click the minus sign (-) to "collapse" the folder and hide the list of templates and subfolders within it.

3. Click the plus sign (+) next to the **Shared Templates** folder to expand the list of templates in that folder.
4. Click the plus sign (+) next to the **CHA/P Templates** folder to expand the list of templates in that folder.
5. Click the plus sign (+) next to the **General** folder to expand the list of templates in that folder, as shown in Figure 11-9.

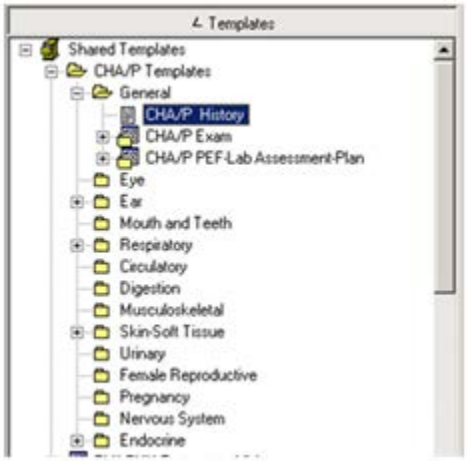


Figure 11-9: Subfolders in the **CHA/P Templates** folder

> **Note:** For new EHR users, typically only the templates stored in the **General** folder in the **Templates** drawer will be used. Advanced users may be using other templates. For example an advanced user may select the template from the **Ear** folder, if the patient has an issue with his/her ear.

6. Locate the template to use in the **Templates** drawer and click its name to open it. In Figure 11-9, the **History** template in the **General** folder has been selected.

An open **History** template is shown in Figure 11-10. The template contains standardized text as well as check boxes and fields for text to be filled in by the CHA/P.

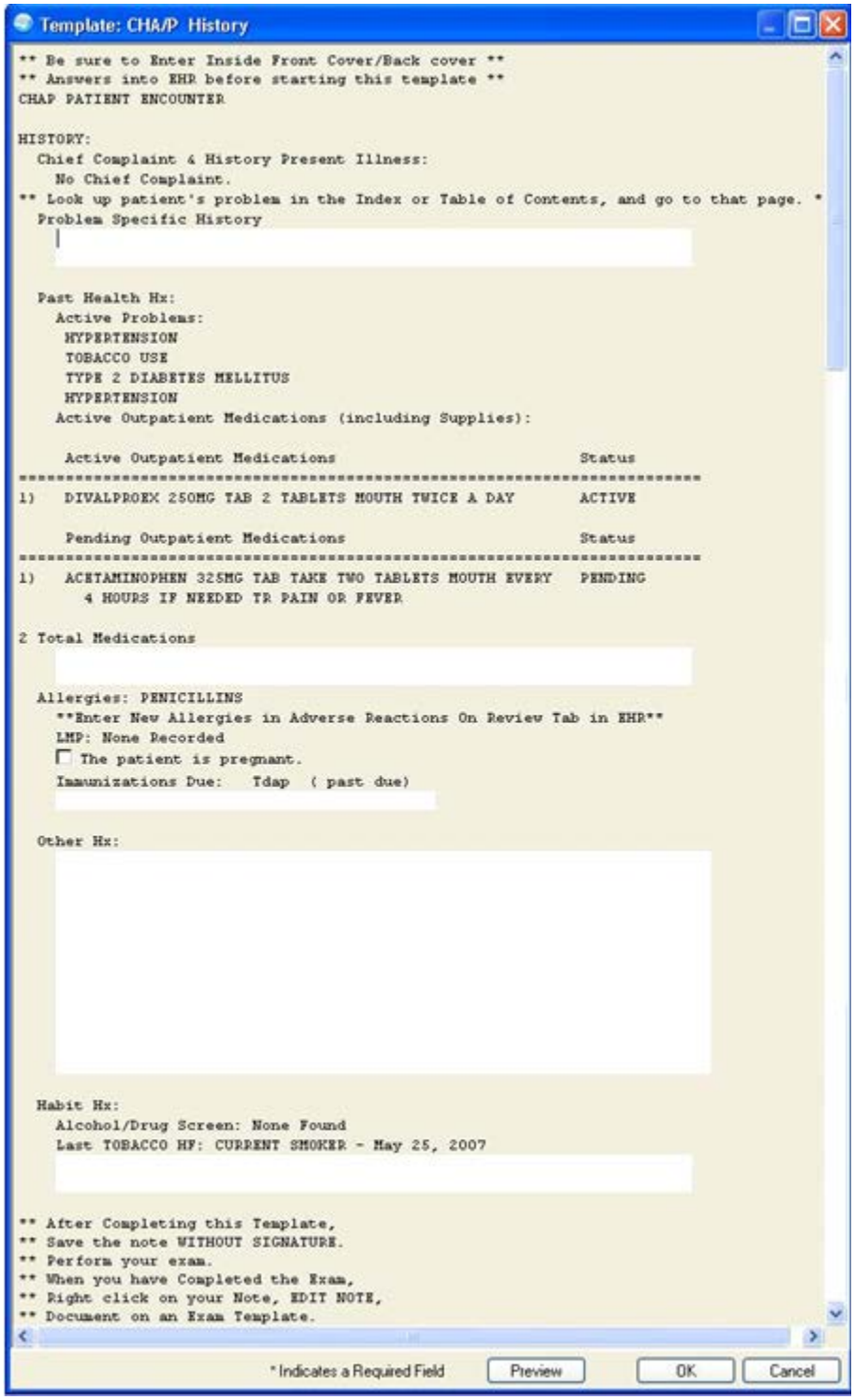


Figure 11-10: **CHA/P History Template**

11.5 Fill in the Fields in the History Template

To fill in the fields in the History template, scroll through the entire template to enter text and select check boxes that apply to the current patient encounter.

1. When the **History** template opens the cursor will be in the **Problem Specific History** field. Document the current issue for this encounter here.

2. If the patient is taking medications that are not listed in the **Active Outpatient Medication** section of the template, type the other medications in the **Total Medications** field below the list. The field is shown in Figure 11-11.

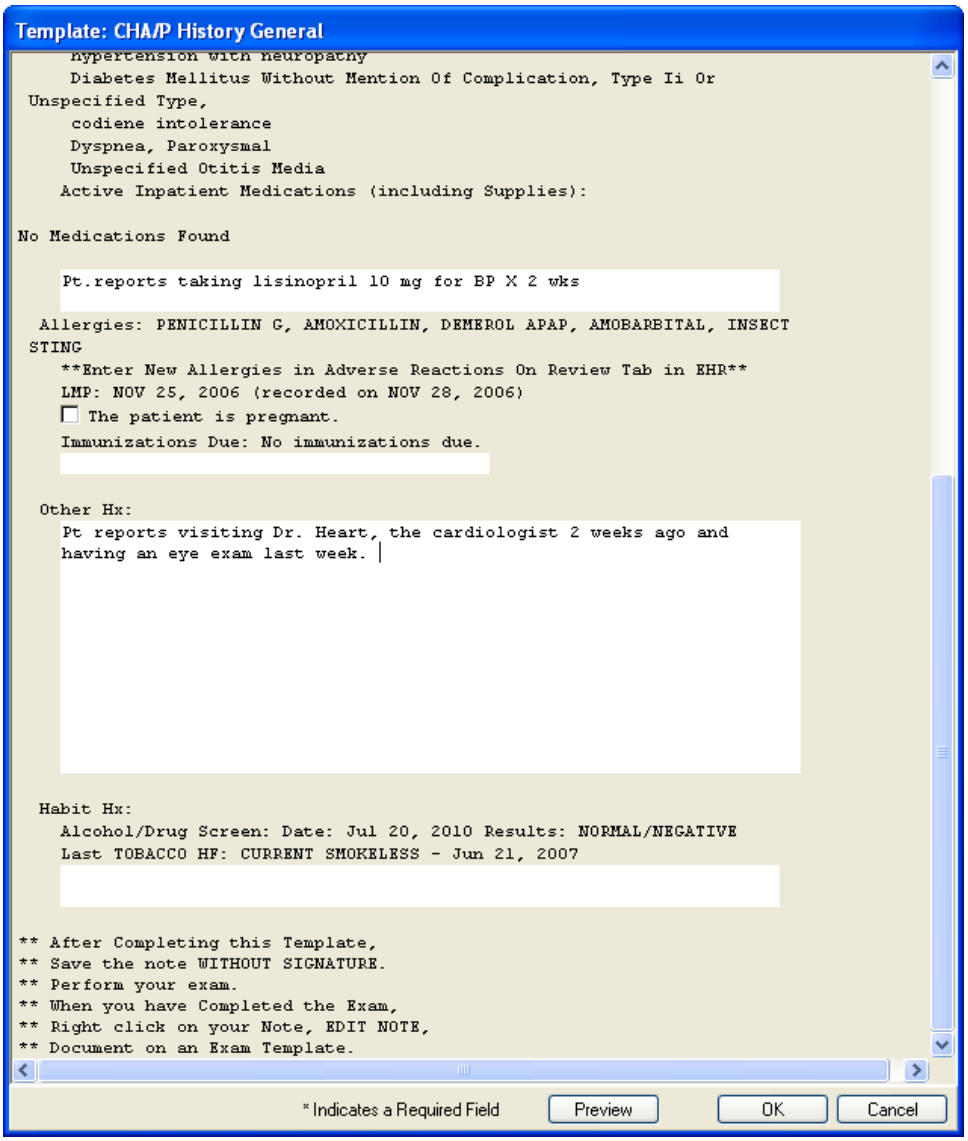


Figure 11-11: **CHA/P History** template showing list of medications and "The patient is pregnant." checkbox selected

3. If the patient is female and pregnant, select the “The patient is pregnant.” check box (Figure 11-11).

4. If the patient is due for any immunizations, the immunizations will be displayed in the **Immunizations Due** section. If there is additional information about the patient’s immunizations, document it in the field below this list.

5. Use the **Other Hx** field to enter information from the patient’s answers to the CHAM questions about chronic issues.

6. Use the **Habit Hx** field to enter additional comments about the patient’s habits regarding tobacco, drugs, or alcohol use.

7. Click **OK** (at the bottom of the **History** template dialog) to save the information and return to the **Notes** tab.

   The information entered in the **History** template is displayed in the **Notes** tab, as shown in Figure 11-12.

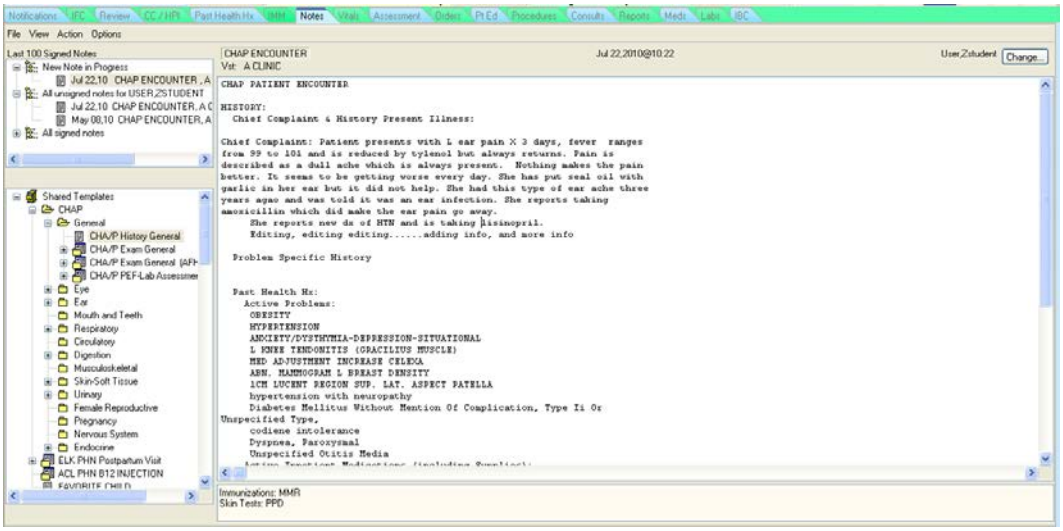


Figure 11-12: CHA/P Patient Encounter in the **Notes** tab

8. To save the information entered in the **History** template in the CHAP ENCOUNTER note, right-click in the window that contains the CHAP ENCOUNTER note to open the context menu, and then select **Save without Signature** as shown in Figure 11-13.

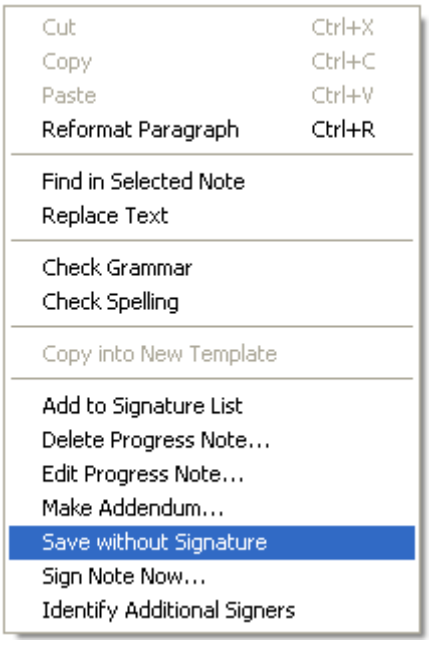


Figure 11-13: Context menu in the **Notes** tab

Important:It is important to save your work. If you accidentally go to another tab without saving, the information entered will still be in the **Notes** tab. However, it is **critical** to save the note **without** a signature.

11.6 Accidentally Clicking the OK Button

If **OK** is accidentally clicked before all information has been entered in a template, there will be an incomplete patient record. The information already entered is saved to the **Notes** tab, but the template must be opened again to be completed.

1. Follow the steps in Section 11.4 to open the template.

   The template is blank because the information that was already entered has been saved in the **Notes** tab.

2. Place the cursor in the section of the template where the new information needs to be entered and begin typing.

Important:Do **NOT** start entering information at the beginning of the template. Starting over will add duplicate information to the note.

Depending upon the template, additional editing of the note may be necessary.

Note: It is important not to click **OK** until all patient information has been entered into the template.

11.7 Delete a Note

Only unsigned notes can be deleted. To delete a note follow the steps below.

1. In the **Last 100 Signed Notes** panel (located at the top left corner of the **Notes** tab), select the unsigned note to be deleted.

2. Right-click in the main window to open the context menu, as shown in Figure 11-14.

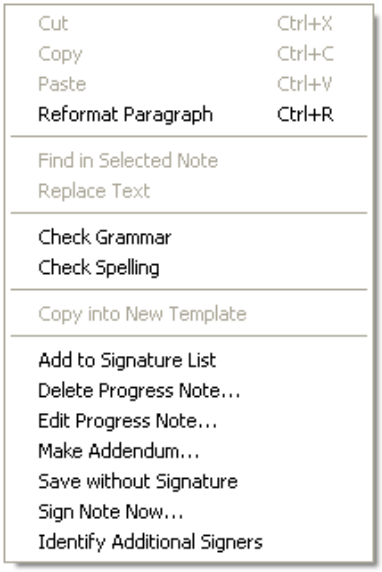


Figure 11-14: Context menu for the **Notes** tab

3. Choose **Delete Progress Note** from the context menu to open the Confirm Deletion dialog, as shown in Figure 11-15.

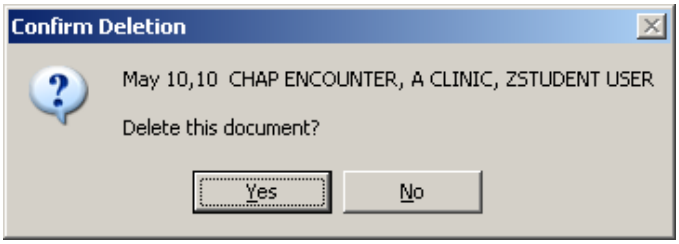


Figure 11-15: **Confirm Deletion** dialog

- To delete the note, click **Yes**.
- To cancel the deletion and return to the **Notes** tab, click **No**.

11.8 The Context Menu for the Notes Tab

Right-clicking anywhere in a note on the right side of the **Notes** tab opens the context menu. The following options are on the context menu.

Option	Action
Add to Signature List	Places the unsigned note with other orders and documents to be signed for the current patient on the **Notifications** tab
Delete Progress Note	Deletes an existing *unsigned* progress note
Edit Progress Note	Opens an existing *unsigned* progress note to be edited
Make Addendum	Opens an existing *signed* progress note to add information
Save without Signature	Saves the current progress note *without signing it*. This allows the note to be edited or deleted it at another time.
Sign Note Now	Saves *and signs* the note, showing that the note is complete
Identify Additional Signers	Designates additional signers for the progress note

12.0 Record Vital Signs

(Vitals Tab)

Use the **Vitals** tab to enter and review vital sign measurements, such as Pain, Temperature, Pulse, Respirations, O2 Saturation, Blood Pressure, Weight, Height, Vision Corrected, Vision Uncorrected, Head Circumference, Fundal Height, Fetal Heart Tones, and Body Mass Index.

In the **Vitals** tab, it is possible to graph a range of selected measurements to review a patient's vitals over a period of time.

Prior Steps

Before using the **Vitals** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 12-1: Example of EHR toolbar showing patient name and encounter information

The left side of the **Vitals** tab lists the values for the last set of vitals taken for the patient in columns labeled **Vital**, **Value**, and **Date**, as shown in Figure 12-2. This list can be sorted by the name of the vital, the value, or the date by clicking one of the column headers.

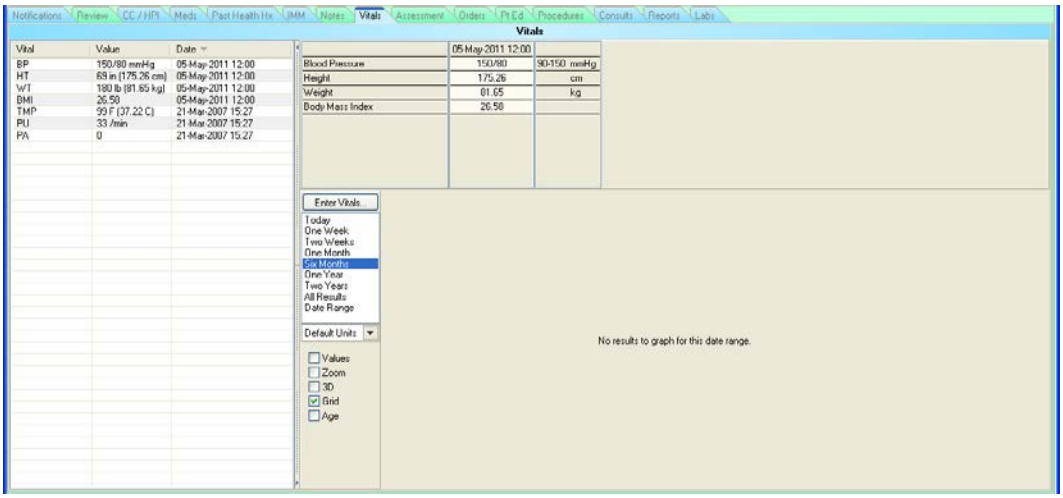


Figure 12-2: **Vitals** tab and the **Enter Vitals** button

The right side of the **Vitals** tab shows a grid containing the values of all vitals taken for the patient over a specified date range (Figure 12-2 shows vitals over a six-month period). A scroll bar appears below the list if there are too many dates in the range to fit in the available space.

- To see vitals taken over a different date range, select the range from the list under the **Enter Vitals** button.
- To add new vitals for the patient, see Section 12.1.
- To see a graph of a selected vital over a period of time, see Section 12.5.

12.1 Record Vitals

1. On the **Vitals** tab, click **Enter Vitals** to open the **Vital Measurement Entry** dialog, as shown in Figure 12-2.

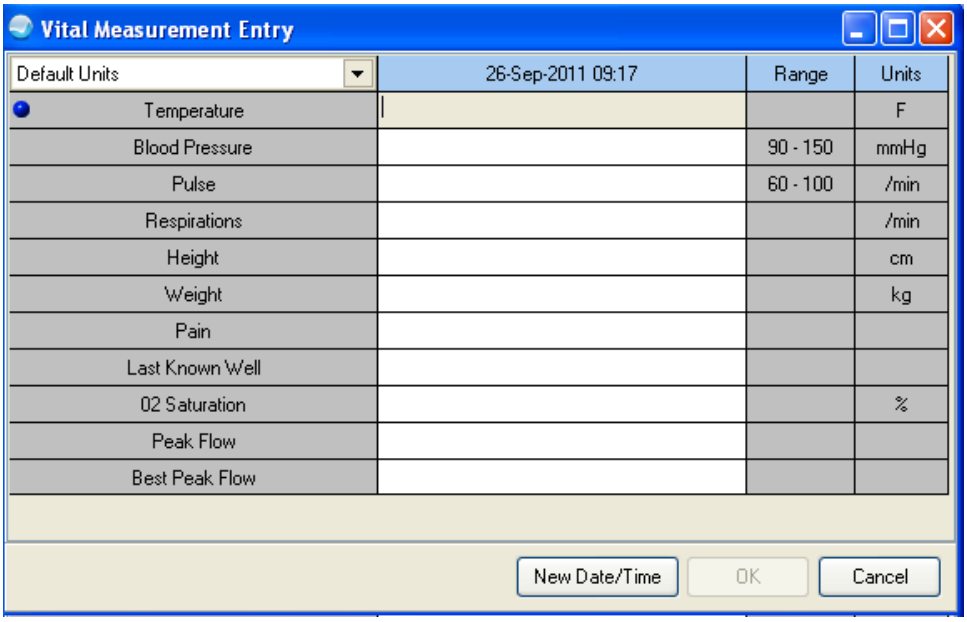


Figure 12-3: **Vital Measurement Entry** dialog

If the patient's **Vitals** pane contains the heading, **No Vitals Found**, the **Enter Vitals** button is not available:

a. Right-click within the pane.

b. Select **Enter Vitals** from the context menu.

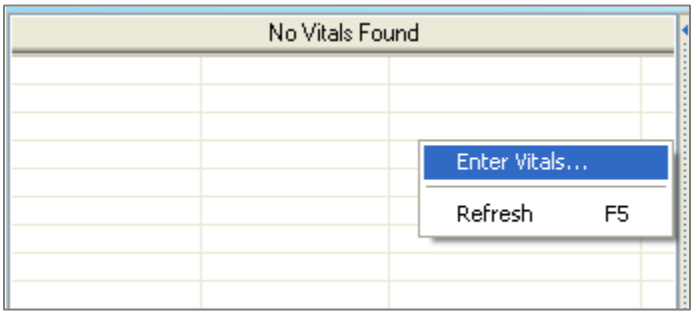


Figure 12-4: Vitals pane with Enter Vitals selected on the Context menu

> **Note**: The EHR regional team determines the list of vital signs available in the **Vital Measurement Entry** dialog. Vital measurements can be displayed using either US units or Metric units. To change the units displayed in the **Vital Measurement Entry** dialog click the arrow next to the **Default Units** field and select "US Units" or "Metric Units."

2. In each field, type the vital measurements taken during the current patient encounter. After each measurement is entered, the field changes to yellow.

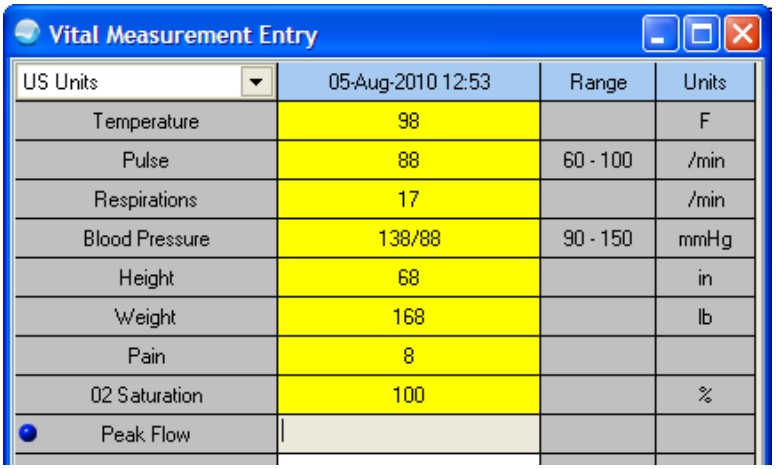


Figure 12-5: Entering new vitals

- If a measurement that is out of the reference range is entered, an error message is displayed. See Figure 12-6.

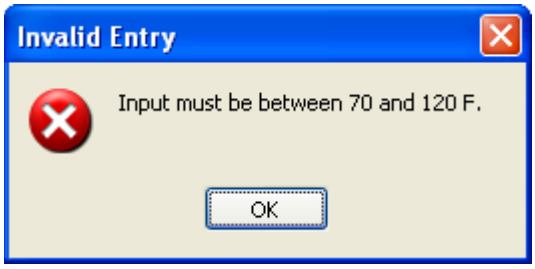


Figure 12-6: **Invalid Entry** dialog

- The patient's body mass index (BMI) is calculated automatically after entering his or her weight and height. The calculated BMI is shown in the list of vitals on the left side of the **Vitals** tab.

3. After all relevant vitals have been recorded, click **OK** to close the dialog and return to the **Vitals** tab.

   The measurements entered are displayed in the top portion of the right side of the tab.

12.2 Record a Second set of Vitals during the Same Visit

To enter more than one measurement during a visit (for example, a second blood pressure measurement):

1. Click **New Date/Time** to display the **Select New Date/Time** dialog (Figure 12-7).

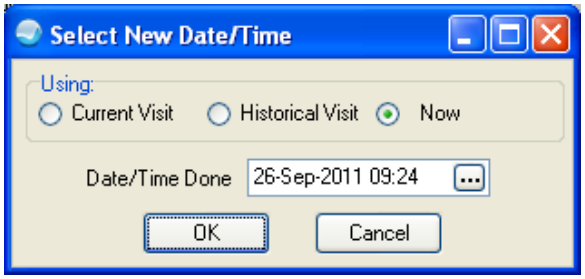


Figure 12-7: **Select New Date/Time** dialog

2. Select the appropriate **Using** option:

   - **Current Visit** sets **Date/Time Done** to match the start of the current visit.
   - **Historical Visit** displays a dialog where an Historical Visit can be selected.
   - **Now** sets **Date/Time Done** to the current date and time.

   Alternatively, click ellipses **[…]** to open the **Select Date/Time** dialog and pick some other date and time.

> When documenting an encounter after-the-fact, be sure to set the Date and Time to match the date and time of the encounter.

3. Click **OK** to close the dialog and to redisplay the **Vital Measurement Entry** dialog with a new entry column to the right of the first one.

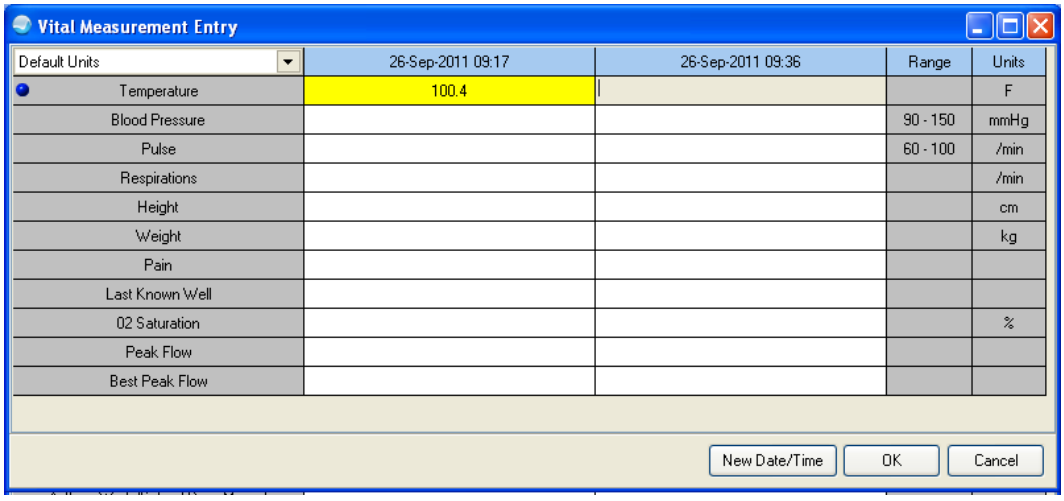


Figure 12-8: **Vital Measurement Entry** dialog with second column added

> **Note:** If the date or time is incorrect, edit it by clicking the Date/Time at the top of the column.

12.3 Record Vision

Snellen results are documented in the **Vital Measurement Entry** dialog in either the **Vision Corrected** or **Vision Uncorrected** field depending upon testing performed with the patient either wearing or not wearing contacts/glasses.

Only document the bottom number, the 'top' 20 is assumed. Always document the right eye first. For example, if the patient is wearing glasses, results are recorded in the **Vision Corrected** field. If the value for the right eye test is 20/40 and left eye test is 20/15, document the findings as 40/15, as shown in Figure 12-9.

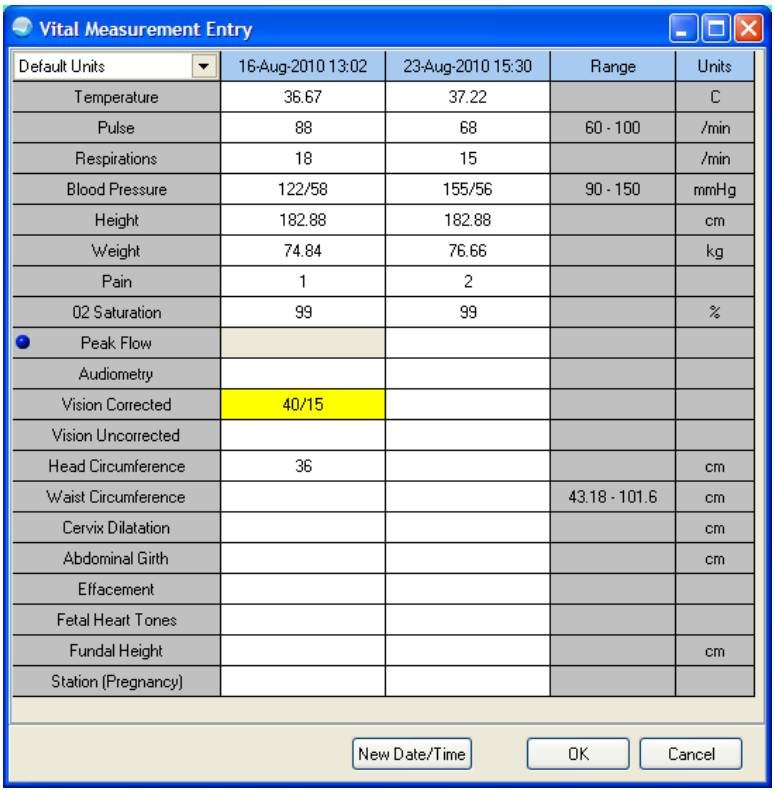


Figure 12-9: Entering Vision Corrected information

12.4 Record Head Circumference

Enter the head circumference in metric units.

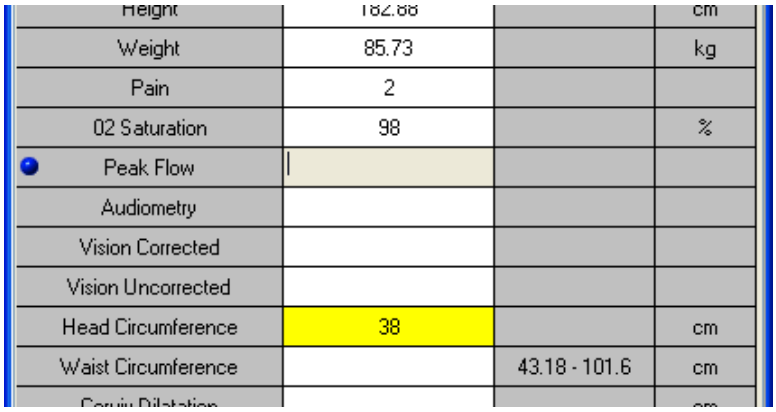


Figure 12-10: Entering head circumference

12.5 Graph Vitals

On the right side of the **Vitals** tab, the area below the grid shows a graph of the values for a selected vital over the same period shown in the grid. Figure 12-11 shows a graph of blood pressure measurements taken over a six-month period.

