



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Community Health Aide/Practitioner Getting Started Guide

Version 1.9 Draft September 2011

Office of Information Technology (OIT) Division of Information Resource Management Albuquerque, New Mexico

Table of Contents

1.0	Introdu	uction	1
	1.1	Electronic Health Record	1
	1.2	Security	1
	1.3	Using this Guide	1
2.0	Genera	al Terms	3
	2.1	Computer Input Devices	3
	2.2	Terminology	
	2.2.1	Bold Type	3
	2.2.2	Bulleted List	4
	2.2.3	Figures	
	2.2.4	Notes	
	2.2.5	Procedure Steps	
	2.2.6	User Interaction	
	2.2.7	Warnings and Cautions	
	2.3	Composition of the EHR Window	
	2.3.1	Display Objects	
	2.3.2	Control Objects	
3.0	Log on	to EHR	14
	3.1	The Inactivity Limit Message	16
	3.2	Log off of EHR	16
4.0	The EF	IR Window	18
	4.1	EHR Main Menu	18
	4.1.1	User Menu	18
	4.1.2	Patient Menu	19
	4.1.3	Refresh Data Option	
	4.1.4	Clear and Lock Option	10
		•	
	4.1.5	Tools Menu	20
	4.1.6	Tools Menu Clear Option	20 22
	4.1.6 4.1.7	Tools Menu Clear Option Help Menu	20 22 22
	4.1.6 4.1.7 4.2	Tools Menu Clear Option Help Menu EHR Tab Set	20 22 22 24
	4.1.6 4.1.7 4.2 4.2.1	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab.	20 22 22 24 24
	4.1.6 4.1.7 4.2 4.2.1 4.2.2	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab PATIENT CHART Tab	20 22 22 24 24 24 25
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab PATIENT CHART Tab WELL CHILD Tab.	20 22 22 24 24 25 26
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3 4.2.3 4.2.4	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab. PATIENT CHART Tab. WELL CHILD Tab. RESOURCES Tab.	20 22 22 24 24 25 26 28
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3 4.2.3 4.2.4 4.2.5	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab PATIENT CHART Tab WELL CHILD Tab RESOURCES Tab COMMUNICATION Tab	20 22 24 24 25 26 28 29
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3 4.2.3 4.2.4 4.2.5 4.3	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab. PATIENT CHART Tab. WELL CHILD Tab. RESOURCES Tab. COMMUNICATION Tab. Patient Toolbar	20 22 24 24 25 26 28 29 31
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3 4.2.3 4.2.4 4.2.5 4.3 4.3.1	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab. PATIENT CHART Tab. WELL CHILD Tab. RESOURCES Tab. COMMUNICATION Tab Patient Toolbar Patient Panel	20 22 24 24 25 26 28 29 31 31
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3 4.2.4 4.2.5 4.3 4.3.1 4.3.2	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab PATIENT CHART Tab WELL CHILD Tab RESOURCES Tab COMMUNICATION Tab Patient Toolbar Patient Panel Visit Panel	20 22 24 24 25 26 28 29 31 31 34
	4.1.6 4.1.7 4.2 4.2.1 4.2.2 4.2.3 4.2.3 4.2.4 4.2.5 4.3 4.3.1	Tools Menu Clear Option Help Menu EHR Tab Set PRIVACY Tab. PATIENT CHART Tab. WELL CHILD Tab. RESOURCES Tab. COMMUNICATION Tab Patient Toolbar Patient Panel	20 22 24 24 25 26 28 29 31 31 34 35

Table of Contents

	4.4	Encounter Tab Set and Workspace	43
	4.5	Status Bar	
	4.6	Common Features	
	4.6.1	Windows Clipboard	
	4.6.2	Table Data	-
	4.6.3 4.6.4	Refresh Data	
	4.6.4 4.6.5	Select Date/Time dialog Print to a Local Printer	
	4.6.6	Web Reference Search	
F 0			
5.0		a Patient and a Visit	
	5.1	Select a Patient	
	5.2 5.2.1	Create a Visit	
	5.2.1 5.2.2	Select from Similar Visits	
6.0		view Tab	
	6.1	Active Problem List Pane	
	6.2	Lab Orders Pane	
	6.3	Appointments & Visits Pane	
	6.4 6.5	Reminders Pane	
		Alerts Pane	
7.0		the CC/HPI	
	7.1	The CC/HPI Tab	
	7.2	Enter the CC/HPI	
	7.2.1		
	7.2.2	Delete a Chief Complaint.	
	7.3 7.3.1	Review Problems in the Problem List Pane	
	7.3.1	Sort problems by date last modified Filter problems by status	
	-		
8.0	The Me	ds Tab	75
9.0	Review	and Update Past Health History	77
	9.1	Medication List Pane	
	9.2	Adverse Reactions Pane	
	9.2.1	Add a New Adverse Reaction	
	9.2.2	Enter No Known Allergies in the Adverse Reactions Pane	
	9.2.3	Enter "Inability to Assess" in the Adverse Reactions Pane	
	9.3 9.3.1	Health Factors Pane Review Health Factors	
	9.3.1	Add a New Health Factor	
	9.3.2 9.4	Exams Pane	
	9.4	Document a New Alcohol/Drug Screening	
	9.4.2	Document a Depression Screening	
	9.4.3	Document "Unable to Screen" for Depression Screening	
	00		

	9.4.4 Document a Refusal for Drug/Alcohol Screening	
	9.4.5 Document a Diabetes Foot Exam	
	9.4.6 Document an Historical Exam	
	9.5 Document Personal Health9.6 Record Reproductive History	
10.0	Update Immunization and Skin Test Records	
	10.1 Immunization Record Pane	
	10.1.1 Add a Contraindication	
	10.1.2 Document a New Immunization 10.1.3 Document a Historical Vaccination	
	10.1.4 Document a Refusal	
	10.1.5 Print a Vaccination Record	
	10.1.6 Edit a Vaccination	
	10.1.7 Document a Reaction to a Vaccine	
	10.2 Skin Test History Pane	116
	10.2.1 Document a New Skin Test	
	10.2.2 Record the Results of an Existing Skin Test	
	10.2.3 Document a Historical Skin Test	
	10.2.4 Document a Refusal	
11.0	Record Patient History	
	11.1 About Notes and Templates	
	11.2 The History Template	
	11.3 Create a New Note	
	11.4 Select a Template in the Templates Drawer11.5 Fill in the Fields in the History Template	
	11.6 Accidentally Clicking the OK Button	
	11.7 Delete a Note	
	11.8 The Context Menu for the Notes Tab	
12 0	Record Vital Signs	135
12.0	12.1 Record Vitals	
	12.2 Record a Second set of Vitals during the Same Visit	
	12.3 Record Vision	
	12.4 Record Head Circumference	141
	12.5 Graph Vitals	141
13.0	Record a Patient Examination	144
14.0	Order a Lab Point of Care Test	151
	14.1 Order a Lab POC Test	151
15.0	Record a POV Diagnosis	160
	15.1 Add POVs to the Visit Diagnosis Pane	
	15.1.1 Add a POV Listed in the CHAM	163
	15.1.2 Add a POV Not Listed in the CHAM	164

16.0	Order M	Nedications	.168
	16.1	Order Medications	.169
17.0	Record	Patient Education	.177
	17.1 17.2 17.3	Add a Patient Education Topic Document a Patient Education Refusal Add a Comment to a Patient Education Record	.182
18.0	Record	Labs, Assessments, and Plans	.183
	18.1	Sign the Note and Other Unsigned Entries	.187
19.0	Review	Billable Items and Historical Services	.189
	19.1	Super-Bills	.190
	19.2	View Historical Services	.191
20.0		nsults Tab	
	20.1.1	Consult Status	.195
21.0	Print a	Health Summary	.197
22.0	The La	bs Tab	.200
23.0	Notifica	ations Tab	.209
	23.1	Process Notifications	.211
		Notifications Requiring Action	
	23.1.2 23.1.3	······································	
		Schedule a Notification	
	23.2	Designate a Surrogate to Receive Notifications	
	23.2.1	Cancel Forwarded Notifications to a Designated Surrogate	.222
Gloss	ary		.247
Conta	ct Infor	mation	.253

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.

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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.

		P			(R		18			E.					B	18	1			E		-	
-1		1			t	n			n		1	1		E	1	1		-		-	11		
	11			P				1			1	۴.	ł			8					2		2.1
	i.		1				1	ŧ.		11	61			Ŵ	1			E	1	184	1		10
		h		۶.	1			P		۲	8		ř.	1		-			8		1.2	R.	
	1											i.	5				-	1	1		1		

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:

Locked by USER,ZSTUDENT									
The application has bee your verify code below									
	Resume	Logout							

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.

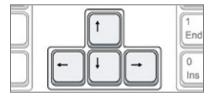


Figure 2-5: Arrow Keys (one variation)

 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.

RPMS-EHR USER,ZSTUDENT		_				
User Patient Refresh Data Tools Help	4					4
PRIVACY PATIENT CHA	BESOURCES COM	MUNICATION				
Demo,Alice Janene A CLINIC 509-A 08-May	Panel	e,Catherine		1	Health	Button Button
109629 30-Nov-1952 (57) F USER_ZSTUDENT	Ambulatory	ding: Niesen,Ma	ary Ann	PWH	Summary	AD AD
Medifications NICO Devices N CO LUDI Deve Health He NIME N Mater N 1984 A Arrest	mont N Ordens Ld Prop		Reports Meds L	abs IBC Tabs		
Rep Evaluation and Management		1 Visit Servi				
	New Patient 💿 Established	🎸 Visit Servi	ces 🧻			Add Edit Delete
Level of Service		Code Narrative	Q	y Diagnosis Prim Modifi	er 1 Modifier 2	Provider CPT 1
Office Visit History and Exam Complexity Approx. Time CPT Consultation Rise Nurse Viet 5 min 9921		4				
Preventive Medicine Brief Nurse Visit 5 min 9921 Proventive Medicine Problem Focused Straightforward 10 min 9921						
Expanded Low 15 min 9921						
Detailed Moderate 25 min 9921		Pane			~	
Comprehensive High 40 min 9921						
					har	
					NP -	
				Scro	/	
		4				
Super-Bills Display Check box escription Cols 5 📫						
┟═──── ───── [─]						
		Add Category		2		
		Category Name		Field		
	-					
		Hosp. Location		ncel		
		Clerc				
		Provider		***		
		Prov. Discipline			Dialog bo	
Show All		riov. Machine 1				
		Mariagers				
Historical Services Surgea Drop-down list						Add Delete
Surginal Drop dottinity		Add				
Visit Date CPT Code Descrit Medical	Facility	Delete				
08/05/2010 29540 Strapp Anesthesia 02/20/2008 36416 CAPILIT Radiology	Demo Hospita –					
02/20/2008 36416 CAPILI Radiology 02/20/2008 29125 APPLN Laboratory	Demo Hospital Demo Hospital					
02/20/2000 20120 APPET Dental	Demo Hospital	1	N		-	4
02/20/2008 20610 DRAIN Miscellaneous	Demo Hospital	1	N			
02/20/2008 17000 DESTRUCTIONALS LESION	Demo Hospital	1	N	Add to C	irrent Visit	
07/18/2007 10120 Remove Foreign Body	Analenisgi	1	N			
07/18/2007 11200 Removal Of Skin Tags	Analenisgi	1	N		rical Procedure	Context menu
03/08/2006 47600 Cholecystectomy	Yrmc	1		Delete Hi	storical Procedure	
04/04/2004 36000 PLACE NEEDLE IN VEIN	Demo Hospital			View Visit	Detail	
11/28/2003 58150 Total Abdominal Hysterectomy (corpus And Cervix), With Dr Without Re	moval Ut Tub Flagstaff Medical C	Center 1				
						N
USERZSTUDENT DEMO-H0.IHS.GOV DEMO HOSPITAL 05-Aug-2010 15:19						
p · · · · · · · · · · · · · · · · · · ·						

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.

CHA/P Getting Started Guide September 2011

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

Pt counseled re: cerumen softening

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:

		•
3	month	
6	month	
ar	nnual	
2	year	

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.

No Detauk
O Providers
○ Teams
O Specialties
Q Clinics
QWards
Q Personal Lists
() All

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).

Category Name	
---------------	--

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:

Cut	Ctrl+X
Сору	Ctrl+C
Paste	Ctrl+V
Reformat Paragraph	Ctrl+R
Find in Selected Note	
Replace Text	
Check Grammar	
Check Spelling	
Copy into New Template	
Add to Signature List	
Delete Progress Note	
Edit Progress Note	
Make Addendum	
Save without Signature	
Sign Note Now	
Identify Additional Signer	s

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.

Encounter Settings for Current Activities									
A CLINIC 19-Jul-2011 16:46 - USER ZSTUDENT									
Encounter Location Appointments / Visits	Hospital Admissions	New Visit							
Location	<u>``</u>)ate/Time	Тур	e					
A CLINIC	1	9-Jul-2011 16:4	5 AME	BULATORY					
			s for this Encounte ZSTUDENT	r Cancel					

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.

Patient not selected	Visit not selected	Primary Care Team Unassig
	USER,ZSTUDENT	

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.

Active Problem List				
Problem 📥	Date			

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**.

Exams 10 DEPRESS	Refresh	F5	Cor E slee
xams	New Adverse Reaction Sign Adverse Reaction		
	Edit Adverse Reaction Delete Adverse Reaction		

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.

Notifications Review CC / HPI Meds Past Health Hx VIMM Notes Witals Assessment Orders Pt Ed Procedures Consults Reports Labs

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.

Patient not selected	Visit not selected USER/ZSTUDENT	Primary Care Team Unassig	POC Lab Entry	PWH	Med Rec	8 Visit Summary		No Postings	Advs React	Medications	C 32
----------------------	-------------------------------------	---------------------------	------------------	-----	------------	--------------------	--	----------------	------------	-------------	---------

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.

RPMS-EHR	Logon		×			
	TANANA CHIEFS CONFERENCE HEALTH SERVICES					
	**** VISION****					
	ł	HEALTHY PEOP	PLE ACROSS GENERATIONS			
ENHANC	TCC HEALTH SERVICES, IN PARTNERSHIP WITH THOSE WE SERVE, PROMOTES AND ENHANCES SPIRITUAL, PHYSICAL, MENTAL AND EMOTIONAL WELLNESS THROUGH EDUCATION, PREVENTION AND THE DELIVERY OF QUALITY SERVICES.					
	A STATE OF STATE		Access Code:			
RP		HR	Cancel			
	Electronic Health Record					
Server	<u>Volume</u>	UCI	Port			
rpmstest	HAI	HAI	9200			

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.

PRIVACY PATIENT CHART	RESOLIDEES COMMUNICATION		
atient not selected	Visit not selected USEB ZSTUDENT	Primary Care Team Unassigned	PWH Health PDC Patien 😒 Por
Ablications IFC Review CC7HPI Patt Health Hx	IMM Notes Wilds Assessment Onders PIEd	Procedures Consults Reports Medis Labs 18C	
Chief Complaint (CC problem) Ask Patient/Parent: > Why have use me to the dink today? -Por size Chief Valit: Oral Inside Back Cover -Por size Chief Valit: Oral Inside Back Cover -Por Size Chief Valit: Oral Inside Back Cover -Por Recence Valit: Oral Inside Back Cover -Por Recence Care Visit: Oral Inside Back Cover -Por Porentie Care Visit: Oral Inside Back Cover -Por Porentie Care Visit: Oral Inside Back Cover -Por Porentie Care Visit: Oral Inside Back Cover -Porentie Care Visit: Oral Inside Back Cover -Porentie Care Visit: Oral Inside Back Cover -Porentie Care Visit: Oral Inside Back Cover -Poes Interview Care Visit: Oral Inside Back Cover -Poes Interview Care Visit: Oral Inside Back -Porentie Care Visit: Oral Inside Back -Poes Interview Care Visit: Oral Inside Back -Note Inside Inside Inside -Note Inside Inside Inside -Note Inside Inside Inside -Note Inside Inside Inside Inside Inside Inside -Note Inside	New Problem or Complaint -Joes anything make it better? (Such as: Time of day, body positon, eating, Moving a body part, exercing) Dees anything make it worse? It began? (If yes] in what way? 3. Have you done anything to treat it? gft medicine (Name? Strength (mg)? -mount heve that? It is a strength (mg)? -mount heve that? It is a strength (mg)? -the strength (mg) (mg)? -bow was treated? -bow was treat	Allergies: Do you have any alergies? [if yes] To what? What reaction did you Bydy (what append?)" To back cousts by you mobile or chew To back cousts by you mobile or chew Actobet use: Do you dink alcohor? [if yes] Mhat? How mud? How often? The second second second second second second What? How mud? How often? The second second second second second second PPDD? What weather second and update Immunizations: Up to date? [Press, No, Unsure[Review record and update Immunizations as needed] For Formale (of chibbeaning ago); Press tay of last memory period (LMP?) What do you up to second second second Are you broadfooding? High Risk; (Prus) How I will ask more Table of Contents and you have a period Second second second second second Second second second second second Second second second second second Second second second second second Second second second second second second second 1 paint second sec	

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:

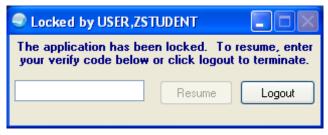


Figure 3-5: Locked by dialog

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:

Confirm	\mathbf{X}
2	Are you sure you want to exit?
	Yes No

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.

RPMS+EHR USER,ZSTUDENT User Patient Refresh Data Clear and Lock Tools Clear Help

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.

User	Patient	Refresh D		
Lock Application				
Exit				

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.

Patient Refresh					
Detail					
Select					

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.

Refresh Data

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.

Clear and Lock

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.

Tools	Clear	Help				
Dosing Calculator						
Calculator						
eSig						
Cha	at					
Opt	ions					
- A ob	US Pro	blom List				

Figure 4-6: Tools menu

Calculator option

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

Calculator		
Edit View Help		
		0.
Backspace CE		С
MC 7 8 9	7	sqrt
MR 4 5 6	×	*
MS 1 2 3	•	1/x
M+ 0 +/	+	=

Figure 4-7: Calculator

e-Sig Option

Change your Electronic Signature	
Enter your current electronic signature:	OK
Enter your new electronic signature:	Cancel
Re-enter your new electronic signature:	

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.

Options	×
Notifications Order Cł	necks Teams Notes Reports
Notes	Configure defaults for editing and saving notes.
	Notes
Document Titles	Configure document list preferences.
	Document Titles
	OK Cancel Apply

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.

Document Titles	? 🛛
Document Document class: Progress Notes Document titles:	t List Preferences Default: <no default="" specified=""> Your list of titles:</no>
ADMIN «KSTEWART ADMIN NOTES» ADULT «ADULT PC NOTE» ADULT PC NOTE ADVANCE «ADVANCE DIRECTIVE» ADVANCE DIRECTIVE ADVERSE «ADVERSE REACTION/ALLERG ADVERSE REACTION/ALLERGY ALL «DEWISON BH ALL»	Add CHAP ENCOUNTER
	OK Cancel

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.

Clear

Figure 4-11: Clear option

4.1.7 Help Menu

Click **Help** to expand the menu.

Help		
Co	ontents	
He	lp On	<u> </u>
Ab	out	

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.

Allergies
Appointments
Chief Complaint
Consults (CPRS)
Crisis Alerts
Encounter Information Header
Evaluation and Management Coding
Exams
Family History
Health Factors
ICD Pick List
Immunizations
Infant Feeding
Lab Orders

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:

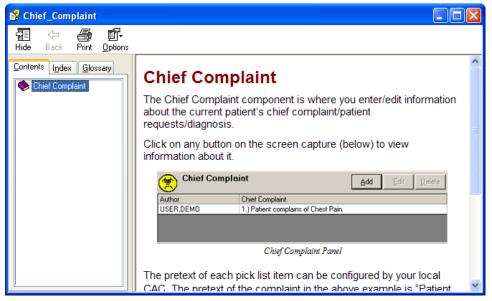


Figure 4-14: "Chief Complaint" help topic selected from the Help on menu

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:

ser Eatient Befresh Dat	a Clear and Lock Iools Clear Help	
PRIVACY	PATIENT CHART WELL CHILD RESOURCES	
	[1] F USER/ZSTUDENT Ambulatory	
oblications Review	Z / HPI Meds Part Health Hz IMM Notes Vials Assessment Order	n APIEd Procedures Consults Reports Labs
	Active Problem List	Lab Orders
-	No Active Problem List Found	No Lab Orders Found
	- Status	Appointments & Visits
	Status 2011 13 AMROLATORY	Appointments & Visite
Appointment/VI., Date * A CUNIC 25-Judi	- Status	Appublishments & Vinite About
A CLINIC 25Jul	Status 2011 13 Additutatory	
A CLINIC 25-Jul-	* Status 2011 1.3 AHRULATORY Balance Date Date Dut Nov	Akets
ICLINIC 25-Jul-	 Status Status AdeBULATORY Beavinders Dute Dute Now DUE NOW 	Akrts
ACLINIC 25-Jul-	Station Station AddBULATORY AddBULATORY Reminder Date Date Dott Nov Dott Nov Dott Nov Dott Nov	Akets
A CUNIC 25-U44 Deminder Diap Instrumination HCT ANIS Head Cocurrence HepB Ped Immunication	Performance Previous	Akets
A CUNIC 25-Jul-	Status Status Status ArdioLATORY Reminder Date Dut NOW DUE NOW	Akets
	Performance Previous	Akets

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:

RPMS-EHR USER,ZSTUDENT	
User Batient Befresh Data Glear and Lock Tools Clear Help	
PRIVACY PATIENT CHART WELL CHILD RESOURCES	COMMUNICATION
Well Child Reminders Male 3 years and 3 months Mother: DEMO,MOTHER	Pediatric Growth Charts O Chart O Table Print Charts Boys Height and Weight Body Mass Index (BMI) Boys
AGE SPECIFIC DXAMS I. Teels, cels Securing Vision, DP Securi	Boys Height and Weight
	Well Child Patient Education
USER_ZSTUDENT DEMO+H0.IHS.GOV DEMO HOSPITAL 02:5ep-2011 12:57	0

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.

Pediatric Grov	vth Charts	 Chart 	🔿 Table	Print Charts
Boys Height and Weight	Body Mass Index (BMI) Boys			

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).

Well C	hild Pati	ent Education Update			
🗆 PT	ED - FA	ILY RELATIONSHIPS			
	1.	Choose responsible caretakers (8/	29/11)		
🗆 PT	ED - HEA	ALTHY HABITS			
	2.	Avoid or limit TV viewing; watch p	rograms together		
	3.	Reinforce bedtime routines, transit	ion object, sleep thro	ugh night	
🗉 PT	ED - INJ	URY AND ILLNESS PRE			
	4.	Car seat in rear seat, NEVER in fro	ont seat with air bag		
	5.	Switch to belt-positioning booster s	eat when child over 4	0# (8/29/11)	
	6.	Childproof home: hot liquids/pots,	knives, poisons, med	icines, guns (8/29/11)	
	7.	Teach stranger safety (8/29/11)			
	8.	Keep home and car smoke-free			
🗆 PT	ED-NU	RITION			
	9.	Provide 3 nutritious meals, 2-3 hea	althy snacks daily (8/2	9/11)	
	10.	Milk 16-24 oz/day (8/29/11)			
	11.	Eat meals as a family (8/29/11)			
	12.	Offer variety of healthy foods; let o	shild decide; avoid str	uggles	×
Patie	nt Educati	on Details			
Patie	ent Educal	ion Time (minutes):			
Leve	el of Under	standing: Good	*		
				Ok	Cancel

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

Update	Status 🔀
٩	Success, patient education has been updated.
	ОК

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:

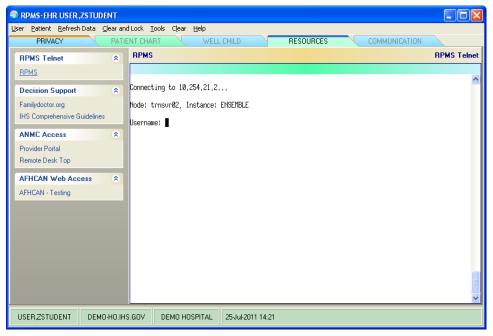


Figure 4-21: EHR RESOURCES tab

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:

	n Data 🛛 🖸 ear and Lock 🛛	Tools Clear Help				
	PATIENT CHA			RESOURCES	COMMUNICATION	
er 👻		Station	Session	Process	Login Time	
ER,ZSTUDENT		NPA65-05695	8199	4800	7/22/2011 1:32:12 PM	
🔀 Ioggle	🖌 🖌					
				Enter Messar	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
				Enter Messag	To Send Below	
Lear Sand				Enter Messag	To Send Below	3

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

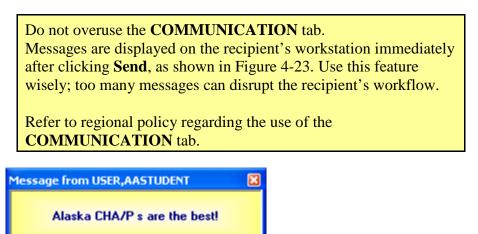


Figure 4-23: Example of a message sent from the COMMUNICATION tab

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:

er -	Station NPA65-05695		RESOURCES	COMMUNICATION	
ER,ZSTUDENT	NIDACE OFCOE	Session	Process	Login Time	
	INPA60-00630	8199	4800	7/22/2011 1:32:12 PM	
🔀 Ioggle 🖌 🖌 🖉					
Toble A St					
			Enter Messa	ge To Send Below	
's a message for someone					

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.

User Patient Refresh Data Glear and Lock Tools (ilear <u>H</u> elp				
PRIVACY PATIENT CHART	WELL CHILD		RESOURCES	COMMUNICATION	
User 👻	Station	Session	Process	Login Time	
USER,ZSTUDENT	NPA65-05695	8199	4800	7/22/2011 1:32:12 PM	
Z Ioggle All					

Figure 4-25: Selecting a recipient for a message

3. Click Send.

4.3 Patient Toolbar

		1		_
Abendroth,Raymond E	A CLINIC	26-Jul-2011 08:58	POC Lab PWH Rec Wist Summary Model No Postings No Postings No No Rywd Nds Rywd Nds Rywd Nds Rywd Nds Rywd Nds Rywd	C
120652 22:Apr-1925 (86) M	USER ZSTUDENT	Ambulatory		32

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.