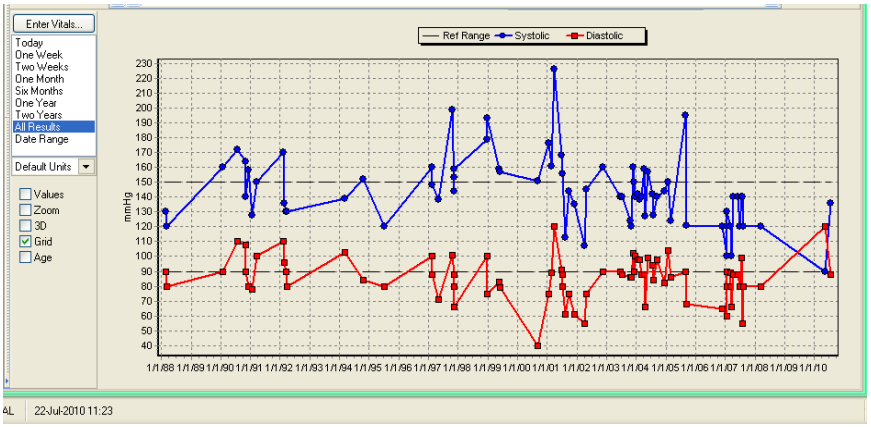


Figure 12-11: Graph of blood pressure values over a six-month period

To see a graph of a specific vital, follow these steps.

1. Select the date range to be graphed from the list below **Enter Vitals**.
2. Select the vital(s) to be graphed by clicking anywhere in its row in the grid at the top of the panel.

   In Figure 12-11, “Blood Pressure” was selected in the grid. The graph is displayed below the list of vitals in the grid.

3. To change the information shown in the graph, select one or more of the check boxes below the list of date ranges.

   - **Values:** Shows the numerical value next to each point on the graph
   - **Zoom:** Allows enlargement or magnification (to "zoom in" on) of a particular area of the graph by drawing a rectangle (clicking and dragging the mouse) around the area to enlarge.

     Note: Select the **Zoom** check box before drawing the rectangle.

     – To click and drag a rectangle on the graph, click a point at the upper left corner of the area to be enlarged.

       While holding the left mouse button down, move the mouse ("drag" it) to the lower right corner of the area to be enlarged. A rectangle is drawn around the area that is selected.

       Release the button to enlarge the rectangle so that it fills the graph viewing area.

     To zoom in on a smaller area, draw a new rectangle in the enlarged graph.

     To return to the full-size graph, uncheck the **Zoom** check box, or right-click the graph and select **Zoom Back** on the context menu.

     Note: If a rectangle is drawn around an area of the graph where no points or lines are visible, the enlarged graph will be blank. Uncheck the **Zoom** check box to return to the original graph.

   - **3D:** Changes the graph to a three-dimensional representation
   - **Grid:** Adds grid marks to the graph
   - **Age:** Change the lower scale of the graph (the x-axis) to age increments.
     – To return to the original date increments on the x-axis, uncheck the **Age** check box.
   - **Percentiles**: Shows percentile increments on the right side of the graph. Percentile data is only available for the Height, Weight, Head Circumference, and BMI measurements.

   Figure 12-12 shows a BMI point (in blue) on a growth chart for a child (a person less than12 years old) with the **Grid** and **Percentiles** check boxes selected.

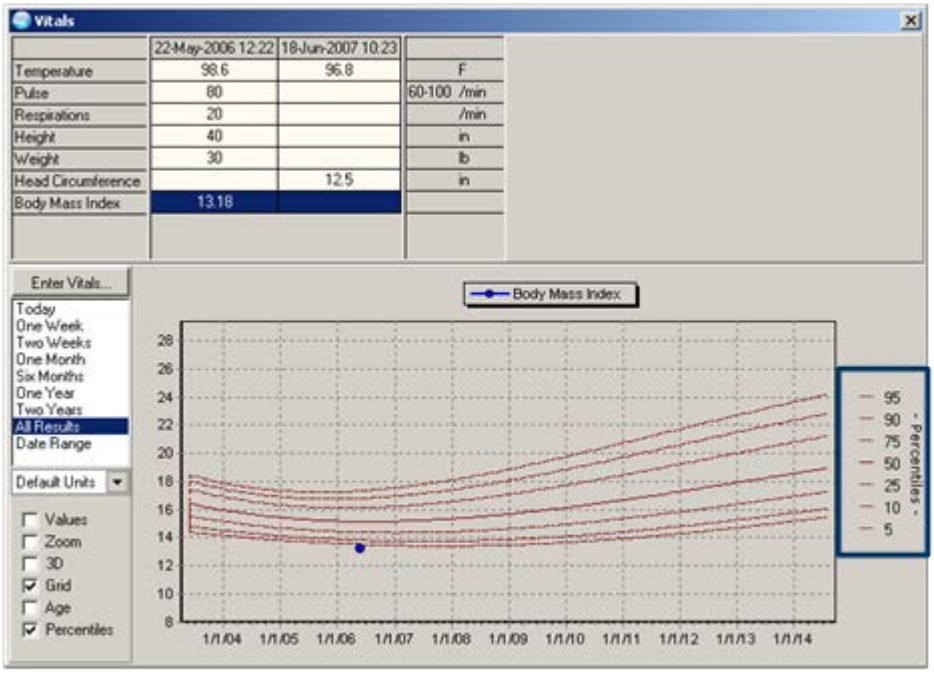


Figure 12-12: Growth chart for a child under 12 years of age with **Grid** and **Percentiles** check boxes selected

The BMI percentile curves, shown in red, are calculated from national averages developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). The standard is to display the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentile curves.

13.0 Record a Patient Examination

(Notes Tab/Exam Template)

After entering the patient's vitals, return to the **Notes** tab to pull vitals data into the **Exam** template.

Prior Steps

Before using the **Exam** template on the **Notes** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 13-1: Example of EHR toolbar showing patient name and encounter information

1. Click the **Notes** tab. Place the cursor at the end of the last note by clicking in the bottom of the note. See Figure 13-2.

   The CHAP ENCOUNTER note created in Section 11.0, including the information entered into the **History** template, appears in the right side of the tab as shown in Figure 13-2.

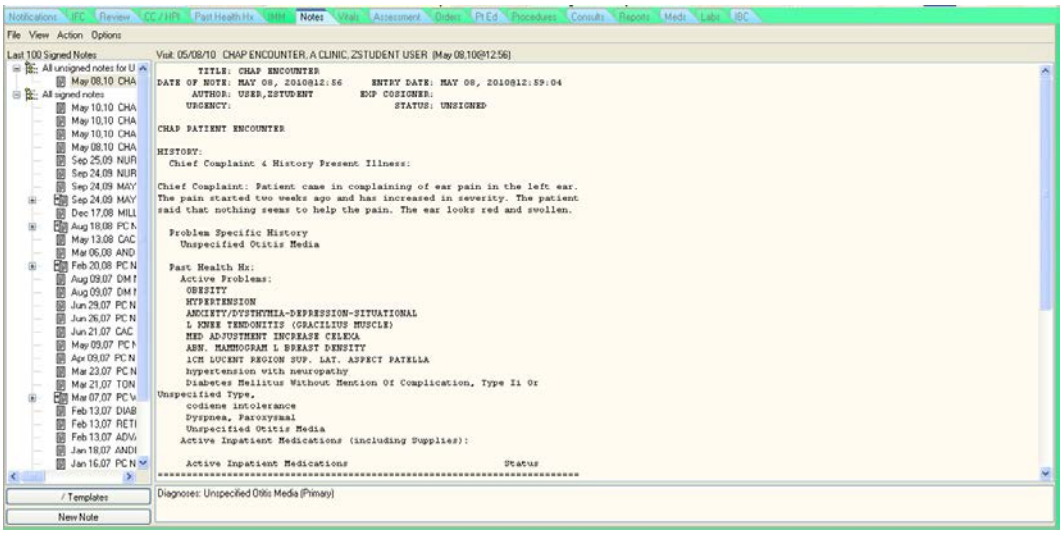


Figure 13-2: **Notes** tab showing CHAP ENCOUNTER note with information previously entered in the **History** template

2. Right-click anywhere in the CHAP ENCOUNTER note to open the context menu and choose **Edit Progress Note**, as shown in Figure 13-3.

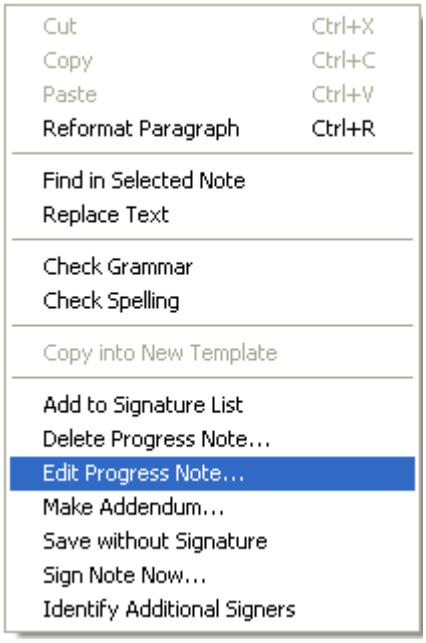


Figure 13-3: Context menu for the **Notes** tab

3. To open an exam template that corresponds to the patient's complaint, double-click the **CHA/P Exam General** template.

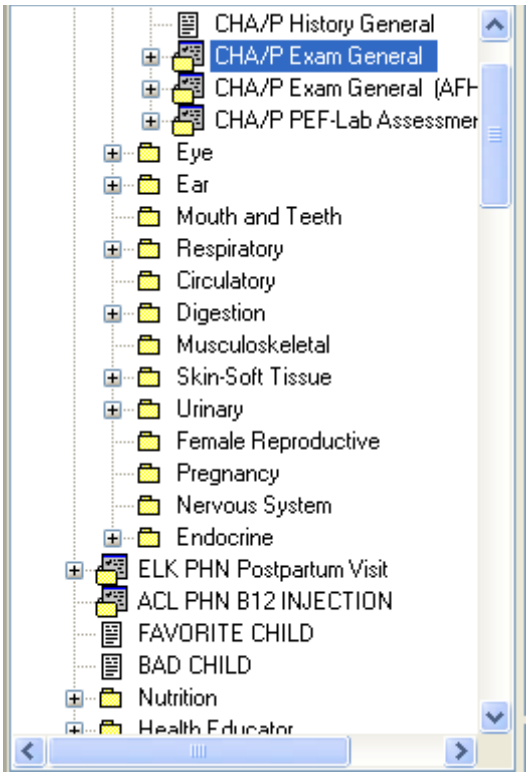


Figure 13-4: **CHA/P Exam General** folder in the **Templates** drawer

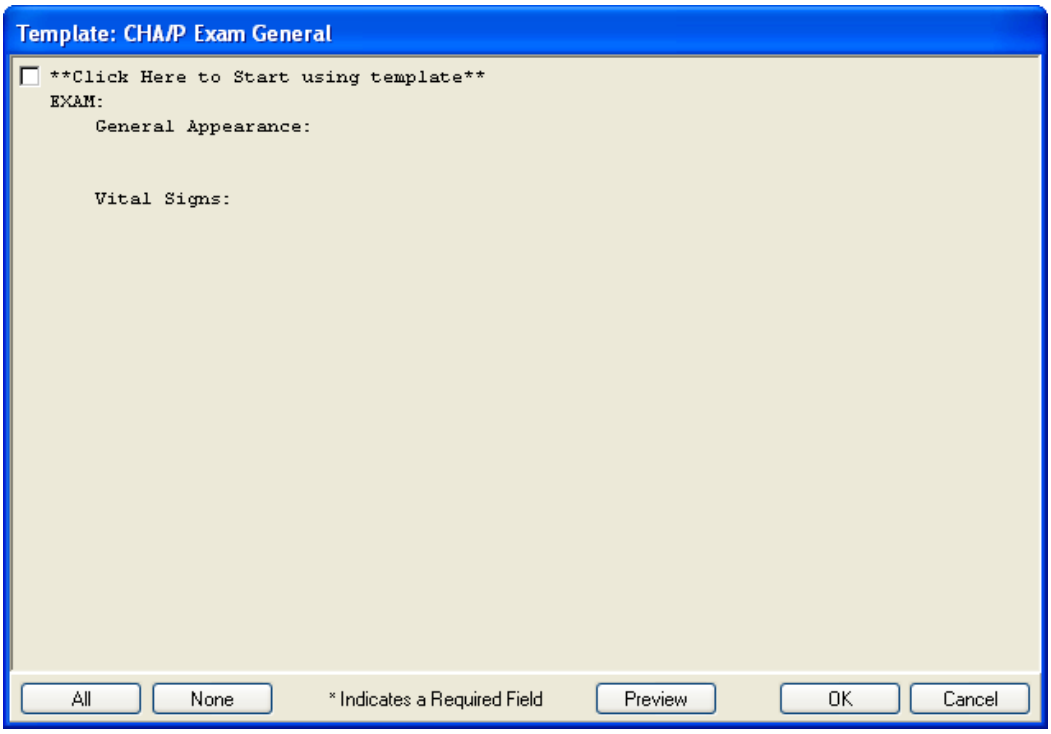


Figure 13-5: **CHA/P Exam General** template

4. Select the ****Click Here to Start using template**** check box to start using the template.

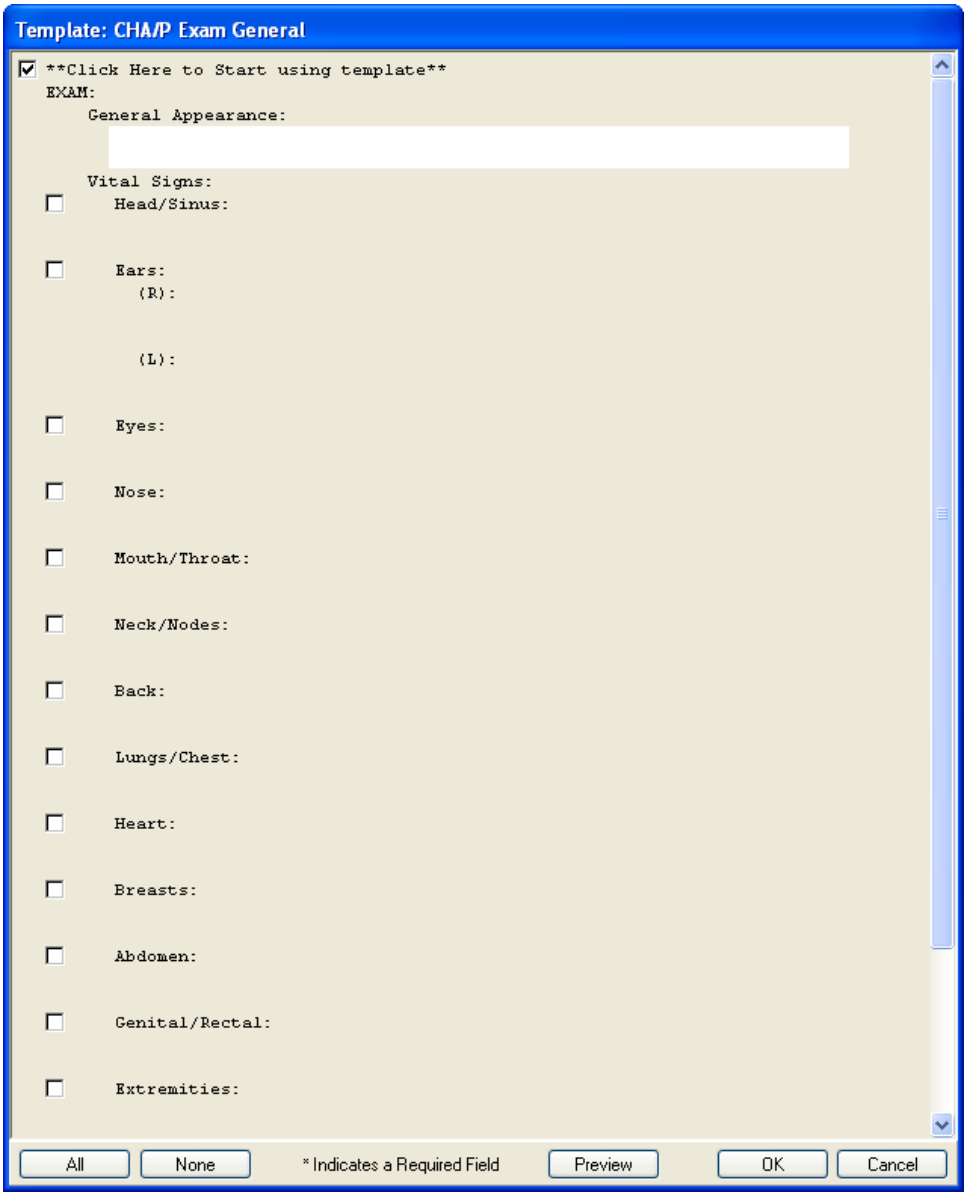


Figure 13-6: **CHA/P Exam General** Template

5. To type the patient's information into the appropriate template fields, select the checkboxes to the left of the item. See Figure 13-7.

> **Note**: Complete this template as if the information was being entered in a paper PEF.

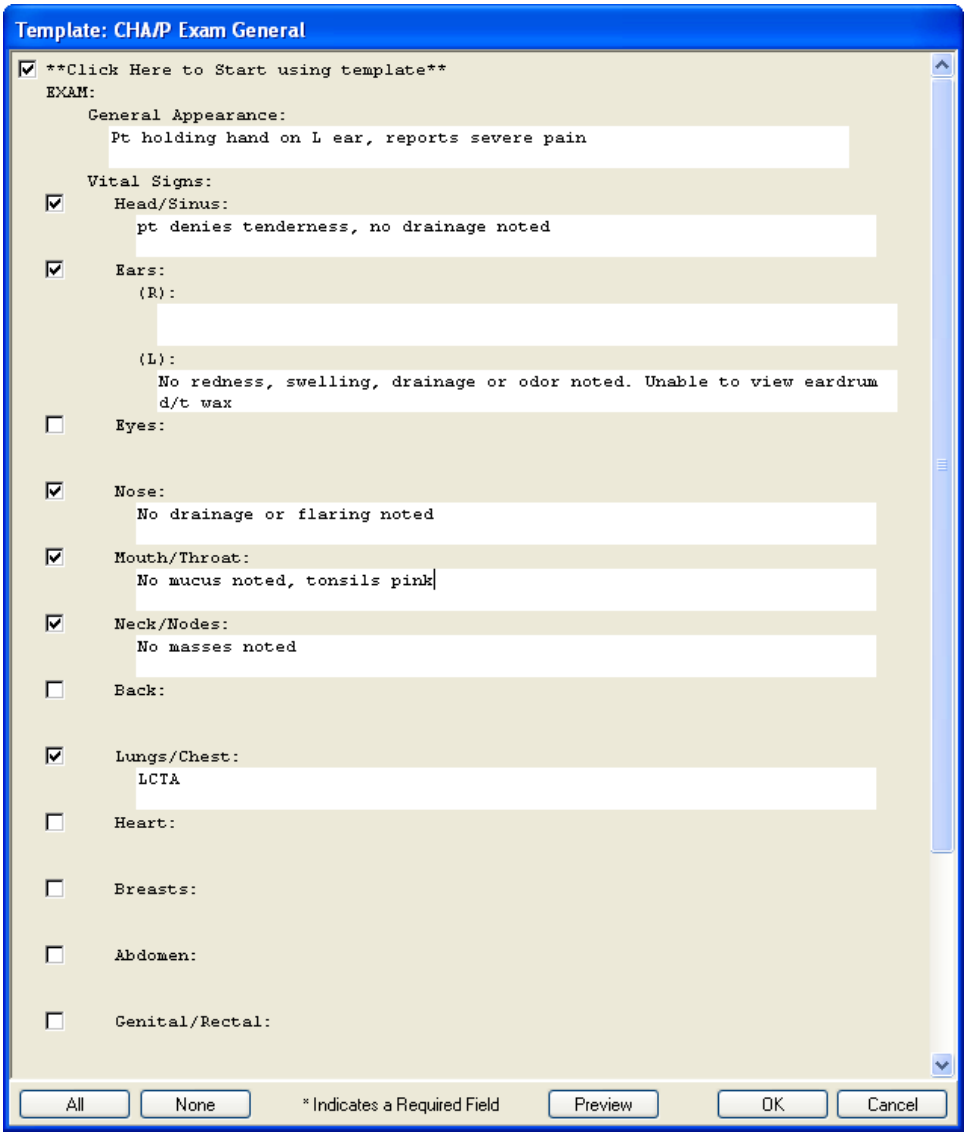


Figure 13-7: Entering information for an ear infection in the **CHA/P Exam General** template

6. Finish entering information and then click **OK** to close the template dialog and return to the **Notes** tab.

The information entered in the exam template is shown at the bottom of the CHAP ENCOUNTER note in the **Notes** tab, as shown in Figure 13-8.

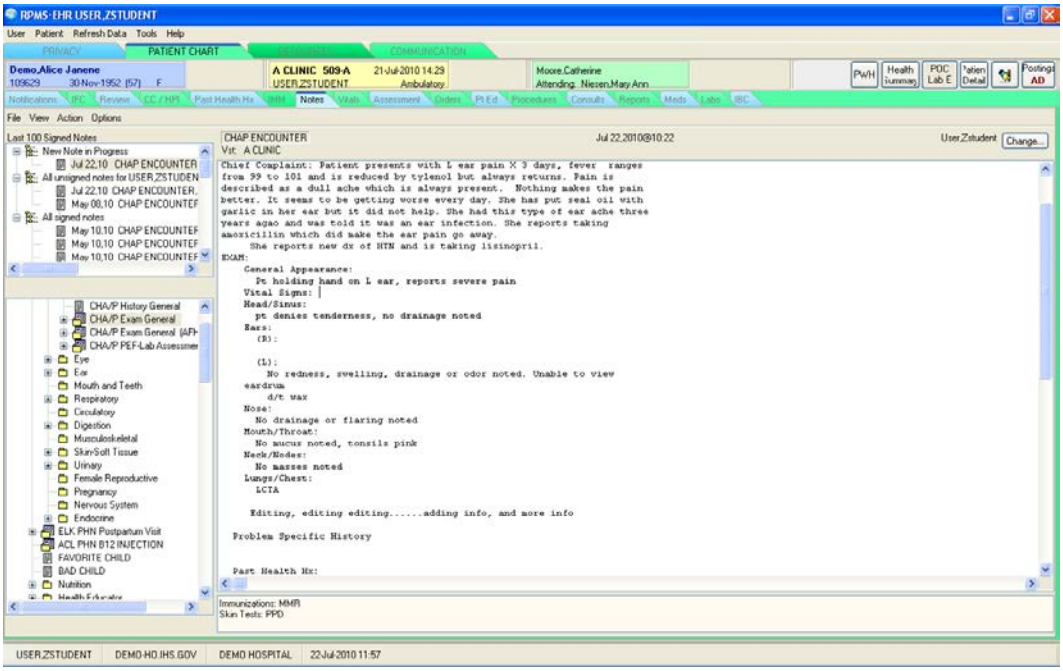


Figure 13-8: Updated CHAP ENCOUNTER note with information from the **History** template and the **CHA/P Exam General** template

7. To enter information about the patient into one or more exam templates, repeat Steps 3–5 above to open each template, fill in the information, and close the template dialog.

8. After completing all appropriate exam templates for the current patient, right-click in the **Notes** pane to open the context menu and select **Save without Signature** from the menu, as shown in Figure 13-9.

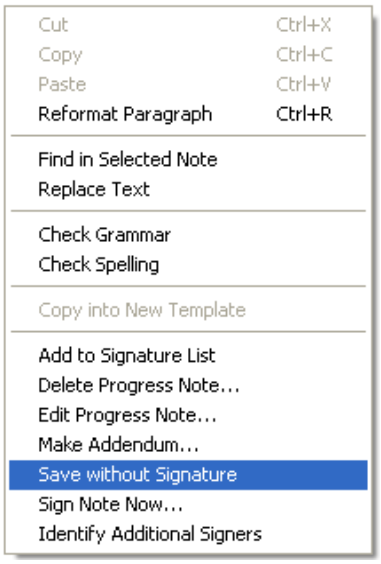


Figure 13-9: **Notes** tab context menu

It is important to save work performed in the **Notes** tab. If you accidentally go to another tab without saving, the information entered will still be in the **Notes** tab. However, it is **critical** to save the note **without** a signature.

14.0 Order a Lab Point of Care Test

(POC Lab Entry button)

Use the **POC Lab Entry** button (located on the toolbar) to order and result a lab point of care (POC) test.

Prior Steps

Before using the **POC Lab Entry** button, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 14-1: Example of EHR toolbar showing patient name and encounter information

14.1 Order a Lab POC Test

1. To start a lab order, click **POC Lab Entry** (Figure 14-2) to open the **Lab Point of Care Data Entry Form** dialog, as shown in Figure 14-3.

Figure 14-2: **POC Lab Entry** button

2. To select the ordering provider:

   a. Click the arrow next to the **Ordering Provider** field.

b. Do one of the following:

- Click the provider's name in the field.
- Type the provider's last name in the field.

Figure 14-3 is an example of using the menu to choose the provider's name.

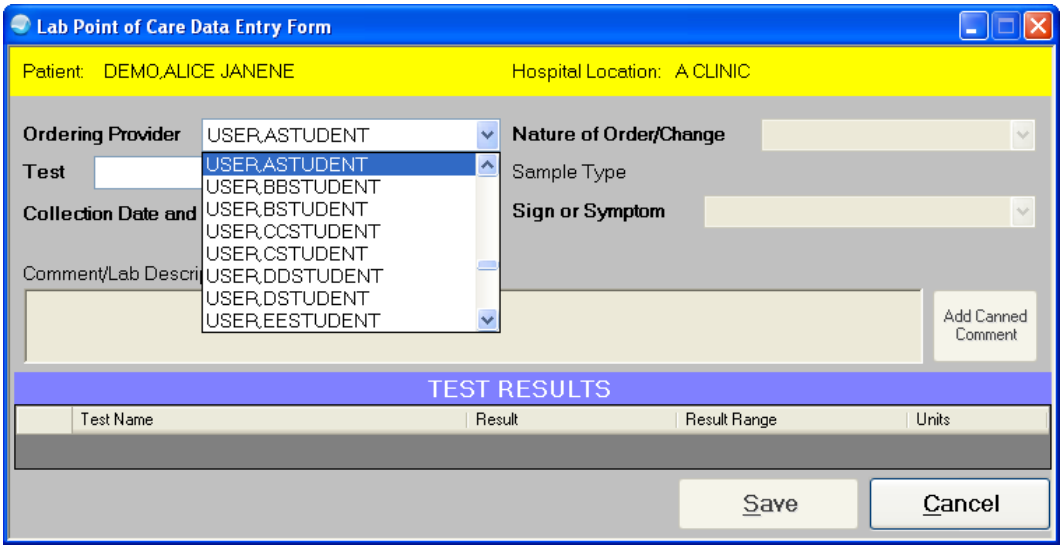


Figure 14-3: Selecting an ordering provider in the **Lab Point of Care Data Entry Form** dialog

3. To select the test to be ordered, click the arrow next to the **Test** field and click the name of the test in the field, as shown in Figure 14-4.

> **Note**: The items in the **Test** field may be different at different facilities.

> Entering a control value for a lab test is a requirement. Every lab results field must be documented or the lab will have a status of pending.

Figure 14-4: Selecting a test in the **Lab Point of Care Data Entry Form** dialog

4. To change the date and time the test was performed, click the arrow next to the **Collection Date and Time** field and select the correct date and time from the calendar, as shown in Figure 14-5. Otherwise, the date and time default to the current encounter date and time.

> When documenting an encounter after-the-fact, be sure to set the Date and Time to match the date and time of the encounter.

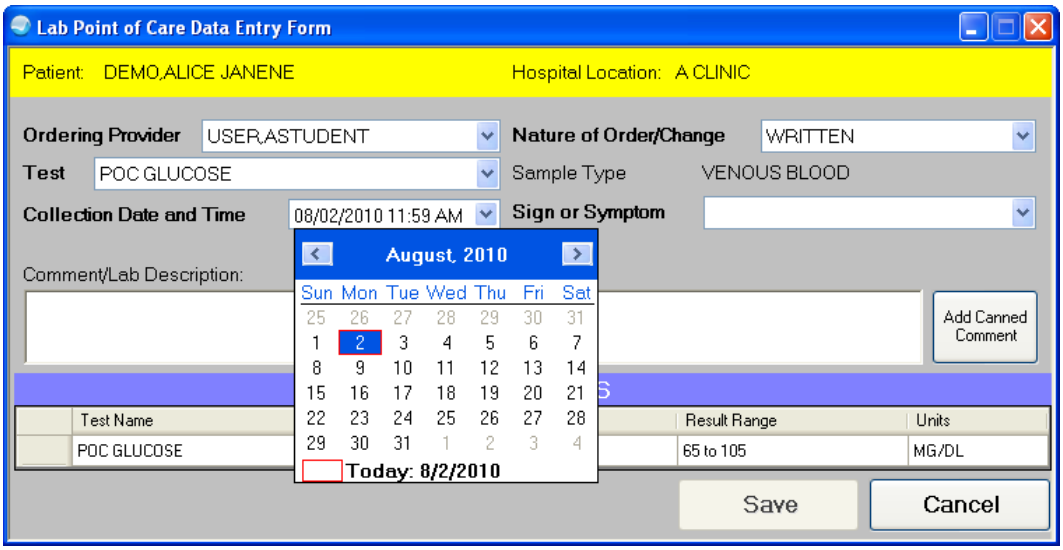


Figure 14-5: Changing the date in the **Lab Point of Care Data Entry Form** dialog

5. If the **Nature of Order/Change** field is not set to "POLICY," click the arrow next to the field and select "POLICY" from the field.

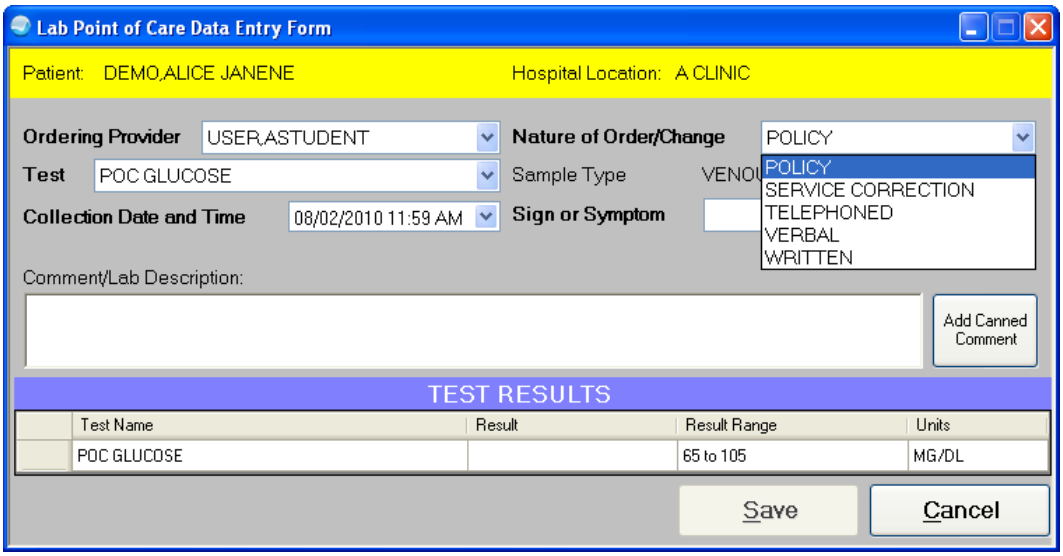


Figure 14-6: **Nature of Order/Change** field should be set to "POLICY"

6. To choose a sign or symptom for this test, click the arrow next to the **Sign or Symptom** field and select the appropriate item from the field.

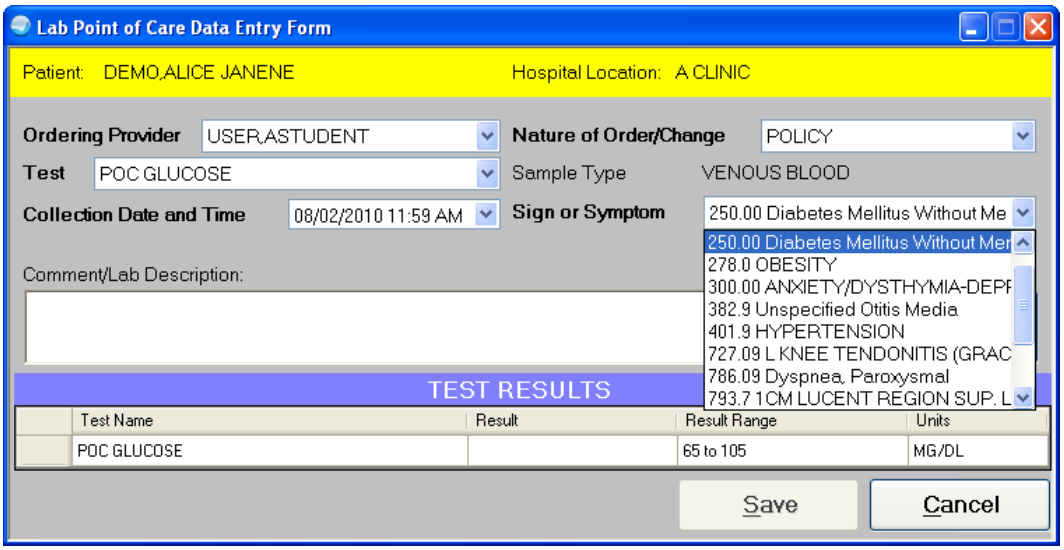


Figure 14-7: Selecting a sign or symptom in the **Lab Point of Care Data Entry Form** dialog

a. If the appropriate sign or symptom is not listed, choose "Other" (the last option in the **Sign or Symptom** list).

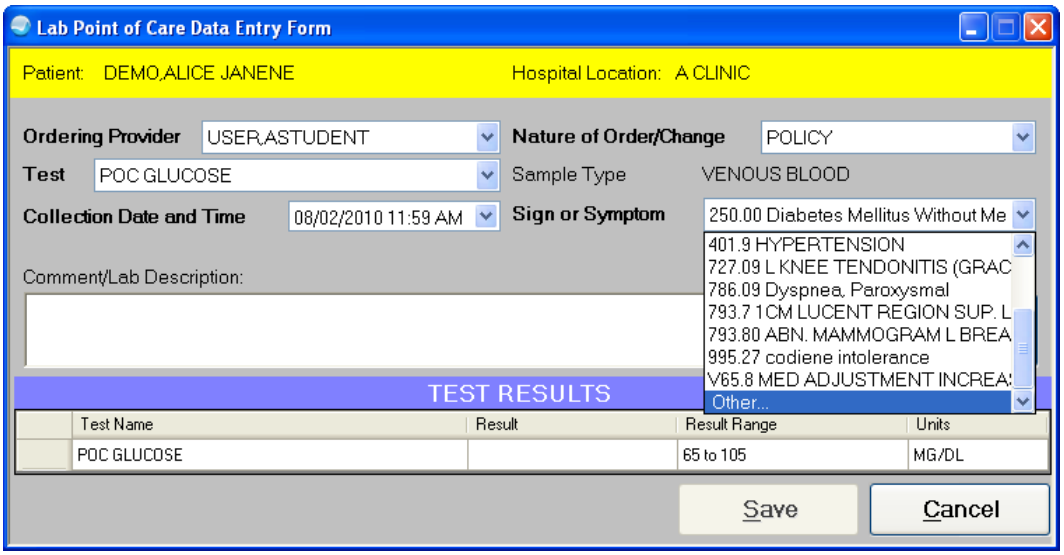


Figure 14-8: Choosing the "Other" list option

b. Choosing "Other" opens the **Lab Point of Care 'Other Sign or Symptom' Entry** dialog. Enter the correct sign or symptom with free text.

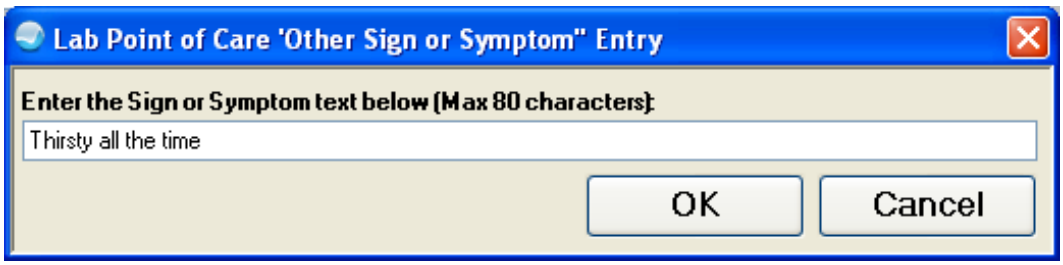


Figure 14-9: Free text entry for entering a sign or symptom

Note:	To determine which sign or symptom to use, ask the following question "Why am I ordering this lab test?" The Purpose of Visit (POV) can help answer this question, which is why it is important to do the POV first.

7. To add information about the test results or a comment about the test being ordered, type the comment in the **Comment/Description** field.

   A canned comment can be added by clicking **Add Canned Comment**. Canned comments are predefined by the EHR team. For example, information about whether the rapid strep test result or whether a culture was sent to the main lab could be entered in the **Comment/Lab Description** field.

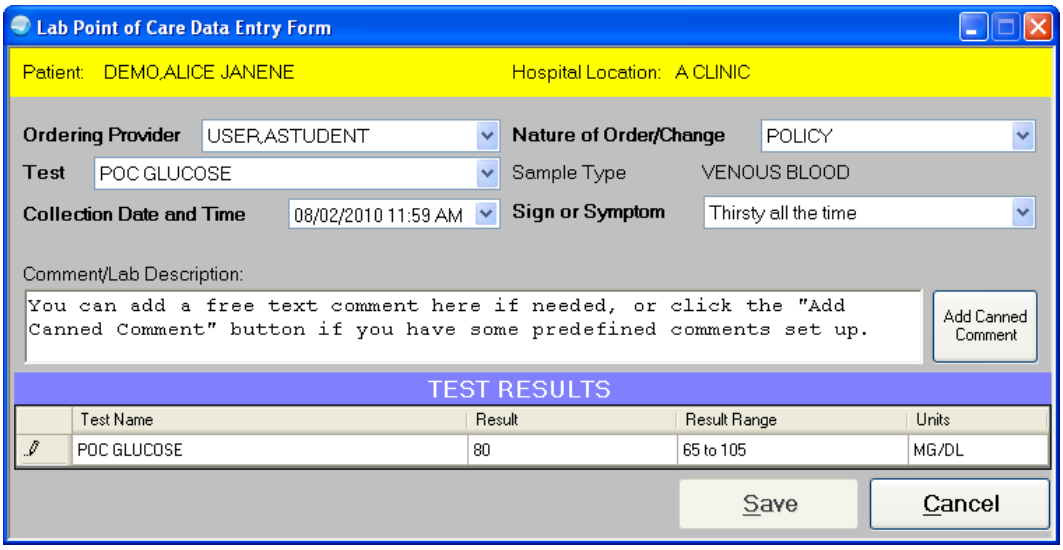


Figure 14-10: Text in the **Comment/Lab Description** field

8. Type the result in the **Result** field, as shown in Figure 14-11.

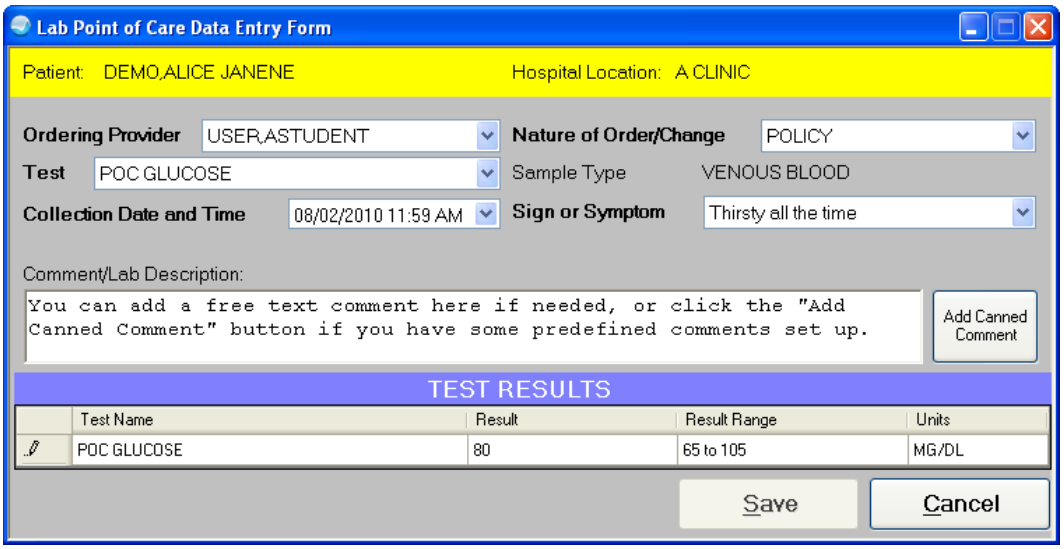


Figure 14-11: Test results entered in the **Lab Point of Care** dialog

9. Press the Tab key to accept and validate the test result.

Note:	It is ***critical*** to press the Tab key to accept the test result that was entered.

Test result entries are controlled to help prevent the entry of incorrect results.

- If a test result was entered that is outside the range of acceptable values for the test, the **Invalid Entry** dialog is displayed, as shown in Figure 14-12. Click **OK** to close the dialog. Enter the correct test result value and press the Tab key again to accept and validate the result.

Note:	If a test panel needs to be entered (as in a urine dipstick), press the Tab key after the last lab result is entered.

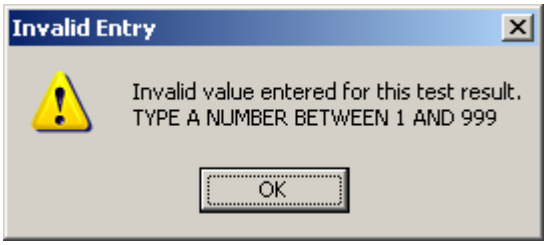


Figure 14-12: **Invalid Entry** error message

- If a result was entered that is within the range of acceptable values for the test, the **Result** field remains white to show that the entered result is appropriate. See Figure 14-3.

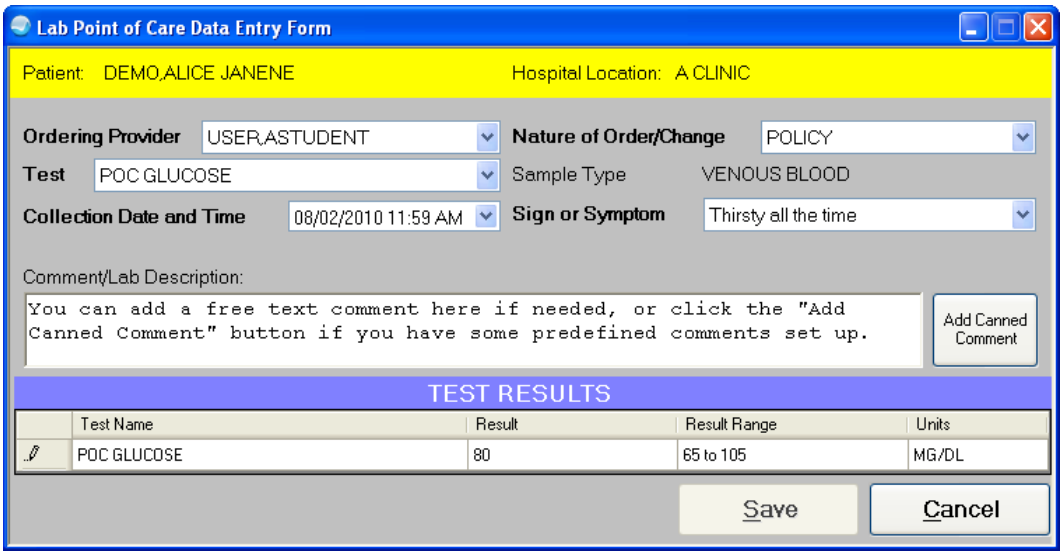


Figure 14-13: Saving the POC results

- If the result is below or above the reference range the **Result** field turns yellow. See Figure 14-14.

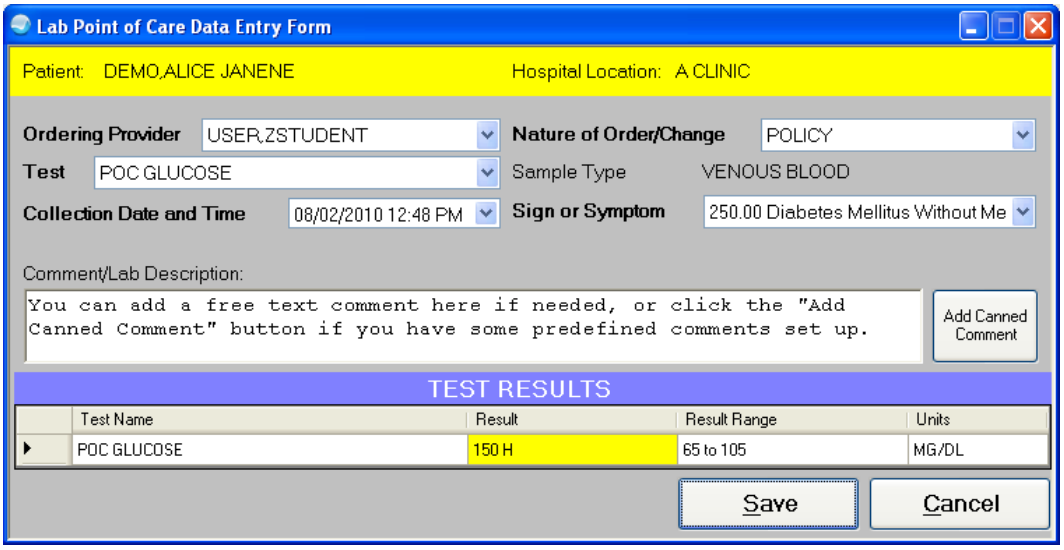


Figure 14-14: Result that is above the result range for a test

- If the result has a defined critical value, the **Result** field turns red.

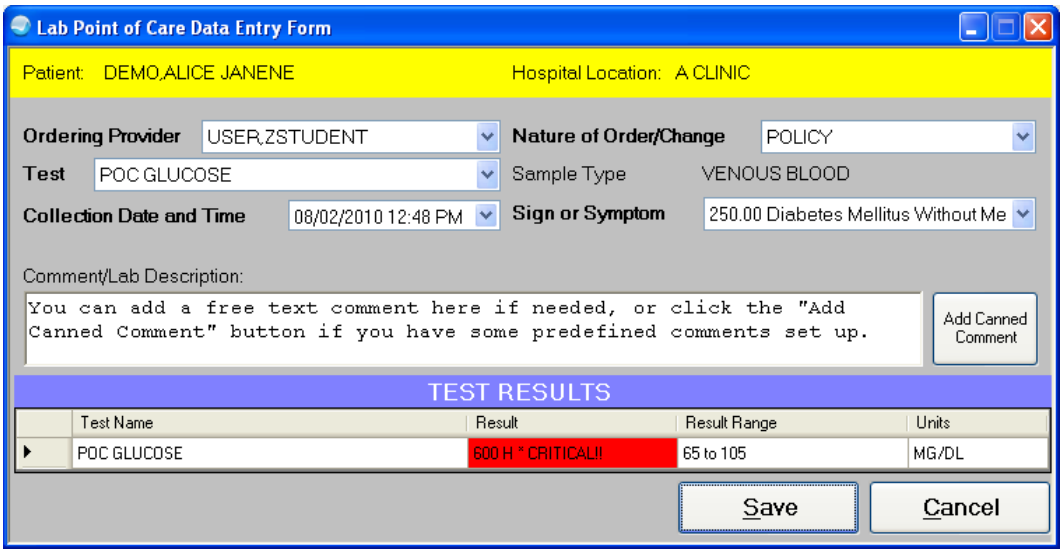


Figure 14-15: Defined critical value for a test result

10. After the correct result has been entered, verify that the correct patient ID, test name, and result have been entered in the **Lab Point of Care Data Entry Form** dialog.

11. If everything is correct press the Tab key, and click **Save** to finalize the test and results that have been entered and close the dialog.

    To not finalize the result, click **Cancel** to cancel the order and start over.

12. Click the **Labs** tab to see the test and results in the list of results, as shown in Figure 14-16.

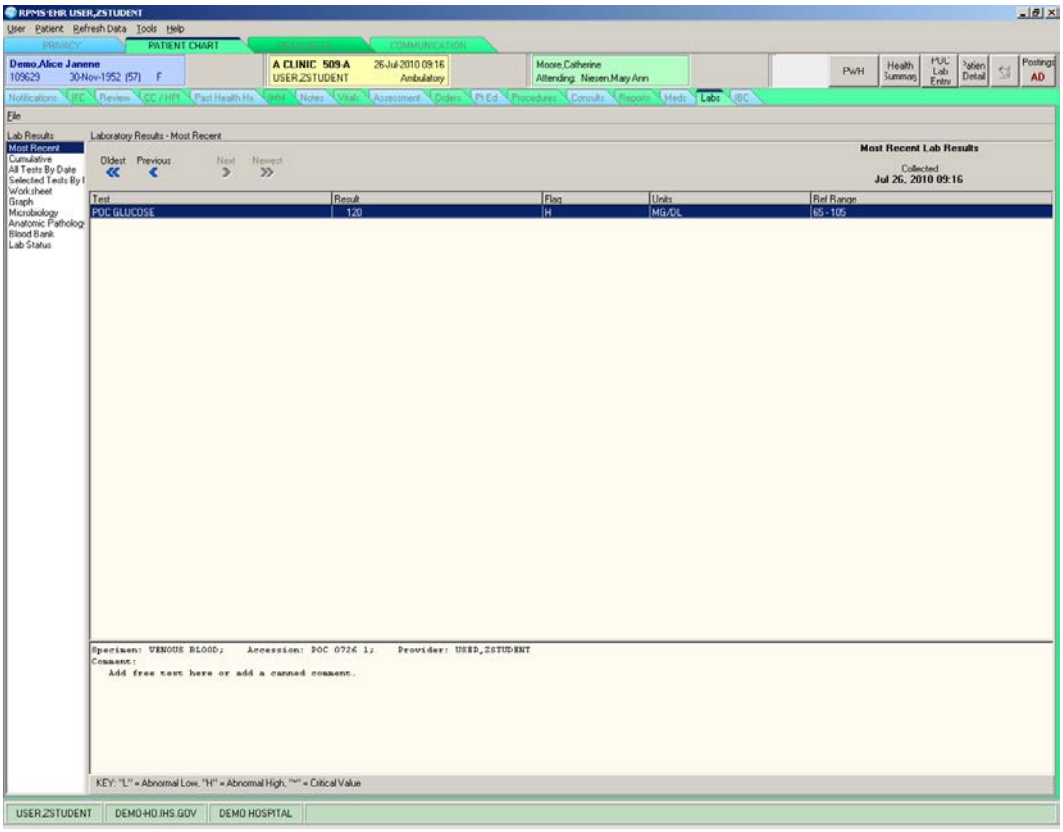


Figure 14-16: Laboratory test results in the **Labs** tab

15.0 Record a POV Diagnosis

(Assessment Tab)

Use the **Assessment** tab to enter a POV diagnosis for the current patient encounter.

Prior Steps

Before using the **Assessment** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 15-1: Example of EHR toolbar showing patient name and encounter information

As shown in Figure 15-2, the **Assessment** tab contains three smaller tabs: a **Problem List** tab, a **Historical Diagnosis** tab, and a **Past Procedures** tab. The **Problem List** tab contains the **Problem List** pane, the **Visit Diagnosis** pane, and the **ICD Pick Lists** pane.

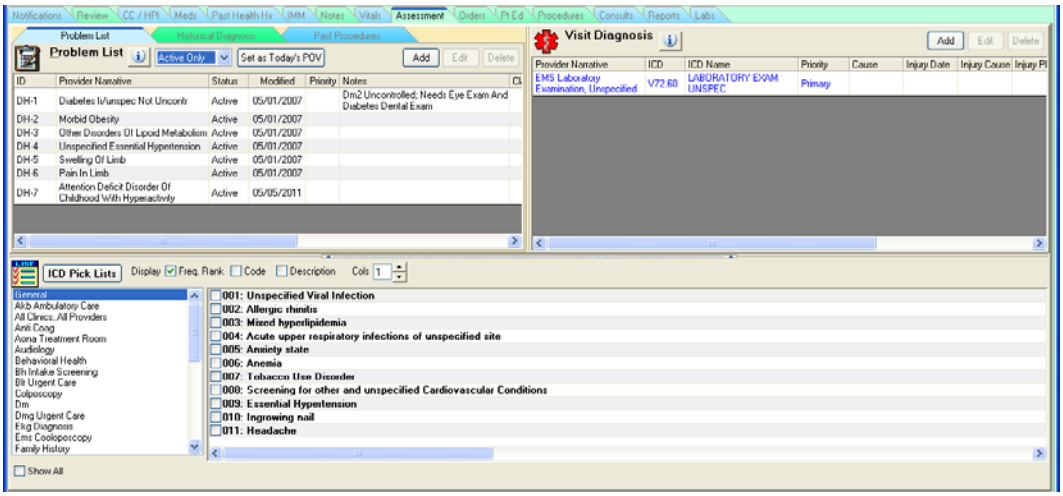


Figure 15-2: **Problem List** tab within the **Assessment** tab, showing the **Problem List** pane, the **Visit Diagnosis** pane, and the **ICD Pick Lists** pane

The Problem List pane can be sorted by:

- All Problems
- Inactive Only
- Personal History
- Active Only
- Family History

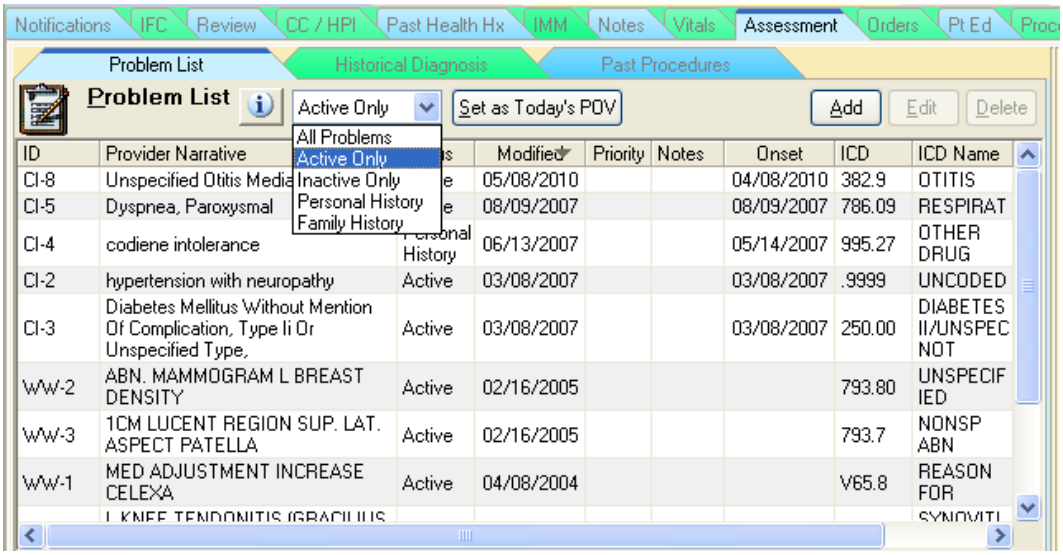
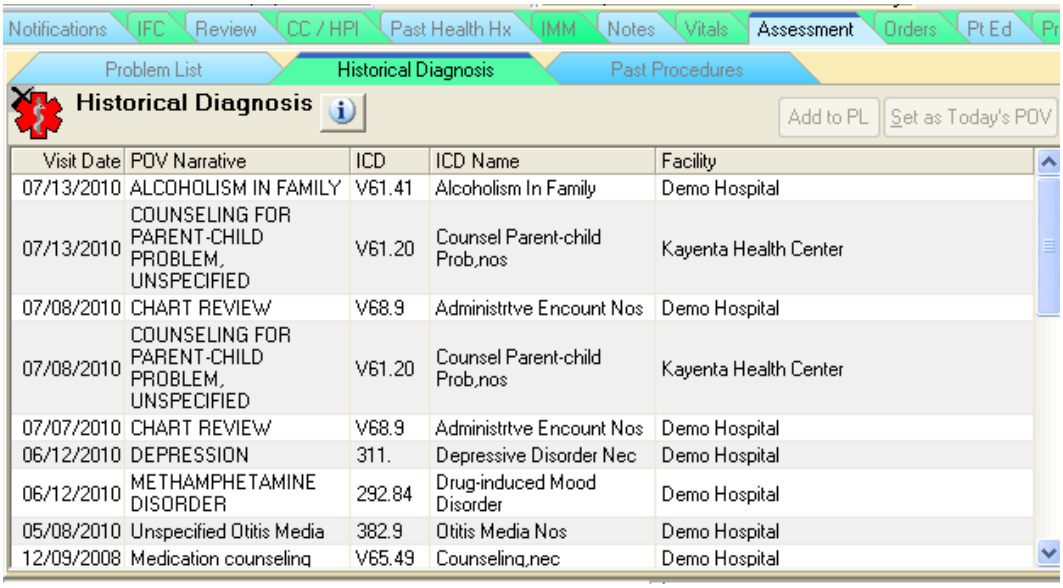


Figure 15-3: Drop-down list for the **Problem List** pane highlighted

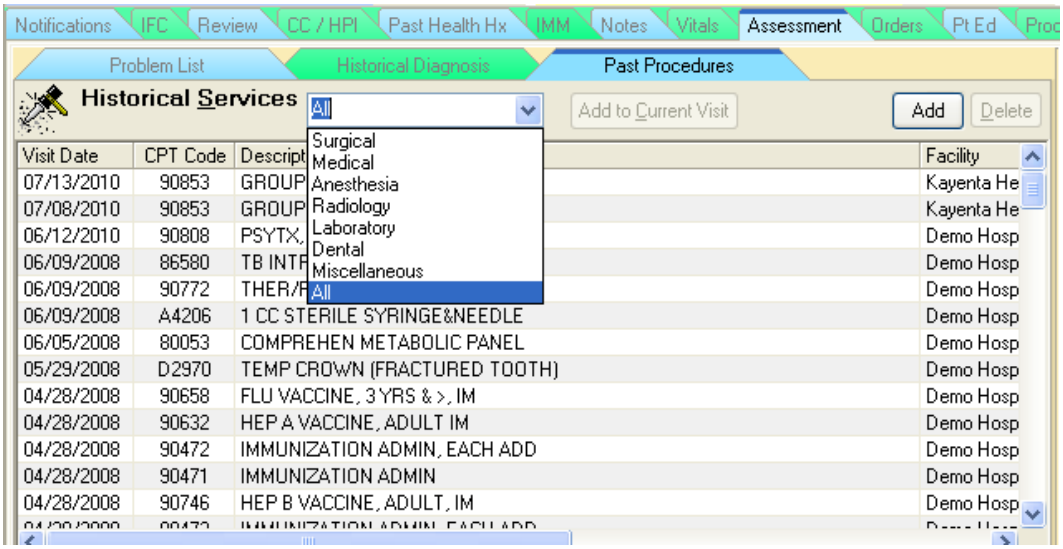
Click the **Historical Diagnosis** tab to view the **Historical Diagnosis** pane. The **Historical Diagnosis** pane can be sorted by clicking in any of the column headers. For example to sort by visit date, click the **Visit Date** column header.



Visit Date	POV Narrative	ICD	ICD Name	Facility
07/13/2010	ALCOHOLISM IN FAMILY	V61.41	Alcoholism In Family	Demo Hospital
07/13/2010	COUNSELING FOR PARENT-CHILD PROBLEM, UNSPECIFIED	V61.20	Counsel Parent-child Prob,nos	Kayenta Health Center
07/08/2010	CHART REVIEW	V68.9	Administrtve Encount Nos	Demo Hospital
07/08/2010	COUNSELING FOR PARENT-CHILD PROBLEM, UNSPECIFIED	V61.20	Counsel Parent-child Prob,nos	Kayenta Health Center
07/07/2010	CHART REVIEW	V68.9	Administrtve Encount Nos	Demo Hospital
06/12/2010	DEPRESSION	311.	Depressive Disorder Nec	Demo Hospital
06/12/2010	METHAMPHETAMINE DISORDER	292.84	Drug-induced Mood Disorder	Demo Hospital
05/08/2010	Unspecified Otitis Media	382.9	Otitis Media Nos	Demo Hospital
12/09/2008	Medication counseling	V65.49	Counseling,nec	Demo Hospital

Figure 15-4: **Historical Diagnosis** pane

The **Past Procedures** tab contains the **Historical Services** pane.



Visit Date	CPT Code	Descript	Facility
07/13/2010	90853	GROUP	Kayenta He
07/08/2010	90853	GROUP	Kayenta He
06/12/2010	90808	PSYTX,	Demo Hosp
06/09/2008	86580	TB INTF	Demo Hosp
06/09/2008	90772	THER/F	Demo Hosp
06/09/2008	A4206	1 CC STERILE SYRINGE&NEEDLE	Demo Hosp
06/05/2008	80053	COMPREHEN METABOLIC PANEL	Demo Hosp
05/29/2008	D2970	TEMP CROWN (FRACTURED TOOTH)	Demo Hosp
04/28/2008	90658	FLU VACCINE, 3 YRS & >, IM	Demo Hosp
04/28/2008	90632	HEP A VACCINE, ADULT IM	Demo Hosp
04/28/2008	90472	IMMUNIZATION ADMIN, EACH ADD	Demo Hosp
04/28/2008	90471	IMMUNIZATION ADMIN	Demo Hosp
04/28/2008	90746	HEP B VACCINE, ADULT, IM	Demo Hosp

Figure 15-5: **Historical Services** pane in the **Past Procedures** tab in the **Assessment** tab

The **Historical Services** pane lists the most recent EKG, mammography, pregnancy test, colonoscopy, or chronic ear infections for a patient. This list can be filtered by the following types of services:

- All
- Surgical

- Medical
- Anesthesia
- Radiology
- Laboratory
- Dental
- Miscellaneous

15.1 Add POVs to the Visit Diagnosis Pane

POVs with ICD codes are added to the **Visit Diagnosis** pane by selecting from a pick list of POVs listed in the CHAM, or by typing a diagnosis and selecting the appropriate diagnosis from a list of possible matches.

POVs without ICD codes can also be added to the **Visit Diagnosis** pane. These POVs appear in the **Visit Diagnosis** pane as uncoded diagnoses.

Multiple POVs can be added to the **Visit Diagnosis** pane for a single patient encounter, as shown in Figure 15-6.

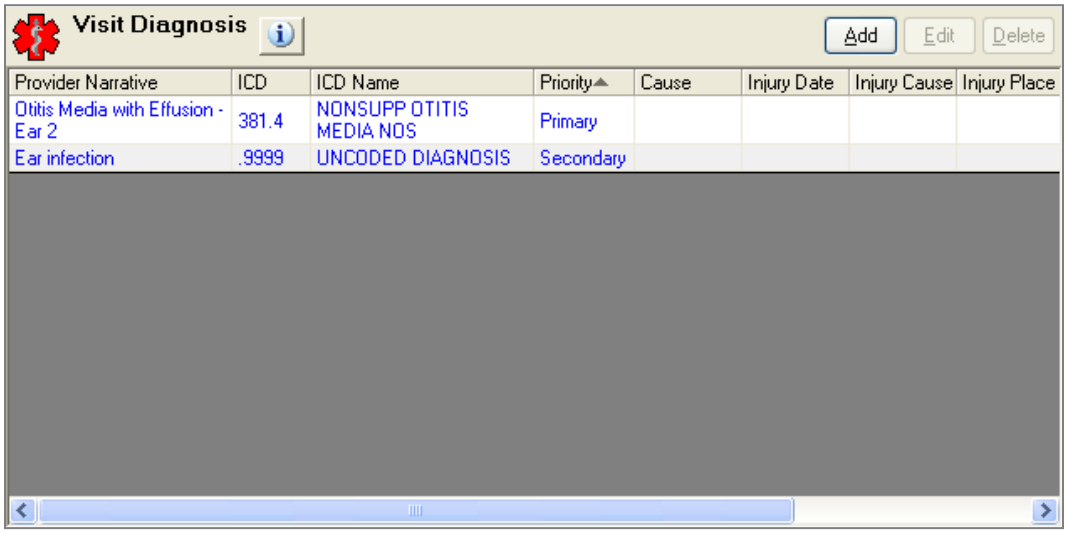


Figure 15-6: Multiple POVs in the **Visit Diagnosis** pane

15.1.1 Add a POV Listed in the CHAM

Use the ICD Pick Lists pane to select a POV that is listed in the CHAM.