Patient Selection		
Patient Lists	Patients	Demographics
O No Default	Demo,Alice Janene	Demo,Alice Janene
Providers Teams	Demo Alice Janene	HRN: 109629 Female, age: 57
Specialties Clinics Wards Personal Lists ⊙ All	Aalvik,Maricela Consuela Abbey,Tressia Lynn Abbott,Charles Woodrow Abbott,Patricia Abbott,Ray Mitchell	D0B: 30-Nov-1952
	Abbott, Rodolfo Almanza	Location: INPATIENT
	Abbott,Yolanda Gale Abee,Chasidy Sha	Room-Bed: 509-A
	Abendroth, Michael	Patient Detail
	Abendroth,Raymond E Abercrombie.David L	Fatient Detail
	Abercrombie, James Mitchell	
	Abercrombie Sierra	
	Abernathy Alice M Abernathy Barbara	
	Abernathy,Carly Emma E	
	Abernathy, Christopher	
	Abernathy,Danielle M Abernathy,Dorothy	
	Abernathy, Edna Minnie	
Manage List	Abernathy,Elijah Thomas	
Manage List	AbernathyJacqueline Lynn AbernathyJennifer	
Save Settings	Abernathy,Jennifer	
Care Sounds	Abernathy,Justina Meredith	
	Abernathy,Kermit Abernathy,Linda L	
	Abernathy, Margaret M 🔍 👽	OK Cancel

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.

🥏 Patient Detail				1×
DEMO,ALICE JANENE		602-68-0084	NOV 30,1952	
		F RECORD: NOT LISTED		
Address: P.O. BOX 1		Temporary: NO TEM	PORARY ADDRESS	
CHEROKEE,N				
County: UNSPECIFIE		From/To: NOT AP		
Phone: 555-555-81		Phone: NOT AP	PLICABLE	
Office: UNSPECIFIE	D			
Bad Addr:				
Confidential Addres	::	Confidential	Address Categories:	
	TIAL ADDRESS			
From/To: NOT APPLIC	ABLE			
POS: UNSPECIFIED	I.	Claim #: UNSPEC	IFIED	
Relig: UNSPECIFIED	I Contraction of the second	Sex: FEMALE		
Race: UNANSWERED		Ethnicity: UNANSW	ERED	
Duineur Elisibilitur	INCORCIETED			
Primary Eligibility: Other Eligibilities:				
buler Erigibilities.				
Status : ACTIVE	INPATIENT-on WA	RD (SERIOUSLY ILL)		
Admitted : FEB 25	,2010012:27:51	Transferred : M	AR 1,2010019:03:38	
Ward : INPATI	ENT	Room-Bed/Ext : 5		
Provider : NIESEN	,MARY ANN	Specialty : G		
Attending : NIESEN	,MARY ANN	Admitted by : N	IESEN, MARY ANN	
Admission LOS: 165				
Currently enrolled i	n PT WIGGINS, DI	ABETIC RN, RADIOLOGY,		
		- RADIOLOGY, GENERAL,		
		S-20, X BAKER 20,		
		rica stark, WINSTEAD	QUANA,	
		PY, PT Wiggins,	- ,	
		HELL-SPECIALTY/HOSP F	U NEW-30,	
Future Appointments:	NONE			
Remarks:				
Primary Care Informs	tion:			Ľ
				▶
Font 9 🛖			Print Close	
3126				

Figure 4-29: Patient Detail dialog

4.3.2 Visit Panel

 BH - BOSWOOD
 14-Jun-2011 11:45

 BAILEY,DONNA R
 Ambulatory

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

Reynolds,Daniel F-Do

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

🥏 Lab Point of Care Data Entry Form	
Patient: DEMO,ALICE JANENE	Hospital Location: INPATIENT
Ordering Provider USER.ZSTUDENT Test Collection Date and Time 02/25/2010 12:27 PM	Nature of Order/Change Sample Type Sign or Symptom
Comment/Lab Description:	Add Canned Comment
TEST	RESULTS
Test Name Res	sult Result Range Units
	<u>S</u> ave <u>C</u> ancel

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

PWH

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).

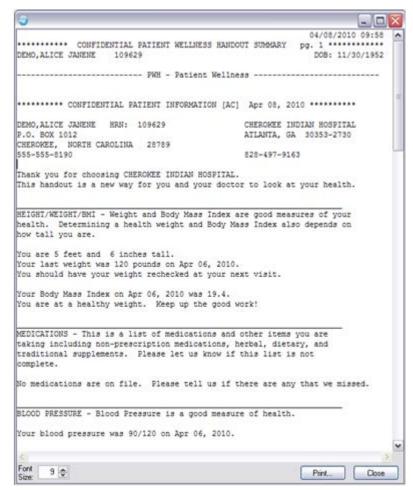


Figure 4-36: Confidential Patient Wellness Handout Summary

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

Available Reminders	
<u>V</u> iew <u>A</u> ction	
Available Reminders	Due Date Last Occurre Pri
HepB Adult Immunization TD Immunization TD Immunization Depression Screen Colon Cancer Blood Pressure Alcohol Screen Applicable Not Applicable All Evaluated Other Categories	DUE NOW DUE NOW DUE NOW DUE NOW DUE NOW 08/02/2011 08/02/2010 09/28/2011 09/28/2010

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.

Detail fo	r Demo,Alice Janene		
DEMO,ALICE	JANENE	602-68-0084	NOV 30,1952 🔥
Address: 1	COORDINATING MASTER OF 10 DEEPWOOD COURT HEROKEE,NC	RECORD: NOT LISTED	
County: U Phone: S	NSPECIFIED 55-555-8190 NSPECIFIED	From/To: NOT APPLICAE Phone: NOT APPLICAE	
NO	al Address: CONFIDENTIAL ADDRESS OT APPLICABLE	Confidential Addres	ss Categories: 🗏
Relig: UN	ISPECIFIED ISPECIFIED IANSWERED	Claim #: UNSPECIFIED Sex: FEMALE Ethnicity: UNANSWERED	
Primary Eli Other Eligi	gibility: UNSPECIFIED bilities:		
Status	: ACTIVE INPATIENT-on WARD	(SERIOUSLY ILL)	
Ward Provider	: FEB 25,2010012:27:51 : INPATIENT : NIESEN,MARY ANN : NIESEN,MARY ANN	Room-Bed/Ext : 509-A , Specialty : GENERAL	/ L MEDICINE
Admission I	OS: 146		
Currently e	nrolled in PT WIGGINS, DIAE DEMO HOSPITAL -	ETIC RN, RADIOLOGY, RADIOLOGY, GENERAL,	×
Kantan Size: 9 ✿			Close

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.

teview/Sign Changes for Demi	o,Raven Danielle
Signature will be applied to checked	d Rems
Orders - Other Unsigned	
	IDE TAB 25MG TAKE TWO TABLETS B
 Discontinue ERYTHROMYCIN 	SUSP 200MG/5ML TAKE 1 TEASPOO
Electronic Signature Code:	
	Sign Cancel

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.

Patient Postings		
Allergies	Severity	Signs / Symptoms
Albuterol		Tachycardia
Metronidazole		Rash
Percocet		Urticaria Anniatud Incohencian Dach
Penicillin Ceftriaxone		Anxiety;Hypotension;Rash Bash
Crisis Notes, Warning Notes, Directi	ues Record Flags	
D ADVANCE DIRECTIVE		May-2006 11:13
		ngy 2000 11.10

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.
С	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.

Problem List	Advs React	Medications
Nds Rywd	Nds Rywd	Nds Rywd

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

PRIVA		ata gear and L			CHILD I		RESOURCES	1	MMUNICAT	100							
atient not i			Visit	not selecter	đ		Primary Care T				Med Rec	Visit Summers	2	A Posting	Problem List	Advs React	Medications
tifications	Review	CC / HPI Min	In Past He	naith Hy 🗐 Iwa	A Notes	Vitals Asse	essment Orders	PIEd	nonduna	Consults	Beports	Lahs					

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.

	Adverse Reactions						
Agent 📥	Туре	Reaction					
AMOXICILLIN	Drug	ANAPHYLAXIS					
BENZALKONIU	Drug, Food	AGITATION					
Status O All 💿 Ac	tive						

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):

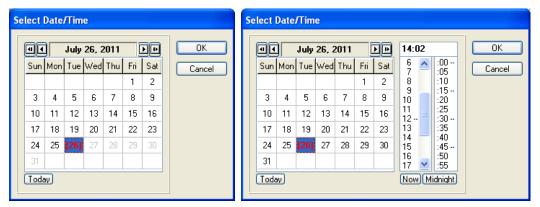


Figure 4-52: Select Date/Time dialogs

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

Date of <u>Onset</u> 07/25/2011	Date/Time:	26Jul-2011 14:11	
---------------------------------	------------	------------------	--

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:

Printer Selection	×
-Local Printers	
PaperPort Image Printer Microsoft XPS Document Writer KONICA MINOLTA mc5670 PS KONICA MINOLTA mc5670 PCL6 HP LJ P3005 Brother PC-FAX v.2 Brother MFC-7840W Printer Brother MFC-7840W BR-Script3	<
Bemote Printers	
80 <scriptpro lat=""> 80 88 <ptbilling> 80 88 CPTBILLING> 80 BILLING <ptbilling> 80 CARD EMBOSSER 80 CODING <ptcode> 80 DDS <prt01> 87 DENTAL <ptdenfd> 80 EHRIT 96 GREEN <ptopatg> 80</ptopatg></ptdenfd></prt01></ptcode></ptbilling></ptbilling></scriptpro>	
Copies: 1 Save as your default printer D Setup OK Cancel	

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.

i

Figure 4-55: Info button

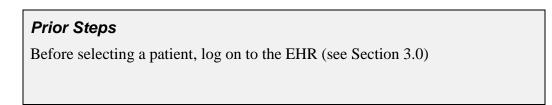
When clicked, the Info button uses search keywords associated with the current EHR page to find pertinent information on the Internet and display it in the default browser window.

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:

Patient not selected	Visit not selected

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



5.1 Select a Patient

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

Patient Lists	Patients	Demographics
	Demo,Immunization Baby	Demo,Immunization Baby
No Default Providers Teams Specialties	Demo,Immunization Baby Abendroth,Raymond E	HRN: 12345 Female, age: 2
O Speciatries Clinics Wards Personal Lists All	Abbey,Tressia Lynn Abbott,Charles Woodrow Abbott,Ray Mitchell Abbott,Rodolfo Almanza	D0B: 01-Feb-2009
	Abee,Chasidy Sha Abendroth,Michael Abendroth,Raymond E Abercrombie,David L Abercrombie,James Mitchell Abernathy,Christopher Abernathy,Edna Minnie Abernathy,Edna Minnie Abernathy,Edna Minnie Abernathy,Linda L Abernathy,Jenda L Abernathy,Melissa Kay Abernathy,Nathaniel Abernathy,Samuel B JR	Patient Detail
Manage List	Abernathy,Summer Mackenzie Abernathy,Susie Abevta,Norma J	
Save Settings	Abner,Douglas Abraham,Cade Jackson	
	Abraham, Melvin Edward Abrams, Brady Warren Abrams, Tabitha Denise	OK Cancel

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.

Patient Lists	
No Default Providers Teams Specialties Clinics Wards Personal Lists All	

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:

Patients
Demo,Immunization Baby
Demo,Immunization Baby
Abendroth,Raymond E
Abbey,Tressia Lynn
Abbott.Charles Woodrow
Abbott,Ray Mitchell
Abbott,Rodolfo Almanza
Abee,Chasidy Sha
Abendroth,Michael
Abendroth,Raymond E
Abercrombie,David L
Abercrombie,James Mitchell
Abernathy Alice M
Abernathy, Christopher
Abernathy,Edna Minnie
Abernathy,Elijah Thomas
Abernathy,Kermit
Abernathy,Linda L
Abernathy, Melissa Kay
Abernathy,Nathaniel Abernathy,Pedro Marvin
Abernathy, Samuel B JR
Abernathy, Summer Mackenzie
Abernathy,Susie
Abevta,Norma J
Abner, Douglas
Abraham.Cade Jackson
Abraham, Melvin Edward
Abrams,Brady Warren
Abrams,Tabitha Denise 🛛 🗸

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.

Demographics
Demo,Immunization Baby
HRN: 12345 Female, age: 2
D0B: 01-Feb-2009
Patient Detail
OK Cancel

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.

-Patient Lists	Patients	Demographics
	Demo,Immunization Baby	Demo,Immunization Baby
No Default Providers Teams Specialties	Demo.Immunization Baby Abendroth,Raymond E	HRN: 12345 Female, age: 2
Clinics Wards Personal Lists All	Abbey,Tressia Lynn Abbott,Charles Woodrow Abbott,Ray Mitchell Abbott,Rodolfo Almanza	D0B: 01-Feb-2009
	Abee, Chasidy Sha Abendroth, Michael Abendroth, Raymond E Abercrombie, James Mitchell Abercrombie, James Mitchell Abernathy, Alice M Abernathy, Edna Minnie Abernathy, Edna Minnie Abernathy, Elijah Thomas Abernathy, Linda L Abernathy, Melissa Kay Abernathy, Melissa Kay Abernathy, Melissa Kay Abernathy, Pedro Marvin	Patient Detail
	Abernathy,Samuel B JR Abernathy,Summer Mackenzie	
Manage List	Abernathy,Susie Abeyta,Norma J	
Save Settings	Abner, Douglas	
	Abraham,Cade Jackson Abraham,Melvin Edward	
	Abrams, Brady Warren Abrams, Tabitha Denise	OK Cancel

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.

🌏 Patient Detail - 🗆 🗵 DEMO,ALICE JANENE 602-68-0084 NOV 30,1952 COORDINATING MASTER OF RECORD: NOT LISTED Address: 110 DEEPWOOD COURT Temporary: NO TEMPORARY ADDRESS CHEROKEE,NC County: UNSPECIFIED From/To: NOT APPLICABLE Phone: NOT APPLICABLE Phone: 555-555-8190 Office: UNSPECIFIED Bad Addr: Confidential Address: Confidential Address Categories: NO CONFIDENTIAL ADDRESS From/To: NOT APPLICABLE POS: UNSPECIFIED Claim #: UNSPECIFIED Relig: UNSPECIFIED Sex: FEMALE Race: UNANSWERED Ethnicity: UNANSWERED Primary Eligibility: UNSPECIFIED Other Eligibilities: Status : ACTIVE INPATIENT-on WARD (SERIOUSLY ILL) Admitted : FEB 25,2010012:27:51 Transferred : MAR 1,2010@19:03:38 Ward : INPATIENT Room-Bed/Ext : 509-A / Provider : NIESEN,MARY ANN Specialty : GENERAL MEDICINE Attending : NIESEN, MARY ANN Admitted by : NIESEN, MARY ANN Admission LOS: 147 Currently enrolled in PT WIGGINS, DIABETIC RN, RADIOLOGY, DEMO HOSPITAL - RADIOLOGY, GENERAL, Payne, X GRIMES-20, X BAKER 20, STARK ERICA, erica stark, WINSTEAD QUANA, PHYSICAL THERAPY, PT Wiggins, PT THOMPSON, SHELL-SPECIALTY/HOSP FU NEW-30, Future Appointments: NONE Remarks: Primary Care Information: Primary Practitioner: MOORE,CATHERINE Service Connection/Rated Disabilities: Service Connected: NO Rated Disabilities: NOT A VETERAN Next of Kin Information: Name: DEMO,JOYCE (MOTHER) 1 Font 9 🚔 Print. Close Size:

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.

Demo,Patie	nt Senior Male		Visit not selected
37930	01-Jan-1935 (76)	M	

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.

Select a location below.> Appointments / Visits Hospital Admissions New Visit Appointments / Visits Hospital Admissions New Visit Visit Location Date of Visit A CLINIC Image: Comparison of the second
Appointments / Visits Hospital Admissions New Visit Visit Location Date of Visit A CLINIC Image: Strategy of the strate
USER ZZSTUDENT VACANT, DONALD J VANDUURAN, MILDRED R WALKER, MARCELINO WATKINS, CHARLES

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.

Encounter Settings for Current Activities	
A CLINIC 21-Jul-2010	0 14:29
A CLINIC 21 Jul-2011	Date of Visit Wednesday, July 21, 2010 V Time of Visit 2:29 PM Type of Visit Ambulatory Historical Telephonic Chart Review In-Hospital Day Surgery Observation Nursing Home
	OK Cancel

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.

Encounter Settings for Current Activit	ies					
<select -<="" td=""><td>a locatio</td><td>n below.></td><td></td><td></td><td></td><td></td></select>	a locatio	n below.>				
Encounter Location Appointments / Visits Hospital Admissions	New V	sit				
Visit Location		Date	e of Visit			
		We	ednesday,	July	21,2010	~
A CLINIC		Time	e of Visit			
AMBER AMBER II	l	2:	29 PM	\$		
		Тур	e of Visit			
CANCER SCREENING		Am	bulatory			¥
CGPHNCLINIC		🕘 🔽 i	Create a Vi	sit Now		
Encounter Providers						
All Providers	_	Providers f	or this Enco	ounter		
USERZSTUDENT	Р					
USER,ZZSTUDENT VACANT,DONALD J	4					
VANDUURAN, MILDRED R						
	\$					
(<u> </u>						
			OK		Cancel	

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 Providers** 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.

Encounter Settings for Current Activities	
<select a="" location<="" th=""><th>below.></th></select>	below.>
USER_ZSTUDENT P USER_ZSTUDENT	Date of Visit Wednesday, July 21, 2010 💌 Time of Visit
VACANT,DONALD J VANDUURAN,MILDRED R WALKER,MARCELINO WATKINS,CHARLES	OK Cancel

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.

Similar Vis	its		×
	ng visits are similar following actions:	to the requested visit. Perfor	m
 To ignor 	e these visits and o	select it and click Select. create a new one, click Ignore dialog, click Cancel	
Location	Visit Date	Primary Provider	
A CLINIC	26Jul-2011 14:53	USER,ZSTUDENT	
	Select	Ignore Cance	

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.

	Active	e Problem List		Lab Orders	
	No Active	e Problem List Found		No Lab Orders Found	
			1		
			1		
			pointments & Visits		
ppointment/Vi	Date - Status		2		
CLINIC	26Jul-2011 14 AMBULATORY				
CLINIC	20Jul-2011 13 AMBULATORY				
HARMACY	24-Sep-2010 1 AMBULATORY				
				43	
	B	3eminders -		Alertz	
	Date		8	No Crisis Alerts Found	
sminder -	D'alle				
ap Immunizatio	DUE NOW				
tap Immunizatio CT/HGB	DUE NOW DUE NOW				
ap Immunization CT/HGB sad Circumferer	DUE NOW DUE NOW				
ap Immunization CT/HGB sad Circumferen sight spA Ped Immun	n DUE NOW DUE NOW DUE NOW DUE NOW 04-May-2011 22:05 zation DUE NOW				
ap Immunization CT/HGB had Circumferen sight spA Ped Immun spB Ped Immun	h DUE NOW DUE NOW DUE NOW 04-May-2011 22:05 ization DUE NOW ization DUE NOW				
tap Immunizatio CT/HGB ead Circumferer eight epA Ped Immun epB Ped Immuni ibiter Immunizat	DUE NOW zation DUE NOW DUE NOW ion DUE NOW				
teminder – tap Immunization ICT/HGB ead Circumferer leight tepA Ped Immun leipter Immunization PV Immunization MB Immunization	h DUE NOW DUE NOW DUE NOW DUE NOW 04-May-2011 22.05 2000 DUE NOW 2000 DUE NOW 000 DUE NOW DUE NOW DUE NOW				

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

	Active Problem List	
Problem	Date 💌	^
codiene intolerance	13Jun-2007	
Diabetes Mellitus Without	08-Mar-2007	
hypertension with neuropa	08-Mar-2007	
1CM LUCENT REGION S	16-Feb-2005	
ABN, MAMMOGRAM L B	16-Feb-2005	
MED ADJUSTMENT INC	08-Apr-2004	
L KNEE TENDONITIS (G	01-Sep-2000	
ANXIETY/DYSTHYMIA-D	21-Mar-1991	
HYPERTENSION	09-Nov-1990	
OBESITY	09-Nov-1990	~

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.

Problem Det	ail 📃 🗖 🔀
Unspecified Ot	itis Media (382.9) 🔥 🔼
Onset:	4/8/10
Status:	ACTIVE/
SC Cond:	UNKNOWN
Exposure:	None
Provider:	
Clinic:	
Recorded:	, by USER,ZSTUDENT
Entered:	5/8/10, by
Updated:	5/8/10
1	
2	X
Font o	
Size: 9	Close

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

CHA/P Getting Started Guide September 2011

The Review Tab

- Provider
- Clinic
- Recorded
- Entered
- Updated

6.2 Lab Orders Pane

		Lab Orders
Lab Order 🔺	Status	Date
POCIA1C VEN	COMPLETE	21-Jul-2010 14:29

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.

Lab Order Detail	
POC A1C VENOUS BLOOD WC LB #60640	~
Collection time: Jul 21, 2010@14:29 Test Name Result Units POC ALC 8 H %	Range 1-6
<u>×</u>	>
Font 9 🗢	Close

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

		Appointments & Visits
Appointment/Vi	Date 🔻	Status
A CLINIC	21-Jul-2010 14:	AMBULATORY
A CLINIC	21-Jul-2010 11:	IN HOSPITAL
A CLINIC	21-Jul-2010 08:	AMBULATORY
AMBER II	21-Jul-2010 08:	AMBULATORY
A CLINIC	20-Jul-2010 14:	AMBULATORY
Unknown	13-Jul-2010 13:	AMBULATORY
Unknown	13-Jul-2010 13:	AMBULATORY
Unknown	08-Jul-2010 13:	AMBULATORY
A CLINIC	08-Jul-2010 10:	IN HOSPITAL
A CLINIC	08-Jul-2010 10:	CHART REVIEW
A CUMIC	07.1.10010.15.	

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.

Appointment/Visit Detail		
	: 21-Jul-2010 14:29 VISIT IEN: 2108876	•
	ORDERS <page l=""></page>	
	(luge 1)	
DRDER #: 406686	STATUS: COMPLETE	
START: Jul 21, 2010@14:29 POC AIC VENOUS BLOOD WC LB #6064	STOP: Jul 21, 2010014:49	
FOC AIC VENOUS BLOOD WE BE #0004	-	
DRDER #: 406684	STATUS: UNRELEASED	
START:	STOP: ication: Diabetes Mellitus Without Mention Of Com *UNSIGN	TED +
ORINE DIPSTICK ORINE SP ONCE ING	ICACION: DIADECES MEILICUS WICHOUC MENCION OF COM "ONSIGN	NED.
ORDER #: 406685	STATUS: UNRELEASED	
START:	STOP:	
AICRUALBUMIN, ORINE ORINE SP ON	CE Indication: Diabetes Mellitus Without Mention Of Com *	"UNSIGNED"
VISIT IEN: 2108876		
VISIT IEN: 2108876		
VISIT IEN: 2108876 HRN: CI 109629	VISIT FILE	
HRN: CI 109629 	010014:29	
HRN: CI 109629 VISIT/ADMIT DATE≪TIME: JUL 21, 2 DATE VISIT CREATED: JUL 21, 20	DIOQ14:29 10 TYPE: TRIBE-NON 638/NON-COMPACT	
HRN: CI 109629 VISIT/ADMIT DATE≪TIME: JUL 21, 2 DATE VISIT CREATED: JUL 21, 20	D10014:29 10 TYPE: TRIBE-NON 638/NON-COMPACT 2 LOC. OF ENCOUNTER: DEMO HOSPITAL	
HRN: CI 109629 VISIT/ADMIT DATE&TIME: JUL 21, 2 DATE VISIT CREATED: JUL 21, 20 PATIENT NAME: DEMO,ALICE JAMEN SERVICE CATEGORY: AMBULATORY DEPENDENT ENTRY COUNT: 1	D10014:29 10 TYPE: TRIBE-NON 638/NON-COMPACT 2 LOC. OF ENCOUNTER: DEMO HOSPITAL CLINIC: GEMERAL DATE LAST MODIFIED: JUL 21, 2010	
HRN: CI 109629 VISIT/ADMIT DATE«TIME: JUL 21, 2 DATE VISIT CREATED: JUL 21, 20 PATIENT NAME: DEMO,ALICE JAMEN SERVICE CATEGORY: AMBULATORY	D10014:29 10 TYPE: TRIBE-NON 638/NON-COMPACT 2 LOC. OF ENCOUNTER: DEMO HOSPITAL CLINIC: GEMERAL DATE LAST MODIFIED: JUL 21, 2010	
HRN: CI 109629 VISIT/ADMIT DATE&TIME: JUL 21, 2 DATE VISIT CREATED: JUL 21, 20 PATIENT NAME: DEMO,ALICE JAMEN SERVICE CATEGORY: AMBULATORY DEPENDENT ENTRY COUNT: 1	D10014:29 10 TYPE: TRIBE-NON 638/NON-COMPACT 2 LOC. OF ENCOUNTER: DEMO HOSPITAL CLINIC: GEMERAL DATE LAST MODIFIED: JUL 21, 2010	

Figure 6-7: Appointment/Visit Detail dialog

CHA/P Getting Started Guide September 2011

6.4 Reminders Pane

Reminders				
Reminder 🔺	Date			
Dtap Immunization	DUE NOW			
HCT/HGB	DUE NOW			
Head Circumference	DUE NOW			
Height	04-May-2011 22:05			
HepA Ped Immunization	DUENOW			
HepB Ped Immunization	DUE NOW			
Hibtiter Immunization	DUE NOW			
IPV Immunization	DUE NOW			
MMR Immunization	DUE NOW	~		
Ded Dates and the second				

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**.

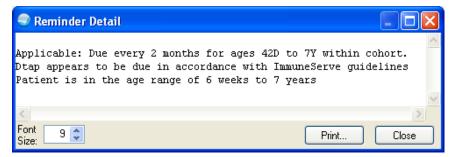


Figure 6-9: Reminder Detail dialog

6.5 Alerts Pane

Alerts				
Crisis Alert 🔺	Date			
ADVANCE DIRECTIVE	13-Feb-2007 10:20			

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.

🥏 Crisis Detail		
TITLE: ADVANCE DIRECTIVE DATE OF NOTE: FEB 13, 2007@10:20 AUTHOR: USER,BSTUDENT URGENCY:	ENTRY DATE: FEB 13, 2007@10:20:42 EXP COSIGNER: STATUS: COMPLETED	~
TEST NOTES FOR ADV DIRECTIVE		
/es/ BSTUDENT USER physician Signed: 02/13/2007 10:21		
		\sim
		>
Font Size: 9 📚	Print	Close

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:

Demo,Patient Senior Male		BH - BOSWOOD	14-Jun-2011 11:45
37930 01-Jan-1935 (76)	М	BAILEY, DONNA R	Ambulatory

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

7.1 The CC/HPI Tab

۲	Chief Complaint			Add Edit Dele				Activ	e Problem List	
				 Boo For Kee	Pro	blem 🔺		Date		
Author	Chief Complant				DIA	DOMINAL PAIN J8ETES betes Melikus W		17-Jan-2007		
3 '	Problem List	Status		lates	Class	Onset	ICD	ICD Name	Classification	Add Edt 0
н-1	Diabetes Melitus Without Mention Of Complication, Type Ii Or Unspecified Type,	Active	01/17/2007			01/17/2007	250.00	DIABETES II/UNSPEC NOT UNCONTR		
H-2	DIARETES	Active	01/17/2007			01/17/2007	250.00	DIABETES II/UNSPEC		
H-3	ABDOMINAL PAIN WITH NAUSEA, VOMMITTING, DIARRHEA	Active	01/17/2007			01/17/2007	.9999	UNCODED DIAGNOSIS		

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.