> **Note**: When working in the **ICD Pick Lists** pane, be sure that all of the **Display** check boxes (**Freq. Rank**, **Code**, and **Description**) are *unchecked*, and that the **Cols** field is set at "2." The **Show All** check box should be selected (located in the lower left corner under the chapter name list).

1. In the list on the left side of the **ICD Pick Lists** pane, select the name of the chapter in the CHAM being used for this patient encounter.

   Assessments from the selected CHAM chapter appear in the list on the right side of the **ICD Pick Lists** pane, as shown in Figure 15-7.

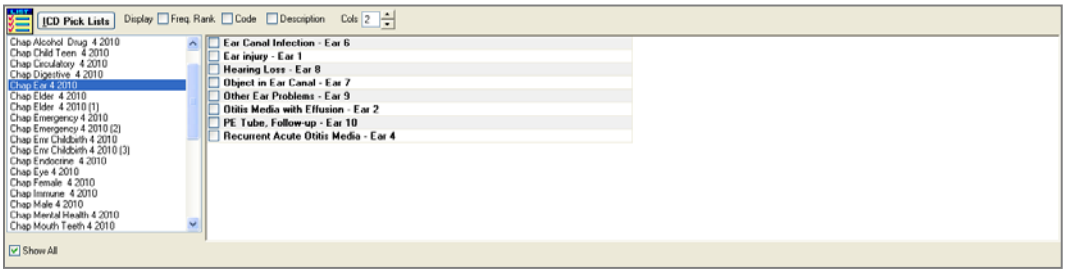


Figure 15-7: **ICD Pick Lists** pane in the **Problem List** tab (a smaller tab within the **Assessment** tab)

2. Select one or more check boxes in the list on the right side of the **ICD Pick List** pane for the assessments that are appropriate for the patient's visit.

3. The selection or selections made in the **ICD Pick Lists** pane are appear with their ICD codes in the **Visit Diagnosis** pane, as shown in Figure 15-8.

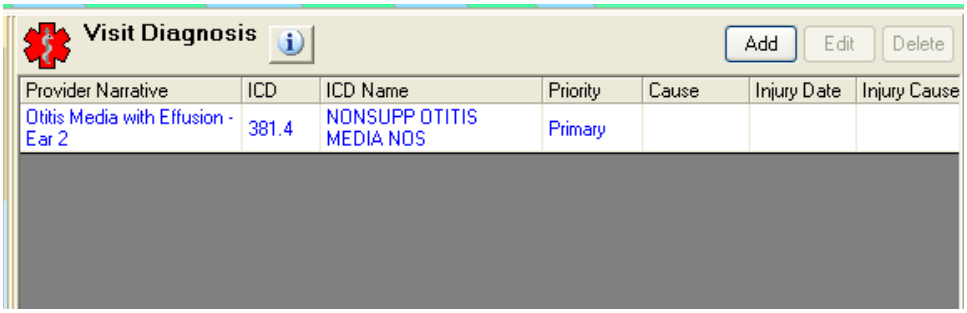


Figure 15-8: **Visit Diagnosis** pane with the **Add** button highlighted

15.1.2 Add a POV Not Listed in the CHAM

1. To choose an assessment that is not from the CHAM, click **Add** in the **Visit Diagnosis** pane to open the **Add POV for Current Visit** dialog,

2. If the the medical issue is injury-related, select the **POV is Injury Related** check box (Figure 15-9).

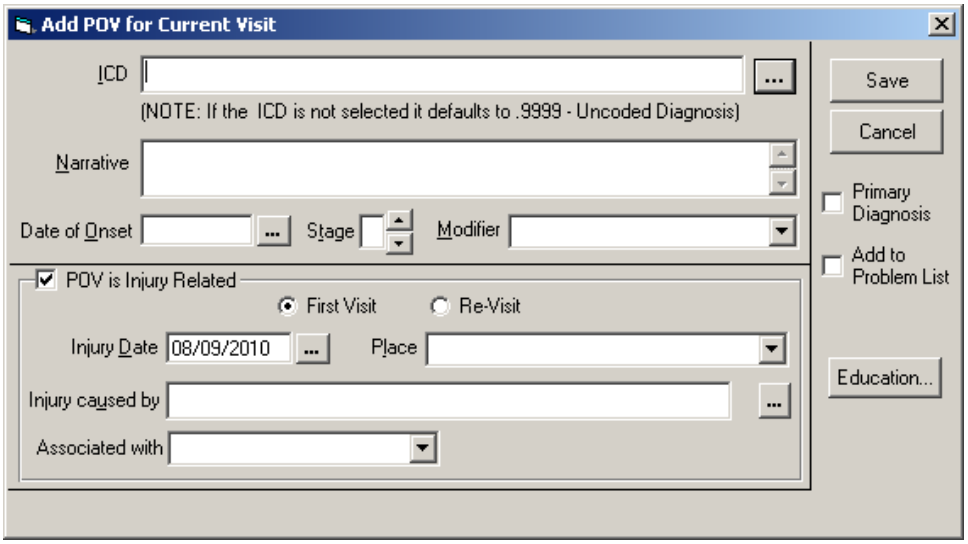


Figure 15-9: **Add POV for Current Visit** dialog showing **POV is Injury Related** check box

3. Type the assessment in the **ICD** field.

4. Click the button to the right of the **ICD** field to perform a search for the current diagnosis, as shown in Figure 15-10.

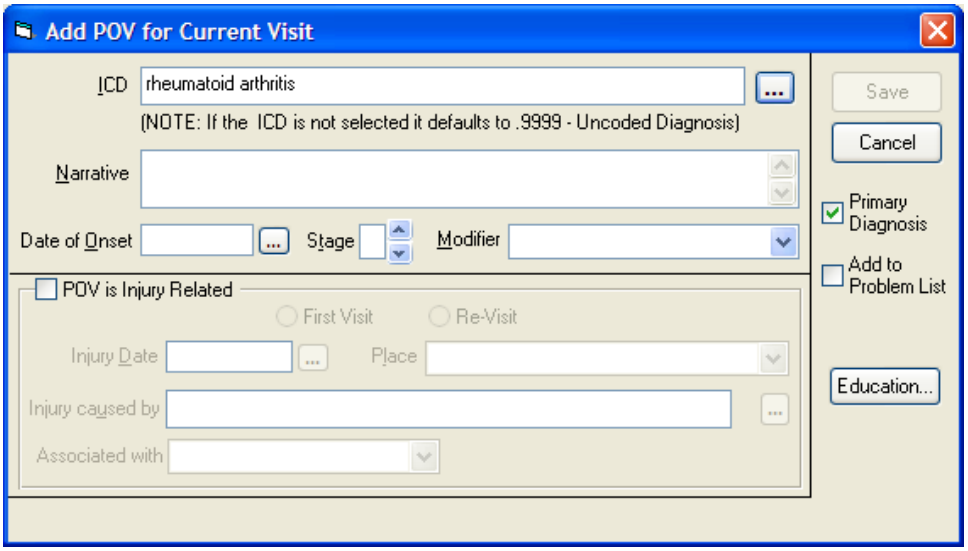


Figure 15-10: **Add POV for Current Visit** dialog

5. The assessment entered in Step 3 appears in the **Search Value** field of the **Diagnosis Lookup** dialog. In Figure 15-11, “rheumatoid arthritis” was entered in the **ICD** field.

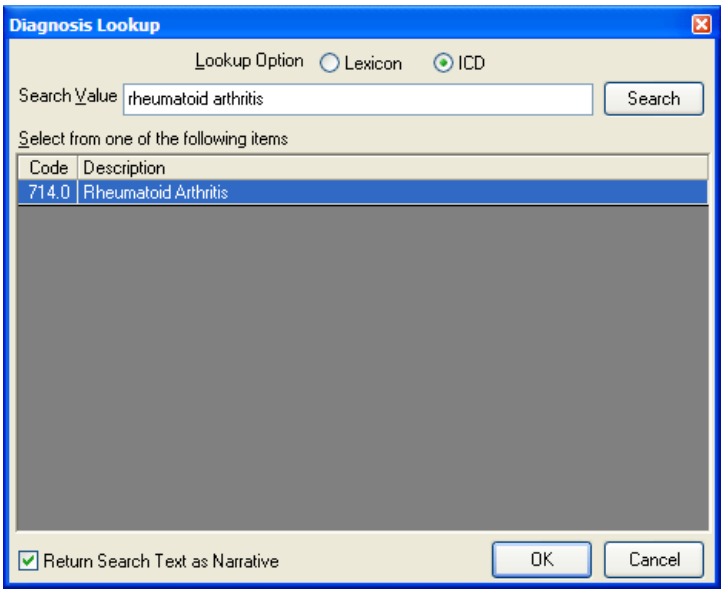


Figure 15-11: **Diagnosis Lookup** dialog

6. If the item listed in the **Search Value** field appears in the **Description** column in the list below, select the item and click **OK** to close the **Diagnosis Lookup** dialog.

   The selected item appears with its ICD code in the **Visit Diagnosis** pane.

7. If the item listed in the **Search Value** field does not appear in the list, click **Cancel** in the **Diagnosis Lookup** dialog to return to the **Add POV for Current Visit** dialog, as shown in Figure 15-12.

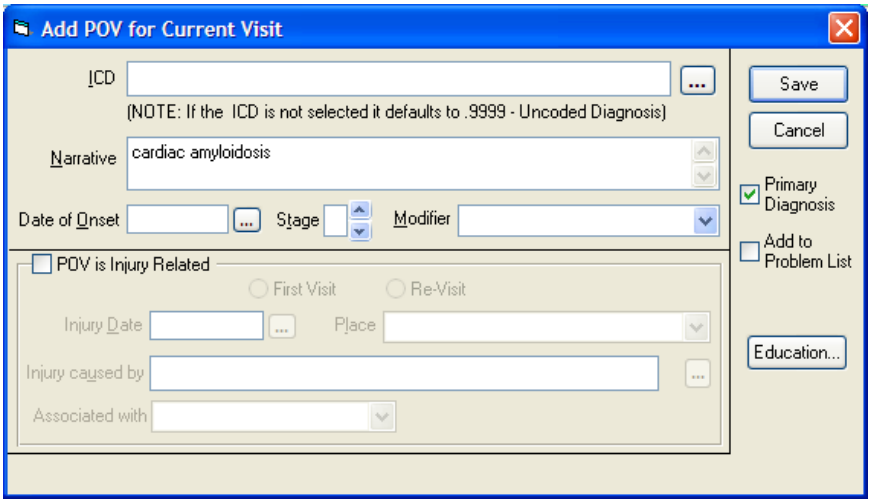


Figure 15-12: Adding a POV that was not found in the ICD diagnosis lookup list

8. Type the diagnosis in the **Narrative** field, and then click **Save.**

   In Figure 15-12, “cardiac amyloidosis” was entered in the **Narrative** field.

> **Note**: The **Narrative** field must include an explanation of why a non-CHAM assessment was chosen. In certain cases, a referring physician may request an ICD that is not from the CHAM.

9. The diagnosis typed in the **Narrative** field appears in the **Visit Diagnosis** pane as an uncoded diagnosis ("ICD .9999"), as shown in Figure 15-13.

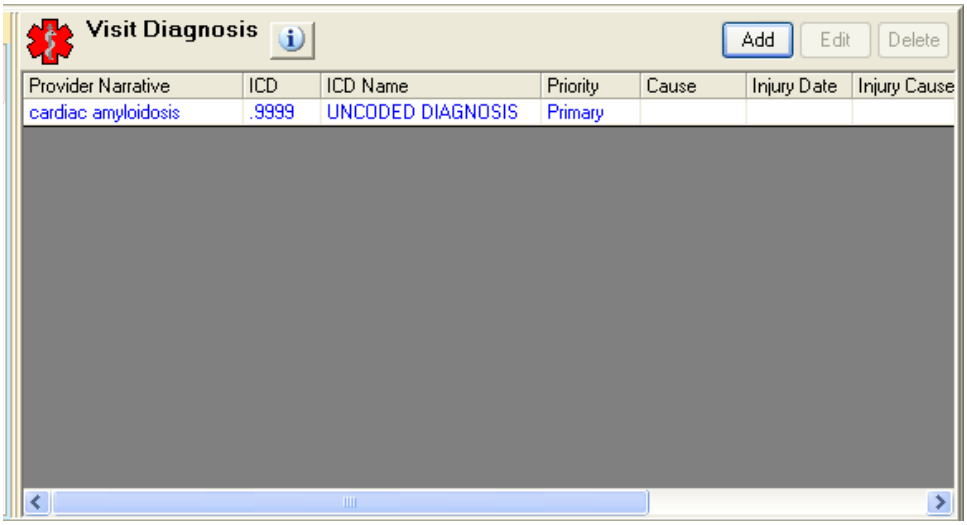


Figure 15-13: New POV diagnosis in the **Visit Diagnosis** pane with an **ICD Name** of "UNCODED DIAGNOSIS"

16.0 Order Medications

(Orders Tab)

Medications administered by the CHA/P are documented in the **Orders** tab. If a referral physician wants a patient to receive a medication that is not stocked in the village, the physician must order the medication through the **Orders** tab.

Prior Steps

Before using the **Orders** tab to order medications and labs, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a Lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 16-1: Example of EHR toolbar showing patient name and encounter information

The left side of the **Orders** tab contains the **View Orders** panel and the **Write Orders** panel. The main area of the tab shows the list of orders selected in the **View Orders** panel, as shown in Figure 16-2.

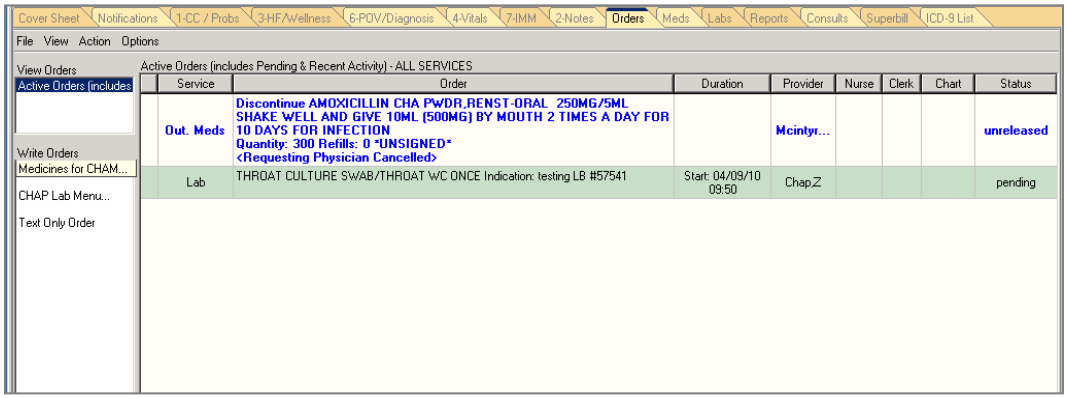


Figure 16-2: **Orders** tab showing “Active Orders” selected in the **View Orders** panel and an unreleased and pending order in the main panel

1. Select the **Orders** tab.

   In Figure 16-2, a provider cancelled an order for Amoxicillin. The provider must sign the cancelled order to change the status from “unreleased” to “cancelled.”

2. Review medications in the **Active Orders** panel to determine whether refills are available. If refills are available, the number of refills is also displayed.

16.1 Order Medications

The **Medicines for CHAM** menu contains menus that correspond to the chapters in the Patient Care Visit section of the CHAM. For the examples in this section, the patient presents with Otitis Media.

1. In the **Write Orders** panel, click **Medicines for CHAM** to open the **Medicines for CHAM** menu.

2. In the **Medicines for CHAM** menu, select the appropriate CHAM plan from the list.

For the example of a patient with Otitis Media, select “Ear Plans.”

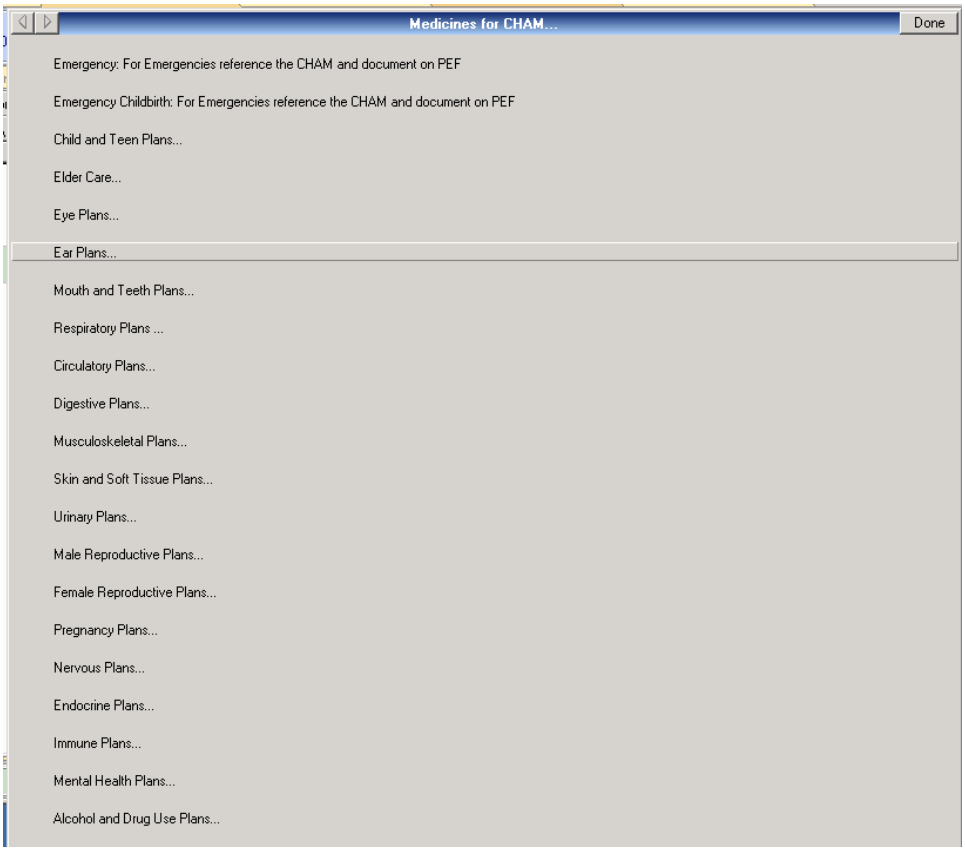


Figure 16-3: **Medicines for CHAM** menu

3. In the submenu for the selected plan, select the appropriate subcategory from the menu.

   The **Ear Plans** menu contains all of the CHAM ear plans that include medications. For the example of a patient with Otitis Media, select **Ear 3: Acute Otitis Media (AOM)**.

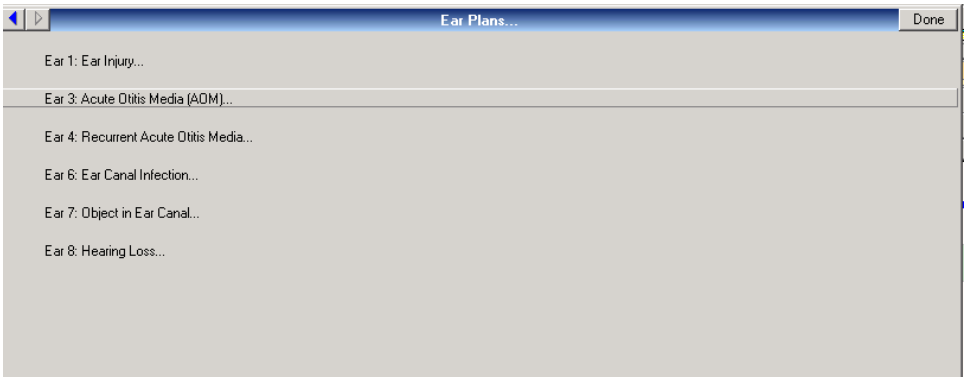


Figure 16-4: **Ear Plan** menu

4. In the menu of medications for the selected plan, select a medication from the list as shown in Figure 16-5.

   The **Ear 3** menu contains medications that can be ordered for infection and for pain. First, place an order for Amoxicillin for infection by selecting the name of the drug. In the example, Amoxicillin is highlighted in blue.

> **Note**: Underlined headings are not clickable. Click on items without an underline to order medications.

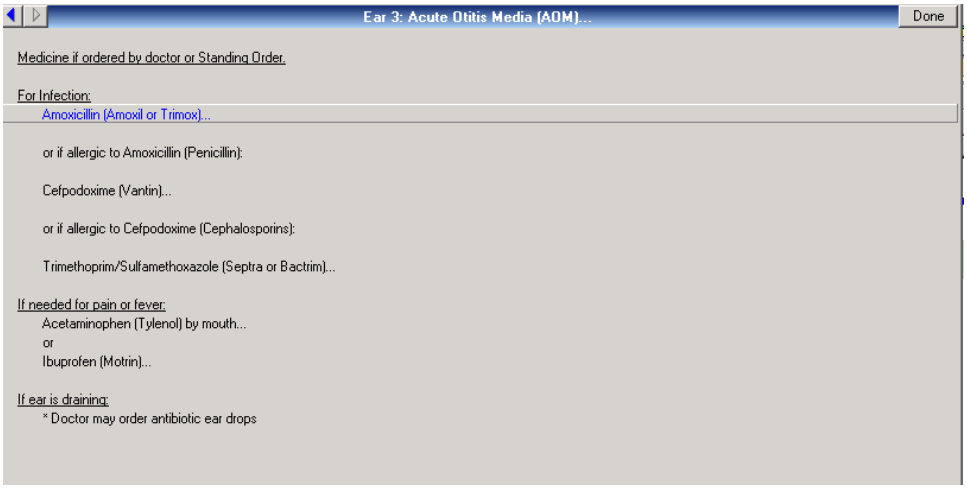


Figure 16-5: Medications for the **Ear 3** plan

5. In the dose selection menu, select the appropriate dose based on the patient's weight or age as shown in Figure 16-6.

   The **Amoxicillin** menu is very similar to what is in the Medicine Handbook of the CHAM.

For this example, the patient weighs 37 pounds. In the **Amoxicillin** menu, select the weight range of 35-39 lb.

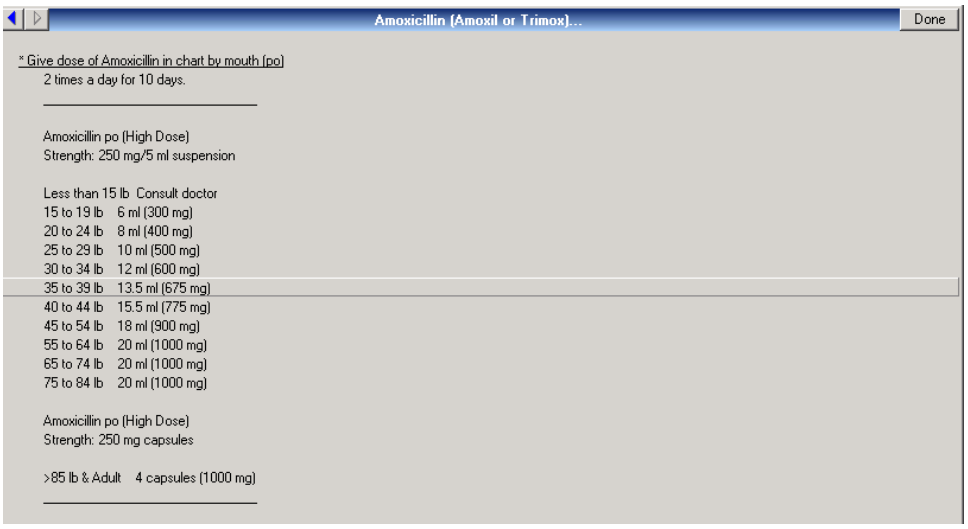


Figure 16-6: Dose selection menu for Amoxicillin

6. The medication and dosage selected in the previous menus are displayed in the fields in the **Medication Order** dialog, as shown in Figure 16-7.

Note: Carefully examine the information in the **Medication Order** dialog to verify that the medication name and the dosage, route, and schedule information are correct.

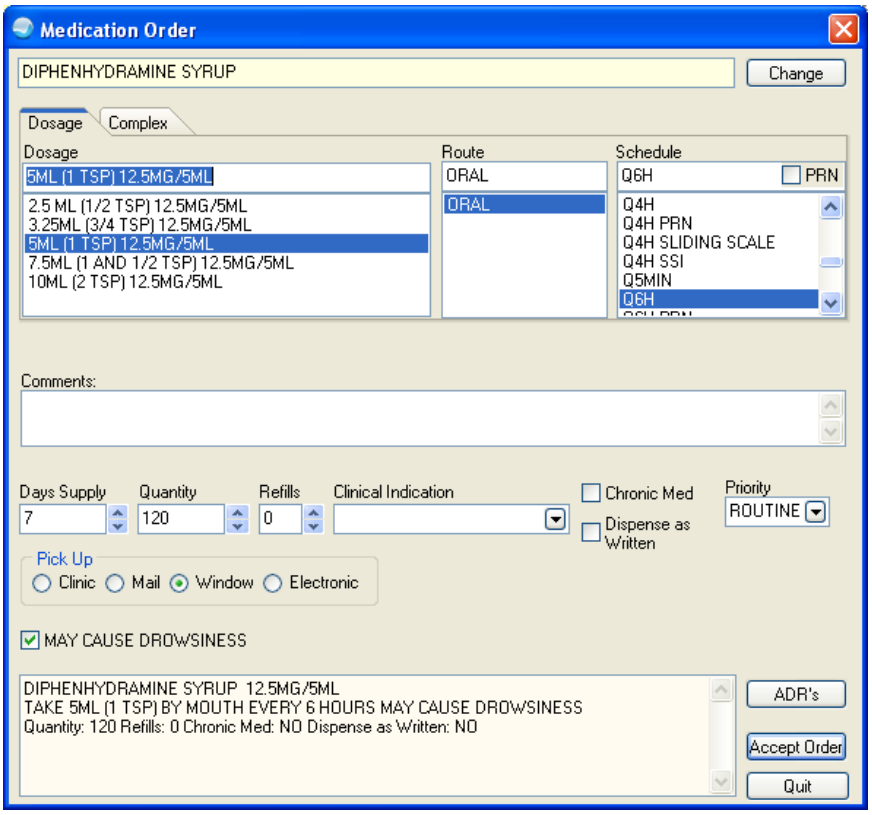


Figure 16-7: **Medication Order** dialog

7. Select a **Clinical Indication** from the list.

8. If the information in the **Medication Order** dialog is correct, click **Accept Order** to close the dialog and return to the dose selection menu.

9. To select one or more additional medications, return to the **Medications** menu by clicking the back arrow (the blue arrow pointing to the left in the upper left corner of the menu window), and repeating the instructions in Steps 4 – 6.

10. If the patient had a prior reaction to a medication being ordered, the **Order Checks** dialog is displayed.

In Figure 16-8, an **Order Check** dialog is displayed when Penicillin is ordered for a patient who had a previous adverse reaction to Penicillin.

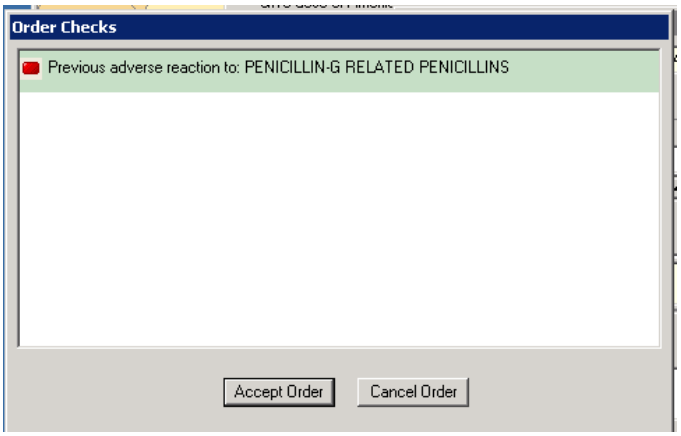


Figure 16-8: **Order Check** dialog

11. In the **Order Check** dialog, do one of the following:

    - If the patient can take the medication listed in the **Order Check** dialog, box click **Accept Order**.
    - If the patient must take a different medication instead, follow these steps to choose another medication:
        - Click **Cancel Order** to return to the **Medication Order** dialog.
        - Click **Quit** in the **Medication Order** dialog to return to the prior menu.

          In this example, the prior menu was the **Amoxicillin** menu.
        - Click the left arrow to return to the plan menu being used to choose another medication to treat the infection.

          In this example, the plan in use was the Ear 3: Acute Otitis Media.
        - Follow Steps 4 through 7 to choose another medication.

12. After selecting all necessary medications, click **Done** (located at the top right corner of the dose selection menu dialog) to return to the **Orders** tab. The medications that were ordered are listed as unreleased orders, as shown in Figure 16-9.

Note:	All unreleased orders are displayed in blue in the **Orders** tab.

13. To sign the medication orders, click **Awaiting Review/Signature** on the EHR toolbar, as shown in Figure 16-9.

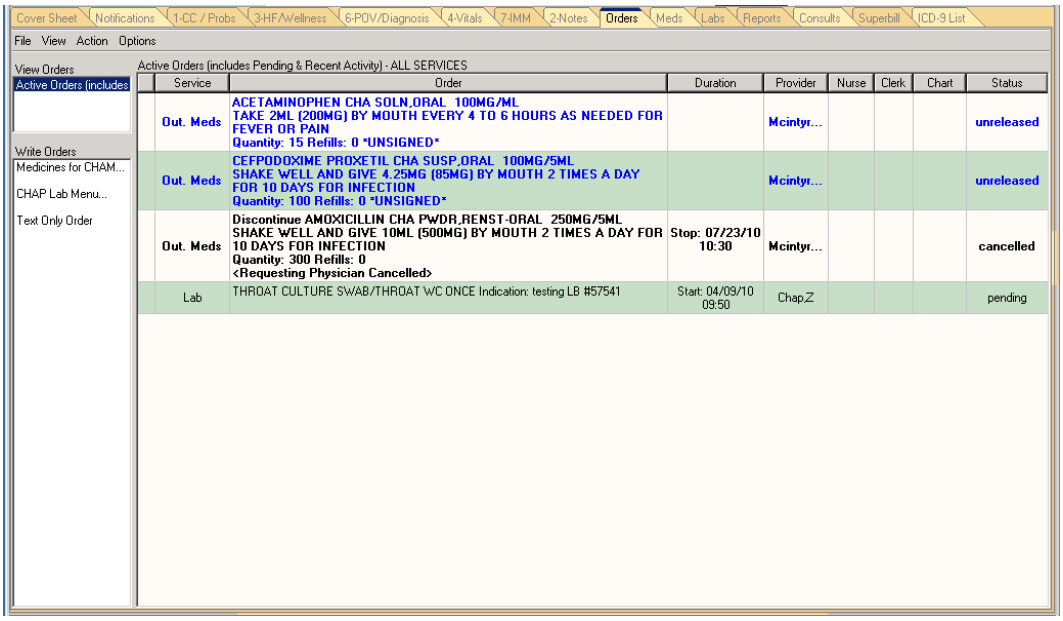


Figure 16-9: Unreleased medication orders in the **Orders** tab

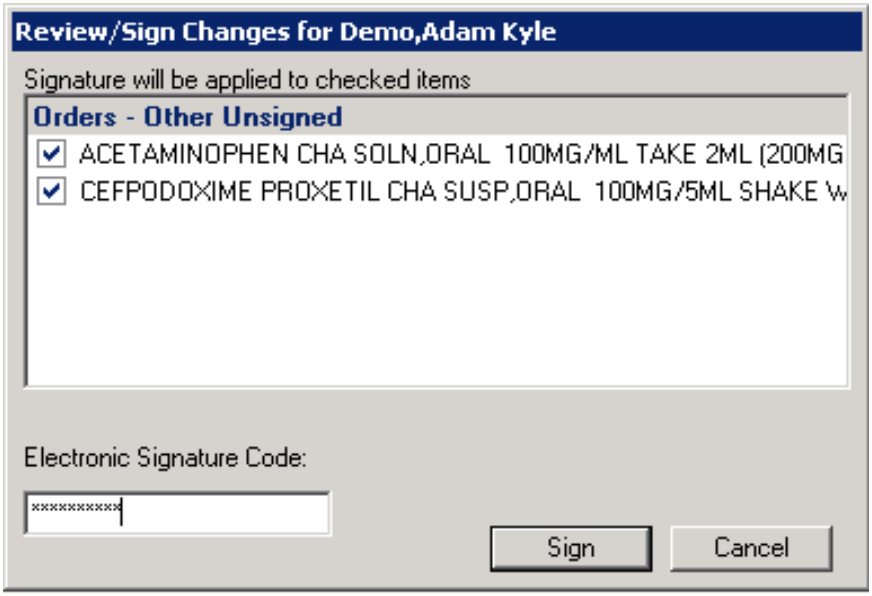


Figure 16-10: **Review/Sign Changes** for <Patient Name> dialog

14. In the **Review/Sign Changes** dialog, select the check boxes to the left of the medications to be ordered. Type the electronic signature code in the **Electronic Signature Code** field.

15. Click **Sign** to close the dialog and enter the medication orders.

The **Order Checks** dialog is displayed one last time. Enter the justification for ordering Cefpodoxime in the **Enter justification for overriding critical order checks** field

After signing the orders, note that the status of the orders has changed from "unreleased" to "pending". This means that the pharmacist can now view the orders in the RPMS Pharmacy package and can review and complete them electronically.

> **Warning**:An unreleased (unsigned) order is not seen by the Pharmacy or Lab.
>
> An order **must** be signed to change its status to "Pending." Once an order is pending, the pharmacy or lab will act on this order.

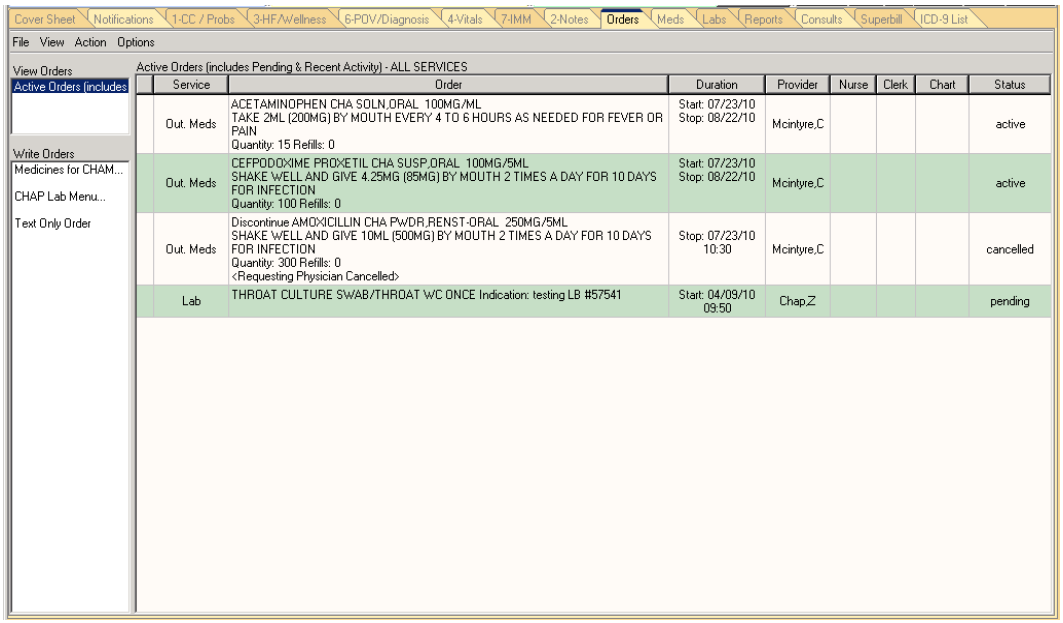


Figure 16-11: **Active Orders** list

After the pharmacist has finished the medication orders, the status will change from "pending" to "active." See Figure 16-11.

17.0 Record Patient Education

(Pt Ed Tab)

Use the **Pt Ed** tab to view, edit, delete, or add patient education topics for a patient.

At the present time, the CHA/P patient education topics have not been approved.

Prior Steps

Before using the **Pt Ed** tab to enter patient education, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 17-1: Example of EHR toolbar showing patient name and encounter information

The **Education** pane in the **Pt Ed** tab lists patient education topics that have been provided to the patient, as shown in Figure 17-2. The listing for each topic includes the visit date and location at which the topic was provided, an assessment of the patient's comprehension of the topic, the name of the provider, the length of time spent, and whether the topic was provided to an individual or a group.

17.1 Add a Patient Education Topic

1. To view the list of patient education topics that the patient has received in the past, click the **Pt Ed** tab.

Figure 17-2: **Pt Ed** tab

2. To add a new patient education record, click **Add** (located at the right side of the **Education** pane) to open the **Education Topic Selection** dialog, as seen in Figure 17-3.

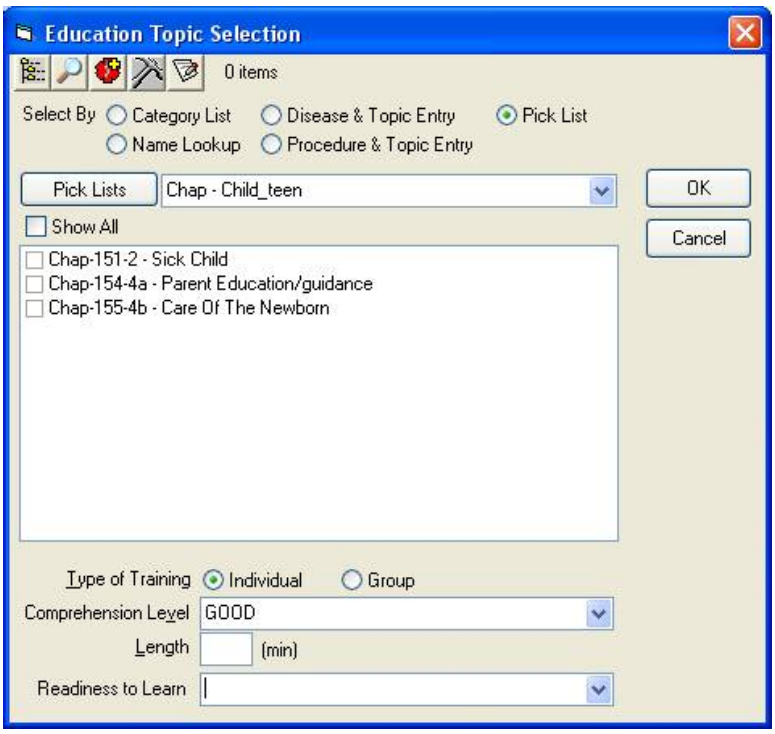


Figure 17-3: Using the **Pick List** option

If the button next to **Pick List**, at the far right of the buttons, is not selected, click it to select it as shown in Figure 17-3.

3. In the field next to **Pick Lists**, select the pick list that matches the chapter in the CHAM for this patient encounter.

   A list of patient education topics for the selected chapter in the CHAM, and the corresponding CHAM page numbers, is displayed in the box below the **Pick Lists** button, as shown in Figure 17-4.

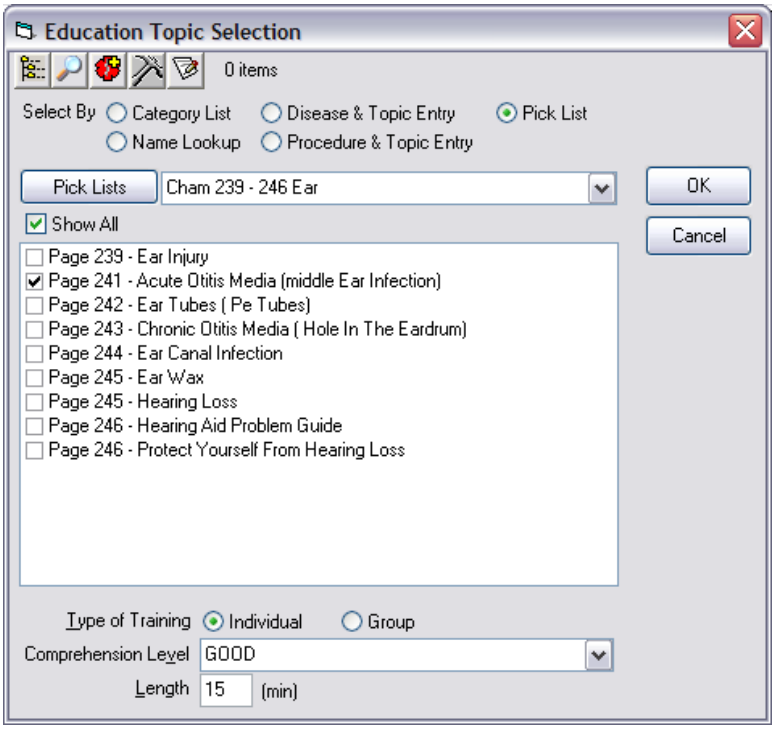


Figure 17-4: Patient education topics for the selected CHAM chapter listed with CHAM page numbers

4. Select one or more check boxes next to the appropriate patient education topic or topics for the patient.

Example: In Figure 17-4, the CHAM chapter "Cham 239-246 Ear" was selected from the **Pick Lists** field, and the patient education topic "Page 241 – Acute Otitis Media (middle Ear Infection)" was selected for the current patient.

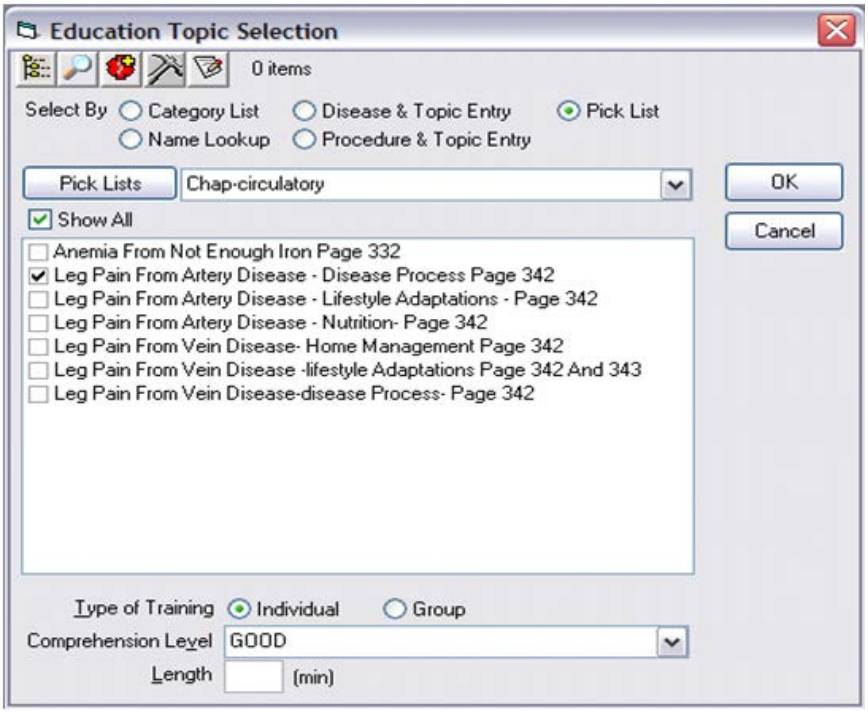


Figure 17-5: Patient education topics for the selected CHAM chapter listed with CHAM page numbers

Example: In Figure 17-5, the CHAM chapter "Chap-circulatory" was selected from the **Pick Lists** field, and the patient education topic "Leg Pain from Artery Disease - Disease Process Page 342" was selected for the current patient.

5. Complete the remaining items in the **Education Topic Selection** dialog.
   - **Type of Training**: Select either **Individual** or **Group**.
   - **Comprehension Level**: Click the arrow next to the **Comprehension Level** field to select **GOOD**, **POOR**, **FAIR**, or **REFUSED** from the field.
   - **Length**: Type the amount of time, in minutes, spent providing this patient education topic.
6. Click **OK** to close the dialog and return to the **Pt Ed** tab. The patient education topics that were selected are shown in blue in the **Education** pane, as shown in Figure 17-6.

7. Add as many patient education topics as necessary.

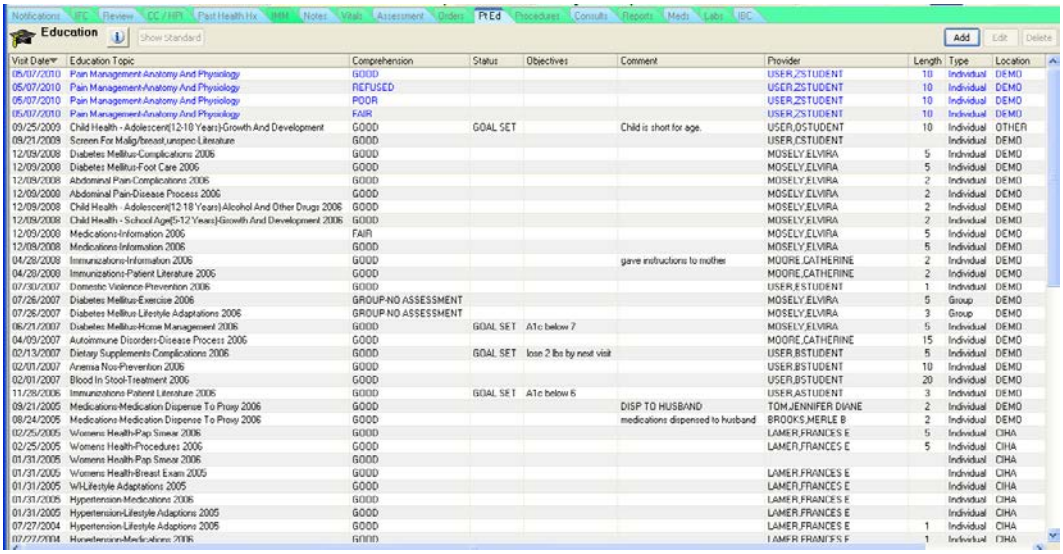


Figure 17-6: Newly added patient education topics appear in blue in the **Pt Ed** tab

8. To view additional information about a patient education topic, select the topic from the list and click **Show Standard** to open the **Standard** dialog. The **Standard** dialog contains a printable list of items to be communicated to the patient as part of patient education.

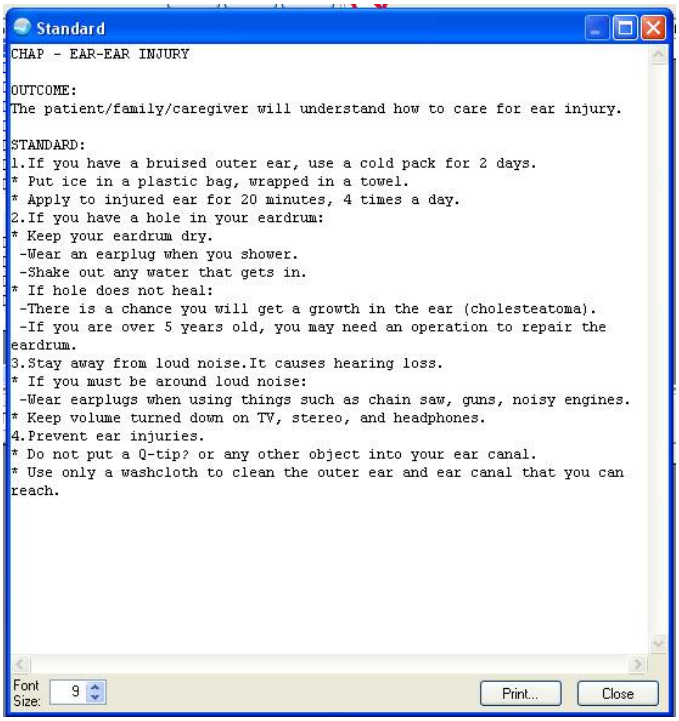


Figure 17-7: Patient education **Standard** dialog for an ear injury

17.2 Document a Patient Education Refusal

If a patient refuses a patient education topic, record the refusal using the **Education Topic Selection** dialog.

1. Follow Steps 1 – 6 in Section 17.1 to add the patient education topic.
2. In the **Comprehension Level** field, click the arrow next to the field.
3. Select **REFUSED** in the field.
4. Click **OK** to close the dialog and return to the **Pt Ed** tab.

17.3 Add a Comment to a Patient Education Record

To add a comment:

1. Select the education topic in the **Education** pane.
2. Click **Edit** at the right side of the pane.
3. Type the comment in the **Comment** field.
4. Click **OK**.

18.0 Record Labs, Assessments, and Plans

(Notes Tab/Lab Assessment Plan Template)

After providing education topics to the patient, return to the **Notes** tab to fill in the **Lab Assessment Plan** template.

This is the third time information is entered in a template on the **Notes** tab. After completing this step, sign the note. Signing a note is a **critical** step in completing the patient encounter.

Prior Steps

Before using the **Lab Assessment Plan** template on the **Notes** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)
13. Record patient education information (Section 17.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 18-1: Example of EHR toolbar showing patient name and encounter information

1. Click the **Notes** tab. Place the cursor at the end of the last note by clicking in the bottom of the note which is showing in the main **Visit** panel. See Figure 18-2.

The CHAP ENCOUNTER note created in Section 11.0, including the information entered into the **History** template and the exam templates, appears in the right side of the tab as shown in Figure 18-2.

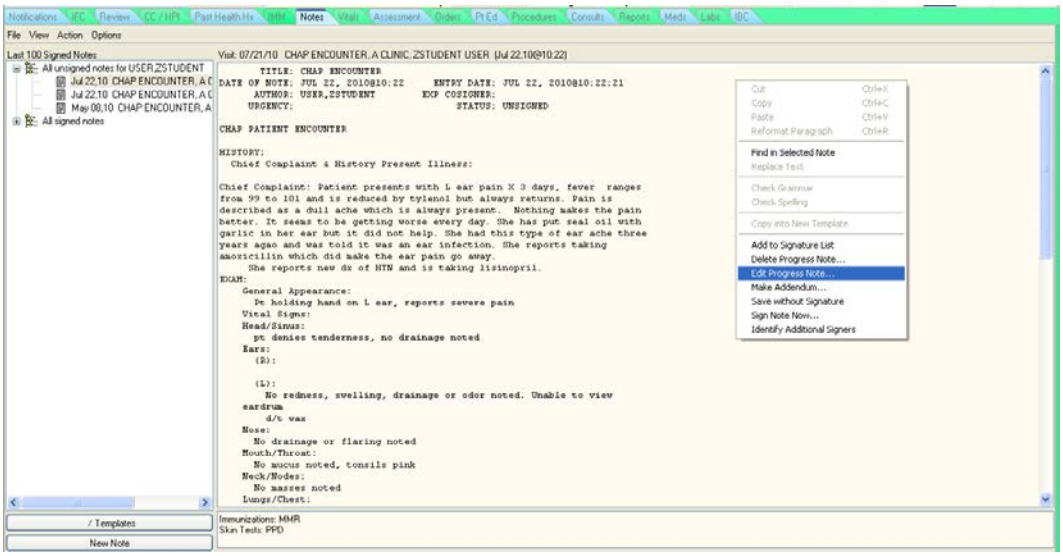


Figure 18-2: **Notes** tab with information from the **History** and **Exam** templates, and the context menu with **Edit Progress Note** highlighted

2. Right-click in the right side of the dialog to open the context menu.

3. Click **Edit Progress Note** as shown in Figure 18-3.

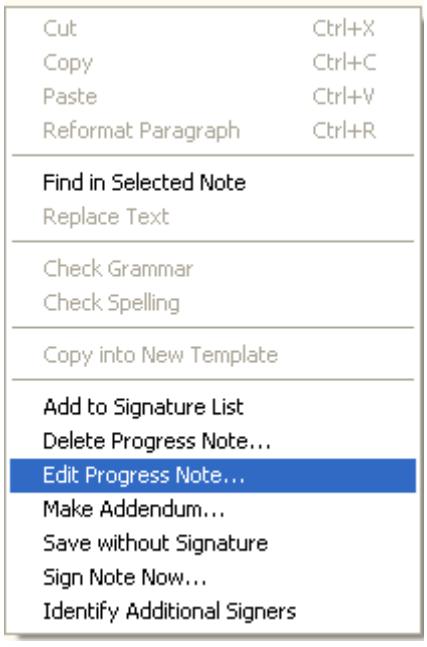


Figure 18-3: Context menu for the **Notes** tab

4. To open a lab assessment plan template that corresponds to the patient's complaint, double-click the **Lab Assessment Plan** template.

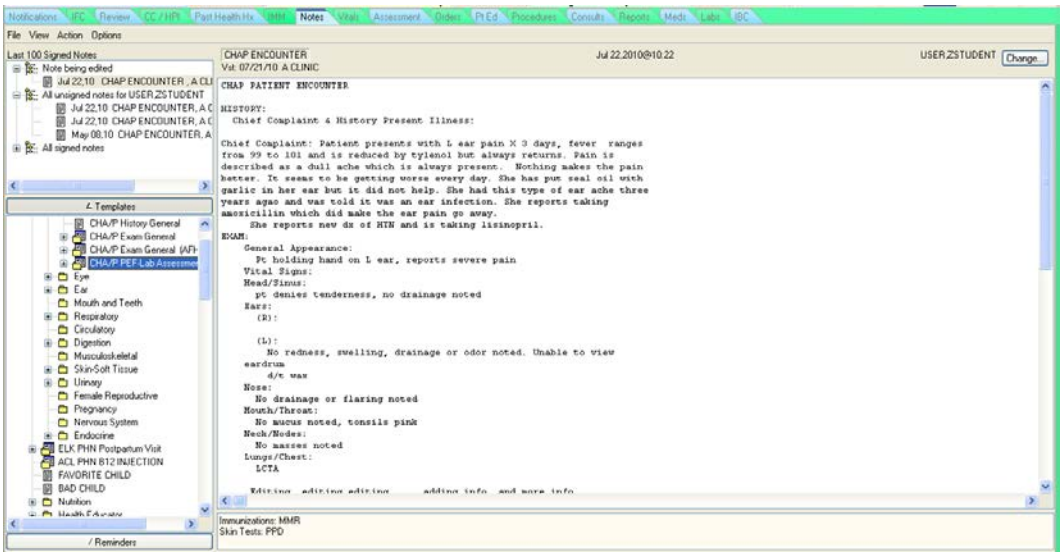


Figure 18-4: **General** folder in the **Templates** drawer

5. To enter text in the **Lab Assessment Plan** template, select the check box next to ****Click Here to Start using template****, as shown in Figure 18-5.

6. To enter comments in each section that applies to the current patient encounter:

   a. Select the checkboxes next to the appropriate sections (**Labs**, **ASSESSMENT**, and/or **PLAN**).

   b. Select the checkbox next to ****Click here to Continue**, as shown in Figure 18-5.

7. Click in the **Comments** field for each section to type comments, as shown in Figure 18-5.

Note: Comments cannot be typed in the **Comments** field unless *both* the checkbox next to the section title (**Labs**, **ASSESSMENT**, and/or **PLAN**) *and* the checkbox next to ****Click here to Continue** for that section are selected.

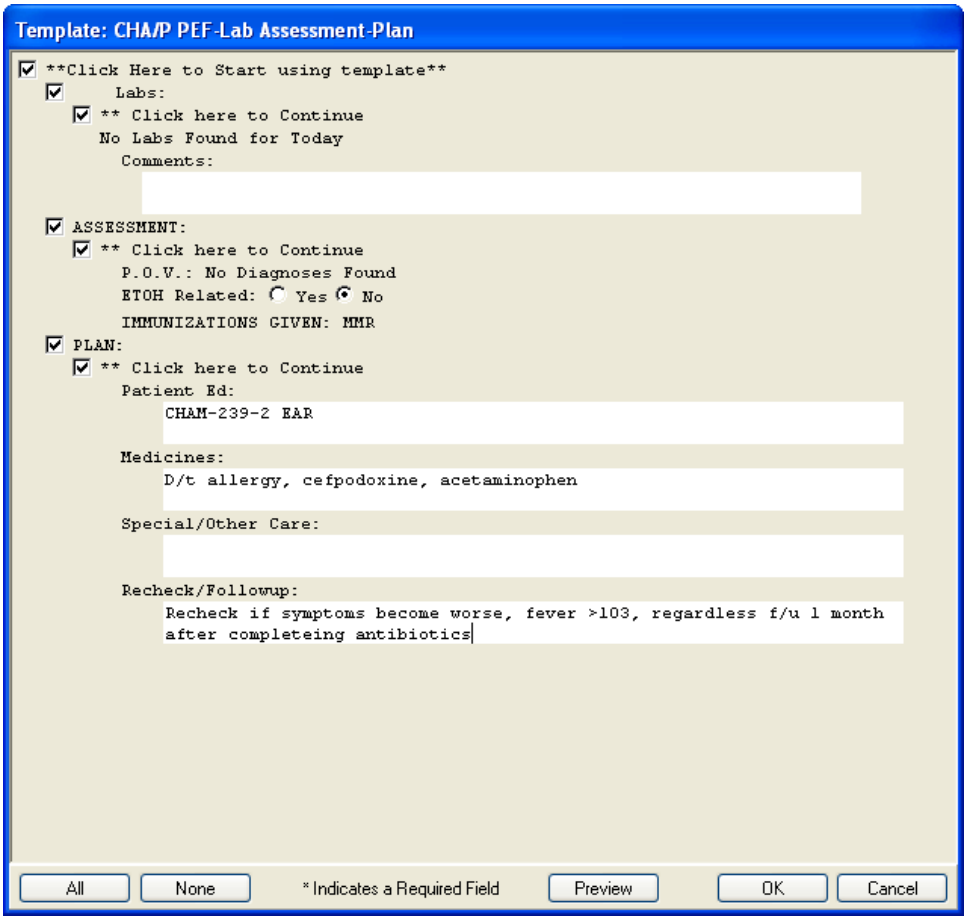


Figure 18-5: **CHA/P PEF-Lab Assessment Plan Template**

Complete this template as if the patient encounter information was being written in the paper PEF.

8. Finish entering comments in each section that is applicable to the patient encounter.

9. Click **OK**.

   The information entered in this template appears at the bottom of the CHAP ENCOUNTER note on the right side of the **Notes** tab, under headings titled according to the items that were selected in the **Lab Assessment Plan** template.

18.1 Sign the Note and Other Unsigned Entries

Fill in all the appropriate templates for this patient encounter, and ensure that the correct information has been added to the CHAP ENCOUNTER note. Then sign this note and any other items that are unsigned for this encounter.

Use the **Review/Sign Changes** dialog to sign the CHAP ENCOUNTER note. If there are unsigned adverse reactions, medication orders, or lab orders that were entered during this patient encounter, they will also appear in the **Review/Sign Changes** dialog.

1. Click **Awaiting Review/Signature** on the EHR toolbar, as shown in Figure 18-6.

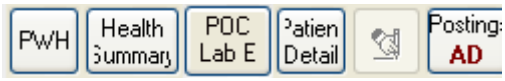


Figure 18-6: **Awaiting Review/Signature** button (when items are unsigned this button will become undimmed)

2. The **Review/Sign Changes** dialog lists the CHAP ENCOUNTER note under "Documents," as shown in Figure 18-7.

   If any adverse reactions, medication orders, or lab orders during this patient encounter have been entered, but are unsigned, they will be listed under "Adverse Reactions" and "Orders."

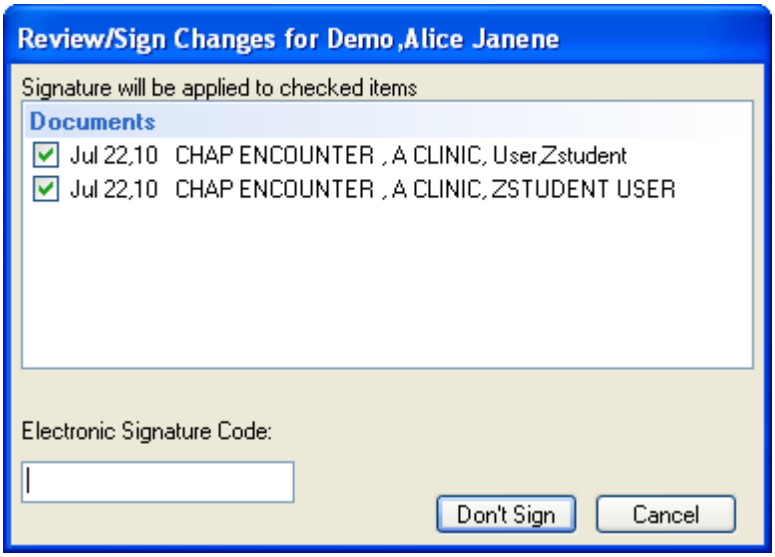


Figure 18-7: **Review/Sign Changes** dialog

3. Select the check boxes to the left of the items to be signed.

> **Note**: All items from the patient encounter that are available to be signed will be listed in the **Review/Sign Changes** dialog. If the CHAP ENCOUNTER note is not complete, deselect the check box next to the note before continuing to electronically sign the other items.

4. To sign the selected items, type the electronic signature code in the **Electronic Signature Code** field.

   While typing the signature code into the field, the **Don't Sign** button at the bottom of the dialog changes to the **Sign** button.

5. Click **Sign** to finalize the electronic signature on the selected items.

19.0 Review Billable Items and Historical Services

(Procedures Tab)

Use the **Procedures** tab to review the patient's billable items and historical services.

Prior Steps

Before using the **Procedures** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)
13. Record patient education information (Section 17.0)
14. Enter information on the Lab Assessment Plan template and sign the note and other items (Section 18.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 19-1: Example of EHR toolbar showing patient name and encounter information

The **Procedures** tab contains the **Evaluation and Management** pane, the **Visit Services** pane, the **Super-Bills** pane, and the **Historical Services** pane, as shown in Figure 19-2.

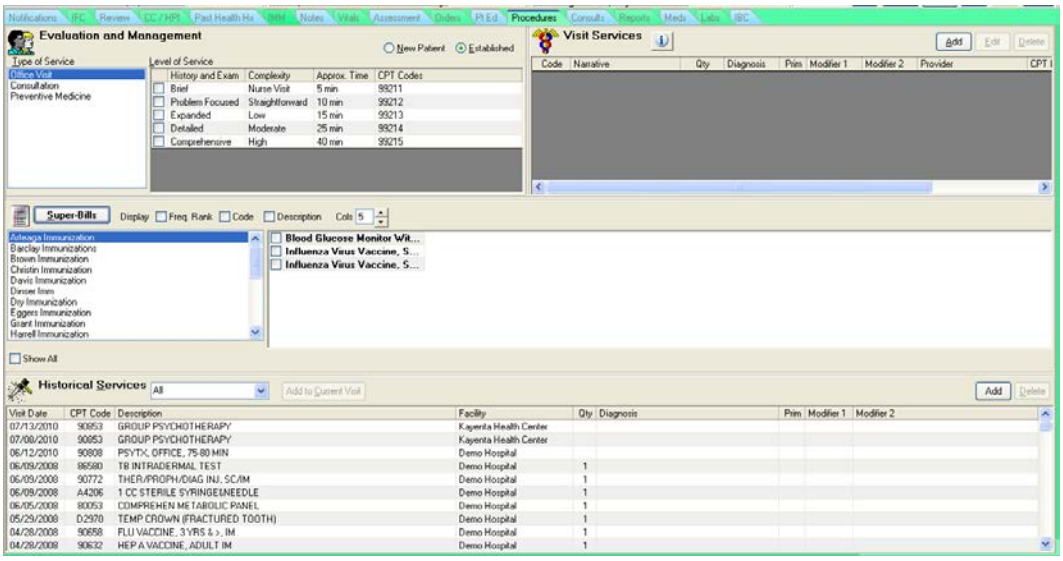


Figure 19-2: **Procedures** tab

The **Evaluation and Management** and **Visit Services** panes are used according to regional policy. CHA/Ps may be asked to use the **Super-Bills Pane**, and may want to review the information displayed in the **Historical Services** pane.