Chief Complaint				
from 101 to 99 po, tempora Tried seal oil with garlic in	go, deep inside left ear; o ng relieves it nor makes i h pills a couple of time y rilly. sar, no relief. sessed as ear infection, i ems the same.	it worse. Getting worse. resterday plus last dose 4 hrs ago: red it was treated with amoxicillin which m		OK Cancel
Acne Anxiety Back Ache Chest Pain Chills Cold Cough Decreased Appetite Diarrhea	Dizziness Ear Ache* Employee Health - Ar Employee Health - Ar Employee Health - In Employee Health - SI Eye Pain* Fever Head Ache	nnual TB Insomnia	Severity Minor Moderate Severe *Location Right Left Both	Duration
💿 Symptom 🛛 🔘 Diagn	osis i 🔘 Patient Requ	uest Clear		Append

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.

Chief Complaint				X
always returns. Pain is describetter. It seems to be getting every day. She has put seal	ribed as a dull ache which is a 9 worse oil with garlic in her ear but it (old it was an ear infection. She which she takes lisinopril.	om 99 to 101 and is reduced by Iways present. Nothing makes I did not help. She had this type reports taking amoxicillin which	the pain of ear ache	OK Cancel
Acne Anxiety back ache* Chest Pain Chills Cold Cough Decreased Appetite Diarrhea	Dizziness Ear Ache* Fever Head Ache Hemmorhoidal Discomfort Hoarseness Infection Insomnia joint pain*	Laceration* Nausea Pain pain in the neck* Rash Running Nose Sinus Pain Sore Throat Toothache*	Severity Minor Moderate Severe * Location Right Left Both	Duration Hours Days Weeks Months Years
<		>	Ľ	
⊙ Symptom 🔿 Diagno	sis 🔵 Patient Request	Clear)	Append

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.

- 2 🛛
PwH Health POC ² atien S Postings Jummary Lab E Detail AD
Add Edit Delete

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.

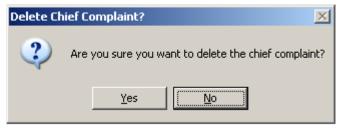


Figure 7-7: Delete Chief Complaint dialog

7.3 Review Problems in the Problem List Pane

	Problem List 🕕 Active Only	<u> </u>	et as Today's I	POV				Add Edit Delete
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-DEPRESSI ON-SITUATIONAL	Active	03/21/1991		Referr 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 Melitus 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	UELEAR	Active	04/08/2004				V65.8	REASON FOR CONSULT NEC
	ADM MANNOCDAM L DDDACT							·

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.

_								
	Problem List 🕕 Active Only	-	et as Today's F	°0V				Add Edit Delete
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-DEPRESSI ON-SITUATIONAL	Active	03/21/1991		Referr To Bev. Med. For Stress Management		300.00	ANXIETY STATE NDS
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 Melitus 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
	ADM MANAGEDAM L DDDACT							· · · · · · · · · · · · · · · · · · ·

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

🗖 Problem	Maintenance 🛛 🔀										
Pro <u>b</u> lem ID	CI-8 Priority 1 - high 5 - low Save Cancel										
<u>I</u> CD:	OTITIS MEDIA NOS (NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)										
<u>N</u> arrative	Inspecified Otitis Media										
Date of <u>O</u> nset Notes	Date of Onset 04/08/2010 Status O Active Problem O Personal History O Inactive Problem O Family History										
Note #	Narrative Date Author										
	Add Note Delete Note										

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.

	Problem List 🚺 Active Only	× 2	et as Today's P0	v				Gaa Ear	Delete
ID	Provider Natrative	Status	Modified P	hority Not	kes .	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	AND/JETY/DYSTHYMIA-DEPRESSI ON-SITUATIONAL	Active	03/21/1991		ferr To Bev. Med. For Stress magement		300.00	AND/JETY STATE NOS	
AA-4	L KNEE TENDONITIS (GRACILIUS MUSCLE)	Active	09/01/2000				727.09	SYNDVITIS NEC	
01-2	hypertension with neuropathy	Active	03/08/2007			03/08/2007	.9999	UNCODED DIAGNOSIS	
CI-3	Diabetes Melitus 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 OBis 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	
WW-2	ABN. MAMMOGRAM L BREAST DENSITY	Active	02/16/2005				793.80	UNSPECIFIED ABNORMAL MAMMOGRAM	
ww-3	1CM LUCENT REGION SUP. LAT. ASPECT PATELLA	Active	02/16/2005				793.7	NONSP ABN FIND-MS SYSTEM	

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.

International In			
	Problem List 🕦	Active Only 🛛 🔽	
		All Problems	
ID	Provider Narrative	Active Only	IS
DH-7	Confusion	Inactive Only	е
DH-10	DIARETES	Acti	UA

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.

1	Problem List 🕕 Active Only	~	et as Today's I	POV					e
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-DEPRESSI ON-SITUATIONAL	Active	03/21/1991		Referr 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 Melitus Without Mention Of Complication, Type Ii Or Unspecified Type,		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	
	ADM MANNOCDAM DDDACT								×

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.

	Problem List	v v (1	el as Today's	POV				êdd Edit Delete
ID	Provider Nanative	Status	Modiled	Priority	Notes	Onset	ICD	ICD Name
ww.3	1CM LUCENT REGION SUP. LAT. ASPECT PATELLA	Inactive	04/09/2010				793.7	NONSPIABN RIND MS SYSTEM
CI-2	Unspecified Essential Hypertension	Inactive	04/09/2010	2			401.9	HYPERTENSION NOS

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:

Demo,Pa	atient Senior Male		BH - BOSWOOD	14-Jun-2011 11:45
37930	01-Jan-1935 (76)	М	BAILEY, DONNA R	Ambulatory

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

ctive Only Chronic Only 180	days Print I	New_ Check 1	Outside Medications	•						
tion Chronic		Outpatien/ Medications		Statur	Issued	Last Filed	Explicit	Refils Remaining	∏×#	Provider
		-								
Action			Outside Medications					S	tatus	Start D
Action			Outside Medications		- *)			S	tatus	Start [
Action			Outside Medications					S	latus	Start
Action			Outride Medications					S	latus	Start I
Action			Outride Medications					S	latus	Start [
Action			Outside Medications					S	tatus	1
			Outride Medications					S	latus	Start Da
Action			Outrade Medicatione					S	latus	Stat D
Action			Outside Medications					S	Latus .	Start D.

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:

Demo,P	atient Senior Male	BH - BOSWOOD	14Jun-2011 11:45
37930	01-Jan-1935 (76) M	BAILEY,DONNA R	Ambulatory

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:

		Medicatio	n List					Adverse Reactions			
fedication	Status	Issue Date 👻			Agent -	Type	Reaction				
ISINOPROLOL	ACTIVE	19 Apr 2011			PENICILLIN	Drug	HIVES				
					<						
	stive 💿 All	V/Outpatient Out O In			O All	 Active 					
Health F	actors			Add Edt [Delete]	Exa	ms				Add Edg	Del
		ategory Comment			Visit Date	Exams		Result	Comments	Provider	Locati
1/17/2007 Smo	kerIn Home T	obacco			09/08/2010	FOOT INSP		NORMAL/NEGATIVE NORMAL/NEGATIVE REFUSED SERVICE		USER/ZZSTUDENT USER/ZZSTUDENT	
					<						
Reproductive I	tealth	Infant Feeding	Personal Health	Family History							
Persone	d Health				10			To add a	ect a form	Add Edi	
T										Mall Cone II was	1.
Refus	al 04/17/2007	INTIMATE PARTNER VIOL	NUE (Exam)								_

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

Notifications VIFC Review VCC / HPI Past Health Hx VIMM Notes Vitals Assessment Orders Pt Ed Proc					
		Medication List			
Medication	Status	Issue Date 💌			
LORazepam= T	ACTIVE*	28-Jun-2001			
L					
Status					

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

		Adverse Reactions
Agent 🔺	Reaction	Status
AMOBARBITAL	DELERIUM	Verified
AMOXICILLIN	ABBHYTHMIA	Verified
DEMEROL APAP	CHEST PAIN	Verified
INSECT STING	ANAPHYLAXIS	Verified
PENICILLIN G	ANAPHYLAXI	Verified

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.

1	Refresh	F5
	Chart Review	F
	Inability to Assess	
	Reactivate Adverse Reaction	
	Inactivate Adverse Reaction	
_	Entered in Error	
	Sign Adverse Reaction	
	New Adverse Reaction	
	Delete Adverse Reaction	
	Edit Adverse Reaction	

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.

Look up Causative Agent	
Enter causative agent for Adverse Reaction: (Enter at least 3 characters)	Search
No Known Allergies	OK Cancel

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.

Look up Causative Agent
Enter causative agent for Adverse Reaction: (Enter at least 3 characters) insect Search
Select from one of the following items
OK Cancel
Select from the matching entries on the list, or search again.

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.

Create Adverse Reaction				
Reaction Causative agent: INSECT STINGS Nature of Reaction Other Event Code Event Code	•••	•	Dbserved Observer: User,Zstudent Reaction Date/Time Severity V	T
- Signs/Symptoms Available		Selected		
AGITATION AGRANULOCYTOSIS ALOPECIA ANAPHYLAXIS ANEMIA ANDREXIA	\$			
ANXIETY APNEA		Date/Time:		
APPETITE, INCREASED		Source:		-
Comments				
Current			OK C	Cancel

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.

Create Adverse Reaction	
Reaction Causative agent: DOXYCYCLINE Image: Constant of Reaction Drug Event Code ALLERGY TO SUBSTANCE Source of Information PATIENT	Observed Observer: UserZstudent Reaction Date/Time Severity
Signs/Symptoms Available RASH POSSIBLE REACTION PRIAPISM PROLONGED PENILE ERECTIC PRURITIS PTOSIS PURPURA RALES RASH RASH, PAPULAR RESPIRATORY DISTRESS	Selected AGRANULOCYTOSIS Aug 31,2011@11:42 Date/Time: 31-Aug-2011 11:42 Source:
Current	OK Cancel

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.

Create Adverse Reaction	
Reaction Causative agent: DOXYCYCLINE Nature of Reaction Drug Event Code ALLERGY TO SUBSTANCE Source of Information PATIENT	Observed Observer: UserZstudent Reaction Date/Time Severity Severity
Signs/Symptoms Available RASH POSSIBLE REACTION PRIAPISM PROLONGED PENILE ERECTIC PRURITIS PURPURA RALES RASH RASH, PAPULAR RESPIRATORY DISTRESS	Selected AGRANULOCYTOSIS Aug 31,2011@11:42 Date/Time: 31-Aug-2011 11:42 Source:
Current	OK Cancel

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.

Adverse Reactions			
Agent 📥	Reaction	Status	
AMOBARBITAL	DELERIUM	Verified	
AMOXICILLIN	ARRHYTHMIA	Verified	
DEMEROL APAP	CHEST PAIN	Verified	
INSECT STING	ANAPHYLAXIS	*Unsigned	
PENICILLIN G	ANAPHYLAXI	Verified	

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

Review and Update Past Health History

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.

Review/Sign Changes for Demo,Alice Janene
Signature will be applied to checked items
Adverse Reaction
Adverse Reaction to INSECT STING
۱ <u>ــــــــــــــــــــــــــــــــــــ</u>
OK Cancel

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.

Look up Causative Agent		
Enter causative agent for Adverse Reaction: (Enter at least 3 characters)		Search
🗹 No Known Allergies	ОК	Cancel

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.

Reason Prompt	
Please select a reason: UNCONSCIOUS LANGUAGE BARRIER ALTERED MENTAL STATUS	 CAREGIVER DOES NOT KNOW PATIENT DOES NOT KNOW OTHER
	OK Cancel

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.

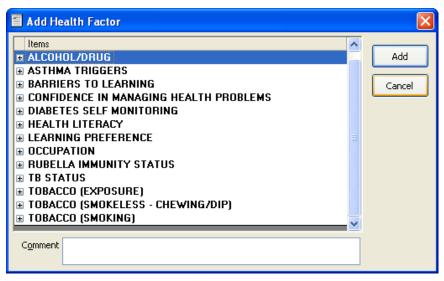


Figure 9-16: Add Health Factor dialog

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.

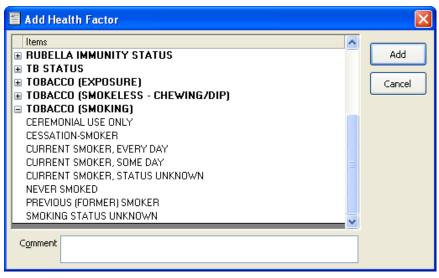


Figure 9-17: List of options for the "TOBACCO (SMOKING)" health factor

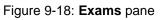
Tobacco health factors and their meanings:

- 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

Exams Add Edit Delete					
Visit Date	Exams	Result	Comments	Provider	Locatio
08/28/2008	DIABETIC FOOT EXAM, COMPLETE	NORMAL/NEGATIVE	nlsglsdglglkslk	MOSELY, ELVIRA	DEMO
05/01/2007	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		USER, BSTUDENT	DEMO
<					>



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.

🖻 Exe	am Selection	
Code	Exams A	
35	ALCOHOL SCREENING	Select
41	COLOR BLINDNESS	
30	DENTAL EXAM	Cancel
36	DEPRESSION SCREENING	
03	DIABETIC EYE EXAM	
28	DIABETIC FOOT EXAM, COMPLETE	
37	FALL RISK	
29	FOOT INSPECTION	
34	INTIMATE PARTNER VIOLENCE	
39	NEWBORN HEARING SCREEN (LEFT)	
38	NEWBORN HEARING SCREEN (RIGHT)	
40	NUTRITIONAL RISK SCREENING	
14	RECTAL EXAM	

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.

🖻 Document an Exam 🛛 🔀			
Exam ALCOHOL SCREENING	Add		
Result 🔽	Cancel		
Comment	 Current 		
Provider USER,ZSTUDENT	 Current Historical 		
	🔘 Refusal		

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."

🖻 Docur	nent an Exam	
<u>E</u> xam	ALCOHOL SCREENING	Add
Result	~	Cancel
Comment	POSITIVE NEGATIVE	 Current
<u>P</u> rovider	USER,ZSTUDENT	 Historical
		🔘 Refusal

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.

🛱 Document an Exam				
<u>E</u> xam	ALCOHOL SCREENING	Add		
Result	NEGATIVE	Cancel		
Comment	Pt reports soberity for 3 years after going to Old Minto Recovery. Sher reports previously drinking 1/5 whiskey and	O Current		
<u>P</u> rovider	USER,ZSTUDENT	 Historical 		
- Historica	al	🔿 Refusal		
Ever	nt <u>D</u> ate 07/20/2010			
Lo	cation Alaska Village			
	 ○ IHS/Tribal Facility Other 			

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.

🛤 Exe	am Selection	×
Code	Exams A	
35	ALCOHOL SCREENING	Select
41	COLOR BLINDNESS	
30	DENTAL EXAM	Cancel
36	DEPRESSION SCREENING	
03	DIABETIC EYE EXAM	
28	DIABETIC FOOT EXAM, COMPLETE	
37	FALL RISK	
29	FOOT INSPECTION	
34	INTIMATE PARTNER VIOLENCE	
39	NEWBORN HEARING SCREEN (LEFT)	
38	NEWBORN HEARING SCREEN (RIGHT)	
40	NUTRITIONAL RISK SCREENING	
14	RECTAL EXAM	

Figure 9-23: The Exam Selection dialog

- 2. Select the "DEPRESSION SCREENING" option.
- 3. Click **Select**.

🖻 Document an Exam 🛛 🛛 🔀			
Exam DEPRESSION SCREENING	Add		
Result POSITIVE	Cancel		
Comment	 Current 		
Provider USER/2STUDENT	O Historical		
	🔘 Refusal		

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.

🐂 Document an Exam	×
Exam DEPRESSION SCREENING	Add
Reason UNABLE TO SCREEN	Cancel
Comment	C Current
Provider USER/ZSTUDENT	 Historical
	Refusal



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:

🐃 Document an Exam	×
Exam DEPRESSION SCREENING	Add
Reason UNABLE TO SCREEN	Cancel
Comment group setting, unable to question in private.	C Current
Provider USER_ZSTUDENT	C Historical
	Refusal

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.

🖻 Ex	am Selection	
Code	Exams A	
35	ALCOHOL SCREENING	Select
41	COLOR BLINDNESS	
30	DENTAL EXAM	Cancel
36	DEPRESSION SCREENING	
03	DIABETIC EYE EXAM	
28	DIABETIC FOOT EXAM, COMPLETE	
37	FALL RISK	
29	FOOT INSPECTION	
34	INTIMATE PARTNER VIOLENCE	
39	NEWBORN HEARING SCREEN (LEFT)	
38	NEWBORN HEARING SCREEN (RIGHT)	
40	NUTRITIONAL RISK SCREENING	
14	RECTAL EXAM	

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**.

🖻 Document an Exam			
Exam ALCOHOL SCREENING	Add		
Result 🔽	Cancel		
Comment	 Current 		
Provider USER/ZSTUDENT	 Historical 		
	🔘 Refusal		

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**.

S Document an Exam	X
Exam ALCOHOL SCREENING	Add
Reason 🔽	Cancel
Comment	O Current
Provider USER,ZSTUDENT	 Historical
	💿 Refusal

Figure 9-29: Documenting a refusal

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

🖻 Document an Exam 🛛 🔀			
<u>E</u> xam	ALCOHOL SCREENING	Add	
Reason	REFUSED SERVICE	Cancel	
Comment	× >	O Current	
<u>P</u> rovider	USERZSTUDENT	 Historical 	
		 Refusal 	

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.

🛤 Exe	am Selection	
Code	Exams A	
35	ALCOHOL SCREENING	Select
41	COLOR BLINDNESS	
30	DENTAL EXAM	Cancel
36	DEPRESSION SCREENING	
03	DIABETIC EYE EXAM	
28	DIABETIC FOOT EXAM, COMPLETE	
37	FALL RISK	
29	FOOT INSPECTION	
34	INTIMATE PARTNER VIOLENCE	
39	NEWBORN HEARING SCREEN (LEFT)	
38	NEWBORN HEARING SCREEN (RIGHT)	

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.

🖻 Document an Exam	X
Exam DIABETIC FOOT EXAM, COMPLETE	Add
Result	Cancel
Comment	 Current
Provider USER_ZSTUDENT) 🔿 Historical
	🔘 Refusal

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.			
🖻 Document an Exam			
Exam DIABETIC FOOT EXAM, COMPLETE	Add		
Result	Cancel		
Comment [Results of exam]			
Provider USER_ZSTUDENT	 Current Historical 		
	 Historical Refusal 		

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.

🖻 Ex	am Selection	
Code	Exams A	
35	ALCOHOL SCREENING	Select
41	COLOR BLINDNESS	
30	DENTAL EXAM	Cancel
36	DEPRESSION SCREENING	
03	DIABETIC EYE EXAM	
28	DIABETIC FOOT EXAM, COMPLETE	
37	FALL RISK	
29	FOOT INSPECTION	
34	INTIMATE PARTNER VIOLENCE	
39	NEWBORN HEARING SCREEN (LEFT)	
38	NEWBORN HEARING SCREEN (RIGHT)	
40	NUTRITIONAL RISK SCREENING	
14	RECTAL EXAM	

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.

🖻 Document an Exam	X
Exam ALCOHOL SCREENING	Add
Result	Cancel
Comment	O Current
Provider USER_ZSTUDENT	 Historical
Historical	🔘 Refusal
Event Date	
Location	
 Other 	

Figure 9-35: Documenting a historical exam

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

🖻 Document an Exam	X
Exam ALCOHOL SCREENING	Add
Result	Cancel
Comment Sober three years.	O Current
Provider USERZSTUDENT	 Historical
Historical	🔘 Refusal
Event Date	
Locațion	
 O IHS/Tribal Facility O Other 	

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.

🗟 Document an Exam	
Exam ALCOHOL SCREENING	Add
Result	Cancel
Comment Sober three years.	O Current
Provider USERZSTUDENT	 Historical
Historical	🔘 Refusal
Event <u>D</u> ate 08/04/2008	
Location Alone at home	
 ○ IHS/Tribal Facility Other 	

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).

🛢 Update Reproduc	tive Factors	X
Last <u>M</u> enstrual Period <u>F</u> amily Planning Method <u>T</u> otal # of Pregnancies <u>F</u> ull Term <u>P</u> remature <u>M</u> ultiple Births <u>L</u> iving Children		OK Cancel
Pregnant	by LMP by Ultrasound y Clinical Parameters	

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:

Demo,Patient Senior Male	BH - BOSWOOD	14-Jun-2011 11:45
37930 01-Jan-1935 (76) M	BAILEY, DONNA R	Ambulatory

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.

K Immunization Record	١											
_ Eorecast							<u> </u>	ations				
MMB past due												Add Delete
HEP A PED past due FLU-TIV past due							VARICELLA		icken Pox 2			
PLOPINY pasticule							PEDIARIX	Anaphyla	exis 2	8-Apr-2008		×
Vaccinations						_						
		-										
Print Record Due Letter Profile	Case Data											Add Edit Delete
Vaccine	Visit Date	Age@Visit	Location	Reactio	on \	/olume	Inj, Site	Lot	VIS Date	Administered By	VFC Eligibility	~
DTaP (PEDIARIX)	04/28/2008		DEMO HOSPITA		sions	.5	Left Deltoid IM	ac21b028AA	07/30/20			
IPV (PEDIARIX)	04/28/2008		DEMO HOSPITA		sions	.5	Left Deltoid IM	ac21b028AA	07/30/20			
HEP B PED	04/28/2008		DEMO HOSPITA			.5	Left Thigh IM	0489P		07 USER,CSTUDENT		
HEP B PED (PEDIARIX)	04/28/2008	5 yrs	DEMO HOSPITA	L Convuls	sions	.5	Left Deltoid IM	ac21b028AA	07/30/20	11 USER,CSTUDENT		
MMB	10/30/2003	12 mths	DEMO HOSPITA			.5	Left Deltoid IM	0992P		33 USER,CSTUDENT		~
1011110	Los puesto		0000000000			r			00.814.000	In the setting of		
💫 Skin Test History Prin	Record											Add Edit Delete
Visit Date Skin Test Location	Age@V	isit Result	Reading Re	ead Date P	Reading Provider	Adr	ninistered By	Other Locati	Site	Volume		
04/28/2008 PPD DEMO HOS	PITAL 5 yrs	Negativ	e 0 0	4/28/08 U	USER,CSTUDEN	T USE	ER,CSTUDENT					
01/17/2007 PPD DEMO HOS	PITAL 51 mth	s Positive	0 0	1/12/07 F	FAULL JENNIFER		EB DSTUDENT					

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.

Enecast	ird 🕕					- <u>C</u> ontraindi	cations					
MMR past due HEPAPED past due FLU-TIV past due						VARICELLA	Hx of Chir Anaphyla	sken Pox 284 vis 284	φr-2008 φr-2008		Add	Delete
Vaccinations												
	rofile Case Data	_									Add Edit	Delete
Vaccine	Visit Date	Age@Visit		Reaction	Volume		Lot			VFC Eligibility	Add	Delete
Vaccine DTaP (PEDIARID()	Visit Date 04/28/2008	Age@Visit	DEMO HOSPITAL	Convulsions	Volume	Left Deltoid IM	ac216028AA	07/30/2001	USER,CSTUDENT	VFC Eligibility	Add Edit	1
Vaccine DTaP (PEDIARIX) PV (PEDIARIX)	Visit Date	Age@Visit	DEMO HOSPITAL		Volume .5 .5			07/30/2001		VFC Eligibility	Add Edi	A
Vaccine DTaP (PEDIARIX) PV (PEDIARIX)	Visit Date 04/28/2008	Age@Visit 5 yrs	DEMO HOSPITAL	Convulsions	.5	Left Deltoid IM	ac216028AA	07/30/2001 07/30/2001	USER,CSTUDENT	VFC Eligibility	Add Edi	A
Vaccine DTaP (PEDIARIX) IPV (PEDIARIX) HEP B PED	Visit Date 04/29/2008 04/28/2008	Age@Visit 5 yrs 5 yrs 5 yrs	DEMO HOSPITAL DEMO HOSPITAL DEMO HOSPITAL	Convulsions Convulsions	.5 .5	Left Deltoid IM Left Deltoid IM	ac216026AA ac216026AA	07/30/2001 07/30/2001 07/18/2007	USER,CSTUDENT USER,CSTUDENT	VFC Elgbility	Add Edi	1
Print Record Due Letter P DT#P (PEDIARDQ) IPV (PEDIARDQ) HEP 8 PED HEP 8 PED HEP 8 PED (PEDIARDQ) MMR	Visit Date 04/28/2008 04/28/2008 04/28/2008	Age@Visit 5 yrs 5 yrs	DEMO HOSPITAL DEMO HOSPITAL DEMO HOSPITAL	Convulsions Convulsions	.5 .5 .5	Left Deltoid IM Left Deltoid IM Left Thigh IM Left Deltoid IM	ac216028AA ac216028AA 0489P	07/30/2001 07/30/2001 07/18/2007 07/30/2001	USER.CSTUDENT USER.CSTUDENT USER.CSTUDENT	VFC Eligibility	Add Edit	A

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

Vaccine	Visit Date	A an Older	Lengther	Reaction	Mahana	Ini Cha	Lot	Vill Date	Administered By	
DT-PEDS	11/06/1990		IHS HOSPITAL	neacoon	A Circletted	ruê bira	LOK	AID Prote	Administered by	
DT #P IPEDIARIXI	06/26/2007		DEMO HOSPITAL		.5	Right Thigh IM	ac21b028AA		MOSELY ELVIRA	
THADULT	11/28/1990		Flagstaff				20010000000			
TJADULT	11/11/1997	44 yrs	IHS HOSPITAL							
TGADULT	12/08/2004	52 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	U1346AA	06/10/1994	BEARDSLEY, STEPHANIE E	
THADULT	05/24/2007	54 yes	DEMO HOSPITAL		0.5	Right Thigh IM	U1597CA	06/10/1994	MOORE,CATHERINE	
Tdap	12/26/2007	55 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	355013	07/12/2006	MOSELY, ELVIRA	

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

10.1.1 Add a Contraindication

	— <u>C</u> ontraindicati	ons			Add Delet	2
	VARICELLA PNEUMO-PS	Hx of Chicken Pox Fever>104F	13-Feb-2007 26-Jun-2007			
_					 	

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.

Enter Patient Contraindication	
Vaccine	Add
Contraindication Reason	Cancel
Anaphylaxis	
Carrier	
Convulsion	
Egg Allergy	
Fever>104f	
Hx Of Chicken Pox	
Immune	
Immune Deficiency	
Immune Deficient Household	
Lethargy/hypotonic Episode	U Contraction of the second se
Neomycin Allergy	
Other Allergy	
Parent Refusal	
Patiant Rafusal	ע

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.

Selection	X
- Search Criteria	ОК
Search <u>V</u> alue	Search
Show All Active Vaccines	
Show Only active Vaccines	with a Lot Number
Select one of the following Records	
	- · · · ·
	Description 🔨
DT (PEDIATRIC)	Diphtheria and tetanus toxoids adsorbed for per
DTAP	Diphtheria, tetanus toxoids and acellular pertus:
DTaP-Hep B-IPV	DTap-hepatitis B and poliovirus vaccine 👘 📄
HBIG	Hepatitus B immune globulin
HEP A, ADULT	Hepatitus A vaccine, adult dosage
HEP A, PED/ADOL, 2 DOSE	Hepatitus A vaccine, pediatric/adolescent dosa
HEP A-HEP B	Hepatitis A and hepatitis B vaccine
HEP B, ADOLESCENT OR PEDIATRIC	Hepatitus B vaccine, pediatric or pediatric/adol
HEP B ADULT	Hepatitus B vaccine, adult dosage
HIB (HBOC)	Haemophilus influenza type b vaccine, HbOC
HIB (PRP-OMP)	Haemophilus influenza type b vaccine, PRP-0N
HIB (PRP-T)	Haemophilus influenza type b vaccine, PRP-T (
HPV QUADRIVALENT	Human papilloma virus vaccine
<	>

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.

🖼 Enter Patient Contraindication	×
Vaccine INFLUENZA, HIGH DOSE SEAS	Add
Contraindication Reason	Cancel
Anaphylaxis	Cancer
Carrier	
Convulsion	
Egg Allergy	
Fever>104f	
Hx Of Chicken Pox	
Immune	
Immune Deficiency	
Immune Deficient Household	
Lethargy/hypotonic Episode	
Neomycin Allergy	
Other Allergy	
Parent Refusal	
Patiant Rafusal 🞽	

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.

Vaccinations Print Record Due Lette											
Vaccine	Visit Date	Age@Visit	Location	Reaction	Volume	Inj. Site	Lot	VIS Date	Administered By		
DT-PEDS	11/06/1990	37 yrs	IHS HOSPITAL								
DT aP (PEDIARD)	06/26/2007	54 yrs	DEMO HOSPITAL		.5	Right Thigh IM	ac21b028AA		MOSELY, ELVIRA		
THADULT	11/28/1990	37 yrs	Flagstaff								
TdADULT	11/11/1997	44 yrs	IHS HOSPITAL								
THADULT	12/08/2004	52 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	U1346AA	06/10/1994	BEARDSLEY, STEPHANIE E		
THADULT	05/24/2007	54 yrs	DEMO HOSPITAL		0.5	Right Thigh IM	U1597CA	06/10/1994	MODRE, CATHERINE		
Tdap	12/26/2007	55 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	355013	07/12/2006	MOSELY, ELVIRA		

Figure 10-10: Vaccinations panel

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

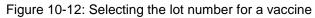
Note: If a vaccine is absent from the vaccine list, follow procedures from the regional immunization coordinator or follow agency procedures to enter the vaccine into the system.

S Vaccine Selection	Σ
Search Criteria Search Value	Search OK
 Show All Active Vaccines Show Only active Vaccines 	with a Lot Number
Select one of the following <u>R</u> ecords	Description
	Description Cytomegalovirus immune globulin, intravenous
DIPHTHERIA ANTITOXIN	Diphtheria antitoxin
DT (PEDIATRIC)	Diphtheria and tetanus toxoids adsorbed for per
DTAP	Diphtheria, tetanus toxoids and acellular pertus:
DTaP-Hep B-IPV	DTap-hepatitis B and poliovirus vaccine
DTaP-Hib-IPV	DTaP-Hib-IPV
DTaP-IPV	Diphtheria, tetanus toxoids and acellular pertus:
HANTAVIRUS	Hantavirus vaccine
HBIG	Hepatitus B immune globulin
HEP A, ADULT	Hepatitus A vaccine, adult dosage
HEP A, PED/ADOL, 2 DOSE	Hepatitus A vaccine, pediatric/adolescent dosa
HEP A-HEP B	Hepatitis A and hepatitis B vaccine
HEP B. ADOLESCENT OR PEDIATRIC	Hepatitus B vaccine, pediatric or pediatric/adol

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).

S Add Immunization	×
Vaccine MMR	ОК
Administered By USER ZSTUDENT	Cancel
Lot 5556 MERCK & CO. (exp 06/30/2020) Injection Site Left Deltoid IM ✓ Volume .5 → ml Vac. Info. Shget 03/13/2008 <u>G</u> iven 07/21/2010 4:21 PM ♥ Patient/Family Counselled by Provider	 Current Historical Refusal



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).

Piece Admission Gpta Podatry Primacy Care Supples Tron Interactication Weight Screening Women's Health Ytic Resp Tix		K	Human Papilloma Virus (h MMR Varicella Virus Vaccine, Li	
Show All		-		
Historical Services	Surgical	8	Add to Quinert Visit	Add Deter

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).

🖻 Add Imr	nunization	X
<u>V</u> accine	MMR	ОК
Administered By	USER ZSTUDENT	Cancel
<u>L</u> ot	×	
Injection Site		💿 Current
Vol <u>u</u> me	.5 🔺 ml Vac. Info. Sheet 03/13/2008 📖	 Historical
<u>G</u> iven	09/22/2011 3:07 PM Patient/Family Counselled by Provider	🔿 Refusal
VFC Eligibility		

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.

🗳 Add Patient Ed	ucation Event	×
Education Topic	IM-LITERATURE	Add
<u>Type of Training</u>	💿 Individual 🛛 Group	Cancel
Comprehension Le <u>v</u> el	GOOD	
<u>L</u> ength	3 (min)	
Co <u>m</u> ment		
		Display Outcome
Provided <u>B</u> y	USER,ZSTUDENT	& Standard
Readiness to Learn	EAGER TO LEARN	
- Status/Outcome -		
🔘 Goal Set	🔾 Goal Met 🛛 🔾 Goal Not Met	

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.

Add Historical Immunization	×
Vaccine HEP A, ADULT	ОК
Documented By USER/ZSTUDENT	Cancel
Event Date 07/14/2010	
Location AKUTAN	🔘 Current
 Other 	 Historical Refusal

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.

Vaccinations										
Print Record Due Lette	er Profile	Case Da	sta							Add Edit Delete
Vaccine	Visit Dater	AgeEVisit	Location	Reaction	Volume	Inj. Site	Lot	VIS Date	Administered By	^
MMB	07/21/2010	57 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	5556	03/13/2008	USER,ZSTUDENT	
HBIG	07/20/2010			REFUSED SERVICE					USER ZSTUDENT	
HEP A ADLT	07/14/2010	57 yrs	Akutan		0				USEB,ZSTUDENT	
HEP 8 ADLT	04/28/2008	55 yrs	DEMO HOSPITAL		1	Left Thigh SQ	AHBVB166AA	07/18/2007	MOORE,CATHERINE	
HEP A ADLT	04/28/2008	S5 yts	DEMO HOSPITAL		1	Left Thigh SQ	AHAVA038AB	03/26/2006	MODRE,CATHERINE	
FLU-TIV	04/28/2008	55 yrs	DEMO HOSPITAL		.5	Right Thigh IM	U1863AA	07/16/2007	MOORE,CATHERINE	
Tdap	12/26/2007	55 yrs	DEMD HOSPITAL		.5	Left Defloid IM	355013	07/12/2006	MOSELY, ELVIRA	~

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.

Add Immunization Refusal	×
Vaccine HBIG	ОК
Documented By USERZSTUDENT	Cancel
Event Date 07/20/2010	
	O Current
	 Historical
	💿 Refusal

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.

46856 01 Aug 1978 (33) F	US	ER ZSTUDE				POC Lab PWA	Med O	Visit		dvs React Medications
	1.11 (m. 11)					Entry	Luce II	Summery	CWAD Nds Rywd	Ids Rywd Nds Rywd
2 Immunization Record		sham Hx	IMM (Notes Vitals Ars	essment (Orders /P	IEB		un sepon	Lans		
-	•									
Eorecast					Con	straindications				
FLU-TIV due					1000					Add Delet
					FLU-1 FLU-1			Jan-2007 Jan-2007		
					PLU-I	rvnk Pabe	rk nerusal 1/	van/2007		
Vaccinations										
Print Record Due Letter Profile	Case Dat	•								Add Edit Deleti
/accine	Visit Date		1	Beaction	Makara	lai Site	Lot	VIS Date	1	
accine IMR	08/15/2006	Age@Visit 28 yrs	Wind River Reservation, Wy	Beaction	Volume	i ini Site	Lot	VIS Date	Administered By	
MB	05/28/2007	28 yrs	Montana Clinic						MOSELY ELVIBA	
MB	05/30/2007	20 yrs	Pinc						MUSELI, ELVINA	
IMB	12/26/2007	29 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	DEDSP	01/15/2003	MOSELY ELVIBA	
ARICELLA	06/27/2007	20 vrs	DEMO HOSPITAL		.5	Left Arm SQ	0327R		MOSELY ELVIRA	
IEP A ADLT	01/01/2007	28 ws	Kalspel							
EP A ADLT (TWINBIK)	01/14/2007	28 ws	Walmart							
IEP A ADLT	06/11/2007	28 ws	DEMO HOSPITAL		1	Right Thigh IM	AHAVAU38AA	08/25/1998	USER BSTUDENT	
EP A ADLT	04/15/2008	29 yrs	DEMO HOSPITAL		1	Left Deltoid IM	AHAVA038AB	03/26/2006	USER BSTUDENT	
IEP A ADLT	12/05/2008	30 yrs	DEMO HOSPITAL		1	Left Thigh SQ	AHAVA038AD	03/26/2006	MOSELY, ELVIRA	
IEP A ADLT	09/23/2009	31 yrs	DEMO INDIAN HOSP		.5	Left Deltoid IM		03/21/2006	GROOM,AMY	
LU-TIVhx	01/10/2007	20 yrs	DEMO HOSPITAL		0.5	Right Thigh IM	U1063AA	07/18/2005	MOSELY, ELVIRA	
LU-TIVhs	01/17/2007	28 yrs	DEMO HOSPITAL		0.5			07/18/2005		
LU-TIVhx	04/15/2008	29 yrs	DEMO HOSPITAL		.5	Right Thigh IM	U1863AA	07/16/2007	USEB, BSTUDENT	
NEUMO-PS	12/20/2006	28 yrs	DEMO HOSPITAL		.5	Right Deltoid IM	0604R	07/25/2003	MOSELY ELVIRA	
NEUMO PS	06/27/2007	28 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	0606R	07/25/2003	MOSELY, ELVIRA	
NEUMO-PS	02/28/2008	29 yrs	DEMO HOSPITAL		.5	Right Thigh SQ	0606R	07/29/1997	USER, BSTUDENT	
NFLUENZA, SPUT (INCL. PURIFIED	01/17/2007			REFUSED SERVICE						
	01/10/2007			REFUSED SERVICE	1	10	*		and the second second	
NFLUENZA, SPLIT (INCL. PURIFIED NFLUENZA, INTRANASAL	09/01/2011								USER 2STUDENT	

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.

Print Record			
			-
26-Jul-2010	Cherokee Ind	NIZATION RECORD dian Hospital 58, Hospital Road NC 28779	
28-041-2010			
ALICE DEMO 110 DEEPWOOD COURT CHEROKEE, NC 28789		30-Nov-1952 (57 yrs) art#: 109629	
Our records show that A immunizations:	ALICE has receive	ed the following	
Immunization	Date Received	Location	
DT-PEDS	06-Nov-1990	Ihs Hospital	
DTaP (PEDIARIX)	26-Jun-2007	Demo Hospital	
Td-ADULT	28-Nov-1990	Flagstaff	
Td-ADULT	11-Nov-1997	Ihs Hospital	
Td-ADULT	08-Dec-2004	Demo Hospital	
Td-ADULT	24-May-2007	Demo Hospital	
Tdap	26-Dec-2007	Demo Hospital	
IPV (PEDIARIX)	26-Jun-2007	Demo Hospital	
HEP B ADLT	10-Sep-2006	Flagstaff Med Cen	
HEP B ADLT	20-Dec-2006	Demo Hospital	
HEP B ADLT	21-Jun-2007	Demo Hospital	
HEP B PED (PEDIARIX)	26-Jun-2007	Demo Hospital	
HEP B ADLT	09-Jul-2007	Demo Hospital	
HEP B ADLT	28-Apr-2008	Demo Hospital	
MMR	21-Jul-2010	Demo Hospital	
HEP A ADLT	26-Jun-2006	Demo Hospital	
HEP A ADLT	26-Jun-2007	Demo Hospital	
HEP A ADLT	09-Jul-2007	Demo Hospital	
HEP A ADLT	28-Apr-2008	Demo Hospital	
HEP A ADLT	14-Jul-2010	Akutan	-
			▶
Font 9 🚔		Print	Close

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.

<u>A</u>dd <u>E</u>dit <u>D</u>elete

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.

iodon	The second secon	Administered by
💐 Edit Imm	unization	×
⊻accine	MMB	ОК
Administered By	USERZSTUDENT	Cancel
Lot	5556 MERCK & CO. (exp 06/30/2020)	
Injection Site	Left Deltoid IM	Current
Vol <u>u</u> me	.5 ml Vac. Info. Sheet 03/13/2008	C Historical
<u>G</u> iven	07/21/2010 4:21 PM Patient/Family Counselled by Provider	C Refusal
<u>R</u> eaction		
<u>D</u> ose Override	None Anaphylaxis or Collapse Arthritis or Arthralgias Convulsions	
	Fever>104	MOSELT, ELVINA
	Lethargy	MOSELY,ELVIRA
		MOSELY,ELVIRA

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

Update Immunization and Skin Test Records

- 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.

Vaccinations										
Print Record Due Lette	r Profile	ace Da	ela							Add Edit Delet
Vaccine	Visit Date"	Age@Visit	Location	Reaction	Volume	Ini Site	Lot	VIS Date	Administered By	
MMR	07/21/2010		DEMO HOSPITAL	and the second s		Left Deltoid IM			USER,2STUDENT	
MMR	07/21/2010	57 yrs	DEMO HOSPITAL	Anaphylaxis or Collapse	.5	Left Deltoid IM	5556	03/13/2008	USER 2STUDENT	
HBIG	07/20/2010			REFUSED SERVICE					USER/2STUDENT	
HEP A ADLT	07/14/2010	57 yrs	Akutan		0				USER,ZSTUDENT	
HEP B ADLT	04/28/2008	55 yrs	DEMO HOSPITAL		1	Left Thigh SQ	AHBVB166AA	07/18/2007	MOORE,CATHERINE	
HEP A ADLT	04/28/2008	55 yrs	DEMO HOSPITAL		1	Left Thigh SQ	AHAVA038AB	03/26/2006	MOORE,CATHERINE	
FLU-TIV	04/28/2008	55 yrs	DEMO HOSPITAL		.5	Right Thigh IM	U1863AA	07/16/2007	MOORE,CATHERINE	
Tdap	12/26/2007	55 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	355013	07/12/2006	MOSELY_ELVIRA	
FLU-TIV	08/27/2007	54 yrs	DEMO HOSPITAL		0.5	Right Arm SQ	U1872AA	05/06/2003	USER_TSTUDENT	
BOTULINUM	07/30/2007	54 yrs	DEMO HOSPITAL		0.5	Left Thigh IM		08/07/2006		
HEP B ADLT	07/09/2007	54 yra	DEMO HOSPITAL		1	Left Thigh SQ	AHBVB166AA	07/11/2001	USER,TSTUDENT	
HEP A ADLT	07/09/2007	54 yrs	DEMO HOSPITAL		1	Right Thigh IM	AHAVA038AB	08/25/1998	USER_TSTUDENT	
DTaP (PEDIARIX)	06/26/2007	54 yrs	DEMO HOSPITAL		.5	Right Thigh IM	ac216028AA		MOSELY, ELVIRA	
IPV (PEDIARIX)	06/26/2007	54 yrs	DEMO HOSPITAL		.5	Right Thigh IM	ac21b028AA		MOSELY, ELVIRA	
HEP B PED (PEDIARDO)	05/26/2007	54 yrs	DEMO HOSPITAL		.5	Right Thigh IM	ac21b028AA		MOSELY, ELVIRA	
HEP A ADLT	05/25/2007	54 yrs	DEMO HOSPITAL		1	Right Deltoid IM	AHAVA021AA	08/25/1998	MOSELY_ELVIRA	
HEP 8 ADLT	06/21/2007	54 yrs	DEMO HOSPITAL		1	Right Thigh IM	AHBVB166AA	07/11/2001	MOSELY, ELVIRA	
PNEUMO-PS	06/21/2007	54 yrs	DEMO HOSPITAL		0.5	Right Thigh IM	1005P	07/25/2003	MOSELY, ELVIRA	
Td-ADULT	05/24/2007	54 yrs	DEMO HOSPITAL		0.5	Right Thigh IM	U1597CA	06/10/1994	MOORE,CATHERINE	
FLU-TIV	02/13/2007	54 yrs	DEMO HOSPITAL		0.5	Right Thigh IM	U1863AA	07/18/2005	USER.BSTUDENT	
HEP 8 ADLT	12/20/2006	54 yrs	DEMO HOSPITAL		1	Left Deltoid IM	ENG5589A4	07/11/2001	MOSELY_ELVIRA	
FLU-TIV	11/01/2006	53 yrs	DEMO HOSPITAL		0.5	Left Thigh SQ	U1872AA	07/18/2005	MOSELY, ELVIRA	
FLUINOS	11/01/2006	53 yrs	DEMO HOSPITAL		0.5	Left Arm SQ	u1839aa	05/06/2003	MOSELY, ELVIRA	
HEP B ADLT	09/10/2006	53 yrs	Flagstaff Med Center							
HEP A ADUT	06/26/2006	53 yrs	DEMO HOSPITAL		1	Right Deltoid IM	AHAVA021AA		MOSELY, ELVIRA	
FLU-TIV	12/06/2005	53 yrs	DEMO HOSPITAL		0.5	Left Deltoid IM	U1929AA	07/18/2005	SINGLETON, ROBERT J	
TJ-ADULT	12/08/2004	52 yrs	DEMO HOSPITAL		.5	Left Deltoid IM	U1346AA	06/10/1994	BEARDSLEY, STEPHANIE E	
FLU,NOS	11/07/2002	49 yrs	DEMO HOSPITAL				U0952AA			
THADULT	11/11/1997	44 sra	IHS HOSPITAL							
Td-ADULT	11/28/1990	37 sra	Flagstaff							

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.

💫 Skin	Skin Test History Print Record												
Visit Date	Skin Test	Location	Age@Visit	Result	Reading	Read Date	Reading Provider	Administered By	Other Location				
06/09/2008	PPD	DEMO HOSPITAL	55 yrs	Negative	0	06/09/08	ADAM, ADAM	MOORE,CATHERINE					
04/28/2008	PPD	DEMO HOSPITAL	55 yrs	Positive	7	04/28/08	MOORE,CATHERINE	MOORE,CATHERINE					
06/26/2007	PPD	DEMO HOSPITAL	54 yrs	Negative	0	06/26/07	MOSELY, ELVIRA	MOSELY, ELVIRA					
06/21/2007	PPD	DEMO HOSPITAL	54 yrs	Positive	0	06/26/07	MOSELY, ELVIRA	MOSELY, ELVIRA					
02/13/2007	PPD	DEMO HOSPITAL	54 yrs	Negative	0	03/08/07	USER, BSTUDENT	USER, BSTUDENT					
11/28/2006	PPD	DEMO HOSPITAL	53 yrs	Negative	0	11/28/06	USER,CSTUDENT	USER ASTUDENT					
11/28/2004	PPD	Results Called In School Nurse	51 yrs	Negative		12/20/06	MOSELY, ELVIRA	USER ASTUDENT	Results Called In School Nurse				

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

💫 Skin	Skin Test History Pint Record														
Visit Date	Skin Test	Location	Age@Visit	Result	Reading	Read Date	Reading Provider	Administered By	Other Location						
06/09/2008	PPD	DEMO HOSPITAL	55 yrs	Negative	0	06/09/08	ADAM ADAM	MOORE,CATHERINE							
04/28/2008	PPD	DEMO HOSPITAL	55 yrs	Positive	7	04/28/08	MOORE,CATHERINE	MOORE,CATHERINE							
06/26/2007	PPD	DEMO HOSPITAL	54 yrs	Negative	0	06/26/07	MOSELY, ELVIRA	MOSELY, ELVIRA							
06/21/2007	PPD	DEMO HOSPITAL	54 yrs	Positive	0	06/26/07	MOSELY, ELVIRA	MOSELY, ELVIRA							
02/13/2007	PPD	DEMO HOSPITAL	54 yrs	Negative	0	03/08/07	USER.BSTUDENT	USER.BSTUDENT							
11/28/2006	PPD	DEMO HOSPITAL	53 yrs	Negative	0	11/28/06	USER,CSTUDENT	USER ASTUDENT							
11/28/2004	PPD	Results Called In School Nurse	51 yrs	Negative		12/20/06	MOSELY, ELVIRA	USER, ASTUDENT	Results Called In School Nurse						

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.

🛱 Lookup Skin Test		×
Search Value	Search	OK Cancel
Select one of the following records		
Skin Test ≜		
CANDIDA		
CHLAMYDIA		
COCCI		
MONO-VAC		
MUMPS		
PPD		
SCHICK		
TETANUS		
TINE		



- 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.

🔌 Add Skin Test	X
Add Skin Test <u>Skin Test PPD</u> <u>Administered By USER_ZSTUDENT</u> <u>Results PENDING</u> Date Applied 09/09/2011 <u>Site Left Forearm</u> <u>Y</u> olume _1 ml	Save Cancel Current Historical Refusal

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.

🔌 Edit Skin Tes	ŧ	X
<u>S</u> kin Test PPD		Save
<u>A</u> dministered By	USERZSTUDENT	Cancel
R <u>e</u> sults	PENDING	
Date Applied	09/09/2011	 Current Historical
<u>S</u> ite	Left Forearm 👻	O Refusal
⊻olume	.1 ml	

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".

💊 Edit Skin Test	X
Skin Test PPD	Save
Administered By USER ZSTUDENT	Cancel
R <u>e</u> sults POSITIVE	
Date Applied 09/09/2011	 Current
<u>S</u> ite Left Forearm	Historical Refusal
⊻olume <mark>.1</mark> ml	O Herusai
Beading 3 (mm)	
Date Read 09/22/2011	
Reading Provider USER ZSTUDENT	

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.

💊 Add Historical Skin Test	
Skin Test PPD	Save
Documented By USER_ZSTUDENT Results ✓ Event Date 09/09/2011 Site Left Forearm Yolume .1 ml	Cancel Current Historical Refusal
Location ◯ IHS/Tribal Facility ⓒ Other	

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**.

💫 Add Historical Skin Test	×
Skin Test PPD	 Save Cancel Current Historical Refusal

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.

Skin Test TETANUS
Documented By USER.ZSTUDENT Cancel Results REFUSED ○ Date Refused 07/21/2010 ○ With the storical ○ Refusal

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.

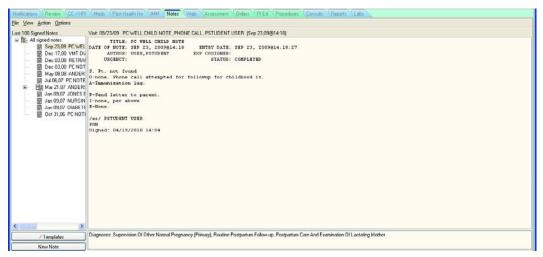


Figure 11-1: Notes tab

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:

Demo,Patient Senior Male		BH - BOSWOOD	14-Jun-2011 11:45
37930 01-Jan-1935 (76) M		BAILEY,DONNA R	Ambulatory
Figure 11-3: Example of EHR toolbar sho	wi	ng patient name and e	ncounter 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.

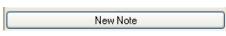


Figure 11-4: New Note button

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.

Progress Note P	roperties	
Progress Note Title:	CHAP ENCOUNTER	ОК
	CHAP ENCOUNTER CHARLESWORTH <charlesworth employee="" health=""> CHARLESWORTH EMPLOYEE HEALTH CHART <chart review=""> CHART REVIEW CHASEMPLOYEEHEALTH CHILD <pc child="" note="" well=""></pc></chart></charlesworth>	Cancel
Date/Time of Note:	06-Sep-2011 08:55	
Author:	UserZstudent	

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.

Lat 100 Signed Notes CHAP ENCOUNT ER S S R New Not Note InSpect VI INPATIENT S S S S S S S S S S S S S S S S S S	Sep 06.2011(408.05 Uter Zituden)

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.