19.1 Super-Bills

Super-bills are lists of CPT codes for billing and for documenting services performed. Each super-bill is associated with a visit. The **Super-Bills** pane shows super-bills on the left part of the pane (located below the **Super-Bills** button). In the default view, the **Show All** check box is deselected (located in the bottom left corner of the pane), and displays items that have either no assigned clinic, no assigned hospital location, no assigned provider, or no assigned provider discipline.

Review a list of the patient's billable items in the **Super-Bills** pane, as shown in Figure 19-3.

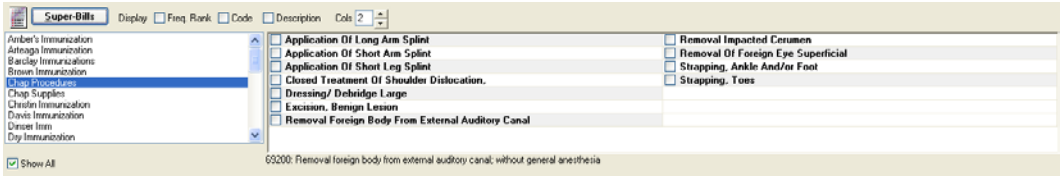


Figure 19-3: Example of the **Super-Bills** pane

> **Note**: When working in the **Super-Bills** pane, be sure that all of the **Display** check boxes to the right of the **Super-Bills** button (**Freq. Rank**, **Code**, and **Description**) are *unchecked*, and that the **Cols** field is set at "2."

To view a list of billable items in the right side of the **Super-Bills** pane, select **CHAP Procedures**, **CHAP Supplies**, or **CHAP Surgery** from the list on the left side of the pane. The list of procedures, supplies, or surgeries appears in the list on the right side of the pane.

Select the box to the left of the appropriate procedure, supply, or surgery. The items selected in the **Chap Procedures** list are displayed in both the **Historical Services** pane and the **Visit Services** pane.

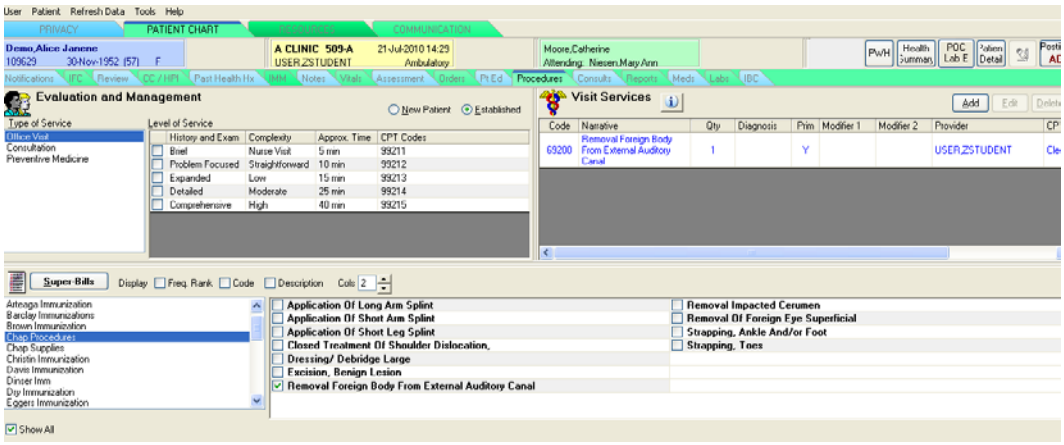


Figure 19-4: Recently selected Super-Bills display in the **Visit Services** pane

19.2 View Historical Services

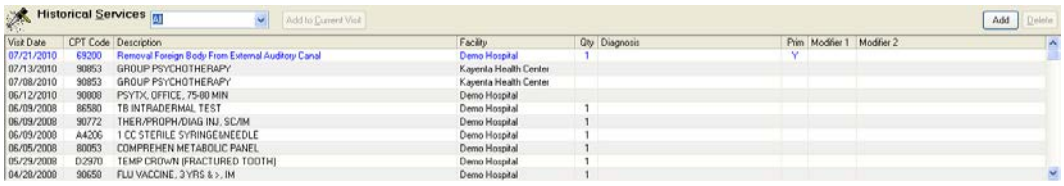


Figure 19-5: **Historical Services** pane

The list at the top of the **Historical Services** pane contains the following items:

- Surgical
- Medical
- Anesthesia
- Radiology
- Laboratory
- Dental Miscellaneous
- All

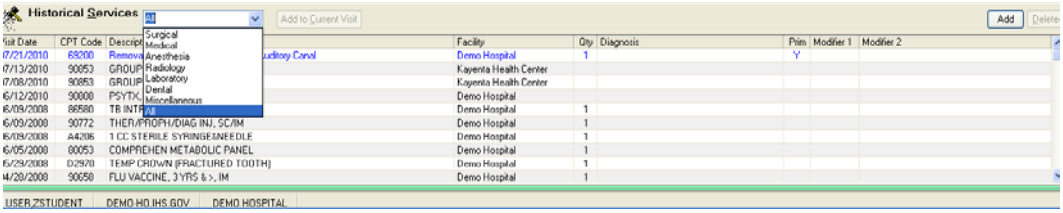


Figure 19-6: List for the **Historical Services** pane

20.0 The Consults Tab

Note: Use the **Consults** tab for review only.

Use the **Consults** tab to review consult notes, which are created when a provider consults a department or another service. Consults are requests from a clinician/provider to a hospital, service, or specialty for a service.

Prior Steps

Before using the **Consults** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)
13. Record patient education information (Section 17.0)
14. Enter information on the Lab Assessment Plan template and sign the note and other items (Section 18.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 20-1: Example of EHR toolbar showing patient name and encounter information

Consult notes include the following information: the patient's current status, order information, the "to service" and "from service," the requesting provider, the place of the consult, the urgency, the orderable items, the consult, a provisional diagnosis, and the reason for the request, as well as notes about the last action, notes, and pertinent history and findings.

1. To view a consult note, click the **Consults** tab, as shown in Figure 20-2.

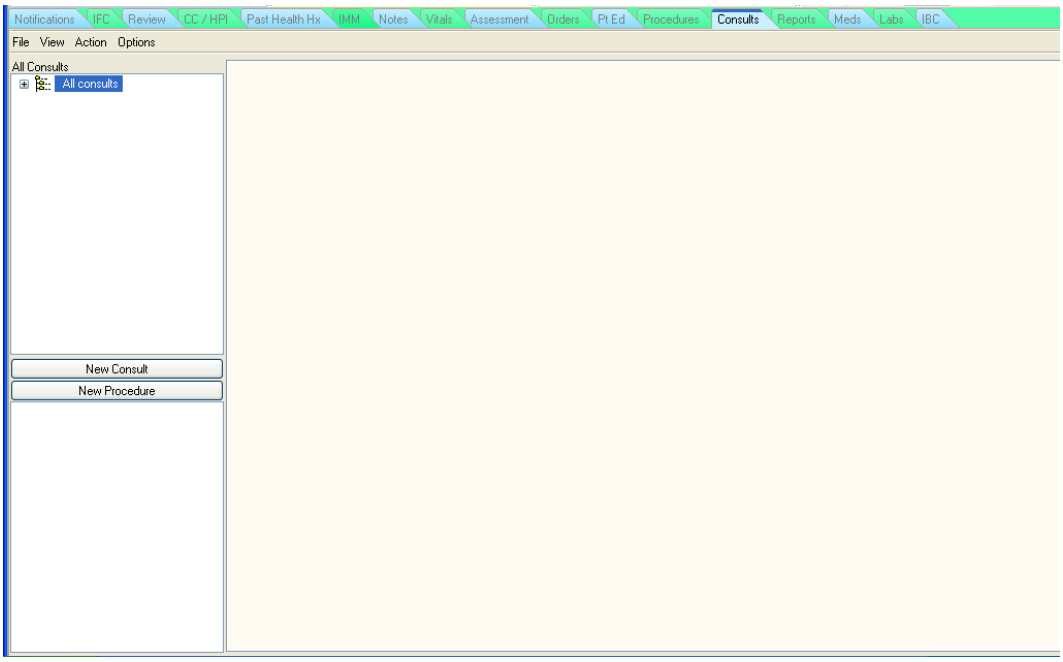


Figure 20-2: **Consults** tab

2. In the **All Consults** panel on the left side of the **Consults** tab, click the plus sign (+) next to the **All consults** folder to display the contents of the folder, as shown in Figure 20-3.

   If there is more than one consult ordered for the patient, the list of consults is displayed when the **All consults** folder is expanded.

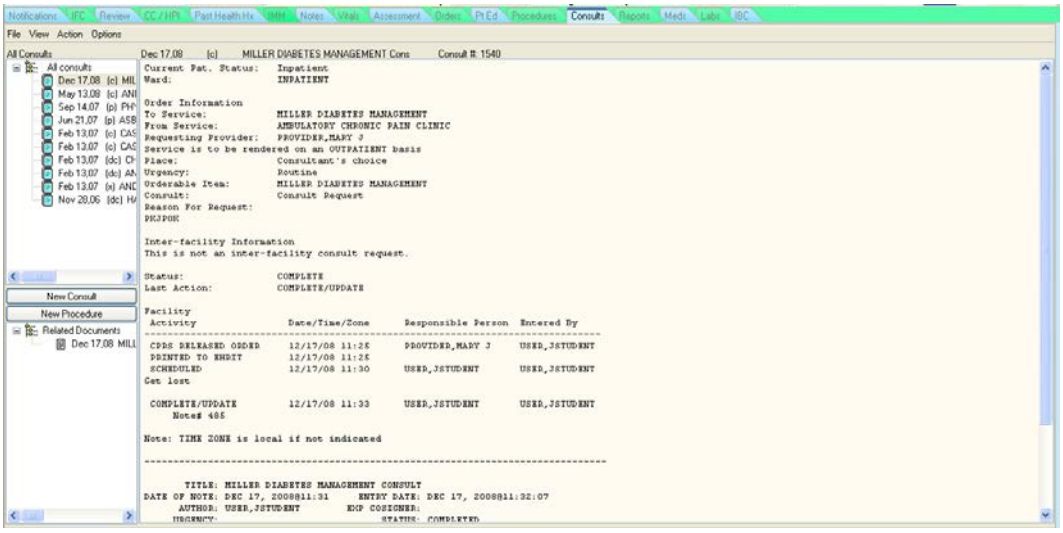


Figure 20-3: Selecting **All Consults**

3. Click a consult in the **All consults** folder to open the consult record in the right side of the **Consults** tab, as shown in Figure 20-4.

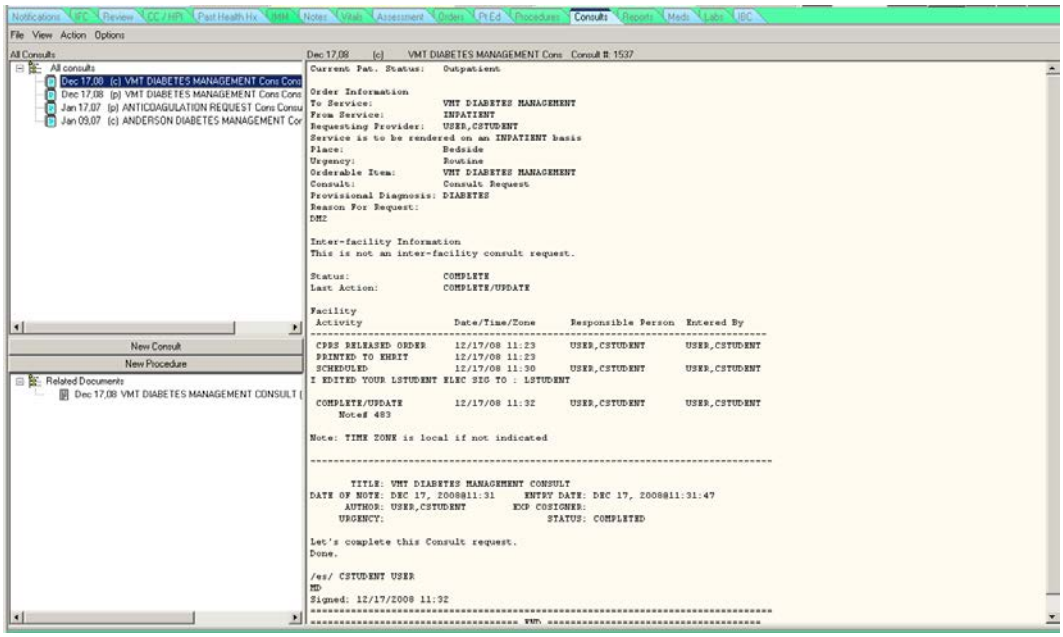


Figure 20-4: Selecting a consult

20.1.1 Consult Status

The status of a consult can be determined by the letter that follows the date. See the table below for a description of the consult status.

Abbreviation	Name	Description
a	Active	Orders that are active or that have been accepted by the service for processing.
c	Complete	Orders that require no further action.
dc	Discontinue	Orders that have been stopped prior to completion.
p	Pending	Orders that have been placed, but are not accepted.
pr	Partial Results	All or part of a consult completion report has been entered, but is unsigned.
s	Scheduled	The receiving clinic has scheduled an appointment for the patient.
x	Cancelled	Orders that have been rejected without being acted on.

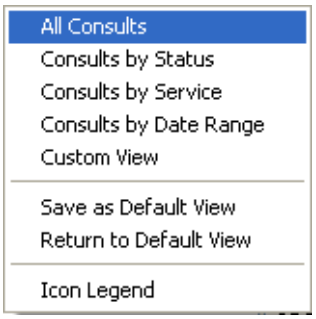


Figure 20-5: **View** menu in the **Consults** tab

Clicking **View** changes the items that will be displayed in this tab, and includes the following:

- All Consults (displays all consults for the current patient)
- Consults by Status (select a status and sort order)
- Consults by Service (select a service and sort order)
- Consults by Date Range (select a date range and sort order)

> **Ref**: If the patient requires a consult, refer to the CHAM or to regional organizational policy.

21.0 Print a Health Summary

(Reports Tab)

Use the **Reports** tab to print a Health Summary Patient Wellness Handout for the patient. This must be done at the end of the encounter.

Prior Steps

Before using the **Reports** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)
13. Record patient education information (Section 17.0)
14. Enter information on the Lab Assessment Plan template and sign the note and other items (Section 18.0)
16. Review information on the Consults tab (Section 20.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 21-1: Example of EHR toolbar showing patient name and encounter information

Figure 21-2: **Reports** tab

The information in the health summary comes from all RPMS packages. The patient wellness handout has a list of current medications, and provides an overview of patient's health information.

A health summary includes patient demographic data, allergies, currently active medical problems, and laboratory results. The health summary information is displayed in the **Health Summary** panel of the **Reports** tab.

A list of reports available for the patient is displayed in the **Available Reports** panel of the **Reports** tab.

- The **All Outpatient** report lists the patient's current and past medications.
- The **Patient Wellness Handout** report provides information about the patient's medical conditions. This handout provides another method for the CHA/P and the patient to review information about his or her health.

Print the **Patient Wellness Handout** report at the end of the patient encounter.

1. To open the patient wellness handout, click the **Patient Wellness Handout** option in the **Available Reports** panel, as shown in Figure 21-3.

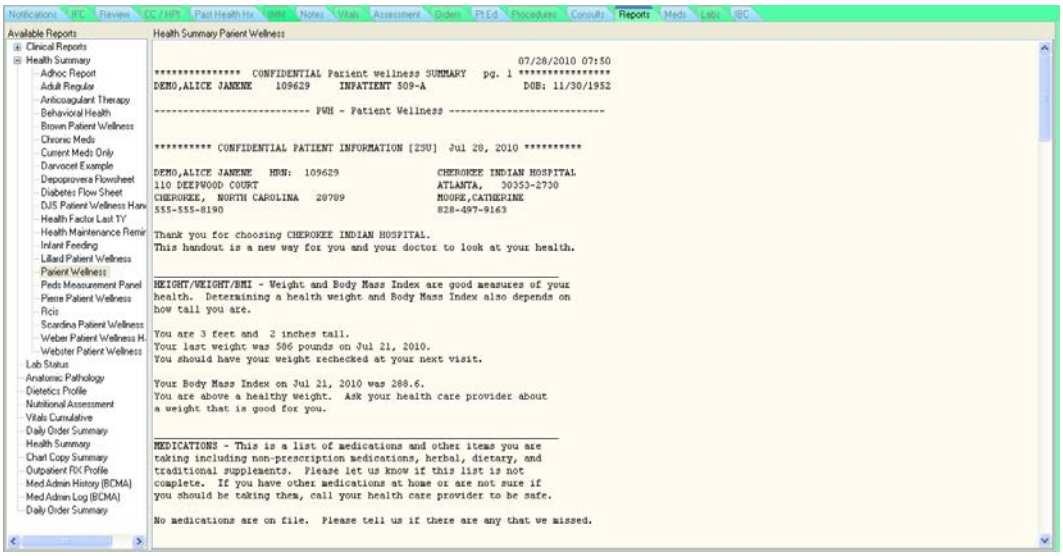


Figure 21-3: Choosing a patient wellness handout

2. To print the patient wellness handout, click **PWH** on the EHR toolbar.

Figure 21-4: **PWH** button

3. In the **Patient Health Summary** dialog, click **Print**, as shown in Figure 21-5.

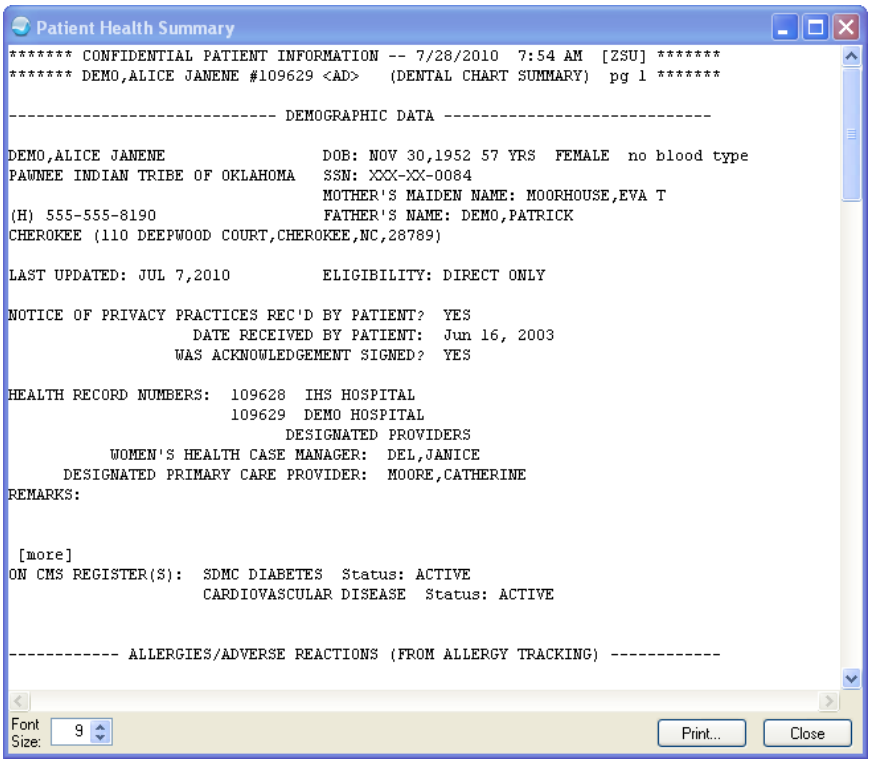


Figure 21-5: **Patient Health Summary** dialog

22.0 The Labs Tab

Use the **Labs** tab to review the current patient's lab tests and results. The **Labs** tab is for review only. No data can be entered on this tab.

Prior Steps

Before using the **Labs** tab, complete the following steps:

1. Log on to the EHR (Section 3.0)
2. Select the patient (Section 5.1)
3. Create a visit (Section 5.2)
4. Enter the patient's chief complaint and history of present illness information (Section 7.0)
5. Review and update the patient's past health history (Section 8.0)
6. Update the patient's immunization and skin test records (Section 10.0)
7. Enter information in the History template (Section 11.0)
8. Enter the patient's vitals (Section 12.0)
9. Enter information in one or more exam templates (Section 13.0)
10. Order a lab Point of Care test (Section 14.0)
11. Enter an assessment of the patient's problem (Section 15.0)
12. Order medications and labs (Section 16.0)
13. Record patient education information (Section 17.0)
14. Enter information on the Lab Assessment Plan template and sign the note and other items (Section 18.0)
16. Review information on the Consults tab (Section 20.0)
17. Print the patient's health summary (Section 21.0)
18. Review the information on the Meds tab (Section 8.0)

The correct patient's name, demographic information, and encounter information must appear on the Patient panel and the Visit panel:

Figure 22-1: Example of EHR toolbar showing patient name and encounter information

The **Labs** tab is for review only. Results can be filtered by Most Recent, Cumulative, All Tests by Date, Selected Tests by Date, Worksheet, Graph, and Lab Status.

> **Note**: The **Labs** tab may have additional items listed in the **Lab Results** panel. Refer to regional policy for additional information about using this tab.

1. Click the **Labs** tab to display the list of the patient's lab tests and results.

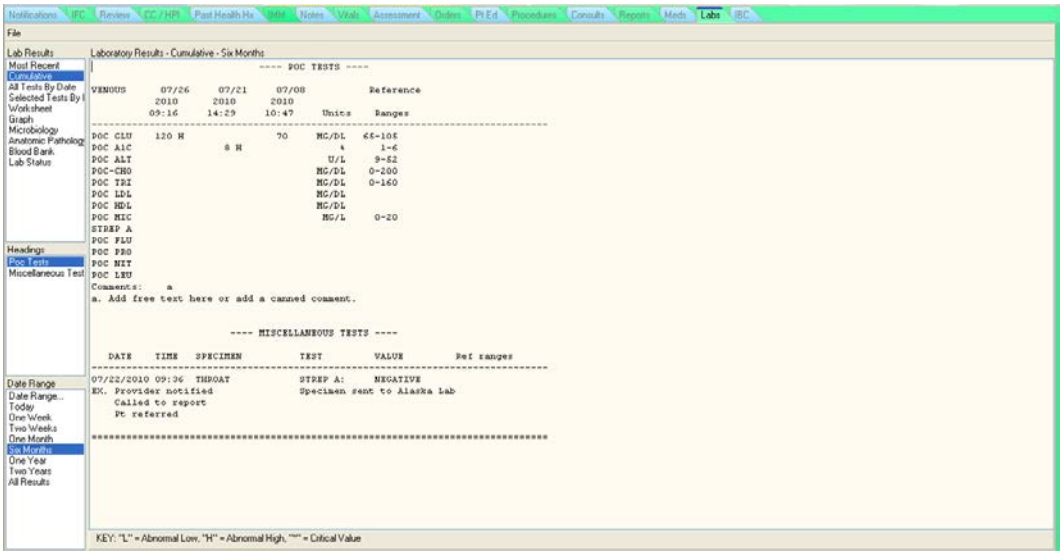


Figure 22-2: **Labs** tab

2. Click **Most Recent** in the **Lab Results** panel to sort the list by the most recent lab result.

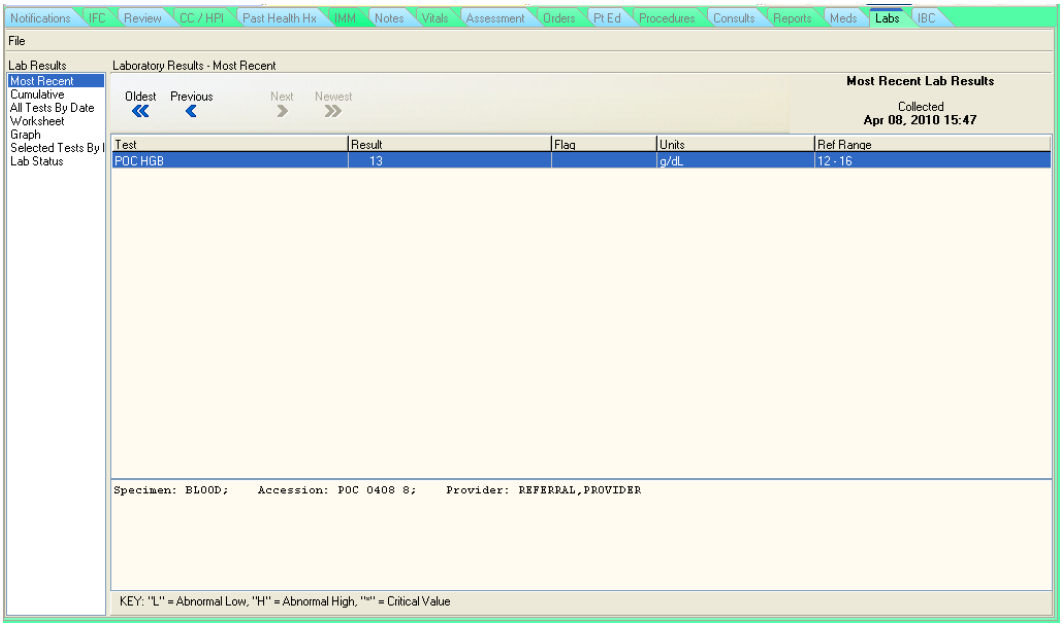


Figure 22-3: Selecting **Most Recent** in the **Lab Results** panel

The **Oldest**, **Previous**, **Next**, and **Newest** arrows at the top of the **Laboratory Results** panel sort lab results by date. Click an arrow to move through the results.

The key at the bottom of the dialog defines the items that may be displayed in the **Flag** column. "L" is Abnormal Low, "H" is Abnormal High, and "*" is Critical Value.

3. In the **Lab Results** panel, click **Cumulative**, and then select a date range and heading. For example, Figure 22-4 shows lab results for six months for a heading of Hematology I.

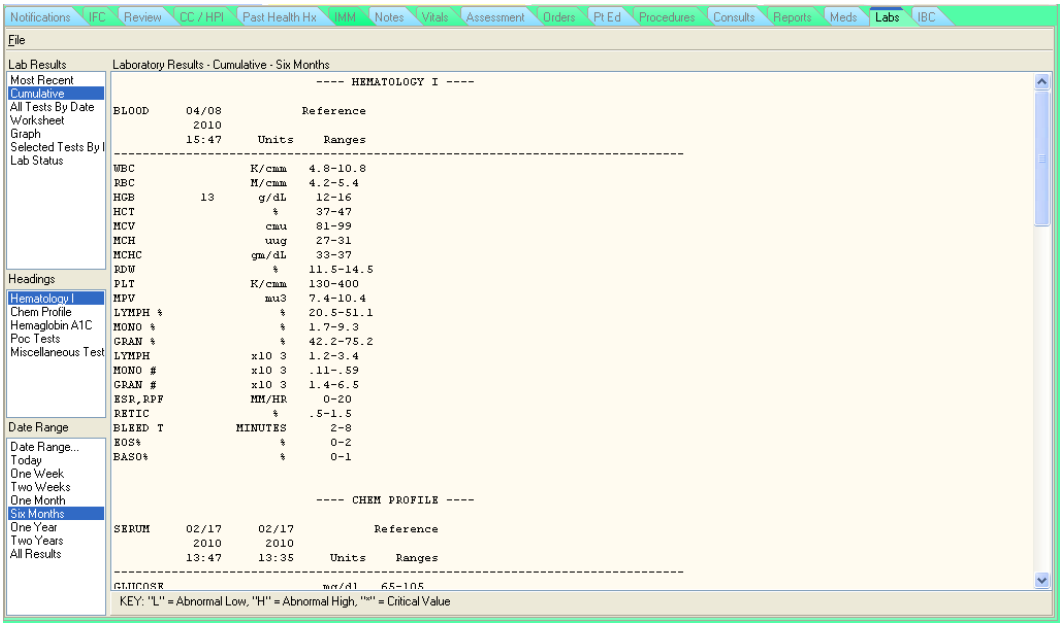


Figure 22-4: Selecting **Cumulative** in the **Lab Results** panel

4. Click the **Date Range** option in the **Date Range** panel to open the **Date Range** dialog.

Note:	If no date range is selected in the **Date Range** panel, no lab results are displayed.

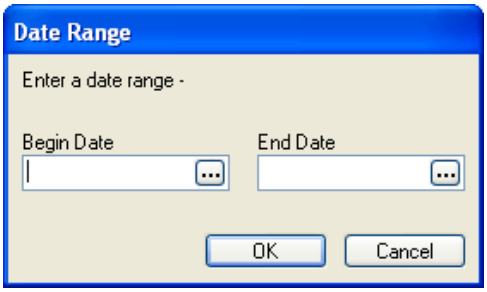


Figure 22-5: **Date Range** dialog

5. Click **More** to open the **Select Date/Time** dialog, which contains a calendar with today's date highlighted in red.

   Click **Today**, or use the arrows at the top to go forward or backwards in time. The single arrow (closest to the date) moves through the calendar by month. The double arrow moves by year. Choose a date and click **OK**.

6. Select **All Tests by Date** in the **Lab Results** panel and choose the date range (Today, One Week, Two weeks, etc.) from the **Date Range** panel. The lab results sort by date, starting with the most recent date in the **Laboratory Results** panel.

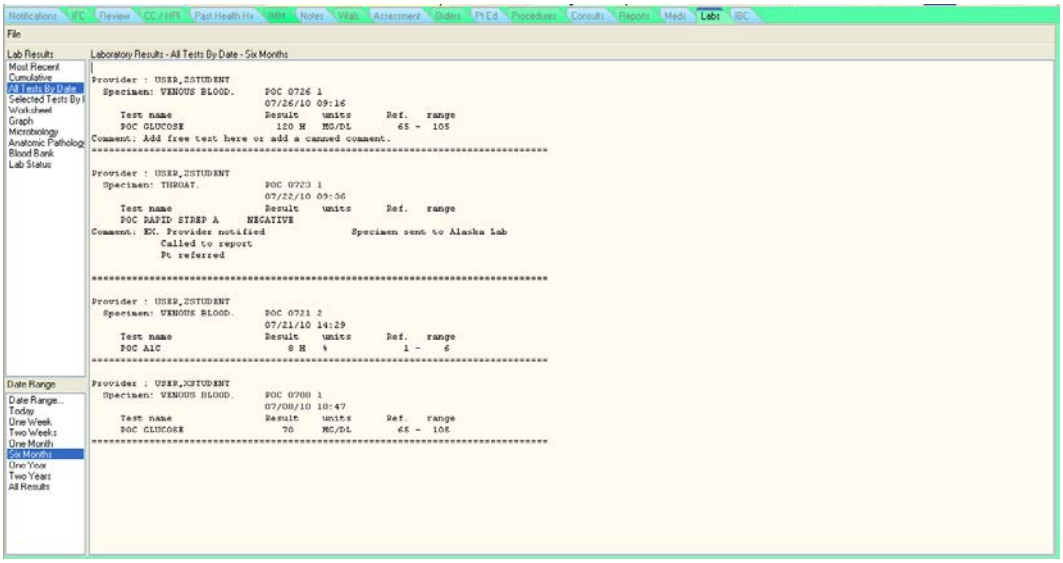


Figure 22-6: **All Tests by Date** option

7. Click **Worksheet** in the **Lab Results** panel to open the **Select Lab Tests** dialog, as shown in Figure 22-7.

Note: Worksheets are site specific, and are created by CACs.