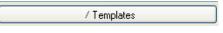


Figure 11-7: Templates button

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

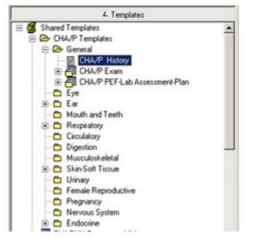
Demo,Alice Janene 109629 30-Nov-1952 (57) F		R USER,ZSTU				
Demo Alice Janene INPAT 109629 30-Nov-1952 (57) F Notifications IFC Review CC / HP Past Health Hx IMM File View Action Options East 100 Signed Notes CHAP ENCOUNTER View Action Options CHAP ENCOUNTER Image: Signed Notes Image: Signed Notes CHAP ENCOUNTER View Action Options CHAP ENCOUNTER Image: Signed notes Image: Signed notes Image: Signed notes CHAP ENCOUNTER View Action Options Image: Signed notes Image: Signed notes Image: Signed notes Image: Signed notes View Action Options Image: Signed notes Image: Signed notes Image: Signed notes View Action Options View Action Options Image: Signed notes Image: Signed notes Image: Signed notes View Action Options View Action Options Image: Signed notes Image: Signed notes Image: Signed notes View Action Options View Action Options Image: Signed notes Image: Signed notes Image: Signed notes View Action Options View Action Options Image: CHA/P Exam General (AFF) Image: CHA/P Exam General (AFF) View Actin Prepancy View Action Optins	User Patient	Refresh Data	Tools	Help		
109629 30-Nov-1952 (57) F USER2 Notifications IFC Review CC / HP Past Health Hx IMM File View Action Options CHAP Encounter Vst INPATIENT Image: State of USER 25 TUDEN Image: State of USER 25 TUDEN Image: State of USER 25 TUDEN Vst INPATIENT Image: May 08:10 CHAP ENCOUNTEF Image: May 10:10 CHAP ENCOUNTEF Vst INPATIENT Image: May 08:10 CHAP ENCOUNTEF Image: May 10:10 CHAP Exam General Image: May 10:10	PRIVA	ACY Y	PATI	ENT CHA	RT	RESOL
Last 100 Signed Notes Last 100 Signed Notes CHAP ENCOUNTER Use Note in Progress Use Nave Note in Progress Use Nave Note in Progress May 10.10 CHAP ENCOUNTER May 10.10 CHAP ENCOUNTER May 10.10 CHAP ENCOUNTER May 10.10 CHAP ENCOUNTER May 10.10 CHAP ENCOUNTER CHAP Exam General CHA/P Exam General CHA/P Exam General CHA/P Ex-M General CHA/P Strate General CHA/P S	109629	30-Nov-1952 (IPI Pa	st Health Hx	INPAT USERZ
 Stim New Note in Progress Jul 22,10 CHAP ENCOUNTER May 08,10 CHAP ENCOUNTEF May 10,10 CHAP ENCOUNTEF ChaP Exam General CHA/P Sam General CHA/P Sam	File View Ad	tion Options				
	■ <mark>18::</mark> New N ■ 18:: All uns ■ 18:: All sign	Note in Progress Jul 22,10 CH/ signed notes for I May 08,10 CH ned notes May 10,10 CH	USER,ZS AP ENCO AP ENCO		Vst: INF	
Shared Templates CHAP CHAP CHA/P History General CHA/P Exam General CHA/P Exam General CHA/P CHA/P Exam Gen		/ Tanalata				
		HAP	am Gener am Gener F-Lab As: eth al ue ductive sm tum Visit ECTION	al (AFF- sessmer		

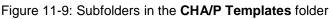
Figure 11-8: Open **Templates** drawer

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.





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.

** Be sure to Enter Inside Front Cover/Back cover	
" Answers into EHR before starting this template CHAP PATIENT ENCOUNTER	
HISTORY: Chief Complaint 4 History Present Illness: No Chief Complaint.	
* Look up patient's problem in the Index or Table	e of Contents, and go to that page. *
Problem Specific History	
Past Health Hx: Active Problems:	
HYPERTENSION	
TOBACCO USE	
TYPE 2 DIABETES MELLITUS	
HYPERTENSION Active Outpatient Medications (including Suppl	lies):
Active Outpatient Hedications	Status
Accive outpatient neutrations	
) DIVALPROEX 250MG TAB 2 TABLETS MOUTH TWICE A	DAY ACTIVE
Pending Outpatient Medications	Status
) ACETAMINOPHEN 325MG TAB TAKE TWO TABLETS MOUT 4 HOURS IF NEEDED TR PAIN OR FEVER	
Total Medications	
<pre>**Enter New Allergies in Adverse Reactions On LMP: None Recorded The patient is pregnant. Immunizations Due: Tdap (past due)</pre>	Review Tab in EHR**
Other Hx:	
Habit Hx: Alcohol/Drug Screen: None Found Last TOBACCO HF: CURRENT SHOKER - Hay 25, 2007	7
	7
Alcohol/Drug Screen: None Found Last TOBACCO HF: CURRENT SHOKER - May 25, 2007 * After Completing this Template,	7
Alcohol/Drug Screen: None Found Last TOBACCO HF: CURRENT SMOKER - May 25, 2007 * After Completing this Template, * Save the note WITHOUT SIGNATURE.	7
Alcohol/Drug Screen: None Found Last TOBACCO HF: CURPENT SHOKER - May 25, 2007 * After Completing this Template, * Save the note WITHOUT SIGNATURE. * Perform your exam. * When you have Completed the Exam,	7
Alcohol/Drug Screen: None Found Last TOBACCO HF: CURRENT SHOKER - May 25, 2007 * After Completing this Template, * Save the note WITHOUT SIGNATURE. * Perform your exam. * When you have Completed the Exam, * Right click on your Note, EDIT NOTE,	7
Alcohol/Drug Screen: None Found	7

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.

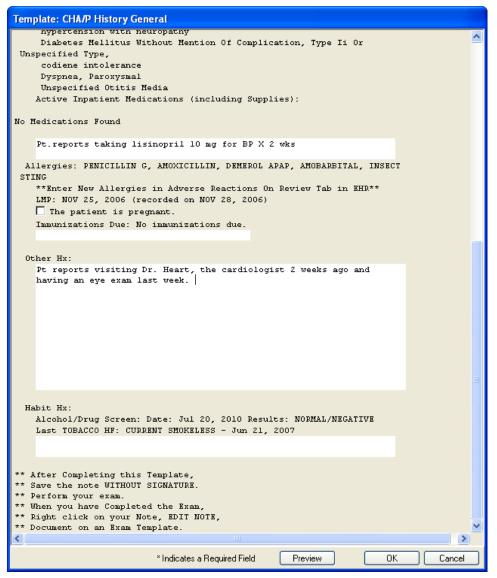


Figure 11-11: **CHA/P History** template showing list of medications and "The patient is pregnant." checkbox selected

- 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.

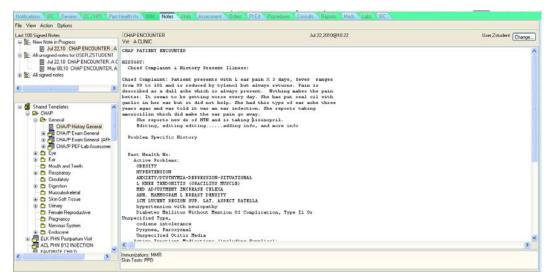


Figure 11-12: CHA/P Patient Encounter in the Notes tab

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.

Cut	Ctrl+X
Сору	Ctrl+C
Paste	Ctrl+V
Reformat Paragraph	Ctrl+R
Find in Selected Note	
Replace Text	
Check Grammar	
Check Spelling	
Copy into New Template	
Add to Signature List	
Delete Progress Note	
Edit Progress Note	
Make Addendum	
Save without Signature	
Sign Note Now	
Identify Additional Signer	s

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.

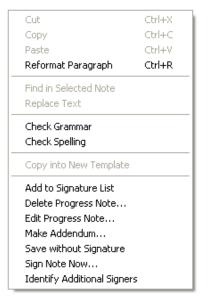


Figure 11-14: Context menu for the Notes tab

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

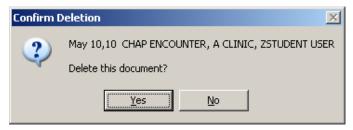


Figure 11-15: Confirm Deletion dialog

- 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 <i>unsigned</i> progress note to be edited
Make Addendum	Opens an existing <i>signed</i> progress note to add information
Save without Signature	Saves the current progress note <i>without signing it</i> . 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.

				Vit	als		
Vital	Value	Date =	1	05 May-2011 12:00			
BP HT	150/80 mmHg	05-May 2011 12:00	Blood Pressure	150/80	90-150 mmHg		
HT WT	69 in (175.26 cm)	05-May 2011 12:00	Height	175.26	cm		
RMI	26.58	05-May-2011 12:00 05-May-2011 12:00	Weight	81.65	kg		
IMP	99 F (37.22 C)	21-Mar-2007 15:27	Body Mass Index	26.50			
PU PA	33 /min	21 Mar 2007 15:27					
19	0	21-Mai-2007 15:27					
			Enter Vitals.				
			Today One Week				
			Two Weeks				
			One Month				
			- Six Months One Year				
			Two Years				
			All Results Date Range				
			Default Units 🔻	No results to graph for this date range.			
			Values			to results to graph for one date range.	
			Zoom				
			3D				
			i ao I Grid				
			Age				
			0.4				

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.

Vital Measurement Entry			
Default Units 🔹	26-Sep-2011 09:17	Range	Units
 Temperature 	Ι		F
Blood Pressure		90 - 150	mmHg
Pulse		60 - 100	/min
Respirations			/min
Height			cm
Weight			kg
Pain			
Last Known Well			
02 Saturation			%
Peak Flow			
Best Peak Flow			
	New Date/Time	IK 🗌 🗌	Cancel

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.

No Vitals Found					
	Enter Vitals.				
	Refresh	F5			

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.

Vital Measurement Entry				
US Units 📃 👻	05-Aug-2010 12:53	Range	Units	
Temperature	98		F	
Pulse	88	60 - 100	/min	
Respirations	17		/min	
Blood Pressure	138/88	90 - 150	mmHg	
Height	68		in	
Weight	168		lЬ	
Pain	8			
02 Saturation	100		%	
Peak Flow				

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.

Invalid	Entry 🔀
8	Input must be between 70 and 120 F.
	ОК

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).

Select New Date/	Time 🔲 🗖 🔀
Using: O Current Visit O I	Historical Visit 💿 Now
Date/Time Done	26-Sep-2011 09:24
ОК	Cancel

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.

Default Units	-	26-Sep-2011 09:17	26-Sep-2011 09:36	Range	Units
Temperature		100.4			F
Blood Pressure				90 - 150	mmHg
Pulse				60 - 100	/min
Respirations					/min
Height					cm
Weight					kg
Pain					
Last Known Well					
02 Saturation					%
Peak Flow					
Best Peak Flow					
		·			
			New Date/Time	ок	Cancel

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.

Vital Measurement End	ntry			
Default Units 📃 💌	16-Aug-2010 13:02	23-Aug-2010 15:30	Range	Units
Temperature	36.67	37.22		С
Pulse	88	68	60 - 100	/min
Respirations	18	15		/min
Blood Pressure	122/58	155/56	90 - 150	mmHg
Height	182.88	182.88		cm
Weight	74.84	76.66		kg
Pain	1	2		
02 Saturation	99	99		%
 Peak Flow 				
Audiometry				
Vision Corrected	40/15			
Vision Uncorrected				
Head Circumference	36			cm
Waist Circumference			43.18 - 101.6	cm
Cervix Dilatation				cm
Abdominal Girth				cm
Effacement				
Fetal Heart Tones				
Fundal Height				cm
Station (Pregnancy)				
	Nev	v Date/Time	ок	Cancel

Figure 12-9: Entering Vision Corrected information

12.4 Record Head Circumference

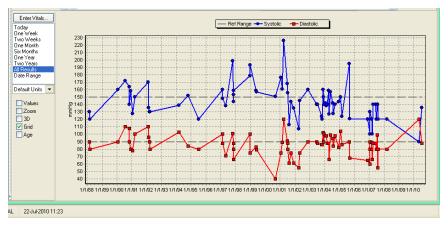
Height	182.88		cm
Weight	85.73		kg
Pain	2		
02 Saturation	98		%
 Peak Flow 			
Audiometry			
Vision Corrected			
Vision Uncorrected			
Head Circumference	38		cm
Waist Circumference		43.18 - 101.6	cm
Coruin Dilatation			000

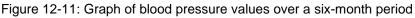
Enter the head circumference in metric units.

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.





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.

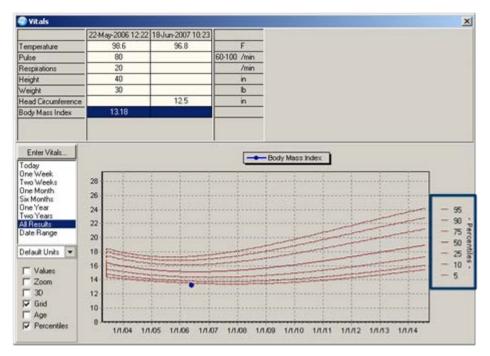


Figure 12-12: Growth chart for a child under 12 years of age with **Grid** and **Percentiles** check boxes selected

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:

Demo,Patient Senior Male	BH - BOSWOOD	14-Jun-2011 11:45
37930 01-Jan-1935 (76) M	BAILEY, DONNA R	Ambulatory

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.

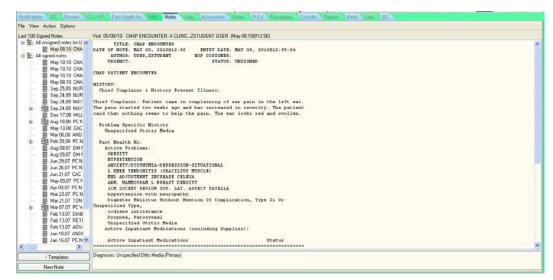


Figure 13-2: **Notes** tab showing CHAP ENCOUNTER note with information previously entered in the **History** template

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.

Cut	Ctrl+X
Сору	Ctrl+C
Paste	Ctrl+V
Reformat Paragraph	Ctrl+R
Find in Selected Note Replace Text	
Check Grammar	
Check Spelling	
Copy into New Template	
Add to Signature List	
Delete Progress Note	
Edit Progress Note	
Make Addendum	
Save without Signature	
Sign Note Now	
Identify Additional Signer	'S

Figure 13-3: Context menu for the Notes tab

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

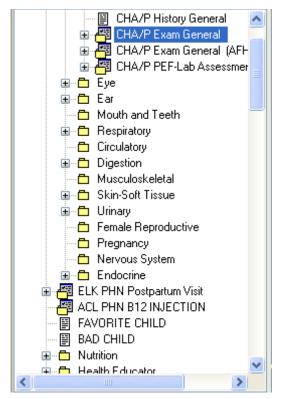


Figure 13-4: CHA/P Exam General folder in the Templates drawer

Template: CHA/P Exam Gene	ral		
<pre>**Click Here to Start + EXAM: General Appearance</pre>			
Vital Signs:			
All None	* Indicates a Required Field	Preview	OK Cancel

Figure 13-5: CHA/P Exam General template

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

Templat	e: CHA/P Exam Gener	al			
▼ **C1 EXAM	ick Here to Start u :	sing template**			^
	General Appearance:				
	Vital Signs: Head/Sinus:				
	Ears: (R):				
	(L):				
	_				
	Eyes:				
	Nose:				
					Ξ
	Mouth/Throat:				
	Neck/Nodes:				
	Back:				
_					
	Lungs/Chest:				
	Heart:				
	Breasts:				
	Abdomen:				
	AD COMENT.				
	Genital/Rectal:				
_					
	Extremities:				
	None	* Indicates a Required Field	Preview	ОК	Cancel
		maicales a riequileu riela	Fieview		Cancel

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.

Template	:: CHA/P Exam General	
	ck Here to Start using template**	^
EXAM:	eneral Appearance:	
ľ	Pt holding hand on L ear, reports severe pain	
v v	ital Signs: Head/Sinus:	
	pt denies tenderness, no drainage noted	
N	Rever	
I.M.	Ears: (R):	
	(L):	
	No redness, swelling, drainage or odor noted. Unable to view eardrum	
	d/t wax	
	Eyes:	
_		
	Nose: No drainage or flaring noted	
	wo drainage of flating noted	
	Mouth/Throat:	
	No mucus noted, tonsils pink	
	Neck/Nodes:	
	No masses noted	
	Back:	
N	Lungs/Chest:	
	LCTA	
	Heart:	
	heato.	
	Proventier	
	Breasts:	
_		
	Abdomen:	
_		
	Genital/Rectal:	
		~
	None * Indicates a Required Field Preview OK Cance	

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.

Jser Patient Refresh Data Tools Help				
PRIVACY PATIENT CHART	COMMUNICA	TION		
Demo,Alice Janene 109629 30 Nov-1952 (57) F	A CLINIC 509-A 21-Jul-2010 14:23 USER_ZSTUDENT Ambulatory	Attending: Niesen,Mary Ann		PWH Health POC Patien Post
Indications IFC Review CC / HPI Past Heal	h Ha Hill Notes Vials Assessment D	iders PLEd Procedures Consults Reports	Meds Labs IBC	
le View Action Options				
Enver Note in Progress July 22:10 CHAP ENCOUNTER July 22:10 CHAP ENCOUNTER July 22:10 CHAP ENCOUNTER July 00:10 CHAP ENCOUNTER July 00:10 CHAP ENCOUNTER July 00:10 CHAP ENCOUNTER July 00:10 CHAP ENCOUNTER	APEPROCLIMITER ACUNC If Complaint: Fatient presents witch m 39 to 101 and is reduced by tylem m 39 to 101 and is reduced by tylem situation in a set of the set of the set print agao and was told it was an ear solution that set but it did not help. witch is have a told it was an ear solution that a set but it did not help. witch is a set of it was an ear the reports new do t it with and is to the distance of the set of the set the set of the set of the set the set of the set of the set is the set of the set of the set the set of the set of the set the set of the set of the set of the set the set of the set of	ol but always returns. Pain is ys present. Nothing aakes the pain very day. The has put seal oil with De had this type of ear ache three infection. She reports taking og a way. awing lisinopril. s severe pain = noted	022	Uter Zihudert (Drange
ACL PHN B12 INJECTION	Editing, editing editingadd Problem Specific History Past Health Hr:	ing info, and more info		
Nutrition Nutrition Models Echanator Models	unization: MMB			3

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, rightclick in the **Notes** pane to open the context menu and select **Save without Signature** from the menu, as shown in Figure 13-9.

Cut	Ctrl+X
Сору	Ctrl+C
Paste	Ctrl+V
Reformat Paragraph	Ctrl+R
Find in Selected Note Replace Text	
Check Grammar	
Check Spelling	
Copy into New Template	
Add to Signature List	
Delete Progress Note	
Edit Progress Note	
Make Addendum	
Save without Signature	
Sign Note Now	
Identify Additional Signers	5

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.

Lab Point of Care I	Data Entry Form				
Patient: DEMO,ALIC	E JANENE	Hospite	al Location: A CLINIC		
Ordering Provider Test Collection Date and Comment/Lab Descri	USERASTUDENT USERBBSTUDENT USERBSTUDENT USERCCSTUDENT USERCSTUDENT USERDDSTUDENT USERDSTUDENT USERESTUDENT	Sample	e of Order/Change e Type r Symptom		Add Canned Comment
1		TEST RESU	LTS		
Test Name		Result	Result Rang	e	Units
			<u>S</u> a	ave	<u>C</u> ancel

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.

🍣 Lab Po	int of Care D)ata Entry F	orm										
Patient:	DEMO,ALIC	E JANENE						Hosp	oital L	ocation:	A CLINIC		
Orderin	g Provider	USERAS	TUDE	ENT			~	Natu	ire of	Order/Cl	nange	WRITTEN	~
Test	POC GLUCO	DSE					~	Sam	ple Ty	уре	VENO	US BLOOD	
Collecti	on Date and	Time	08/02	/2010	11:5	3 AM	~	Sigr	or S	ymptom			~
Commer	ıt/Lab Descri	ption:	K.	Mon		ust, 2 Wed			Sat				
			25 1	26 2	27 3	28 4	29 5	30 6	31 7				Add Canned Comment
			8 15	9 16	10 17	11 18	12 19	13 20	14 21	5			
Τε	est Name		22	23	24	25	26	27	28		Result Rar	nge	Units
PC	IC GLUCOSE		29	30]-	31	ן הייטיי	2	3	4		65 to 105		MG/DL
			[[100	iay: i	3/2/2	010				S	ave	Cancel

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.

🍣 Lab Po	int of Care D	ata Entry	Form						
Patient:	DEMO,ALIC	E JANEN	E		Hospital Location:	A CLINIC			
Test	g Provider POC GLUCC on Date and	DSE	3TUDENT 08/02/2010 11:59 AM	*	Nature of Order/Cl Sample Type Sign or Symptom	-	POLICY POLICY SERVICE CO TELEPHONE		TION
Commer	nt∕Lab Descri	ption:					VERBAL WRITTEN		Add Canned Comment
			TES	ST	RESULTS				
Τe	est Name			Res	sult	Result Ran	ige	Ur	nits
PC	C GLUCOSE					65 to 105		М	G/DL
						<u>S</u>	ave	<u>(</u>	<u>C</u> ancel

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.

🍣 Lab Po	int of Care D	ata Entry	Form						×
Patient:	DEMO,ALIC	E JANEN	E		Hospital Location:	A CLINIC			
Ordering	g Provider	USERAS	STUDENT	~	Nature of Order/Change POLICY				2
Test	POC GLUCO	DSE		~	Sample Type	VENO	US BLOOD		
Collectio	on Date and	Time	08/02/2010 11:59 AM	~	Sign or Symptom	250.00) Diabetes M	ellitus Without Me 🚽	•
Commen	t/Lab Descri	ption:	TES	бТ	RESULTS	278.0 (300.00 382.9 (401.9) 727.09 786.09	OBESITY ANXIETY/D Unspecified (HYPERTENS L KNEE TEN Dyspnea, Pi	SION NDONITIS (GRAC	
Te	st Name			Re	ult	Result Ran		Units	-7
PO	C GLUCOSE					65 to 105		MG/DL	
						<u>S</u>	ave	<u>C</u> ancel	

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).

🔍 Lab Po	int of Care D	ata Entry	Form						
Patient:	DEMO,ALIC	E JANEN	E		Hospital Location:				
	g Provider		TUDENT	~	Nature of Order/Change POLICY				~
Test	POC GLUCO	DSE		*	Sample Type	VENO	US BLOOD		
Collecti	on Date and	Time	08/02/2010 11:59 AM	۷	Sign or Symptom	250.0	0 Diabetes M	ellitus Without N	1e 🔽
Commer	n∜Lab Descrij	ption:	тес	27	RESULTS	727.0 786.0 793.7 793.8 995.2 V65.8	9 Dyspnea, Pr 1 CM LUCENT 0 ABN, MAMM 7 codiene into MED ADJUS	NDONITIS (GR/ aroxysmal TREGION SUF 10GRAM LBRI	P. L EA
T	est Name			Res		Othei Result Ra		Units	<u> </u>
	C GLUCOSE					65 to 105		MG/DL	
						Š	ave	Cance	el 📃

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.

Lab Point of Care 'Other Sign or Sympt	om" Entry	×
Enter the Sign or Symptom text below (Max 80 c	:haracters):	
Thirsty all the time		
	ОК	Cancel

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.

🍣 Lab Po	int of Care D	ata Entry	Form							
Patient:	DEMO,ALIC	E JANENE	E	Hospital Location:	A CLINIC					
Ordering Test	g Provider POC GLUCC	USERAS)SE	TUDENT	*	Nature of Order/Change POLICY Sample Type VENOUS BLOOD				~	
Collectio	on Date and	Time	08/02/2010 11:59 AM	~	Sign or Symptom	Thirst	y all the time		~	
You ca	Comment/Lab Description: You can add a free text comment here if needed, or click the "Add Canned Comment" button if you have some predefined comments set up.									
			TES	ST	RESULTS					
	est Name			Res	sult	Result Rar	ige	Unit	s	
.∥ PC)C GLUCOSE			80		65 to 105		MG/	DL	
						<u>s</u>	ave	C	ancel	

Figure 14-10: Text in the Comment/Lab Description field

8. Type the result in the **Result** field, as shown in Figure 14-11.

🔍 Lab P	oint of Care I)ata Entry	Form				
Patient	DEMO,ALIO	E JANENI	E	Hospital Location:	A CLINIC		
	ng Provider	USERAS	TUDENT	Nature of Order/C	2	POLICY	~
Test	POC GLUC		08/02/2010 11:59 AM	 Sample Type Sign or Symptom 		US BLOOD y all the time	~
				e if needed, or some predefined			Add Canned Comment
			TES	T RESULTS			
	Test Name			Result	Result Rar	nge	Units
./ F	POC GLUCOSE			80	65 to 105		MG/DL
					<u>s</u>	ave	<u>C</u> ancel

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

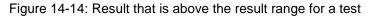
• If a result was entered that is within the range of acceptable values for the test, the **Result** field remains white to show that the entered result is appropriate. See Figure 14-3.

🔍 Lab P	Point of Care D	ata Entry	Form						
Patient	: DEMO,ALIC	E JANENI	E		Hospital Location:	A CLINIC			
Orderi Test	in g Provider POC GLUCC	USER.AS)SE	TUDENT		Nature of Order/C Sample Type	2	POLICY US BLOOD		~
Collec	tion Date and	Time	08/02/2010 11:59 AM	*	Sign or Symptom	Thirst	y all the time		*
Comme	ent/Lab Descrij	ption:							
			ext comment her on if you have		•			1100.0	Canned nment
			TES	ST F	RESULTS				
	Test Name			Resu	ult	Result Rar	nge	Units	
J F	POC GLUCOSE			80		65 to 105		MG/DL	
						5	ave	<u>C</u> anc	el

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.

🗢 Lab Po	oint of Care D	ata Entry	Form								
Patient:	DEMO,ALIC	E JANENE	E		Hospital Location:						
Orderin Test	g Provider POC GLUCC	USER.ZS DSE	TUDENT	*	Nature of Order/C Sample Type	2	POLICY US BLOOD	~			
Collecti	on Date and	Time	08/02/2010 12:48 PM	*	Sign or Symptom	250.00) Diabetes Mell	itus Without Me 👻			
You c	Comment/Lab Description: You can add a free text comment here if needed, or click the "Add Canned Comment" button if you have some predefined comments set up.										
			TES	ST I	RESULTS						
Te	est Name			Res	ult	Result Rar	nge	Units			
► PC	DC GLUCOSE			150	н	65 to 105		MG/DL			
						<u>S</u>	ave	<u>C</u> ancel			



• If the result has a defined critical value, the **Result** field turns red.

🔍 Lab Po	int of Care D	ata Entry	Form					
Patient:	DEMO,ALIC	E JANENE			Hospital Location: A			
	g Provider POC GLUCC	USER,ZS ISE	TUDENT	*	Nature of Order/Cha Sample Type	-	POLICY US BLOOD	~
Collecti	on Date and	Time	08/02/2010 12:48 PM	~	Sign or Symptom	250.00) Diabetes Mell	itus Without Me 🔽
You c	Comment/Lab Description: You can add a free text comment here if needed, or click the "Add Canned Comment" button if you have some predefined comments set up.							
			TES	ST I	RESULTS			
Τe	est Name			Res	ult	Result Ran	ige	Units
► PC	C GLUCOSE			600	H * CRITICAL!!	65 to 105		MG/DL
						<u>S</u>	ave	<u>C</u> ancel

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.

RPMS EHR USEF												-	e ×
User Patient Befr	resh Data Iools He	D IT CHART		COMMUNICATIO									
Demo Alice Jane	and the second se		A CLINIC 509-A	26-Jul-2010 09:16 Ambulatory		Moore,Catherine Attending: Niesen,May A	Ann		PWH	Health	HUU >a Lab De		AD
	Review VCC /HP	Past Health Ha	I Known and a second print of the lot of the	Assessment Orden	PiEd Phot	dures Consults Flee		Labs UBC	-	J	CENNUT		
Elle					and Second states								
Lab Results	Laboratory Results - M	out Recent											
Most Recent Cumulative	Oldest Previous	Next Ne	west						Me		Lab Resul		
All Tests By Date Selected Tests By I	« «	> 3	>>							Jul 26, 20	cted 10 09:16		
Worksheet Graph	Test		Result			Flag	Units		Bel Bange				
Microbiology Anatomic Pathology Blood Bank	POC GLUCOSE		120			н	MG/DL		65 - 105				
		t here or add a	wreion: POC 0726 carned comment.	Ly Provider: 1	uses, Zstud-ent								
	KEY: "L" = Abnorma	Low, "H" = Abnormal	High, """ = Critical Value										
USER,2STUDENT	T DEMO-HO.IHS.	GOV DEMO HOS	SPITAL										

Figure 14-16: Laboratory test results in the Labs tab

15.0 Record a POV Diagnosis

(Assessment Tab)

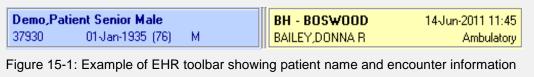
Use the Assessment tab to enter a POV diagnosis for the current patient encounter.

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:



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.

and the second		al Diagno:		_	Procedures		🐉 Visit Diagnos	is 🕦				Add	Edk	Delete
Ê	Problem List 1 Active Only	~ [s	et as Today's F	20V	Add Edit Del	ote	Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cause	Injury Pl
ID	Provider Narrative	Status	Modified	Priority		CL	EMS Laboratory Examination, Unspecified	V72.60	LABORATORY EXAM UNSPEC	Primary				
DH-1	Diabetes li/unspec Not Uncontr	Active	05/01/2007		Dm2 Uncontrolled; Needs Eye Exam An Diabetes Dental Exam	đ	Examination, Unspecialed		UNSPEC					
DH-2	Morbid Obesity	Active	05/01/2007											
DH-3	Other Disorders Of Lipoid Metabolism	Active	05/01/2007											
DH-4	Unspecified Essential Hypertension		05/01/2007											
DH-5	Swelling Of Limb	Active	05/01/2007											
DH-6	Pain In Limb	Active	05/01/2007											
DH-7	Attention Deficit Disorder Of Childhood With Hyperactivity	Active	05/05/2011											
						>	<		•					2
General	ICD Pick Lists Display V Freq. F	001:	Unspecified	Viral Ir		>	<							>
General Akb Am	xulatory Care	001:	Unspecified Allergic rhini	Viral Ir tis	nfection	2	<		13 					2
General Akb Ami All Clinic Anti Cor	xulatory Care s, All Providers g	001: 002: 003:	Unspecified Allergic rhini Mixed hyperl	Viral Ir lis lipidemi	nlection	2	<		(d) - • 1					2
General Akb Ami All Clinic Anti Cos Aona Tr	outatory Care s, All Providers g astrnerk Room	001: 002: 003: 004:	Unspecified Allergic rhini Mixed hyperl Acute upper	Viral In lis lipidemi respira	nfection	2	٢		11 • • • •					>
General Akb Ami All Clinic Anti Cos Aona Tr Audiolog	xulatory Care c, All Providers g satment Room	001: 002: 003: 004: 005:	Unspecified Allergic rhini Mixed hyper Acute upper Anxiety state	Viral In lis lipidemi respira	nlection	>			20 20					2
General Akb Ami All Clinic Anti Can Audiolog Behavio Bh Intak	Aldrom Care A s. All Providers 9 satiner/ Room 9 vial Health e Scienting	001: 002: 003: 004: 005: 006:	Unspecified Allergic rhini Mixed hyperl Acute upper Anxiety state Anemia	Viral Ir lis lipidemi respira	nfection ia atory infections of unspecified site	2	<		14 - 10					<u>></u>
Beneral Akb Ami All Clinic Anti Coa Anti Coa Aona Ti Audiolog Behavio Bh Intak Bir Urge	vulatory Care , All Providers admert Room y ral Health a Screening xt Care	001: 002: 003: 004: 005: 006: 007:	Unspecified Allergic rhini Mixed hyper Acute upper Anxiety state Anemia Tobacco Us	Viral Ir lis lipidemi respira e Disor	nfection ia atory infections of unspecified site				14 ••					
Beneral Akb Ami All Clinic Anti Cas Aona Ti Audiolog Behavio Bh Intak Bir Urge Colpose	vulatory Care , All Providers admert Room y ral Health a Screening xt Care	001: 002: 003: 004: 005: 006: 007: 008:	Unspecified Allergic rhini Mixed hyper Acute upper Anxiety state Anemia Tobacco Us Screening fo	Viral Ir tis lipidemi respira o o Disor or other	nfection iia atory infections of unspecified site rder r and unspecified Cardiovascular C				14 •					2
Beneral Akb Ami All Cirric Anti Car Anti Car Anti Car Avai olog Behavio Bh Intak Bh Intak Bh Intak Bh Unge Colpose Dm Dmg Un	xulatory Care s. All Providers g submert Room by the Somering the Care services the Care	001: 002: 003: 004: 005: 006: 007: 008: 009:	Unspecified Allergic rhini Mixed hyper Acute upper Anxiety state Anemia Tobacco Us	Viral Ir lis lipidemi respira e Disor or other pertens	nfection iia atory infections of unspecified site rder r and unspecified Cardiovascular C				н •					
General Akb Ami All Cleric Andi Con Andi Con Andi Con Bh Intak Bir Urge Colpose Dim Dimg Urj Ekg Dia	Addroy Care a. All Provotes admert Room y tal Heath S Screening t Care sy pert Care proces sy	001: 002: 003: 004: 005: 006: 007: 000: 000: 000: 009: 009: 010:	Unspecified Allergic rhini Mixed hyperi Acute upper Anxiety state Anemia Tobacco Us Screening fo Essential Hy	Viral Ir lis lipidemi respira e Disor or other pertens	nfection iia atory infections of unspecified site rder r and unspecified Cardiovascular C				14 • 1					
Signeral Akb Ami Akb Ami Anti Cico Anti Cico Anti Colposc Dim Ding Un Ekg Dia	Addroy Care A Minwades Satirer Room y Screening Sc	001: 002: 003: 004: 005: 006: 007: 000: 000: 000: 009: 009: 010:	Unspecified Allergic rhini Mixed hyperi Acute upper Anxiety state Anemia Tobacco Us Screening fo Essential Hy Ingrowing na	Viral Ir lis lipidemi respira e Disor or other pertens	nfection iia atory infections of unspecified site rder r and unspecified Cardiovascular C				1					2

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

Notificatio	ns (IFC Review (CC)	/ HPI Pa	ast Hea	ilth Hx (IMM)	Notes	Vitals	Assessmen	t Orde	rs Pt Ed	Pro
	Problem List	Historica	l Diagn	osis	Past P	Procedure	s			
		tive Only Problems	-	<u>S</u> et as Today's	POV			Add	<u>E</u> dit <u>D</u> ele	ete
ID		tive Only	IS	Modifie🕁	Priority	Notes	Onset	ICD	ICD Name	^
CI-8	Unspecified Otitis Media Ina		е	05/08/2010			04/08/2010	382.9	OTITIS	
CI-5		rsonal Histo		08/09/2007			08/09/2007	786.09	RESPIRAT	
CI-4	codiene intolerance	mily History	- crson History				05/14/2007	995.27	OTHER DRUG	
CI-2	hypertension with neuropat	hy i	Active	03/08/2007			03/08/2007	.9999	UNCODED	
CI-3	Diabetes Mellitus Without M Of Complication, Type Ii Or Unspecified Type,		Active	03/08/2007			03/08/2007	250.00	DIABETES II/UNSPEC NOT	
WW-2	ABN. MAMMOGRAM L BR DENSITY	EAST	Active	02/16/2005				793.80	UNSPECIF IED	
WW-3	1CM LUCENT REGION SL ASPECT PATELLA	JP. LAT.	Active	02/16/2005				793.7	NONSP ABN	
WW-1	MED ADJUSTMENT INCR CELEXA	EASE	Active	04/08/2004				V65.8	REASON FOR	
	L KNEE TENDONITIS (GR								SYNOVITI	\mathbf{r}
<									>	

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.

Notifications	(IFC Review CC / HI	PI Past	Health Hx IMM Notes	Vitals Assessment Orders Pt Ed	P
Pro	oblem List 🛛 📕	listorical D	liagnosis Past	Procedures	
辥 Histo	orical Diagnosis 🧕			Add to PL Set as Today's PC	JV
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	L
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	1

Figure 15-4: Historical Diagnosis pane

Notifications	IFC Rev	iew CC	/ HPI Past Health I	нх (тм	M Notes Vitals	Assessment	Orders Pt Ed Pro
Pro	blem List		Historical Diagnosis		Past Procedures		
🔆 Histo	orical <u>S</u> e		All Surgical	*	Add to <u>C</u> urrent Visit		Add Delete
Visit Date	CPT Code	Descript	Medical				Facility 🔥
07/13/2010	90853	GROUP,	Anesthesia				Kayenta He 📃
07/08/2010	90853		Radiology				Kayenta He
06/12/2010	90808		Laboratory				Demo Hosp
06/09/2008	86580		Dental Miscellaneous				Demo Hosp
06/09/2008	90772	THER/R					Demo Hosp
06/09/2008	A4206	1 CC STE	RILE SYRINGE&NEE	DLE			Demo Hosp
06/05/2008	80053	COMPRE	HEN METABOLIC PA	NEL			Demo Hosp
05/29/2008	D2970	TEMP CF	ROWN (FRACTURED	тоотн)			Demo Hosp
04/28/2008	90658	FLU VAC	CINE, 3 YRS & >, IM				Demo Hosp
04/28/2008	90632	HEPAV	ACCINE, ADULT IM				Demo Hosp
04/28/2008	90472	IMMUNIZ	ZATION ADMIN, EACH	I ADD			Demo Hosp
04/28/2008	90471	IMMUNIZ	ZATION ADMIN				Demo Hosp
04/28/2008	90746	HEP B V	ACCINE, ADULT, IM				Demo Hosp 🧹
04/200/2000	00470	ILALA INT		LADD			D 11 🗹

The Past Procedures tab contains the Historical Services pane.

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.

🗱 Visit Diagnosi	s 🚺					<u>A</u> dd <u>E</u> dit	
Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cause	Injury Place
Otitis Media with Effusion - Ear 2	381.4	NONSUPP OTITIS MEDIA NOS	Primary				
Ear infection	.9999	UNCODED DIAGNOSIS	Secondary				
<							>

Figure 15-6: Multiple POVs in the $\ensuremath{\textit{Visit Diagnosis}}$ 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.

ICD Pick Lists Display Freq. Re	ank Code Description Cols 2 •	
Chase Accived Drug 4 2010 Chase Accived Drug 4 2010 Chase Chait Cree 4 2010 Chase Chait Cree 4 2010 Drug Dogethere 4 2010 Chase Chait Cree 4 2010 Drug Dogethere 4 2010 Chase Chait Cree 4 2010 Drug Dogethere 4 2010 Chase Environment 4 2010 Drug Dogethere 4 2010 Chase Environment 4 2010 Drug Drug Hart Active 4 2010 Chase Environment 4 2010 Drug Event Active 4 2010 Chase Environment 4 2010 Drug Event Active 4 2010 Chase Environment 4 2010 Drug Event Active 4 2010 Chase Environment 4 2010 Drug Event Active 4 2010 Chase Environment 4 2010 Drug Event Active 4 2010 V	Eur Canal Infection - Eur 6 Eur Anjury - Ear 1 Henring Lots - Ear 8 Dignet in Ear Canal - Ear 7 Dignet in Ear Canal - Ear 7 Dithis Media with Effusion - Ear 2 PE Tube, Follow up - Ear 10 Recurrent Acute Othis Media - Ear 4	
Show All		



- 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.

Visit Diagnosis 🕦 Add Edit Delete								
Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cause		
Otitis Media with Effusion - Ear 2	381.4	NONSUPP OTITIS MEDIA NOS	Primary					

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).

🛋 Add POV for Current Visit	×
ICD .	Save
(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)	Cancel
<u>N</u> arrative	Primary Diagnosis
Date of Onset Stage Modifier	- Add to
POV is Injury Related First Visit C Re-Visit	Problem List
Injury Date 08/09/2010 Place	Education
Injury caused by	
Associated with	

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.

🛤 Add POV	for Current Visit		×
<u>I</u> CD	rheumatoid arthritis		Save
	(NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)		Cancel
<u>N</u> arrative			Cancer
D. (D.)			Primary Diagnosis
Date of <u>O</u> nset		*	Add to
POV is In	j ury Related O First Visit O Re-Visit		Problem List
Injury <u>D</u> a	ate Place	~	
Injury ca <u>u</u> sed	by		Education
Associated v			

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.

Diagnosis Loc	okup				×
	Lookup Option	O Lexicon	💽 ICD		
Search <u>V</u> alue	rheumatoid arthritis			S	earch
Select from on	e of the following items				
Code Desc	ription				
714.0 Rheu	imatoid Arthritis				
			_		
🗹 Return Sea	arch Text as Narrative			ок с	ancel

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.

🗟 Add POV 1	for Current Visit		×
ICD (NOTE: If the ICD is not selected it defaults to .9999 - Uncoded Diagnosis)		Save Cancel
<u>N</u> arrative	cardiac amyloidosis	~	
Date of <u>O</u> nset	Stage <u>M</u> odifier	~	Diagnosis
POV is Inju	ury Related O First Visit O Re-Visit		Problem List
Injury <u>D</u> at	te Pjace	~	Education
Injury ca <u>u</u> sed b			Eucadon
Associated wi	ith 🔽		

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.

Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cau
cardiac amyloidosis	.9999	UNCODED DIAGNOSIS	Primary			

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:

Demo,Patient Senior Male	BH - BOSWOOD	14-Jun-2011 11:45
37930 01-Jan-1935 (76) M	BAILEY, DONNA R	Ambulatory

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.

		s (3-HF/Wellness 6-POV/Diagnosis 4-Vitals 7-IMM (2-Notes Diders (M	eds (Labs (Rep	iorts Consu	ilts (Su	perbill	ICD-9 List	
File View Action Optio	ons							
View Orders		udes Pending & Recent Activity) - ALL SERVICES						
Active Orders (includes	Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Write Orders	Out. Meds	Discontinue AMOXICILLIN CHA PWOR, RENST-ORAL 250MG/5ML SHAKE WELL AND GIVE 10ML (500MG) BY MOUTH 2 TIMES A DAY FOR 10 DAYS FOR INFECTION Quantity: 300 Refilt: 0 "UNSIGNED" (Requesting Physician Cancelled)		Mcintyr				unreleased
Medicines for CHAM	Lab	THROAT CULTURE SWAB/THROAT WC ONCE Indication: testing LB #57541	Start: 04/09/10 09:50	Chap,Z				pending
Text Only Order								

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	exam	nle	of a	a patient	with	Otitis	Media	select	"Ear	Plans	,,
TOL	uic	слаш	pic	01 6	i patient	with	Ouus	wieura,	SCIECI	Lai	1 14115	•

4	Medicines for CHAM Done
	Emergency: For Emergencies reference the CHAM and document on PEF
- -	Emergency Childbirth: For Emergencies reference the CHAM and document on PEF
ĩ	Child and Teen Plans
	Elder Care
	Eye Plans
	Ear Plans
	Mouth and Teeth Plans
	Respiratory Plans
	Circulatory Plans
	Digestive Plans
	Musculoskeletal Plans
	Skin and Soft Tissue Plans
	Urinary Plans
	Male Reproductive Plans
	Female Reproductive Plans
	Pregnancy Plans
	Nervous Plans
	Endocine Plans
	Immune Plans
	Mental Health Plans
	Alcohol and Drug Use 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)**.

Ear Plans	Done
Ear 1: Ear Injury	
Ear 3: Acute Othis Media (AOM)	
Ear 4: Recurrent Acute Otitis Media	
Ear 6: Ear Canal Infection	
Ear 7: Object in Ear Canal	
Ear 8: Hearing Loss	

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.

Ear 3: Acute Otitis Media (AOM)	Done
Medicine if ordered by doctor or Standing Order.	
For Infection: Amoxicillin (Amoxil or Trimox)	
or if allergic to Amoxicillin (Penicillin):	
Cefpodoxime (Vantin)	
or if allergic to Cefpodoxime (Cephalosporins):	
Trimethoprim/Sulfamethoxazole (Septra or Bactrim)	
<u>If needed for pain or fever;</u> Acetaminophen (Tylenol) by mouth or Ibuprofen (Motrin)	
I <u>f ear is draining</u> * Doctor may order antibiotic ear drops	

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.

ve dose of Amoxicillin in chart by mouth (po)	
2 times a day for 10 days.	
Amoxicillin po (High Dose)	
Strength: 250 mg/5 ml suspension	
Less than 15 lb Consult doctor	
15 to 19 lb 6 ml (300 mg)	
20 to 24 lb 8 ml (400 mg)	
25 to 29 lb 10 ml (500 mg)	
30 to 34 lb 12 ml (600 mg)	
35 to 39 lb 13.5 ml (675 mg)	
40 to 44 lb 15.5 ml (775 mg)	
45 to 54 lb 18 ml (900 mg)	
55 to 64 lb 20 ml (1000 mg)	
65 to 74 lb 20 ml (1000 mg)	
75 to 84 lb 20 ml (1000 mg)	
Amoxicillin po (High Dose)	
Strength: 250 mg capsules	
>85 lb & Adult 4 capsules (1000 mg)	

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.

Medication Order			X
DIPHENHYDRAMINE SYRUP			Change
Dosage Complex			
Dosage	Route	Schedule	
5ML (1 TSP) 12.5MG/5ML	ORAL	Q6H	PRN
2.5 ML (1/2 TSP) 12.5MG/5ML 3.25ML (3/4 TSP) 12.5MG/5ML 5ML (1 TSP) 12.5MG/5ML 7.5ML (1 AND 1/2 TSP) 12.5MG/5ML 10ML (2 TSP) 12.5MG/5ML	ORAL	Q4H Q4H PRN Q4H SLIDING S Q4H SSI Q5MIN Q6H	
Comments:			~ ~
Days Supply Quantity Refills Clinical Indication 7 120 0 0 0 Pick Up Clinic Mail • Window Electronic			⁹ riority ROUTINE 🗨
DIPHENHYDRAMINE SYRUP 12.5MG/5ML TAKE 5ML (1 TSP) BY MOUTH EVERY 6 HOURS MAY CA Quantity: 120 Refills: 0 Chronic Med: NO Dispense as Writte		×	ADR's Accept Order Quit

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.

)rd	er Checks
•	Previous adverse reaction to: PENICILLIN-G RELATED PENICILLINS
	Accept Order Cancel Order
	Calceronder

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.

Orders Ac									
e Orders (includes	Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status	
Orders	Out. Meds	ACETAMINOPHEN CHA SOLN,ORAL 100MG/ML TAKE 2ML (200MG) BY MOUTH EVERY 4 TO 6 HOURS AS NEEDED FOR FEVER OR PAIN Quantity: T5 Rofils: 0 "UNSIGNED"		Mcintyr				unrelease	
hes for CHAM Lab Menu	Out. Meds	CEFPODOXIME PROXETIL CHA SUSP,ORAL 100MG/5ML SHAKE WELL AND GIVE 4.25MG (85MG) BY MOUTH 2 TIMES A DAY FOR 10 DAYS FOR INFECTION Quantity: 100 Refills: 0 "UNSIGNED"		Mcintyr				unreleas	
nly Order	Out. Meds	Discontinue AMOXICILLIN CHA PWOR, RENST-ORAL 250MG/5ML SHAKE WELL AND GIVE 10ML (500MG) BY MOUTH 2 TIMES A DAY FOR 10 DAYS FOR INFECTION Quantity: 300 Refile: 0 (Requesting Physician Cancelled)	Stop: 07/23/10 10:30	Mcintyr				cancelle	
	Lab	THROAT CULTURE SWAB/THROAT WC ONCE Indication: testing LB #57541	Start: 04/09/10 09:50	Chap,Z				pending	

Figure 16-9: Unreleased medication orders in the **Orders** tab

Review/Sign Changes for Demo,Adam Kyle
Signature will be applied to checked items
Orders - Other Unsigned
ACETAMINOPHEN CHA SOLN, ORAL 100MG/ML TAKE 2ML (200MG
CEFPODOXIME PROXETIL CHA SUSP,ORAL 100MG/5ML SHAKE W
Electronic Signature Code:

Sign Cancel
Canoor

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.

w Orders 🖉	Acti	ve Orders (incl	udes Pending & Recent Activity) - ALL SERVICES						
ive Orders (includes	Т	Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
		Out. Meds	ACETAMINOPHEN CHA SOLN,ORAL 100MG/ML TAKE 2ML (200MG) BY MOUTH EVERY 4 TO 6 HOURS AS NEEDED FOR FEVER OR PAIN Quantity: 15 Refills: 0	Start: 07/23/10 Stop: 08/22/10	Mcintyre,C				active
e Orders dicines for CHAM AP Lab Menu		Out. Meds	CEFPODOXIME PROXETIL CHA SUSP.ORAL 100MG/5ML SHAKE WELL AND GIVE 4.25MG (85MG) BY MOUTH 2 TIMES A DAY FOR 10 DAYS FOR INFECTION Quantity: 100 Feflix: 0	Start: 07/23/10 Stop: 08/22/10	Mcintyre,C				active
Only Order		Out. Meds	Discontinue &MCX0CILLIN CHA PWOPR RENST-ORAL 250MG/GML SHAKE WELL AND GIVE 10ML (500MG) BY MOUTH 2 TIMES A DAY FOR 10 DAYS FOR INFECTION Quantity: 300 Refills: 0 (Requesting Physician Cancelled)	Stop: 07/23/10 10:30	Mcintyre,C				cancelle
		Lab	THROAT CULTURE SWAB/THROAT WC ONCE Indication: testing LB #57541	Start: 04/09/10 09:50	Chap,Z				pending

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:

Demo,Patient Senior Male	BH - BOSWOOD	14-Jun-2011 11:45
37930 01-Jan-1935 (76) M	BAILEY, DONNA R	Ambulatory

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.

Edu									and the second	elete
finit Dater	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length		Location	1
5/07/2010	Pain Management-Anatomy And Physiology	G00D				USER/2STUDENT	10	Individual		
6/07/2010	Pain Management Anatomy And Physiology	REFUSED				USEB,2STUDENT	10	Individual		
5/07/2010	Pain Management Anatomy And Physiology	POOR				USER_2STUDENT	10	Individual		
5/07/2010	Pain Management-Anatomy And Physiology	FAIR				USER/2STUDENT	10	Individual		
2/25/2010	Pain Management Anatomy And Physiology	G000	GOAL SET			USER,2STUDENT	15	Individual		
2/25/2010	Pain Management-Cultural/spintual Aspects 01 Health	REFUSED				USER,2STUDENT		Individual		
9/25/2009	Child Health - Adolescent(12-18 Years)-Growth And Development	600D	GOAL SET		Child is short for age.	USER, OSTUDENT	10	Individual		
9/21/2009	Screen For Malig/breast, unspec Literature	600D				USER,CSTUDENT		Individual	DEMO	
2/09/2008	Diabetes Mellitus-Complications 2006	600D				MOSELY, ELVIRA	5	Individual	DEMO	
2/09/2008	Diabetes Melitus-Foot Care 2006	GOOD				MOSELY, ELVIRA	5	Individual	DEMO	
2/09/2008	Abdominal Pain-Complications 2006	GOOD				MOSELY, ELVIRA	2	Individual	DEMO	
2/09/2008	Abdominal Pain Disease Process 2006	G000				MOSELY, ELVIRA	2	Individual	DEMO	
2/09/2008	Child Health - Adolescent(12-18 Years)-Alcohol And Other Drugs 2006	GDOD				MOSELY, ELVIRA	2	Individual	DEMO	
2/09/2008	Child Health - School Age(5-12 Years)-Growth And Development 2006	GOOD				MOSELY, ELVIRA	2	Individual	DEMO	
2/09/2008	Medications-Information 2006	FAIR				MOSELY_ELVIRA	5	Individual	DEMO	
2/09/2008	Medications-Information 2006	GOOD				MOSELYELVIRA	5	Individual	DEMO	
4/28/2008	Immunizations-Information 2006	GOOD			gave instructions to mother	MOORE,CATHERINE	2	Individual	DEMO	
4/28/2008	Immunizations-Patient Literature 2006	GOOD				MOORE CATHERINE	2	Individual	DEMO	
7/30/2007	Domestic Violence-Prevention 2006	GOOD				USER_ESTUDENT	1	Individual	DEMO	
7/26/2007	Diabetes Melitus-Exercise 2006	GROUP-NO ASSESSMENT				MOSELYELVIRA	5	Group	DEMO	
7/26/2007	Diabetes Melitus Lifestyle Adaptations 2006	GROUPINO ASSESSMENT				MOSELY_ELVIRA	3	Group	DEMO	
5/21/2007	Diabetes Melitus Hone Management 2006	600D	GOAL SET	A1c below 7		MOSELY ELVIRA	5	Individual	DEMO	
4/09/2007	Autoimmune Dicorders-Dicease Process 2006	GOOD				MOORE CATHERINE	15	Individual	DEMO	
2/13/2007	Dietary Supplements-Complications 2006	GOOD	GOAL SET	lose 2 lbs by next visit		USERIBSTUDENT	5	Individual	DEMO	
2/01/2007	Anemia Nos-Prevention 2006	6000				USER BSTUDENT	10	Individual	DEMO	
2/01/2007	Blood In StockTreatment 2006	GOOD				USER BSTUDENT	20	Individual	DEMO	
/28/2006	Immunizations-Patient Literature 2006	GOOD	GOAL SET	A1c below 6		USER ASTUDENT	3	Individual	DEMO	
	Medications-Medication Dispense To Proxy 2006	6000			DISP TO HUSBAND	TOM JENNIFER DIANE	2	Individual		
/24/2005	Medications-Medication Dispense To Provy 2006	GDOD			medications dispensed to husband	BROOKS MERLE B	2	Individual		
/25/2005	Womens Health-Pap Smear 2006	G000				LAMER FRANCES E	5	Individual		
	Womens Health Procedures 2005	GOOD				LAMER FRANCES E	5	Individual		
	Women: Health-Pap Smear 2006	G000				Part 10 100 100 0 0		Individual		
	Womens Health-Breast Exam 2005	G000				LAMER FRANCES E		Individual		
	Willeria riedarrareda Examizado MU Bartela Adartatione 2005	6000				LAMER FRANCES E		Individual		
								1000		5

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.