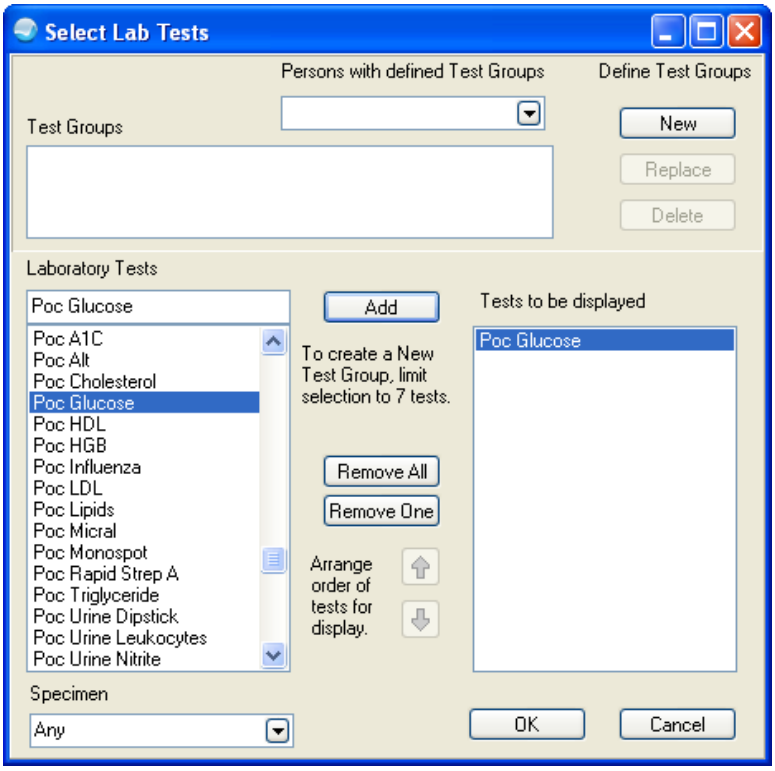


Figure 22-7: Selecting tests in the **Select Lab Tests** dialog

8. To choose tests, click on items in the **Laboratory Tests** lists and click **Add** to move them to the **Tests to be displayed** list. Choose as few or as many tests as necessary.

9. Arrange the order of tests by selecting a test in the **Tests to be displayed** list and clicking either the up arrow or the down arrow (located between the **Laboratory Tests** list and the **Tests to be displayed** list).

10. Click **OK** to display a worksheet with the list of tests that have been selected. In Figure 22-8, POC GLU is the only test that was selected.

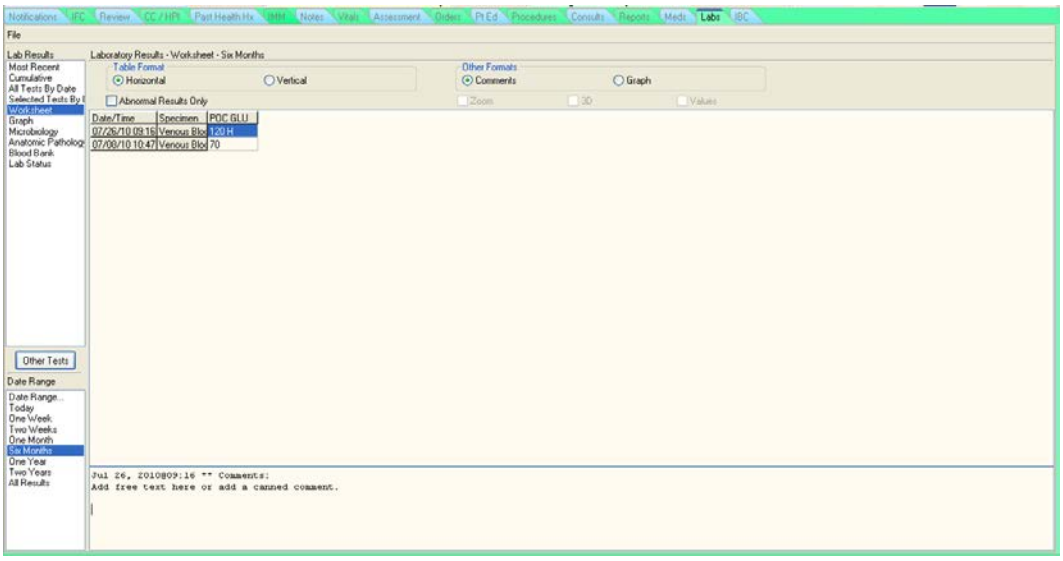


Figure 22-8: Worksheet showing the selected tests

The **Worksheet** shows labs that were selected in the order that they were picked in the **Select Lab Tests** dialog.

11. Click **Graph** in the **Lab Results** panel to open the **Select Lab Test for Graph** dialog.

    - Click on an item from the **Laboratory Test** list to choose it, and then click **OK**.

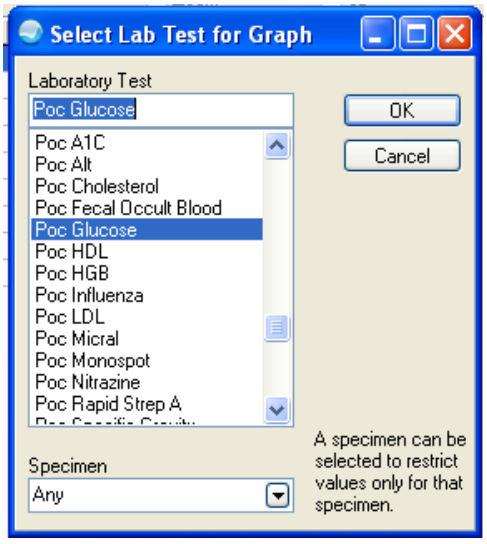


Figure 22-9: Selecting a test to graph

    - Select a date range from the **Date Range** panel.
    - Click either **Horizontal** or **Vertical** in the **Table Format** panel to display the graph in either horizontal or vertical format.

- Click either **Comments** or **Graph** in the **Other Formats** panel to display the lab results with comments or as a graph.

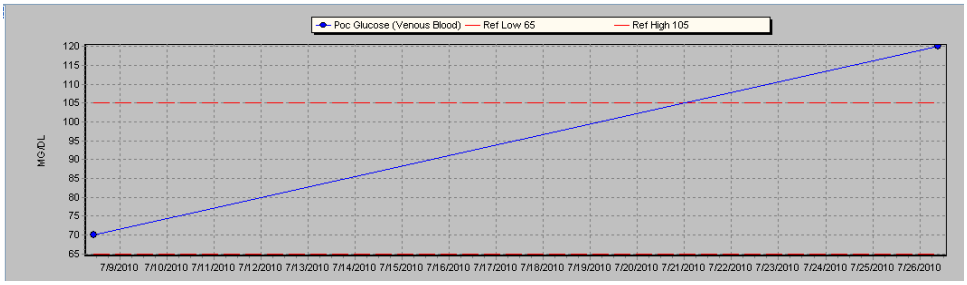


Figure 22-10: Graph showing results over a six-month period with **Zoom**, **3D**, and **Values** highlighted

The graph can be viewed using the **Zoom**, **3D**, or **Values** options.

- **Zoom** enlarges an area of the graph by clicking and dragging.
- **3D** makes the graph into a three-dimensional representation.
- **Values** places numeric results next to each point on the graph.

Comments are displayed in the area below the graph.

12. Click **Selected Tests by Date** in the **Lab Results** panel, and click **OK** to open the **Select Lab Tests** dialog. Choose a lab test by clicking an item in the **Laboratory Tests** list and clicking **Add**. Choose as many or as few tests as necessary.

> **Note**: If an item is accidentally added to the **Tests to be displayed** panel, use **Remove One** or **Remove All** to remove one or all items from the list.

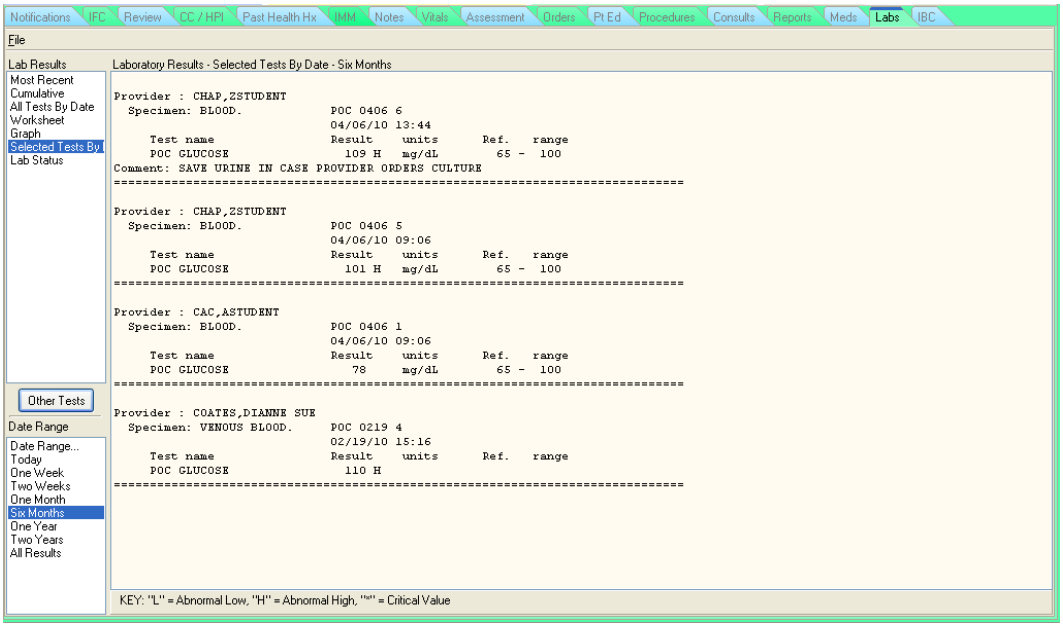


Figure 22-11: **Selected Tests By** with a date range of six months highlighted

The lab results are displayed in order with the most recent lab first.

Figure 22-12: Lab Status option

The **Lab Status** option shows tests that were ordered by status:

- Unreleased

- Pending
- Active
- Complete

There are no results on this page.

23.0 Notifications Tab

Notifications are messages that provide important patient information or alert the recipient to act on a clinical event. Clinical events, such as critical lab values or a change in orders, trigger a notification. Notifications may require action or may be informational only. If action is required, instructions are displayed in the **Notification** column.

New notifications can be scheduled to be delivered to recipients at a specified time, and existing notifications can be forwarded to other recipients.

A CHA/P who is going to be on leave or traveling can designate another person as a surrogate to receive his or her notifications. All notifications that would ordinarily come to the CHA/P during that time are forwarded to the designated surrogate.

Each individual tribal health organization may choose not to use notifications, or may use these features on a limited basis.

> **Note**: Follow regional policy to determine if and how the tribal health organization uses the **Notifications** tab.

Click the **Notifications** tab. When there are no notifications to act on, this screen will be blank.

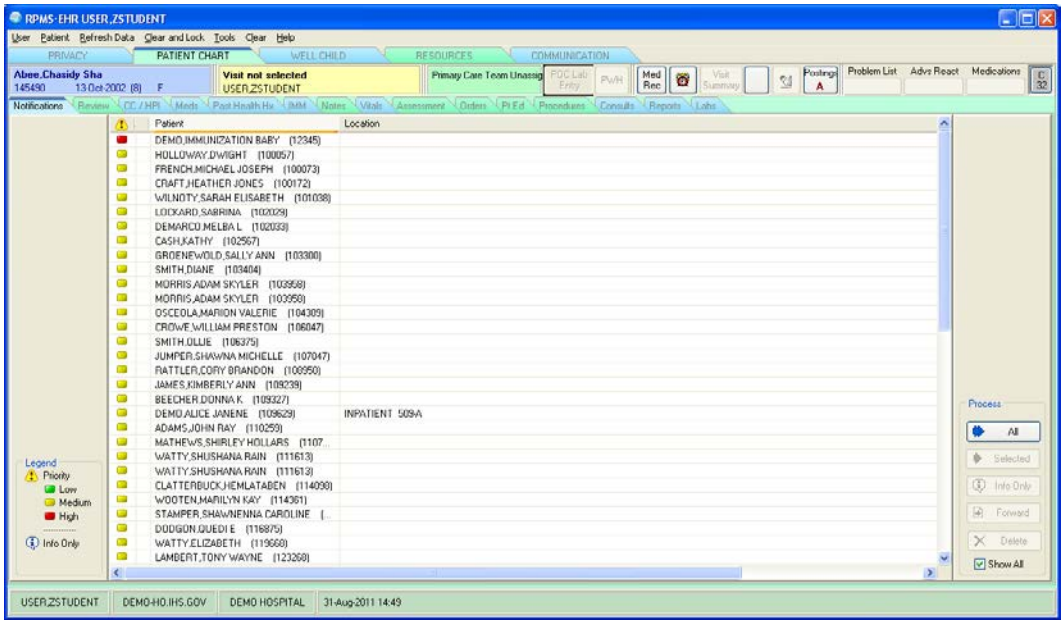


Figure 23-1: **Notifications** tab

Notifications for multiple patients can appear in the **Notifications** tab if the **Show All** check box is selected. Each patient's HRN appears in parentheses next to the patient name to ensure that a notification is being processed for the correct patient.

Notifications can include orders requiring a signature, a visit missing a POV, or lab results. Providers may also include information regarding required actions for patients.

> **Note**: To see only notifications for the current patient, deselect the **Show All** checkbox in the lower right corner. To see *all* notifications, select the **Show All** checkbox, as shown in Figure 23-1.

Notifications are only displayed for a period of time specified by the site.
Information in a notification is not a part of the patient's official medical record.
When working in the **Notifications** tab, confirm that the correct patient has been selected in the patient panel.

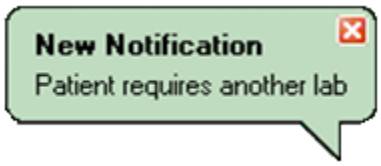


Figure 23-2: **New Notification** alert

When a new notification is received, an alert is displayed in the lower right corner of the EHR window. The alert is displayed regardless of the tab that is currently selected.

To close an alert, click the red "X" in the top right corner of the **New Notification** pop-up.

> **Note**: After the alert is closed, the notification still appears in the list on the **Notifications** tab.

Notifications stay on the **Notifications** tab for a period of time determined by the site, or until the notification is processed.

Each notification is assigned a priority of low, medium, or high when it is created. There are two types of notifications:

- Notifications requiring the CHA/P to perform an action in the EHR, such as signing a note or providing a purpose of visit.
- Information-only notifications that must be reviewed by the CHA/P.

If a notification has an **Info Only** icon (Figure 23-3) next to the patient name, hold the cursor over the icon to display a tooltip containing additional information about the patient.

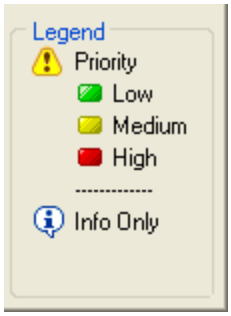


Figure 23-3: Legend at the bottom left corner of the **Notifications** tab

To sort the list of notifications, click a column heading. For example, to sort the notifications by priority, click the **Priority** icon (Figure 23-3).

Double-click a notification in the list to open the tab referenced by the notification. For example, if a notification for an unsigned note is displayed, double-clicking the notification automatically opens the **Notes** tab.

23.1 Process Notifications

Notifications can be processed by doing one of the following:

- Right-click in the white part of the **Notifications** tab and select one of the options in the context menu (Figure 23-4)

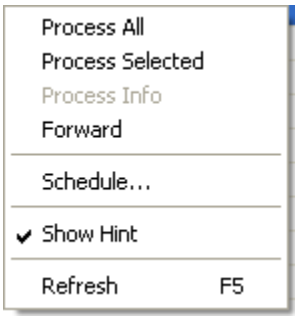


Figure 23-4: Context menu in the **Notifications** tab

- Click one of the buttons in the **Process** panel in the lower right corner of the **Notifications** tab (Figure 23-5).

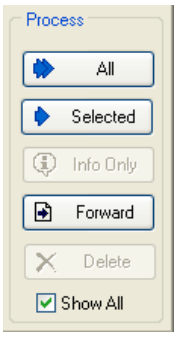


Figure 23-5: **Process** buttons in right corner of **Notifications** tab

Table 23-1: Buttons in **Process** panel of **Notifications** tab

Button	Function
All	Click to process all notifications. Use the **Processing Notifications** dialog to go to the tab referenced by the first notification, and follow the instructions to process the notification. Click **Next** to go to the next notification.
Selected	Select a notification and click **Selected** to go to the tab referenced by the first notification, and follow instructions to process the notification.
Info Only	Click **Info Only** to process all information-only notifications in the column marked with mark.
Forward	Click **Forward** to display **the Notification Recipients** dialog. Users and/or groups can be selected to become the recipients of the selected notification.
Delete	Click **Delete** to delete a selected information-only notification.

23.1.1 Notifications Requiring Action

Notifications requiring action must be processed by going to the appropriate EHR tab and completing the required activity. A single notification can be processed by itself, or all the notifications in the list can be processed in sequence.

23.1.1.1 Process a Single Notification

To process a single notification requiring action:

1. Click the notification to select it.
2. Do one of the following to open the EHR tab referenced by the notification and take the appropriate action:
   - Double-click on the notification.

- Right-click anywhere on the white part of the window and select **Process Selected** in the context menu.
- Click **Selected** in the **Process** panel in the lower right corner of the **Notifications** tab.

23.1.1.2 Process All Notifications in the List

To process all the notifications in the list requiring action:

1. Do one of the following to display the **Processing Notifications** dialog:
   - Right-click anywhere on the white part of the window and select **Process All** in the context menu.
   - Click **All** in the **Process** panel in the lower right corner of the **Notifications** tab.
2. In the **Processing Notifications** dialog, click **Next** to open the EHR tab referenced by a notification.
3. Take the appropriate action for the notification.
4. Click **Next** again to go to the next notification.

23.1.2 Information-Only Notifications

A notification with an **Info Only** icon requires review, as shown in Figure 23-6. A single information-only notification can be processed by itself, or all the information-only notifications in the list can be processed in sequence.

Figure 23-6: Processing an information-only notification

Process a Single Information-Only Notification

To process a single information-only notification:

1. Click the notification to select it.
2. Do one of the following to open the notification dialog:

- Double-click on the information-only notification.
- Right-click anywhere on the white part of the window and select **Process Info** in the context menu.
- Click **Info Only** in the **Process** panel in the lower right corner of the **Notifications** tab.

3. Click one of the buttons in the notification dialog to process the information-only notification.

Process All Information-Only Notifications in the List

To process all the information-only notifications:

1. Do one of the following without any notifications selected in the list to open the notification dialog for the first notification:

   - Right-click anywhere on the white part of the window and select **Process Info** in the context menu.
   - Click **Info Only** in the **Process** panel in the lower right corner of the **Notifications** tab.

2. Click one of the buttons in the notification dialog to process each information-only notification. Clicking **Delete** or **Skip** opens the next information-only notification in the list for processing.

Notification Dialog Buttons

The following buttons are available in the notification dialog:

- **Delete:** Removes the current information-only notification from the **Notifications** tab
- **Skip:** Moves to the next information-only notification in the **Notifications** tab
- **Cancel:** Closes the notification dialog
- **Delete All:** Removes all of the information-only notifications from the **Notifications** tab
- **Skip All:** Stops processing the information-only notifications
- **View Patient:** Opens the patient's chart

23.1.3 Forward a Notification

To forward a notification to another person, follow these steps:

1. Click a notification to select it, and do one of the following to display the **Notification Recipients** dialog:

- Right-click anywhere in the white area of the window and select **Forward** in the context menu.
- Click **Forward** in the **Process** panel in the lower right corner of the **Notifications** tab.

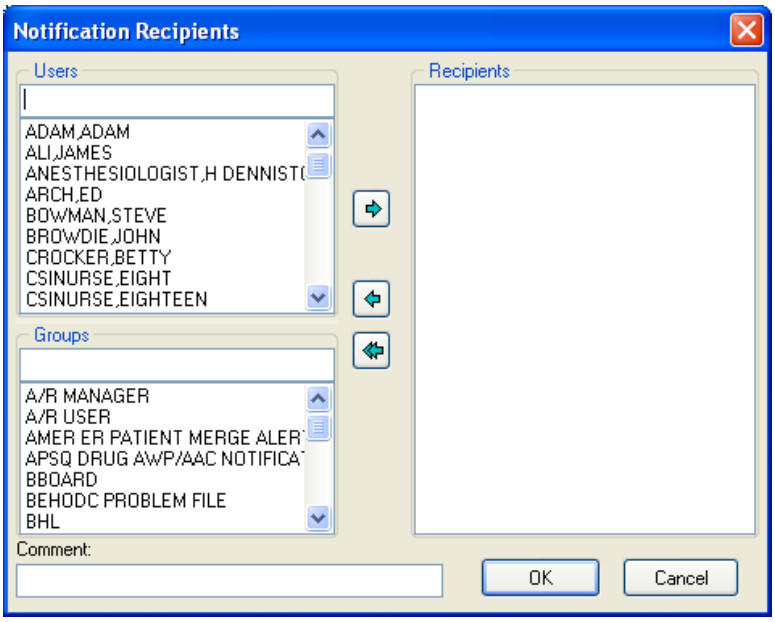


Figure 23-7: **Notification Recipients** dialog

2. To choose the names of the people to receive this notification, select one or more names in the **Users** list. To move the name or names to the **Recipients** list, click the green arrow pointing to the right.

   If a name is accidentally added to the **Recipients** list, select the name in the **Recipients** list and click the green arrow pointing to the left (Figure 23-8) to remove it.

   To remove all names from the **Recipients** list, click the double green arrow pointing to the left (Figure 23-8).

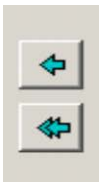


Figure 23-8: The top arrow pointing to the left removes the selected name or names from the **Recipients** list. The bottom double arrow removes all names from the **Recipients** list.

- A group may also be added as a recipient. For example, the Diabetes Group may include a dietician, a physician, a nurse, and an educator in the list. When a group has been selected as a recipient, every name included in the group receives the notification.

3. To add a comment to the forwarded notification, type the comment in the **Comment** field.

4. Click **OK** to forward the notification to the selected recipients.

23.1.4 Schedule a Notification

The **Schedule** option on the context menu creates an information-only notification and schedules it for delivery to recipients at a future date and time. The notification is displayed to the recipients at the scheduled delivery time.

1. Right-click anywhere in the white part of the **Notifications** tab. Click **Schedule** in the context menu to display the **Notification Scheduling** dialog, as shown in Figure 23-9.

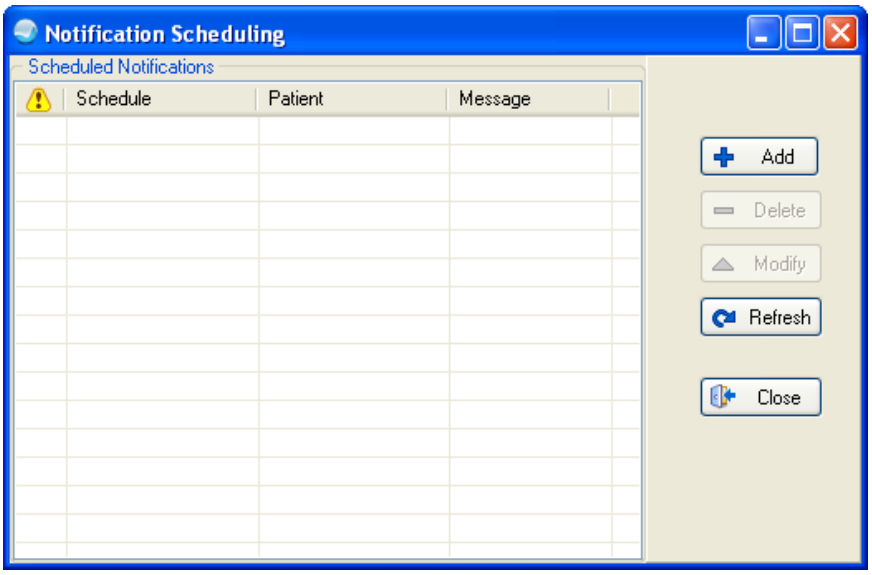


Figure 23-9: **Notification Scheduling** dialog

The following buttons are available in the **Notification Scheduling** dialog:

- **Add**: Adds a new scheduled notification
- **Delete**: Removes the selected scheduled notification
- **Modify**: Allows modifications to the selected scheduled notification
- **Refresh**: Updates the **Scheduled Notifications** list with the most recent changes
- **Close**: Closes **the Notification Scheduling** dialog

2. Click **Add** to display the **Schedule a Notification** dialog, as shown in Figure 23-10.

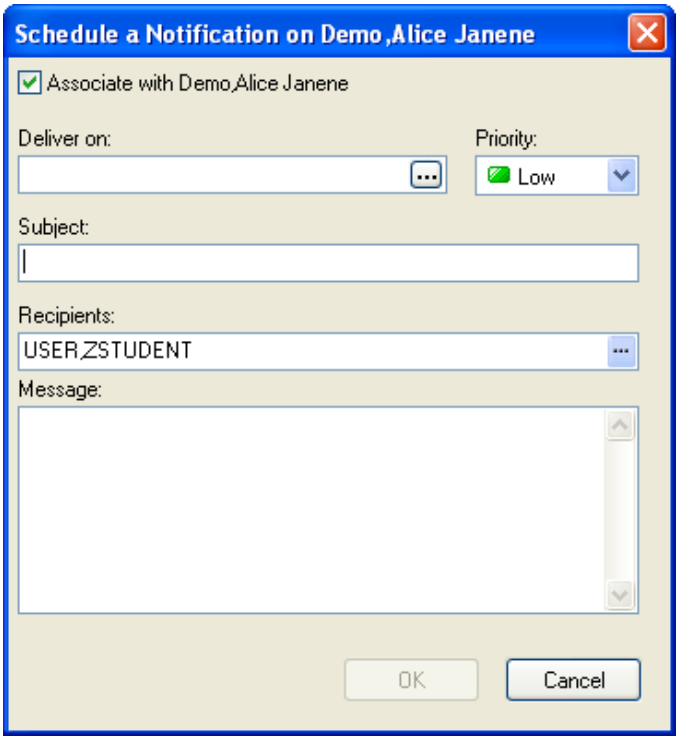


Figure 23-10: **Schedule a Notification** dialog

3. To associate the notification with a specific patient, select the **Associate with <Patient Name>** check box.

   To send a general notification not associated with a specific patient, unselect the **Associate with <Patient Name>** check box.

4. Click the button at the right of the **Deliver on** field to open the **Select Date/Time** dialog, as shown in Figure 4-52.

5. Select a date and time in the future to schedule delivery of the notification, and then click **OK** to return to the **Schedule a Notification** dialog.

   – Click **Now** to deliver the notification immediately.
   – The current date is displayed in red. Click the arrow buttons (located on either side of the date) to move to a different month in the calendar. The single arrow (>) advances the calendar by months. The double arrow (>>) advances by years.

– If a date before the current date is selected, the error message shown in Figure 23-11 is displayed.

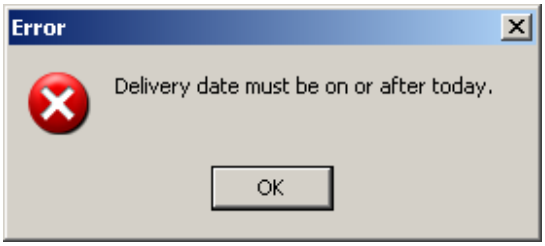


Figure 23-11: Error message for a date selected before the current date

6. In the **Schedule a Notification** dialog, type a brief description of the notification in the **Subject** field. This subject is displayed in the **Notifications** tab.

7. Click the button to the right of the of the **Recipients** field to display the **Notification Recipients** dialog, as shown in Figure 23-12.

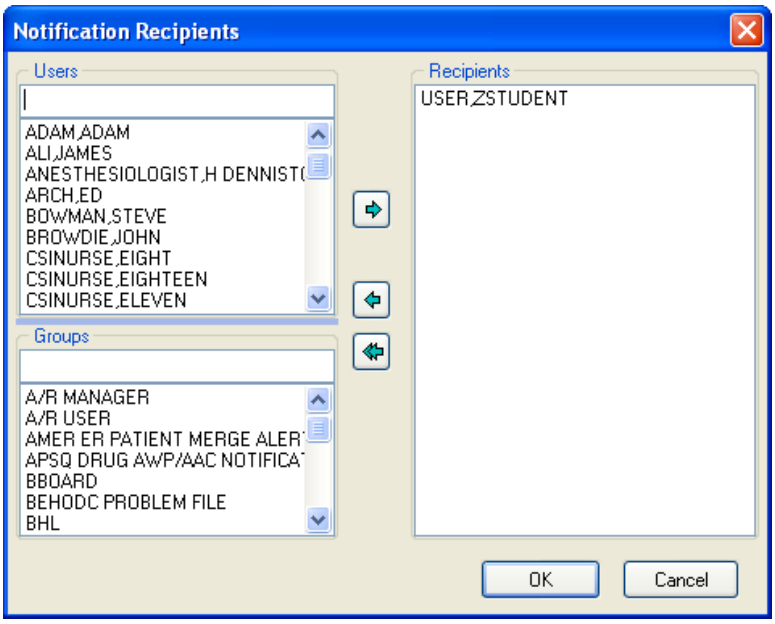


Figure 23-12: **Notification Recipients** dialog

8. To choose the names of the people to receive this notification, select one or more names in the **Users** list. To move the name or names to the **Recipients** list, click the green right arrow.

   If a name is accidentally added to the **Recipients** list, select the name in the **Recipients** list and click the green left arrow (Figure 23-8) to remove it.

   To remove all names from the **Recipients** list, click the double green left arrow.

For example, to send a notification to the pharmacist, the referral doctor, and the case manager, select all of their names in the **Users** list and click the green arrow pointing to the right to add them to the **Recipients** list.

> **Note**: The encounter provider's name will always appear in the **Recipients** list (see Figure 23-12).

- A group may also be added as a recipient. For example, the Diabetes Group may include a dietician, a physician, a nurse, and an educator in the list. When a group has been selected as a recipient, every name included in the group receives the notification.

9. When all recipients have been added, click **OK** to close the **Notification Recipients** dialog and return to the **Schedule a Notification** dialog.
10. Type the notification message in the **Message** field.
11. Click **OK** to schedule the notification for delivery.

23.2 Designate a Surrogate to Receive Notifications

If a CHA/P is going to be on leave or traveling, he or she can designate another person as a surrogate to receive notifications. All notifications that would ordinarily come to the CHA/P during the specified time are forwarded to the designated surrogate.

1. On the **Tools** menu, click **Options** to display the **Options** dialog, as shown in Figure 23-13.

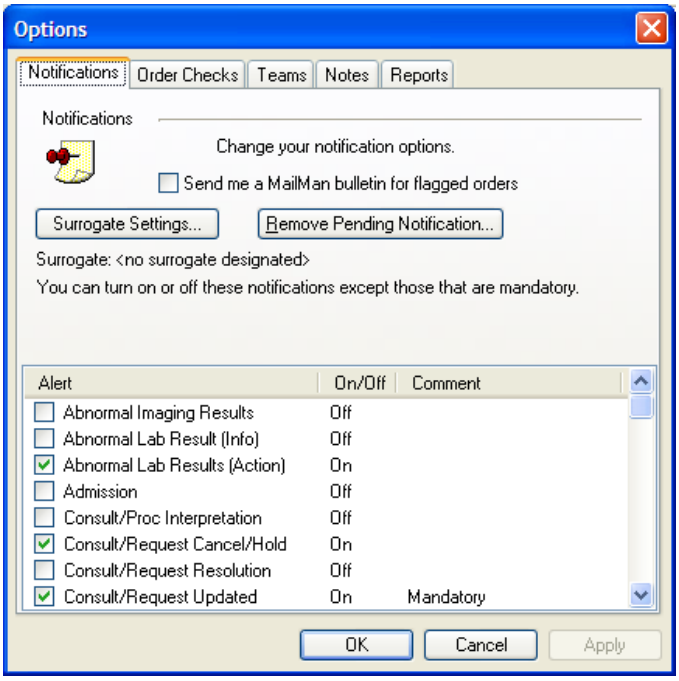


Figure 23-13: **Notifications** tab of the **Options** dialog

2. Click **Surrogate Settings** to open the **Surrogate for Notifications** dialog, as shown in Figure 23-14.

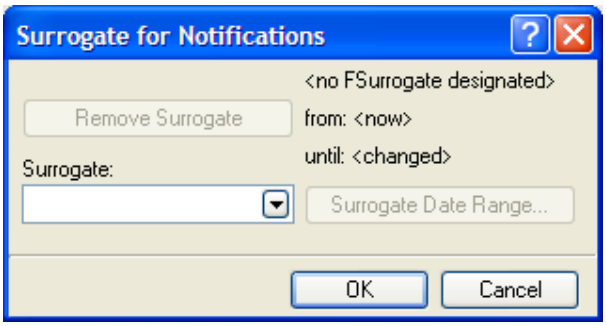


Figure 23-14: **Surrogate for Notifications** dialog

3. Click the arrow to the right of the **Surrogate** field, and select the name of the person to receive forwarded notifications from the list.