Education Topic Selection	
🐮: 🔎 🚱 🎢 🐼 0 items	
Select By O Category List O Disease & Topic Entry O Pick List Name Lookup O Procedure & Topic Entry	
Pick Lists Chap - Child_teen	ОК
Show All	Cancel
☐ Chap-151-2 - Sick Child ☐ Chap-154-4a - Parent Education/guidance ☐ Chap-155-4b - Care Of The Newborn	
Lype of Training Individual Group	<u>_</u>
Lype of Training Individual O Group	1
Length (min)	
Readiness to Learn	

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.

🛱 Education Topic Selection 🛛 🔀							
Select By Category List Disease & Topic Entry Pick List Name Lookup Procedure & Topic Entry Pick List Pick Lists Cham 239 - 246 Ear Image: Cham 239 - 246 Ear Pick Lists Cham 239 - 246 Ear Image: Cham 239 - 246 Ear Page 239 - Ear Injury Page 239 - Ear Injury Image: Page 241 - Acute Otitis Media (middle Ear Infection) Page 242 - Ear Tubes (Pe Tubes) Page 243 - Chronic Otitis Media (Hole In The Eardrum) Page 244 - Ear Canal Infection Page 245 - Ear Wax Page 245 - Hearing Loss Page 246 - Protect Yourself From Hearing Loss	OK Cancel						
Ivpe of Training Individual O Group Comprehension Level GOOD ✓ Length 15 (min)							

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.

e 🔎 🚱 🎢 🛛	c Selection 0 items		
Select By O Category Name Lo	→ List ODisease & Topic Entry pokup OProcedure & Topic Entr		
Pick Lists Cha	p-circulatory	· · · ·	0K Cancel
Leg Pain From Arter	ry Disease - Disease Process Page ry Disease - Lifestyle Adaptations - F ry Disease - Nutrition- Page 342	Page 342	
Leg Pain From Vein	Disease-Home Management Page Disease-lifestyle Adaptations Page Disease-disease Process-Page 34	e 342 And 343	
Leg Pain From Vein	Disease -lifestyle Adaptations Page Disease-disease Process- Page 34	e 342 And 343	
Leg Pain From Vein	Disease -lifestyle Adaptations Page Disease-disease Process- Page 34 O Individual O Group	e 342 And 343	

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.

🎓 Edu	Cation (Show Standard)							Add	Edit De	siete
Visit Date*	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location	1
05/07/2010	Pain Management Anatomy And Physiology	GOOD				USEB,2STUDENT	10	Individual	DEMO	
05/07/2010	Pain Management-Anatomy And Physiology	REFUSED				USER/2STUDENT	10	Individual	DEMO	
05/07/2010	Pain Management Anatomy And Physiology	POOR				USER,2STUDENT	10	Individual	DEMO	
05/07/2010	Pain Management-Anatomy And Physiology	FAIR				USER/2STUDENT	10	Individual	DEMO	
09/25/2009	Child Health - Adolescent(12-18 Years)-Growth And Development	6000	GOAL SET		Child is short for age.	USER, OSTUDENT	10	Individual	OTHER	
09/21/2009	Screen For Malig/breast, unspec-Literature	GOOD				USER,CSTUDENT		Individual	DEMO	
12/09/2008	Diabetes Melitus-Complications 2006	GOOD				MOSELY, ELVIRA	5	Individual	DEMO	
12/09/2008	Diabetes Melitus-Foot Care 2006	GOOD				MOSELY, ELVIRA	5	Individual	DEMO	
12/08/2008	Abdominal Pain Complications 2006	GOOD				MOSELY, ELVIRA	2	Individual	DEMO	
12/09/2009	Abdominal Pain-Disease Process 2006	GOOD				MOSELY, ELVIRA	2	Individual	DEMO	
12/09/2008	Child Health - Adolescent(12:18 Years) Alcohol And Other Drugs 2006	GOOD				MOSELV, ELVIRA	2	Individual	DEMO	
12/09/2008	Child Health - School Age(5-12 Years)-Growth And Development 2006	GOOD				MOSELY, ELVIRA	2	Individual	DEMD	
12/09/2008	Medications-Information 2006	FAIR				MOSELY, ELVIRA	5	Individual	DEMO	
12/08/2008	Medications Information 2006	GOOD				MOSELY ELVIRA	5	Individual	DEMO	
04/28/2008	Immunizations-Information 2006	GOOD			gave instructions to mother	MOORE CATHERINE	2	Individual	DEMO	
04/28/2008	Immunizations-Patient Literature 2005	600D				MOORE CATHERINE	2	Individual	DEMO	
07/30/2007	Domestic Violence Prevention 2006	6000				USER,ESTUDENT	1	Individual	DEMO	-
07/26/2007	Diabetes Melitus-Exercise 2006	GROUP-NO ASSESSMENT				MOSELY ELVIRA	5	Group	DEMO	
07/26/2007	Diabetes Melitus Lifestyle Adaptations 2006	GROUP NO ASSESSMENT				MOSELY, ELVIRA	3	Group	DEMO	
06/21/2007	Diabetes Mellihzs-Home Management 2006	GOOD	GOAL SET	A1c below 7		MOSELY ELVIRA	5	Individual	DEMO	
04/09/2007	Autoimmune Disorders-Disease Process 2006	GOOD				MOORE,CATHERINE	15	Individual	DEMO	
02/13/2007	Dietary Supplements Complications 2006	GOOD	GOAL SET	lose 2 lbs by next visit		USER BSTUDENT	5	Individual	DEMD	
02/01/2007	Anemia Nos-Prevention 2006	GOOD				USER.BSTUDENT	10	Individual	DEMD	
02/01/2007	Blood In Stool-Treatment 2006	GOOD				USER, BSTUDENT	20	Individual	DEMO	
11/28/2006	Immunizationo Patient Literature 2005	GOOD	GOAL SET	A1c below 6		USER,ASTUDENT	3	Individual	DEMO	
09/21/2005	Medications-Medication Dispense To Proxy 2006	GOOD			DISP TO HUSBAND	TOM JENNIFER DIANE	2	Individual	DEMO	
08/24/2005	Medications Medication Dispense To Proxy 2006	GOOD			medications dispensed to husband	BROOKS MERLE B	2	Individual	DEMO	
	Womens Health-Pag Smear 2006	6000				LAMER FRANCES E	5	Individual	CIHA	
02/25/2005	Womens Health-Procedures 2006	GOOD				LAMER FRANCES E	5	Individual	CIHA	
01/31/2005	Womens Health Pap Smear 2006	GOOD						Individual	CIHA	
01/31/2005	Womens Health-Breast Exam 2005	GOOD				LAMER FRANCES E		Individual	CIHA	
01/31/2005	WHLifestyle Adaptations 2005	6000				LAMER FRANCES E		Individual		
	Hypertension Medications 2006	6000				LAMER FRANCES E		Individual		
	Hypertension-Lifestyle Adaptions 2005	600D				LAMER FRANCES E		Individual	CIHA	
	Hypertension Lifestyle Adaptions 2005	GOOD				LAMER FRANCES E	1	Individual		
	Honetlenson-Medications 2016	6000				LAMER FRANCES F	1	Individual	CIHA	

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.

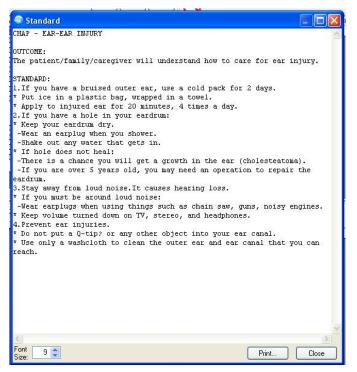


Figure 17-7: Patient education **Standard** dialog for an ear injury

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:

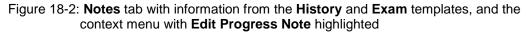
	BOSWOOD 14	Jun-2011 11:45
7930 01-Jan-1935 (76) M BAIL	EY,DONNA R	Ambulatory

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.

	Health Hx Mill Notes Vials Assessment Orders PLEd Procedures Consults Reports Medi	Laber IBC
File View Action Options		
	Visit: 07/21/10 CHAP ENCOUNTER, A CLINIC, ZSTUDENT USER (Jul 22,10(910.22)	
E: Al unigred notes for USER 25TUDENT El Jul 22.10 CHAP ENCOUNTER, A C El Jul 22.10 CHAP ENCOUNTER, A El May 00.10 CHAP ENCOUNTER, A E: Al signed notes	TITLE: CHAR BECOUNTER DATE OF NOTE: JUL 22, COLOBIO.22: ENTRY DATE: JUL 22, COLOBIO.22: 21 MURDOR: USER_2STUDENT UNCHARY: STATUS: UNSIGNED CHAR PATIENT ENCOUNTER	Cut ColeX Copy CtHC Pacte CtHV Reformst Paragraph CtH4V
	HISTORY: Chief Complaint & History Present Illness:	Find in Selected Note Replace Test.
	Chief Complaint: Patient presents with L ear pain X 3 days, fever ranges from 99 to 101 and is reduced by tylenol but always returns. Pain is described as a dull ache which is always present. Nothing makes the pain	Check Grammar Oned: Spelling
	better. It seems to be getting worse every day. She has put seal oil with garlic in her ear but it did not help. She had this type of ear ache three	Copy into New Template
	years agao and was told it was an ear infection. She reports taking amovicillin which did make the ear pain go away.	Add to Signature List Delete Progress Note
	The reports new dx of NTN and is taking lisinopril. EXAT: General Appearance: The holdship hand on L ear, reports severs pain Mead/Sinus: The definition of the several several pain The several several several several several several several several set denies tenderness, no drainage noted	EdR Progress Putch Maile Addredum Save without Signiture Sign Note Now Identify Addreda Signers
<	<pre>Marr: int official and a sector (8): (L): E or edness, swelling, drainage or odor noted. Unable to view and/or was Nose: No drainage or flaring noted Houth/Throat: No accurs noted, tonsils plank NewS/Thodes: Lungs/(Host: Lungs/(Host:</pre>	
/ Templates	Immunization: MMR	
New Note	Skin Tests: PPD	
rvew Note		



- 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.

Cut	Ctrl+X
Сору	Ctrl+C
Paste	Ctrl+V
Reformat Paragraph	Ctrl+R
Find in Selected Note Replace Text	
Check Grammar Check Spelling	
Copy into New Template	
Add to Signature List	
Delete Progress Note	
Edit Progress Note	
Make Addendum	
Save without Signature	
Sign Note Now	
Identify Additional Signers	;

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.

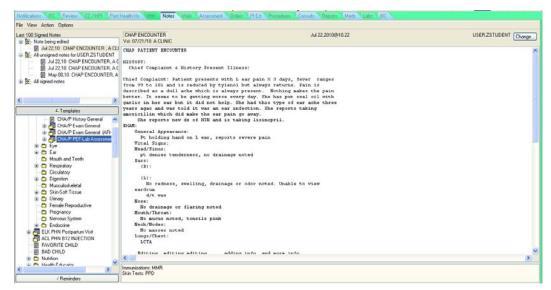


Figure 18-4: General folder in the Templates drawer

- 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.

Template: CHA/P PEF-Lab Assessment-Plan
 Click Here to Start using template Labs: ** Click here to Continue No Labs Found for Today
Comments:
ASSESSMENT:
▼ ** Click here to Continue
P.O.V.: No Diagnoses Found
BTOH Related: C Yes 🖲 No
IMMUNIZATIONS GIVEN: MMR
V PLAN:
🗹 ** Click here to Continue
Patient Ed:
CHAM-239-2 EAR
Medicines:
D/t allergy, cefpodoxine, acetaminophen
Special/Other Care:
Recheck/Followup:
Recheck if symptoms become worse, fever >103, regardless f/u l month after completeing antibiotics
All None * Indicates a Required Field Preview OK Cancel

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."

Review/Sign Changes for Demo,Alice Janene						
Signature will be applied to checked items Documents Jul 22,10 CHAP ENCOUNTER , A CLINIC, UserZstudent						
Jul 22,10 CHAP ENCOUNTER , A CLINIC, ZSTUDENT USER						
Electronic Signature Code:						
Don't Sign Cancel						

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:

Demo,Patient Senior Male		BH - BOSWOOD	14Jun-2011 11:45
37930 01-Jan-1935 (76)	М	BAILEY, DONNA R	Ambulatory

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.

1 33	id Management		O New Paler	nt @Established	Visit Services	D				Add	Edf Deleb
Type of Service	Level of Service		Q.Heart. and		de Narrative	Qtv	Diagnosis	Prim Modifier 1	Modifier 2	Provider	CP
lifice Valt	History and Exam Co	omplexity Appro	x Time CPT Codes			49	Ungion	THE PRODUCT T	Provence E	TIGTISH	
onsultation		useVisit 5 min	99211								
teventive Medicine	Problem Focused Sh	raightforward 10 min	n 99212								
	Expanded Lo	w 15 mir	n 99213								
	Detailed Mr	oderate 25 mir	n 99214								
	Comprehensive His	gh 40 me	n 99215								
				<							
Super-Bills	Display Freq Rank Code	Description 0	olt 5								
Isaga Immunization			ose Monitor Wit								
aclay Immunizations	^		irus Vaccine, S								
own Immunization			irus Vaccine, S								
hristin Immunization		Influenza V	rus vaccine, 5								
avis Immunization											
riser littm											
nser Imm y Immunization ggess Immunization											
incer Imm ny Immunization ggess Immunization sant Immunization											
incer Imm ny Immunization ggess Immunization sant Immunization											
inset linin ty Immunization gent Immunization ant Immunization artell Immunization											
nser Imm y Immunization gens Immunization ant Immunization arrell Immunization		 Add to <u>Super</u> 	t Vot							(Add
neer Imm y Immunization gen Immunization and Immunization Show All Historical Ser			t Vait	Facility	Oty Disgnorie			Prim Modilier 1	Modifier 2	(Add Deb
neer from y Innunization gent Innunization and Innunization Show At Historical Ser of Date CPT Code			t Val	Facility Kayerda Health Center	Oty Disgnoris			Prim Modifier 1	Modifier 2	(Add Dek
Insue time y Insurviçation gest Immunication ant Immunication ant Immunication Show All All Listorical Ser All Date CPT Code V132/2010 90853 20053	VICES AI Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY		(Vol	Kayerita Health Center Kayerita Health Center	Qty Disgnosis			Prim Modifier 1	Modifier 2	(Add
Insur Imm y Insurization gets Immunization and Immunization Show All Historical Ser Part CPT Code PJ 2000 90653 V08/2010 90653 V08/2010 90808	Vices All Description GROUP PSYCHOTHERAPY		t Vest	Kaperita Health Center	Qty Disgnosis			Prim Modifier 1	Modifier 2	(Add Deb
Insur Inno y Innunization gets Immunization ard Innunization Show All Historical Ser Al Date CPT Code 1/13/2010 90653 /08/2010 90653	VICES AI Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY		t Val	Kayerita Health Center Kayerita Health Center	Oty Disgnosis			Prim Modifier 1	Modifier 2	(Add
reset time gees Immunication and Immunication and Immunication Show All Historical Ser All 2016 CPT Code V08/2010 90653 V08/2010 90653 V12/2010 90653	VICES AI Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY PSYCK, OFFICE, 75-80 MN		t Vot	Kaperita Health Center Kaperita Health Center Demo Hospital				Prim Modifier 1	Modifier 2	(Add Dev
reset frem gees Immunication and Immunication and Immunication Show All Historical Ser in Date CPT Code 1/13/2010 90653 1/12/2010 90653 1/12/2010 90653 1/12/2010 90653 1/12/2010 90653	VICES AL Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY PSYTX, OFFICE, 7580 MIN TB INTRADERMAL TEST	Add to Summ	t Visit	Kayerita Health Center Kayerita Health Center Demo Hospital Demo Hospital	1			Prim Modifier 1	Modifier 2		Add Des
International State (Constraint) (Constraint	VICES AI Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY PSYTX: OFFICE: 75-60 MIN TE INTRACEMAL, TEST TER/RROPHYLAG INJ. SC/M	Add to Queen	(Val	Kaperita Health Ceriter Kapenta Health Ceriter Demo Hospital Demo Hospital Demo Hospital	1			Prim Modifier 1	Modifier 2	[Add Det
Inser terms genes Termanization areal Immunization areal Immunization areal Immunization I Show AI A Date CPT Code I Date CPT	Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY PSYCHOTHERAPY PSYCHOTHERAPY TEINTRADERMAL TEST THERAPROPHYCIAG INJ. SCIM 1 C STERILE SYRINGENEEDLE COMPREHEN METABOLIC PANEL	Add to Summ	t Vot	Kayenta Health Center Kayenta Health Center Demo Hospital Demo Hospital Demo Hospital Demo Hospital	1 1			Prim Modilier 1	Modifier 2	(Add Del
hines tens gges lineurization gges lineurization sarel timunization sarel lineurization sarel lineurization sate lineurization	VICES AI Description GROUP PSYCHOTHERAPY GROUP PSYCHOTHERAPY PSYTX: OFFICE, 75 00 MIN THERAFRIANAL TEST THERAFROPHIDIAG INI, SCIM TO CSTERILE SYNNEELINEEDU	Add to Summ	a vaa	Kayenta Health Center Kayenta Health Center Demo Hospital Demo Hospital Demo Hospital Demo Hospital	1 1			Prim Modifier 1	Modifier 2		Add Dei

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.

Super-Bills Display	Freq Bank 🗌 Code 🔲	Description Cols 2 *	
Amber's Immunization	~	Application Of Long Arm Splint	Removal Impacted Cerumen
Arteaga Immunization		Application Of Short Arm Splint	Removal Of Foreign Eve Superficial
Barclay Immunizations Brown Immunization	8	Application Of Short Leg Splint	Strapping, Ankle And/or Foot
Chap Procedures		Closed Treatment Of Shoulder Dislocation.	Strapping, Toes
Chap Supplies		Dressing/ Debridge Large	
Christin Immunization		Excision, Benign Lesion	
Davis Immunization Dincer Imm		Removal Foreign Body From External Auditory Canal	
Day Immunization	<u>~</u>		
Show All	é	3200: Removal foreign body from external auditory canal; without general anesthesia	

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.

A CLINI USER 25 USER 25 ast Heath Hx and No nd Exam Complexity Name Visit Focused Straightforward Modersize Hernine High	STUDENT Xes Vitals	21 Jul 2010 14:29 Ambulatoy Assessment Orders Oteos 99211 99212 99213 99214	Pt Ed Proce	dures	etherine g. Niesen:MayAnn Consults Reports Med Tisit Services J Narrative Remark Foreign Body Form External Auditory Canal	2 Labs Qty 1	IBC Diagnosis	Prim Mod Y	Pw1	H Summar		
ice and Exam Complexity Nuise Visit Focused Straightforward ed Low Moderste	Approx. Time 5 min 10 min 15 min 25 min	<u>New Patient</u> <u>93211</u> <u>93212</u> <u>93213</u> <u>99214</u>		Code	Tisit Services				ñer 1 M	odifier 2	Provider	
ice and Exam Complexity Nurse Visit Focused Straightforward ed Low Moderate	5 min 10 min 15 min 25 min	CPT Codes 99211 99212 99213 99214	Established	Code	Narrative Removal Foreign Body From External Auditory	Qty 1	Diagnosis		ñer 1 M	odifier 2	Provider	
and Exam Complexity Nurse Visit Focused Straightforward ed Low Moderate	5 min 10 min 15 min 25 min	99211 99212 99213 99214			Removal Foreign Body From External Auditory	Qty 1	Diagnosis		ñer 1 M	odifier 2		(
Focused Straightforward ed Low Moderate	5 min 10 min 15 min 25 min	99211 99212 99213 99214		69200	From External Auditory	1		Y			USER/2STUDENT	
ed Low Moderate	15 min 25 min	99213 99214										
		99215										
rik 🗆 Code 🔲 Descripti	on Cols 2	-		<								
	cation Of Lon	g Arm Splint							cial			
Close	d Treatment	Of Shoulder Disloc	ation,					/or Foot				
Excisi	ion, Benign L	esion	Auditory Canal									
	Appli Appli Close Dress Excis	Application Of Lon Application Of Sho Application Of Sho Closed Treatment Dressing/ Debridg Excision, Benign L	Application Of Long Arm Splint Application Of Shott Arm Splint Application Of Shott Leg Splint Closed Treatment Of Shoulder Disloc. Dressing/ Debridge Large Excision, Breingin Laison	Code Description Cole 2 Application 0f Long Arm Splint Application 0f Short Arm Splint Deplication 0f Short Leg Splint Closed Treatment 0f Shoulder Dislocation, Desting/ Debling Large	Code Description Cells 2 - Application Of Long Arm Splint Application Of Short Arm Splint Application Of Short Leg Splint Coded Transmort Of Short Cells Discription Description Description Description Lesion	Code Description Cale 2 * Application Of Long Arm Splint Application Of Short Arm Splint Application Of Short Leg Splint Code Treatment Of Shoulder Dialocation, S Detersing Debridge Large Excision, Bening Lesion	Code Description Cale 2 - Application Of Long Am Splint Premoval Application Of Shott Am Splint Application Of Shott Am Splint Application Of Shott Am Splint Strapping Dresting/ Debridge Large Excitance, Benign Lexinn	Code Description Cele 2 Application Of Long Am Splint Application Of Shotd Am Splint Application Of Shotd Am Splint Application Of Shotd Am Splint Stapping, Ankle And Oresting/ Debridge Large Exciting, Renign Lesion	Code Description Cale 2 - Application Of Long Am Splint Application Of Should Am Splint Code of Texament Of Should Am Splint Description Description Strapping, Ankle And/or Foot Description Description Strapping, Texe Strapping, Texe	Code Description Cute 2 Application Of Long Atm Splint Application Of Shout Arm Splint Strapping, Ankle And/or Foot Code of Treatment Of Shout Arm Splint Description Description Strapping, Taes	Code Description Cele 2 Application Of Long Am Splint Application Of Should Parallel Application Of Should Parallel Stapping, Ankle And/or Foot Cosed Treatment Of Should Parallel Stapping, Ankle And/or Foot Oresting/ Debridge Large Excitance Renigned Leaine	Code Description Cate 2 - Application Of Long Am Splint Premoval Impacted Cerumen Application Of Short Am Splint Application Of Short Leg Splint Application Of Short Leg Splint Strapping, Ankle And/or Foot Description Description Strapping, Tees Strapping, Tees

Figure 19-4: Recently selected Super-Bills display in the Visit Services pane

19.2 View Historical Services

Visit Date	CPT Code	Description	Facility	Qty Diagnosis	Prim M	fodifier 1	Modifier 2	
7/21/2010	69200	Removal Foreign Body From External Auditory Canal	Demo Hospital	1	Y			
7/13/2010	90853	GROUP PSYCHOTHERAPY	Kayenta Health Center					
7/08/2010	90853	GROUP PSYCHOTHERAPY	Kayenta Health Center					
6/12/2010	90808	PSYTX, OFFICE, 75-80 MIN	Demo Hospital					
6/09/2008	86580	TB INTRADERMAL TEST	Demo Hospital	1				
6/09/2008	90772	THER/PROPH/DIAG INJ, SC/IM	Demo Hospital	1				
6/09/2008	A4206	1 CC STERILE SYRINGEINEEDLE	Demo Hospital	1				
06/05/2008	80053	COMPREHEN METABOLIC PANEL	Demo Hospital	1				
15/29/2008	D2970	TEMP CROWN (FRACTURED TODTH)	Demo Hospital	1				
04/28/2008	90659	FLU VACCINE, 3 YRS & >, IM	Demo Hospital	1				

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

		Surgical			-					
isit Date	CPT Code	Descript Medical		Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	
7/21/2010	69200	Remova Anesthesia	uditory Canal	Demo Hospital	1		Y			
7/13/2010	90853	GROUP Radiology		Kayenta Health Center						
7/08/2010	90853	GROUP Laboratory		Kayenta Health Center						
6/12/2010	90808	PSYTX, Dental Miscellaneous		Demo Hospital						
6/09/2008	86580	TB INTE AL		Demo Hospital	1					
6/09/2008	90772	THER/PROPH/DIAG INJ, SC/IM		Demo Hospital	1					
5/09/2008	A4206	1 CC STERILE SYRINGE&NEEDLE		Demo Hospital	1					
6/05/2008	80053	COMPREHEN METABOLIC PANEL		Demo Hospital	1					
5/29/2008	D2970	TEMP CROWN (FRACTURED TOOT	(H)	Demo Hospital	1					
4/28/2008	90658	FLU VACCINE, 3 YRS & >, IM		Demo Hospital	1					

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.

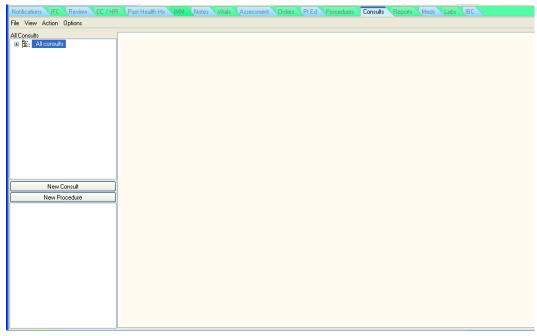


Figure 20-2: **Consults** tab

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.

le View Action Options					
I Consults	Dec 17.08 [c] MILLE	R DIABETES MANAGEMENT	Cons Consult #: 1540		
Al consult Dee 17.08 (c) MIL (May 13.08 (c) ANI Sep 14.07 (p) PH Jun 21.07 (p) ASS Feb 13.07 (c) CAS Feb 13.07 (c) CAS Feb 13.07 (c) CAS (c) Feb 13.07 (c) CAS (c) CA	Current Pat. Status: Ward: Order Information To Service: Prom Service: Dequesting Frovider: Service it to be rend Flace: Place:	Ingetient INFAILENT HILLES DIABETES HAM AMBULATORY CHRONIC FROUTER, HARAY J werd on an OUTPAILENT Consultant's choice Routine HILLER DIABETES HAM Consult Request	AGEMENT PAIN CLINIC Dasis		
New Consult	Inter-facility Inform This is not an inter- Status: Last Action: Facility		est.		
	Accivity	Date/Time/Zone	Responsible Person	Intered Dy	
E Related Documents	CPRS BELEASED OBDED PRINTED TO EMPIT SCHEDULED Get lost	12/17/08 11:28 12/17/08 11:28 12/17/08 11:30	PROVIDER, MARY J USER, JSTUDENT	USES, JSTUDIET USES, JSTUDIET	
			USER, JSTUDENT	USED, JSTUDENT	

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.

Authoritons VEC Review CC/HP Part Health Hx UMM	Notes Vitals Assessment	Orders RPLEd Procedu	Consults Reports Me	di Ngaba Njeo	
le View Action Options					
I Consults		DIABETES MANAGEMENT C	ons Consult #: 1537		
BE - AI consult Ober 77.00 Ic) VMT DIABETES MANAGEMENT Com Co Dee 77.00 Ic) VMT DIABETES MANAGEMENT Com Co Den 77.00 Ic) VMT DIABETES MANAGEMENT Com Co Jan 703.07 (c) ANDERSON DIABETES MANAGEMENT C	n Order Information To Service:	ered on an INPATIENT Bedside Boutine VHT DIAESTEE MANAGI Consult Request : DIAESTES ation	basis HENT		
(<u> </u>	Facility Activity	Date/Time/Zone	Responsible Person	Entered By	
New Consult	CPPS PRLEASED OFDER PRINTED TO EMPIT	12/17/08 11:23 12/17/08 11:23	USER, CSTUDENT	USER, CSTUDENT	
New Procedure	SCHEDULED I EDITED YOUR LETUDEN	12/17/08 11:30	USER, CSTUDENT	USER, CSTUDENT	
Dec 17,08 VMT DIABETES MANAGEMENT CONSUL	COMPLETE/UPDATE Notef 483 Note: TIME ZONE is lo		USER, CSTUDENT	USER, CSTUDENT	
	TITLE: WHT DIA DATE OF NOTE: DEC 17. AUTHOR: USER,CS URDENCY: Let's complete this C Done. /es/ CSTUDENT USER ND Signed: 12/17/2009 11	BETES HANAGEMENT COM 2009811:31 ENTEN TUDENT EXP CO onsult request.	DATE: DEC 17, 2008011		

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
а	Active	Orders that are active or that have been accepted by the service for processing.
С	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)

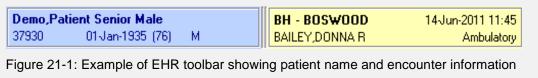
Use the **Reports** tab to print a Health Summary Patient Wellness Handout for the patient. This must be done at the end of the encounter.

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:



Available Reports	Health Summay	
er: Cinical Reports en Hochk Summay Lab Status Imaging (local ork) Daly Order Summay Order Summay for a Date Ran Dreft Copy Summay Order Summay Outpainter RK: Pottle Wah Summay Van Summay Van Summay E Prescribing Receipt		

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.

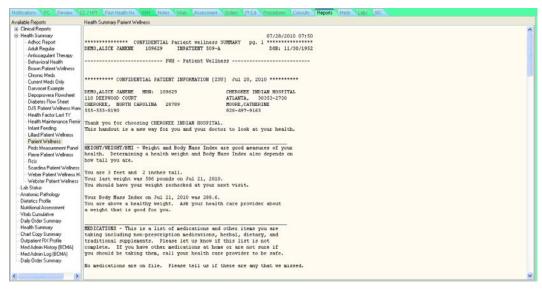


Figure 21-3: Choosing a patient wellness handout

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.

Patient Health Summary			
	RMATION 7/28/2010 7:54 AM [ZSU <ad> (DENTAL CHART SUMMARY) pg</ad>		^
DEM	OGRAPHIC DATA		
PAWNEE INDIAN TRIBE OF OKLAHOMA	DOB: NOV 30,1952 57 YRS FEMALE 1 SSN: XXX-XX-0084 MOTHER'S MAIDEN NAME: MOORHOUSE,EV FATHER'S NAME: DEMO.PATRICK		=
CHEROKEE (110 DEEPWOOD COURT, CHER)			
LAST UPDATED: JUL 7,2010	ELIGIBILITY: DIRECT ONLY		
	BY PATIENT? YES BY PATIENT: Jun 16, 2003 MENT SIGNED? YES		
	EMO HOSPITAL IGNATED PROVIDERS WAGER: DEL,JANICE		
[more] ON CMS REGISTER(S): SDMC DIABETE: CARDIOVASCULA	5 Status: ACTIVE AR DISEASE Status: ACTIVE		
ALLERGIES/ADVERSE REA	ACTIONS (FROM ALLERGY TRACKING)		*
Font Size: 9 🗢		Print	Close

Figure 21-5: Patient Health Summary dialog

22.0 The Labs Tab

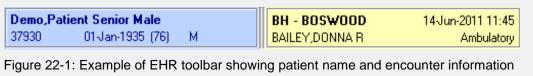
Use the **Labs** tab to review the current patient's lab tests and results. The **Labs** tab is for review only. No data can be entered on this tab.

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:

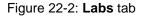


The **Labs** tab is for review only. Results can be filtered by Most Recent, Cumulative, All Tests by Date, Selected Tests by Date, Worksheet, Graph, and Lab Status.

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.

Notifications IFC	Review	EC / HPI	Past Health Ha	DMM N	lotes Vizal	Assessment	Oiden PiEd Piec	edure Consults Reports	Meda	Labs IBC		
File												
Lab Results Most Recent	Laboratory Re	esults - Cumul	lative - Six Mont		TESTS							
All Tests By Date Selected Tests By I Worksheet Graph	VENCOS	07/26 2010 09:16	07/21 2010 14:29	07/08 2010 10:47	Unics	Reference Ranges						
Microbiology Anatomic Pathologi Blood Bank Lab Status	POC ALC POC ALT POC-CHO POC TRI POC LDL POC HDL POC HIC STPEP A POC FLU POC PRO POC NIT POC LEU Comments:	120 H	\$ H	70 a canned	HC/DL W/L HC/DL HC/DL HC/DL HC/DL HC/L	65-105 1-6 9-52 0-200 0-160						
	DATE		SPECIMEN	T	NEOUS TES EST	VALUE	Ref ranges					
Date Range Date Range Today One Week Two Weeks Dne Morith Six Moriths Six Moriths One Year Two Years All Results	07/22/201 EX. Provi Calle Pt re	0 09:36 der notif d to repo ferred	lied ort	9 9	TREP A: pecimen s	NEGATIVE ent to Alask	ra Lab					
	KEY: "L" -	Abnormal Los	v. "H" = Abnom	al High """	- Critical Valu							



2. Click **Most Recent** in the **Lab Results** panel to sort the list by the most recent lab result.

	Laboratory Results - Most Recent				
Recent Ilative ests By Date sheet n		ext Newest			Most Recent Lab Results Collected Apr 08, 2010 15:47
ı ted Tests By I	Test	Result	Flag	Units	Ref Range
atus	POC HGB	13		g/dL	12.16

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.

Notifications (IFC	Review	(CC / HPI)	Past Health		Notes Vitals	Assessment	Orders	Pt Ed Procedur	es Consults Reports	Meds Labs	IBC	
File												
Lab Results	Laboratory F		nulative - Six N	d a contra c								
Most Recent		nesults - Cul	iulauve - 5ix iv		ATOLOGY I -							~
Cumulative				HEM.	RIOLOGY I -							
All Tests By Date Worksheet	BLOOD	04/08 2010		Reference								
Graph Selected Tests By I		15:47	Units	Ranges								
Lab Status	WBC		K/cmm	4.8-10.8								
	RBC		N/cmm	4.2-5.4								
	HGB	13	g/dL	12-16								
	HCT		- +	37-47								
	MCV		cmu	81-99								
	MCH		uug	27-31								
	MCHC		gm / dL	33-37								
Headings	RDW		\$	11.5-14.5								
-	PLT		K/cnm	130-400								
Hematology I	MPV		mu3	7.4-10.4								
Chem Profile Hemaglobin A1C	LYMPH *		*	20.5-51.1								
Poc Tests	MONO % GRAN %		*	1.7-9.3								
Miscellaneous Test	GRAN * LYMPH		*	42.2-75.2								
initioonarioodo rook	MONO #		x10 3 x10 3	1.2-3.4								
	GRAN #		x10 3 x10 3	1.4-6.5								
	ESR, RPF		MM/HR	0-20								
	RETIC		111/HK %	.5-1.5								
Date Range	BLEED T		MINUTES	2-8								
Date Range	EOSt		*	0-2								
Today	BAS0%		*	0-1								
One Week												
Two Weeks												
One Month Six Months				CHE	M PROFILE -							
One Year	SERUM	02/17	02/17		Reference							
Two Years		2010	2010									
All Results		13:47	13:35	Units	Ranges							
												~
	GLUCOSR			mer/dl	65-105							<u> </u>
	KEY: "L" =	Abnormal L	ow, "H" = Abi	normal High, ''*''	= Critical Value							

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.

Date Range	
Enter a date range -	
Begin Date	End Date
	OK Cancel

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.

Tesuits	Laboratory Results - All Tests By Date - S	ix Months					
I Robert I Robert Charles D Join Control Texts By Active Active Instancing Instancing Instancing Instancing I Romic Active I Romic I R	Provider : UDER_ISTUDENT Specimen: VINUUS BLOOD. Test name BCC CUCOSE Comment: Add free test here Provider : UDER_ISTUDENT Specimen: THEDAT. Test name	POC 0725 07/25/10 Result 120 H or add a cc Doc 0723 07/25/10 Result ted Poc 0721 07/21/10 Result 8 B	09:16 units HG/DL nued comm 09:36 units Spe 2 14:29 units 4	65 - went. Def. cimen ser Pef. 1 -	range n to Alasha Lab range 6		
te Bange te Bange dau	Provider : USER,XSTUDENT Specimen: VENOUS BLOOD. Test name POC GLUCOSE	FOC 0700 07/00/10 Result 70	10:47 units HC/DL	Pef. 65 -	range 105		

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.

Select Lab Tests			
	Persons with defined T	est Groups	Define Test Groups
Test Groups			New
			Replace
			Delete
Laboratory Tests			
Poc Glucose	Add	Tests to be a	displayed
Poc A1C Poc Alt Poc Cholesterol Poc Cholesterol Poc HDL Poc HGB Poc Influenza Poc LDL Poc Lipids Poc Micral Poc Monospot Poc Rapid Strep A Poc Triglyceride Poc Urine Dipstick Poc Urine Dipstick Poc Urine Dipstick Poc Urine Nitrite	To create a New Test Group, limit selection to 7 tests. Remove All Remove One Arrange order of tests for display.	Poc Glucose	
Specimen			
Any		ОК	Cancel

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.

	Review CC / HPI Past Health H	A ININ Notes Vial	Assessment Orde	PIEd Ploced	ures Consults	Reports	Medi Labs (B)	
le								
ab Results Most Recent	Laboratory Results - Worksheet - Six Mo Table Format			Other Formats				
Cumulative All Tests By Date	 Horizontal 	O Vertical		 Comments 		() Graph		
selected Tests By Worksheet				Zoom	300.		Values	
Graph Microbiology Anatomic Patholog Blood Bank Lab Status	Date/TimeSpecimePDC GLU 2072/SP1018154/2004218b1204 0778971011047/Vencuz Biol 201 077897101047/Vencuz Biol 70							
Other Tests ate Range								
Date Bange Today One Week Two Weeks								
One Month Six Months One Year								

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**.

Select Lab Test for G	rap	oh 💶 🗖
Laboratory Test Poc Glucose		ОК
Poc A1C Poc Alt Poc Cholesterol	^	Cancel
Poc Fecal Occult Blood Poc Glucose Poc HDL		
Poc HGB Poc Influenza Poc LDL		
Poc Micral Poc Monospot Poc Nitrazine	۳	
Poc Rapid Strep A	~	
Specimen		A specimen can be selected to restrict
Any	•	values only for that specimen.

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.

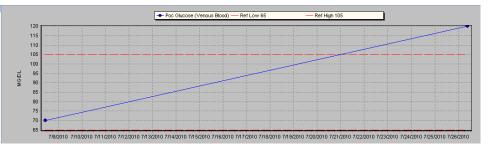


Figure 22-10: Graph showing results over a six-month period with **Zoom**, **3D**, and **Values** highlighted

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.

	Review CC / HPI Past Health Hx IMM Notes Vitals Assessment Orders Pt Ed Procedures Consults Reports Meds Labs BC	
<u>F</u> ile		
Lab Results	Laboratory Results - Selected Tests By Date - Six Months	
Most Recent Cumulative All Tests By Date Worksheet Graph Selected Tests By I Lab Status	Provider : CHAP,ZSTUDENT Specimen: ELOOD. POC 0406 6 04/06/10 13:44 Test name Result units Ref. range POC GLUCOSE 109 H mg/dL 65 - 100 Comment: SAVE UNITE IN CASE PROVIDER ODDERS CULTURE	
	Provider : CHAP,2STUDENT Specimen: BLOOD. POC 0406 5 04/06/10 09:06	
	04/06/10 05/06 Test name Result units Ref. range POC GUTCOSR 101H mg/dL 65 - 100	
	Provider : CAC,ASTUDENT Specimen: BLOOD. POC 0406 1 04/06/10 09:06 Test name Result units Ref. range POC GLUCOSE 78 mg/dL 65 - 100	
Other Tests Date Range Date Range Today One Week	Provider : COATES,DIANNE SUE Specimen: VENOUS BLOOD. POC 0219 4 02/19/10 15:16 Test name Result units Ref. range POC GLUCOSE 110 H	
Two Weeks One Month Six Months One Year Two Years All Results		
	KEY: "L" = Abnormal Low, "H" = Abnormal High, "" = Critical Value	

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.

Laboratory Results - Lab Status - One Ye	nar		
Lab Order # 60712	Status	Accession Provider: USER,2STUDENT	
POC GLUCOSE	Test Complete	07/26/2010 09:54 POC 0726 1	
	Status	Accession	
SWAB/THROAT	Test Complete	07/23/2010 08:49 POC 0723 1	
Orders for date: 07/21/10	1.00		
Lab Order # 60640	Status	Accession Provider: USER,ZSTUDENT	
POC ALC	Test Complete	07/21/2010 14:49 POC 0721 2	
Orders for date: 07/08/10 Test Urgency Lab Order # 60071 VENOUS BLOOD	Status	Accession Provider: USER_XSTUDENT	
POC GLUCOSE	Test Complete	07/08/2010 10:49 POC 0700 1	
Test. Urgency Lab Order # 60069	Status	Accession Provider: USED,2STUDENT	
BLOOD SERUN CLUCOSE ROUTINE	Requested (SEND	PATIENT) for: 05/08/2010	
	Orders for dace: 07/26/10 Test Urgency Lab Order # 60712 VINUOUS BLOOD POG GLUDOUS DOG GLUDOUS POG GLUDOUS Test Urgency Lab Order # 60660 SWAD/HEDOLT POC SAPID STAFF A Orders # 60640 Test VENDOUS ELOOD POC ALC Orders # 60640 POC ALC Orders # 60071 VINNOUS ELOOD POC GLUDOUS SLOOD Orders for dace: 07/09/10 Test Test Urgency Lab Order # 60071 VINNOUS ELOOD Orders for dace: 050/06/10 Test Lab Order # 60062 ELOOD	Test Urgency Status Lab Order # GOT22 VENUUS BLOOD POC GLUCOS Test Complete Orders for date: 07/22/10 Test Urgency PoC BAPED STABP A Test Complete Orders for date: 07/21/10 Test Urgency POC BAPED STABP A Test Complete Orders for date: 07/09/10 Test Urgency POC ALC Test Complete Orders for date: 07/09/10 Test Urgency Dec GLUCOS Test Complete Orders for date: 01/09/10 Test Urgency Dec GLUCOS For Status Lab Order # 60069 Test Complete Orders for date: 01/09/10 Test Urgency Status	Orders for date: 07/26/20 Test Urgency Status Accession Lab Order & GOI2 Test Complete 07/26/2010 09:54 POC 0726 1 Dorder & GOI2 Test Complete 07/26/2010 09:54 POC 0726 1 Dorder & GOAC Status Accession Lab Order & GOAC Provider: USED_STUDENT Lab Order & GOAC Provider: Accession Test Urgency Status Accession Lab Order & GOAC Provider: USED_STUDENT POC BAPID STRE A Test Complete 07/21/2010 08:49 POC 0723 1 Orders & Go4ed Urgency Status Accession Lab Order & GO4ed Test Complete 07/21/2010 14:49 POC 0721 Z VENUES BLOOD Test Complete 07/21/2010 14:49 POC 0721 Z Orders & GOAC Test Complete 07/01/2010 14:49 POC 0720 I Codes for date: 07/00/2010 10:49 POC 0700 I Test Urgency Test Complete 07/00/2010 10:49 POC 0700 I Orders for date: 050/10 Test Accession Test Urg

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.

PRIVACY		PATIENT CHART WELL CHIL	D RESOURCES COMMUNICATION	
e.Chasidy Sha		Visit not selected	Primary Care Team Unaccig FOC Late (and Med) (and Visit (and Posting) Problem List Advo React	Medications
		F USER/2STUDENT		
fications Revin	1		es Wilds Assessment Orders PIEd Procedures Consults Reports Lahs	
		Patient	Location	
		DEMO, IMMUNIZATION BABY (12345)		
		HOLLOWAY.DWIGHT (100057)		
	•	FRENCH.MICHAEL JOSEPH (100073)		
		CRAFT, HEATHER JONES (100172)		
		WILNOTY, SARAH ELISABETH (101038)		
		LOCKARD, SABRINA (102029)		
		DEMARCO MELBA L (102033)		
		CASH,KATHY (102567)		
		GROENEWOLD, SALLY ANN [103300]		
		SMITH, DIANE (103404)		
		MORRIS ADAM SKYLER (103958)		
		MORRIS ADAM SKYLER (103950)		
		OSCEOLA, MARION VALERIE (104309)		
		CROWE, WILLIAM PRESTON (106047)		
		SMITH.OLLIE (106375)		
		JUMPER.SHAWNA MICHELLE (107047)		
		RATTLER, CORY BRANDON (100950)		
		JAMES, KIMBERLY ANN (109239)		
		BEECHER, DONNA K. (109327)		Process
		DEMO ALICE JANENE (109629)	INPATIENT 509-A	
		ADAMS, JOHN RAY (110259)	2.42 (2014) - 2.42	🚺 🐴
		MATHEWS, SHIRLEY HOLLARS (1107		
egend		WATTY, SHUSHANA RAIN (111613)		Selected
Priority Priority Evy Medium High High Info Only		WATTY, SHUSHANA RAIN (111613)		
		CLATTERBUCK, HEMLATABEN (114090)		D Info Only
		WOOTEN, MARILYN KAY (114361)		
		STAMPER, SHAWNENNA CARIOLINE [Forward
		DODGON.QUEDI E (116875)		
		WATTY,ELIZABETH (119668)		X Delete
		LAMBERT, TONY WAYNE (123268)	×	Show All
	1			In worke 1

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.

New Notification Patient requires another lab

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.

Legend
🔔 Priority
🖉 Low
😕 Medium
🛑 High
🤹 Info Only

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)

Process All	
Process Selected	
Process Info	
Forward	
Schedule	
 Show Hint 	
Refresh	F5

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

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 v 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.	

Table 23-1: Buttons in Process panel of Notifications tab

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.

Subject From De:	Due for Deps CHAP 35 TUDENT 00 Apr 2010 00 55
Peace cal pt retection Thanks, Phantasy	and renard her that she is due for her DICPO
	Select an action for this information only alert

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 informationonly 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.

1	Notification Recipients			
1	Users		 Recipients 	
	ADAM,ADAM ALI,JAMES ANESTHESIOLOGIST,H DENNIST(ARCH,ED BOWMAN,STEVE BROWDIE,JOHN CROCKER,BETTY CSINURSE,EIGHT CSINURSE,EIGHT	¢		
	Groups	(*)		
	A/R MANAGER A/R USER AMER ER PATIENT MERGE ALER BBOARD BEHODC PROBLEM FILE BHL	44		
[OK Ca	ncel

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.

🗢 Notification Scheduling 📃 🗖 🔀					
Scheduled Notifications —	Scheduled Notifications				
🚹 Schedule	Patient	Message			
			💠 Add		
			💻 Delete		
			🛆 Modify		
			🔁 Refresh		
			🚯 Close		

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.

Schedule a Notification on Demo,	Alice J	anene	×
Associate with Demo,Alice Janene			
Deliver on:		Priority:	
		🖉 Low	~
Subject:			
<u> </u>			
Recipients:			
USER,ZSTUDENT			
Message:			
			~
			~
	OK	Can	cel

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.

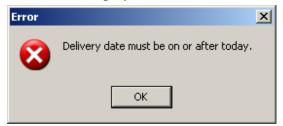


Figure 23-11: Error message for a date selected before the current date

- 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.

Notification Recipients			
Users	\$	Recipients USER,ZSTUDENT	
A/R MANAGER A/R USER AMER ER PATIENT MERGE ALER APSQ DRUG AW/P/AAC NOTIFICA BBOARD BEHODC PROBLEM FILE BHL			
		ОК	Cancel

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.

Options		
Notifications Order Checks Teams	Notes Reports	
Notifications	notification options.	
	an bulletin for flagged orders	
Surrogate Settings <u>Remove Pending Notification</u>		
Surrogate: <no designated="" surrogate=""></no>		
You can turn on or off these notification	ins except those that are mandatory.	
Alert	On/Off Comment 🔼	
Abnormal Imaging Results	Off 📃	
📃 🔲 Abnormal Lab Result (Info)	Off	
🔽 Abnormal Lab Results (Action)	On	
📃 Admission	Off	
Consult/Proc Interpretation	Off	
🔽 Consult/Request Cancel/Hold	On	
📃 Consult/Request Resolution	Off	
Consult/Request Updated	On Mandatory 💌	
	OK Cancel Apply	

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.

Surrogate for Notifications	
	<no designated="" fsurrogate=""></no>
Remove Surrogate	from: <now></now>
Surrogate:	until: <changed></changed>
	Surrogate Date Range
	OK Cancel

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.

Date Range		
Enter a date range to begin in effect. Otherwise it will all		
Start Date	Stop Date	
	OK Cancel	

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.

Surrogate for Notifications	
	User,Zzcstudent
Remove Surrogate	from: <now></now>
Surrogate:	until: <changed></changed>
User,Zzcstudent 🕞	Surrogate Date Range
	OK Cancel

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.

Options		×		
Notifications Order Checks Teams	Notes Reports			
Notifications		_		
Change your r	notification options.			
📃 🐷 🔲 Send me a MailMa	n bulletin for flagged orders			
Surrogate Settings	Surrogate Settings Remove Pending Notification			
Surrogate: <no designated="" surrogate=""></no>				
You can turn on or off these notification	ns except those that are mandatory.			
Alert	On/Off Comment	<u> </u>		
Abnormal Imaging Results	Off			
Abnormal Lab Result (Info)	Off			
🛛 🗹 Abnormal Lab Results (Action)	On			
🗌 🔲 Admission	Off			
Consult/Proc Interpretation	Off			
🔽 Consult/Request Cancel/Hold	On			
Consult/Request Resolution	Off			
🔽 Consult/Request Updated	On Mandatory	~		
L	OK Cancel Apply			

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.

Surrogate for Notifications	
	User,Zzcstudent
Remove Surrogate	from: <now></now>
Surrogate:	until: <changed></changed>
User,Zzcstudent 🕞	Surrogate Date Range
	OK Cancel

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.

Surrogate for Notifications	
	<no designated="" fsurrogate=""></no>
Remove Surrogate	from: <now></now>
Surrogate:	until: <changed></changed>
	Surrogate Date Range
	OK Cancel

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 LocationAdd 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	

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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.

A-663 (ANQ) rev. 5/05 COMMUNIT Clinic Code	Y HEALTH AIDE/PRAC	TITIONER PATIEN		FORM	Medicald: o AU o AY APL DIS Initial/Cod
Hx of Present Illness:	Notes Tab. History Te	mplate		CHOOSE TH	
Allergies: Past Healt Other Hbc Notes Ta	t meds. Compare to Me he in CC/HPI Tab. th Hx Tab. Adverse Reac b. History Template Past Health Hx	tions panel (Tab. Exams pan		munization stat	LMP: Past Health Hx Tab. If Pre Personal Health pane us: IMM Tab PPD status: Rcco : Past Health Hx Tab. Health Factors pane
Vital Signs: Head: Eyes: Ears: (l) Nose/Sinus: Mouth/Throat: Neck/Nodes: Back: Lungs/Chest: Heart: Breasts: Abdomen: Genital/Rectal:	varance: Notes Tab. Exa Vitals Tab otes Tab. cam Template	m Template		Snellen Test:	Vitals Tab
Extremities: Nervous System: Skim: Lab Tests/Results: ASSESSMENT PLAN Pt. Education: Medicines: Special/Other Care: Recheck/Follow-up: Date:	Orders Tab. Medicin Notes Tab. Lab Asso	nes for CHAM		Tab	Immunizations given: Initials/Vaccine/Lot # () IMM Tab for () IMM Tab for Immunizations TB Skin Test () PPD 0.1 ml () PPD mm (when reed) on: / /
Narme: (L) Normal Clinic Hrs o	Patient SS #: Rev I on SS #: den ar to (F) info name. Age: .	nographic prmation. 0	Doctor: Dr.'s Assessme CHAM Plan Pag CHA/CHP: Village: Visit panel	tab Asse Template	b. ssment Plan

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 L	AB BLOOD DRAW ONLY ENCOU	NTER
DEMO, PATIENT A	DULT MALE	AUG 15, 2011
CC/HPI: Chief Complain Fitch	t: 54 y/o male here toda	y for blood draw, ordered by Dr.

CHA/P Getting Started Guide September 2011

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 forvaccination	
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:
```

CHA/P Getting Started Guide September 2011 Immunization-only Visit

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 0–10	
Cervix Dilatation (CXD) Edema (ED)		
Effacement (EF)	0, 1+, 2+, 3+, or 4+ 0–100	
Fetal Heart Tones (FT)	0–400 (whole number) 0–100 in.	
Fundal Height (FH)	10–100 m.	
Head Circumference (HC)		
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	Сору
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 [
I need to rearrange my sentence.	This happens very frequently. To switch the subject and the object or simply move the verb. Use Ctrl+[III to move to the word(s) to be moved. Just before the word(s), hold Shift, and continue to use Ctrl+[IIII to highlight the text. When finished Highlighting, press Ctrl+X to cut, then move the cursor with Ctrl+[IIII or Ctrl+[IIII (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

СНАМ

Alaska Community Health Aide/Practitioner Manual

СНАР

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.

HΧ

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