4. Click **Surrogate Date Range** to open the **Date Range** dialog, as shown in Figure 23-15.

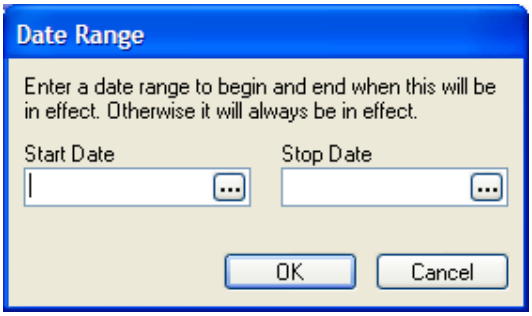


Figure 23-15: **Date Range** dialog

5. To specify the beginning of the date range (the date and time when forwarding will begin), click the button to the right of the **Start Date** field to open the **Select Date/Time** dialog, as shown in Figure 4-52.

6. Select a date and time in the future to begin forwarding notifications, and then click **OK** to return to the **Date Range** dialog.

   - Click **Now** to deliver the notification immediately.
   - The current date is displayed in red. Click the arrow buttons (located on either side of the date) to move to a different month in the calendar.
   - The single arrow (>) advances the calendar by months. The double arrow (>>) advances by years.

7. To specify the end of the date range (the date and time when forwarding to the surrogate will end), click the button at the right of the **Stop Date** field to open the **Select Date/Time** dialog.

8. Repeat Step 6 to select the date and time.

9. Click **OK** to return to the **Date Range** dialog.

10. Click **OK** to return to the **Surrogate for Notifications** dialog.

    The name of the surrogate and the dates that notifications will be forwarded appear on the right side of the dialog, as shown in Figure 23-16.

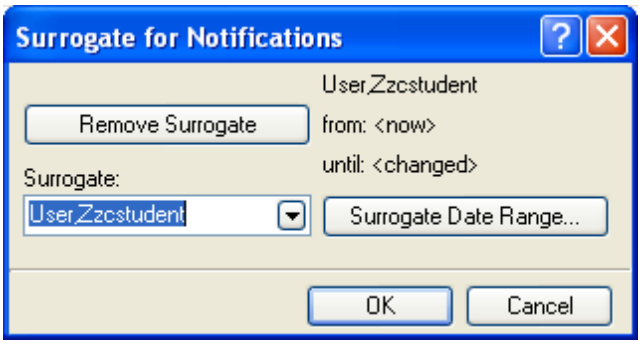


Figure 23-16: **Surrogate for Notifications** dialog showing designated surrogate and date range

11. Click **OK** to close the dialog.

12. Click **OK** to close the **Options** dialog.

23.2.1 Cancel Forwarded Notifications to a Designated Surrogate

To cancel forwarding notifications to a surrogate, follow these steps:

1. On the **Tools** menu, click **Options** to display the **Options** dialog, as shown in Figure 23-13.

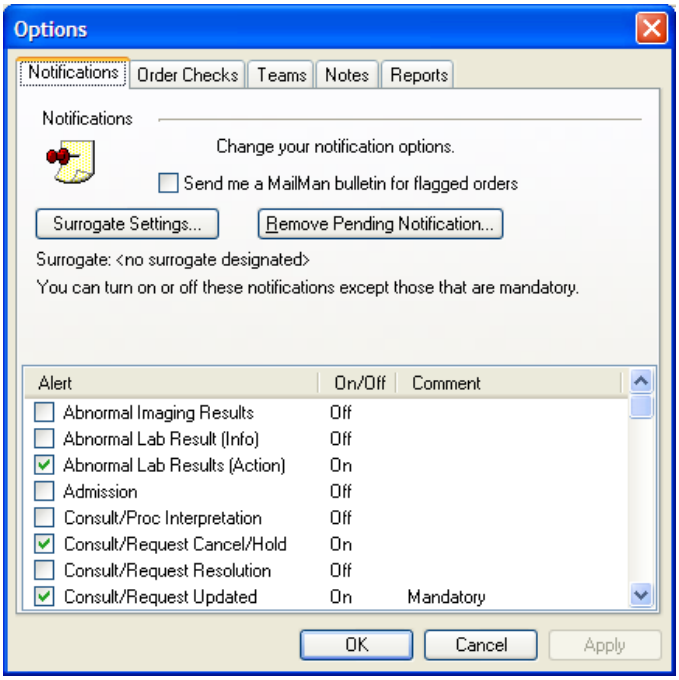


Figure 23-17: **Notifications** tab of the **Options** dialog

2. Click **Surrogate Settings** to open the **Surrogate for Notifications** dialog with the surrogate name and date range displayed, as shown in Figure 23-14.

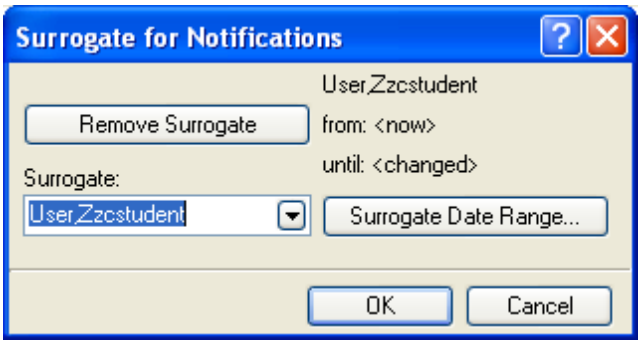


Figure 23-18: **Surrogate for Notifications** dialog showing designated surrogate and date range

3. Click **Remove Surrogate** to cancel forwarding and display the dialog with no surrogate name or date range, as shown in Figure 23-19.

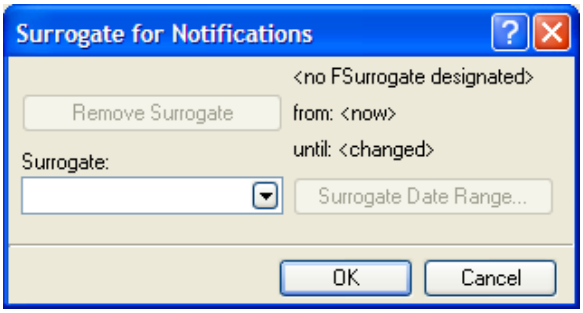


Figure 23-19: **Surrogate for Notifications** dialog

4. Click **OK** to close the dialog.
5. Click **OK** to close the **Options** dialog.

Appendix A: EHR Summary Sheet

Tanana Chiefs Conference CHA/P-EHR Patient Entry Summary Sheet

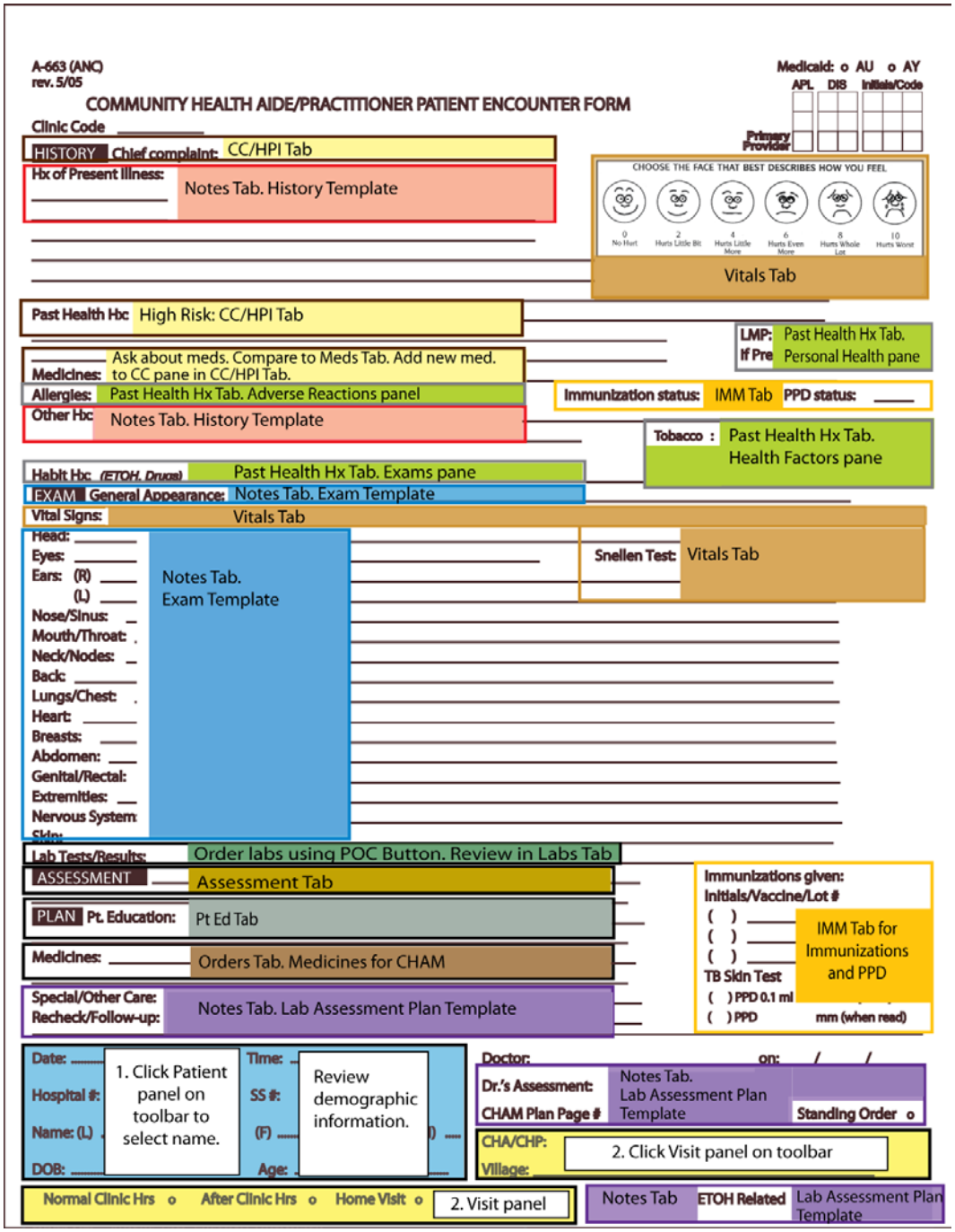
Steps for routine CHA/P patient encounter entry	Comments
Patient & Visit Panel	
Select correct Patient (Blue Panel)	*Verify by checking Health Record Number and Date of Birth*
Create New Visit (Yellow Panel) • Select correct Visit Location • Add Encounter Provider	
CC/HPI Tab - History	
Chief Complaint: Add new chief complaint and CHAM inside front/back cover information	
Problem List: Compare to what patient reports	*Note any new items on separate paper- enter into Note-History-Past Health History text box*
Past Health Hx Tab - History	
Medication List: Compare to what patient reports	*Note any new items on separate paper- enter into Note-History-Medication text box*
Adverse Reactions Pane: • Compare Adverse Reactions list to allergies reported by patient • Add Allergy Assessment • Add new Allergy	
Health Factors Pane: • Add Tobacco Habits • Use comment box to describe use	
Exams Pane: • Add ETOH/Drug Habits • Enter Current/Historical/Refusal • Use comment box to describe drug & EtOH use	
Personal Health Pane: Add LMP / Family Planning	
IMM Tab - History	
Verify up date	
Vaccine Pane: • Add new • Enter Current/Historical/Refusal	*Must have shot record to document historical*

Steps for routine CHA/P patient encounter entry	Comments
Skin Test Pane: enter new or historical PPD	*If entering historical – remember to select historical*
Notes Tab - History	
Select New Note	
Select CHAP PEF	*Press OK*
Select Templates	
Select General CHA/P History Template	
Enter History Present Illness	*Problem Specific History in CHAM*
Enter Past Health History	*Items not list on problem list and CHAM*
Enter Medication History not in medication list	*Write No Change if all correct*
Enter Other History (CHAM questions)	*Write "None" if no questions in CHAM*
Save Without Signature	
Vitals Tab - Exam	
Switch to US units	
Enter Vitals	
Notes Tab - Exam	
Edit Progress Note, place cursor at bottom of note	
Select General CHA/P Exam Template	*Double Click*
Enter General Appearance	
Enter Problem Specific Exam	*Directly from CHAM*
Save without signature	
POC Button	
Enter Point of Care labs	
Assessment Tab	
ICD Pick Lists Pane: select correct Assessment from Chap pick lists	*Located bottom left of Assessment Tab Window*
Visit Diagnosis Pane: Add Assessment as per CHAM	*If Assessment not found in CHAM, write in Narrative Box the Diagnosis*
Orders Tab	
Select correct medicine from CHAP Medicine Menu pick lists	
Sign Medicine order (can wait until signing note)	*Create but do not sign order if reporting on medical traffic*
If allergy alert for medicine you order contact CAIHC BEFORE giving medicine	

Steps for routine CHA/P patient encounter entry	Comments
Notes Tab – Lab/Assessment/Plan	
Edit Progress Note, put cursor at bottom of note	
Select General CHA/P PEF Lab-Assessment-Plan Template	
Check if ETOH related	
Enter Patient Education (Do not utilize Pt. Ed Tab at this time)	*Pg. # Blue Education Box & Medication Ed.*
Enter Special/Other Care	*As listed in CHAM*
Enter Recheck/Follow-up	*As listed in CHAM*
Sign Note (Right Click in Note, Select "Sign Note Now")	*Must sign note to complete the process and for anyone else to read*
Sign medicine order if medical standing order	
Identify Additional signer	*For any case you want/are required to present on medical traffic*
Notifications Tab	
Create & Send Notification – only as needed	
Process pending notifications	
Notifications-Notes Tab	
Create Addendum – only as needed	
Sign Addendum	

Appendix B: PEF EHR Summary Sheet

Refer to the following marked-up PEF EHR Summary sheet to determine which tab or toolbar button or pane to click to enter information that used to be entered on the paper form.



Appendix C: Lab-only Visit

Note: Physician must communicate the diagnosis (the reason blood is to be drawn).

Steps for Lab-only Visit	Comments
CC/HPI TAB:	
CC: Age/Gender/Here for what/Who ordered.	
ASSESSMENT TAB:	
In the **Visit Diagnosis** Pane select **Add**.	
In the **NARRATIVE** box type **Diagnosis given by Doctor**	
PROCEDURES TAB:	
In the Super-Bills pane, • Click CHAP Laboratory • Select **Blood draw by Venipuncture**	*If **CHAP Laboratory** is not visible in the list, check **Show All** at the bottom of the list.*
NOTES TAB:	
Start a new Note	
Start a new Template	
Double Click **CHAP Lab Draw Only** template to open	
Check the box to continue.	*As you check the boxes, information added in other sections of the E.H.R. will pull automatically to this note.*
Click **OK** and sign	
Identify Additional Signer	
Label EACH tube and complete the paper requisition form	*You do not need to document which tubes you used, how many, or where they were sent in the E.H.R. note to unless your doctor requests this info, or it helps you with tracking. No plan needed!*

A Blood Draw/Lab only visit should look like this when finished:

```
CHAP PATIENT LAB BLOOD DRAW ONLY ENCOUNTER

DEMO,PATIENT ADULT MALE                AUG 15, 2011

CC/HPI:
Chief Complaint: 54 y/o male here today for blood draw, ordered by Dr.
Fitch
```

```
PROCEDURE:
CPT codes: ROUTINE VENIPUNCTURE (36415)

ASSESSMENT: Hypertension;
```

Appendix D: Immunization-only Visit

Steps for Immunization-only Visit	Comments
CC/HPI TAB	
CC: Age/Gender/ Here for_____vaccination	
MEDS TAB	
Review Medications with patient, Click the **Medications-Nds Rvwd** button.	*New procedure to meet Meaningful Use*
NOTES TAB	
Click **New Note**	
Choose **CHAP_PEF**	
Click **OK**	
Click **Templates**	
Click **+ Shared Templates**	
Click **+CHAP**	
Double click **CHAP Immunizations For All Ages** Template	
Click **Immunizations for all Ages**	
Click box **Chief Complaint**	
Answer History questions by clicking **Yes**, **No** or **Unknown**.	*These are straight from the CHAM*
Click **OK**	
VITALS TAB	
Record Temperature	
Record Weight	
PROCEDURES TAB	
Click **CHAP Immunizations**	
Click the Immunization to be given.	
Select the **Lot Number**.	
Select the **Injection Site**.	
Click **Patient/Family Counseled by Provider**.	
Click **OK.**	
NOTES TAB	
Click **CHAP Immunizations For All Ages** template.	*This is still open*
Click **Immunizations given** to open template.	

Steps for Immunization-only Visit	Comments
Scroll to **Todays Vitals** and click box.	*If done as above, VS import*
Answer the questions.	
Click **OK.**	
Click Hand in upper right of screen & sign note.	
Identify Additional Signer.	

This is what the Note should look like when completed.

```
TITLE: CHAP_PEF
DATE OF NOTE: AUG 15, 2011@16:58     ENTRY DATE: AUG 15, 2011@16:59:10
      AUTHOR: CHRISTIAN,STEPHANNIE EXP COSIGNER:
     URGENCY:                        STATUS: COMPLETED

                 Immunizations for all Ages
Chief Complaint: 41 y/o Male here today for Tdap Vaccination
*If temp is more than 101 or with infant under 3 months, if temp is
more than 100.4 rectally, go to CHAM pg 145
Allergies:IBUPROFEN, SHELL FISH, ASPIRIN, PENICILLIN
Active Outpatient Medications (including Supplies):

     Active Outpatient Medications                          Status
==============================================================================
1)   SIMVASTATIN 40MG TAB RX792 TAKE ONE (1) TABLET BY      ACTIVE
       MOUTH EVERY EVENING FOR CHOLESTEROL
Active Non-VA Medications                                Status
==============================================================================
DO NOT GIVE VACCINE IF ANY 'YES' OR 'UNKNOWN' ANSWERS BELOW
Consult a physician or public health nurse.
******************************************************************************
Screening Questions for Immunizations:
Are you sick today? ..............................No
   Comments:

Do you have allergies to any medications, vaccines,
   or foods (such as eggs, yeast, or gelatin)?.....No
   If yes, what?
   Comments:

Have you had a serious reaction to a vaccine
   in the past?.....................................No
   If yes, what?
   Comments:

Have you received any vaccinations in the past
   4 weeks?.........................................No
   If yes, what?
   Comments:

Have you ever had a seizure?.......................No
   If yes, when was your last seizure?
   Comments:

Do you have cancer, leukemia, HIV,AIDS, or any
   other immune system problems?...................No
   Comments:
```

```
Do you take: Cortisone, Prednisone, or other
   steroids? Medicine for Rheumatoid Arthritis or
   Anti-cancer drugs? Have you had x-ray
   treatments for cancer in the past 3 months?.....No
   Comments:

During the past year, have you received a blood
   or blood products transfusion? Have you been
   given a medicine called immune globulin?........No
   If yes, when?
   Comments:

Do you have a history of chicken pox?.............No
     Comments:

Are you pregnant?................................No
   If no, what is your method of birth control?....Patient is male
   Comments:

Is there a chance of you becoming pregnant in
   the next month?..............................No
   Patient is male
   Comments:

Immunizations for all Age Today's Vitals: TMP:98.6 (37 C), WT:180.00 (81.72
kg)
Tdap
*Medication Given?

No Orders.
*Did patient remain in clinic for at least 20 minutes after receiving
Immunizations?:............Yes
Medical Standing Orders: No
```

Appendix E: Value Ranges for Measurements

Measurements may be in either the US or Metric system depending upon the default unit. Below is a list of what each field in the **Vitals** tab requires:

Measurement	Acceptable Value Range
Abdominal Girth (AG)	0–150 in.
Audiometry (AUD)	8 readings for right ear followed by 8 readings for left ear, all followed by slashes. Example: 100/100/100/95/90/90/85/80/105/105/105/105/100/100/95/90/
Blood Pressure (BP)	20–275/mmHg for systolic and 20–200/mmHg for diastolic
Cardiac Ejection Fraction (CEF)	5–99
Cervix Dilatation (CXD)	0–10
Edema (ED)	0, 1+, 2+, 3+, or 4+
Effacement (EF)	0–100
Fetal Heart Tones (FT)	0–400 (whole number)
Fundal Height (FH)	0–100 in.
Head Circumference (HC)	10–30 in.
Hearing (HE)	N (for normal) or A (for abnormal)
Height (HT)	10–90 in. (decimals allowed)
O2 Saturation (O2)	50–100 This is entered as a number, and changes to a percent automatically.
Pain (PA)	0–10
Peak Flow (PF)	50–900
Presentation (PR)	VT (for Vertex) CB (for Complete Breach) DF (for Double Footling) SF (for Single Footling) FB (for Franch Breach) FA (for Face) UB (for Unspecified Breach) TR (for Transverse) OT (for Other) UNK (for Unknown)
Pulse (PU)	30–250/min. (whole number)
Respirations (RS)	8–100/min. (whole number)
Station (pregnancy) (SN)	-6 to +4
Temperature (TMP)	92–109.9 Fahrenheit
Tonometry (TON)	0–80 Use the format: reading of right ear / reading for left ear For example, left only /20, right only 18/, both 10/13
Vision Corrected (VC)	10–999
Vision Uncorrected (VU)	Enter denominators only; the 20/ is assumed. Enter information in the following format: right eye/left eye. For right eye **only**, enter n (ex: 30). Left eye **only**, enter /n (ex: /40)
Waist Circumference (WC)	20–99 in. This is used in patients who are not pregnant as a measure of body fat distribution.
Weight (WT)	2–750 lb. (decimals allowed)

- When a measurement is entered, the cell color changes to yellow. If any measurement is out range, an error message is displayed.

- Body Mass Index (BMI) will be displayed automatically. BMI is automatically calculated after weight and height have been entered into the **Vitals** tab.

Appendix F: Keyboard Shortcuts for EHR and Windows

This section contains two parts: text editing shortcuts and EHR-specific shortcuts. Many of the text editing shortcuts apply to the EHR.

F.1 Windows Shortcuts for Text Editing

There are many shortcuts that are standard to Windows that make text editing much faster. All of these shortcuts can be used in EHR TIU notes and EHR text boxes of any kind. In addition, shortcuts can be used in Web browsers, most Windows text editors, and most Word Processors.

The "+" sign means two keys must be pressed together simultaneously, e.g., Ctrl+V. The "," means to press the keys separately in the order they appear. For example, the shortcut "Alt+F, P" means press Alt and F together, release the keys, and then press P by itself.

F.1.1 Cutting/Copying and Pasting

Shortcut	Action
Ctrl+x	Cut
Ctrl+c	Copy
Ctrl+c	Paste

F.1.2 Text Navigation

Shortcut	Action
Home	Go to the beginning of the line
End	Go to the end of the line
Ctrl+Home	Go to the beginning of the document
Ctrl+End	Go to the end of the document

F.1.3 Highlighting

Shift+(Any Text Navigation) will highlight. For example, if the cursor is at the end of a sentence, and "Shift+Home" is pressed the entire line will be highlighted.

Ctrl+A selects all. Use Carefully!

F.1.4 Correcting Errors

Delete or **Backspace** keys are usually used to erase text. Here are some shortcuts:

- **Ctrl+Backspace** erases the entire word immediately to the left of the cursor. This shortcut does not work in some old text boxes provided by Windows.
- **Ctrl+Z** is Undo. Press Ctrl+Z, and anything that was accidentally deleted will appear again.
- Redo differs by application. Most applications use **Ctrl+Y**; other applications use **Ctrl+Shift+Z**.

Most applications allow undo and redo operations to be done multiple times. However, EHR enables just one.

F.1.5 Examples

Below are specific examples of how to use text-editing shortcuts.

Need to Edit	What To Do
Delete a misspelled word.	Ctrl+Backspace
Delete all text from a certain point down (a very common situation in EHR)	Hold Shift to highlight, navigate to the end by pressing Ctrl+End. Then use Backspace or Delete.
Oops, I didn't intend to do that...	Ctrl+Z for undo
I hate what I wrote; I want to start over.	Ctrl+A for highlight all, then Delete or Backspace.
I want to change the verb in the middle of the sentence.	Ctrl+[□□ to move to the verb one word at a time; just before the verb, hold the Shift key and press Ctrl+[□□. This highlights the verb. Use a different verb by typing over it.
I don't like the sentence/paragraph I wrote.	Hold the Shift key to highlight. If Home is pressed, all text to the beginning of the line will be highlighted. Subsequently, use the [□□ or [□□ arrows to highlight lines above or below.
I need to rearrange my sentence.	This happens very frequently. To switch the subject and the object or simply move the verb. Use Ctrl+[□□ to move to the word(s) to be moved. Just before the word(s), hold Shift, and continue to use Ctrl+[□□ to highlight the text. When finished Highlighting, press Ctrl+X to cut, then move the cursor with Ctrl+[□□ or Ctrl+[□□ (or going up and down). Place the cursor when the word will now appear, and press Ctrl+V to paste. Word makes sure the spacing is correct before and after; EHR does not.

F.1.6 Miscellaneous Shortcuts for Windows

Most of the following shortcuts will not work in EHR, but can be used when working in Windows applications.

Shortcut	Action
Ctrl+s	Save
Ctrl+f	Find (MS Word uses Ctrl+h for Replace)
Ctrl+o	Open File
Ctrl+p	Print
Ctrl+b	Bold
Ctrl+i	Italics
Ctrl+u	Underline

F.2 EHR

What are underlined words in dialogs and windows?

In the **Orders** Tab, underlined words are chapter headings and cannot be clicked. However, the items below chapter headings are menu items which can be clicked to order medications.

Can I highlight rows in EHR like I do in Excel?

Yes. The cells in EHR either represent medications (on the **Medications** tab) or orders (in the **Orders** tab). Highlight rows by using the mouse. Double click to select an entire row.

Using the Tab Key

The tab key cycles between different fields in dialogs. Pressing the Tab key moves the cursor from one field to the next. In the **Orders** tab, there is a place in entering lab information where pressing the Tab key is required to enter the information.

Appendix G: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

G.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

G.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.

- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

G.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS polices and procedures prior to interconnection to or transferring data from RPMS.

G.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

G.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

G.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

G.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.

- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

G.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

G.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

G.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

G.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

G.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

G.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

G.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

G.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

G.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Acute

Used to describe a condition that lasts for a short time. Used in contrast to *chronic*.

Button

Small area within a window or dialog which is clicked to execute commands, display dialoges, or display additional menus.

CAC

Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading software programs for the end users.

CC

Chief Complaint

CHAM

Alaska Community Health Aide/Practitioner Manual

CHAP

Community Health Aide Program

CHA/P

Community Health Aide/Practitioner

Chart Number

A unique numerical identifier assigned to each patient. This is also referred to as a Health Record Number.

Check Box

A square box that is selected or cleared to turn on or off an option. When this setting is selected, a visual indicator is displayed in the check box.

Chronic

Used to describe a condition that has an indefinite duration or with a frequent occurrence. Used in contrast to *acute*.

CLIA

Clinical Laboratory Improvement Act

Clinical

To do with treatment in or as a clinic: involving or concerned with direct observation and treatment of patients.

Clinical Reminders

Clinical Reminders are used to track and improve preventive healthcare for patients by reminding clinicians that specific actions such as examinations, immunizations, and mammograms should be performed by the clinician.

Consult

Referral of a patient by the primary care physician to another hospital service/specialty, to obtain a medical opinion based on patient evaluation and completing of any procedures, modalities, or treatments the consulting specialist deems necessary to render a medical opinion. Consults in EHR are used to request and track consultations from one clinician to another clinician or service

CPRS

Computerized Patient Record System

Default Response

The default is generally set to the most frequently used response for the field or item.

Demographics

The characteristics of a patient which can include information regarding birth, marriage, disease, and death.

Dialog

Dialoges contain command buttons and other options that users can carry out a particular command or task.

DOB

Date of Birth

Drop-down box

A text box with a list box attached. Users can either type or select an item from the list.

DX

Common abbreviation for the word “diagnosis.”

EHR

Electronic Health Record

Fields

Input area for text. Fields function like blanks on a form. For each field, a specific type of data is entered.

Free Text Field

This field type accepts numbers, letters, and the symbols on the keyboard. There may be restrictions on the number of characters that can be entered.

GUI

Graphical User Interface. Applications that have a GUI (such as the EHR) contain items such as icons, buttons, menus and other graphical items.

Health Factors

Health Factors are data elements utilized by RPMS to record health status information about the patient. Current Smoker is an example of a health factor in the Tobacco category.

Health Summary

The Health Summary is a patient report displaying related data from the PCC V files such as laboratory and pharmacy. There are many different types of Health Summaries available to users at each site.

HPI

History of Present Illness

HRN

Health Record Number; a unique numerical identifier assigned to each patient. This is also referred to as a chart number.

HS

Health Summary, a summary of a patient's medical care. Examples of standard health summaries are: Adult Regular, Behavioral Health, CHR, and Dental.

HX

Abbreviation for the word "History." History is an event taking place in the past, such as a past surgery, immunizations, etc.

IBC

Inside Back Cover (of the CHAM).

ICD

International Classifications of Diseases. This is a national coding system primarily used for: (1) classifying morbidity and mortality information for statistical purposes, (2) indexing of hospital records by disease and operations, and (3) data storage and retrieval. In addition, this is the coding system physicians must use for billing purposes of Medicare, Medicaid, and private insurance for services rendered.

IFC

Inside Front Cover (of the CHAM).

Menu

A menu is a list of different options that may be selected at a given time. To choose a specific task, select one of the items from the list by clicking on it. A menu option followed by the ellipsis (…) indicates there are submenus.

Messages

Messages are online descriptions, instructions, or warnings that inform the user about conditions that may require special consideration.

Pane

A separate area within an EHR window. A window may contain several panes which are used for review, for entering details regarding a patient encounter, or for entering new patient data.

Panel

The EHR toolbar contains three panels. The Patient panel is blue, the Visit panel is yellow, and the Primary Care Team panel is green. Panels can be clicked like buttons, but they also display information for the current patient whose encounter is being recorded. Also: a portion of a pane.

Patient Wellness Handout

The Patient Wellness Handout is a type of Health Summary that is directed to the patient. It contains personal medical information in easy-to-understand language.

PEF

Patient Encounter Form. A paper based form that was previously used to record information from a patient encounter.

POC

Point of Care.

POV

Purpose of Visit, one or more diagnoses (ICD codes) that are identified as the reason for the patient's visit

Problem List

A list of important/chronic medical, social, or psychiatric problems, related notes, and treatment plans for a patient that are recorded and updated as part of the patient's health record. The Health Summary has two categories: Active and Inactive.

Progress Notes

A component of TIU that is available for input in EHR. These notes are clinicians' textual records of a patient's status at the time of an encounter.

Provider

A person who provides direct medical care to a patient i.e., physician, nurse, mid-level provider.

Provider Narrative

A detailed description of the patient's conditions, using words rather than codes.

RPMS

Resource and Patient Management System; a suite of integrated software packages used by IHS

Secondary Providers

A provider for a patient's visit other than the patient's primary visit provider. A patient visit might have multiple secondary providers, depending on the services provided.

Select

To choose one option from a list of options.

Site Manager

The person in charge of setting up and maintaining the technical aspects of the RPMS System at the facility or area level.

SSN

Social Security Number

Submenu

A menu that is accessed through another menu. A menu option followed by the ellipsis (…) indicates there are submenus.

TIU

Text Integrated Utility

Toolbar

The EHR toolbar contains panels and buttons in the region below the main EHR tabs (PRIVACY, PATIENT CHART, RESOURCES, and COMMUNICATION). The toolbar may look different depending upon the site.

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov