

Touchworks Training

Patient Intake Process

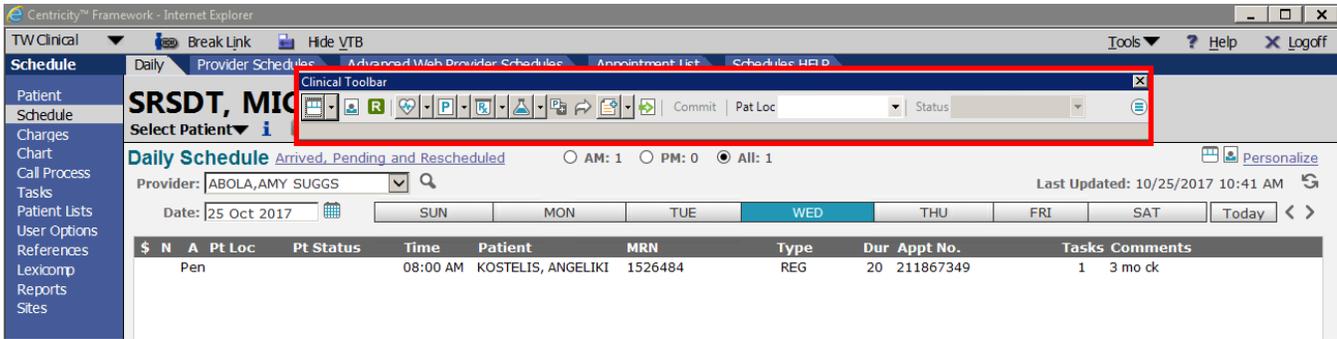


A guide to Sharp Rees-Stealy's
Ambulatory Electronic Health Record (EHR)

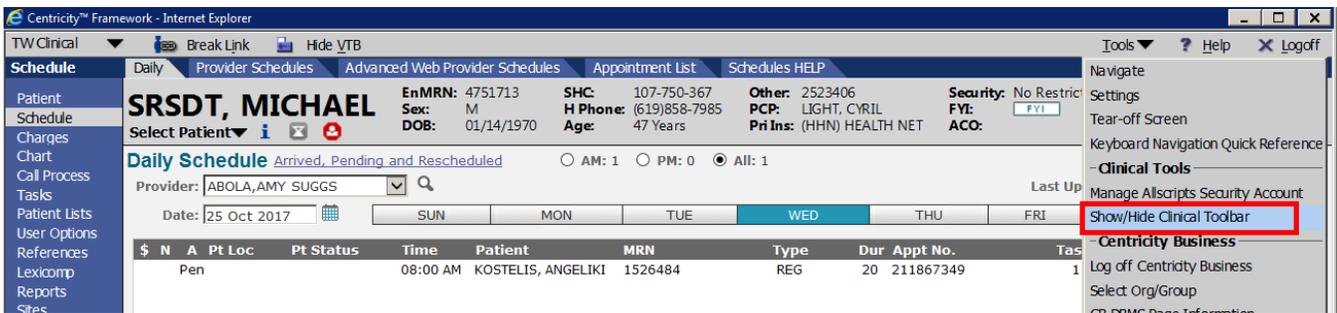
Table of Contents

The Floating Clinical Tool Bar.....	3
Schedules.....	4
Patient Banner Bar.....	6
Patient Profile.....	8
Appointment Details.	9
FYI Button.	10
Chart.	12
Patient Intake Form.....	13
Starting a New Provider Note.	15
Note Authoring Window.	16
Chief Complaint.	17
Medication History.	18
Edit Medication.	21
Remove Medication	22
Renew Medication.	23
Print Medication List.	25
Allergies.	26
Med/Allergy Reconciliation.	30
Adding a Pharmacy.	31
Vitals.	33
Meaningful Use Guidelines.	35
Social History.....	39
Sign as Co-Participant.	42

The Floating Clinical Tool Bar

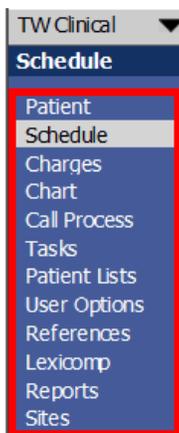


The Clinical Tool Bar allows users to quickly access chart information, medications and problems. The tool bar can be dragged to different positions on the screen by using the mouse.



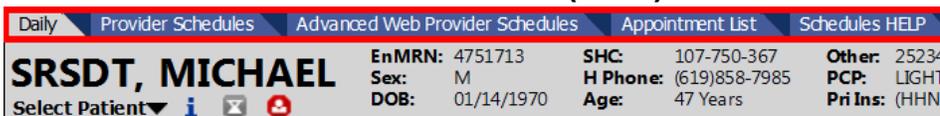
To bring the Clinical Tool Bar back, click Tools, then click Show/Hide Clinical Toolbar

Vertical Tool Bar (VTB)



The VTB contains a vertical list of menu items on the left hand side

Horizontal Tool Bar (HTB)

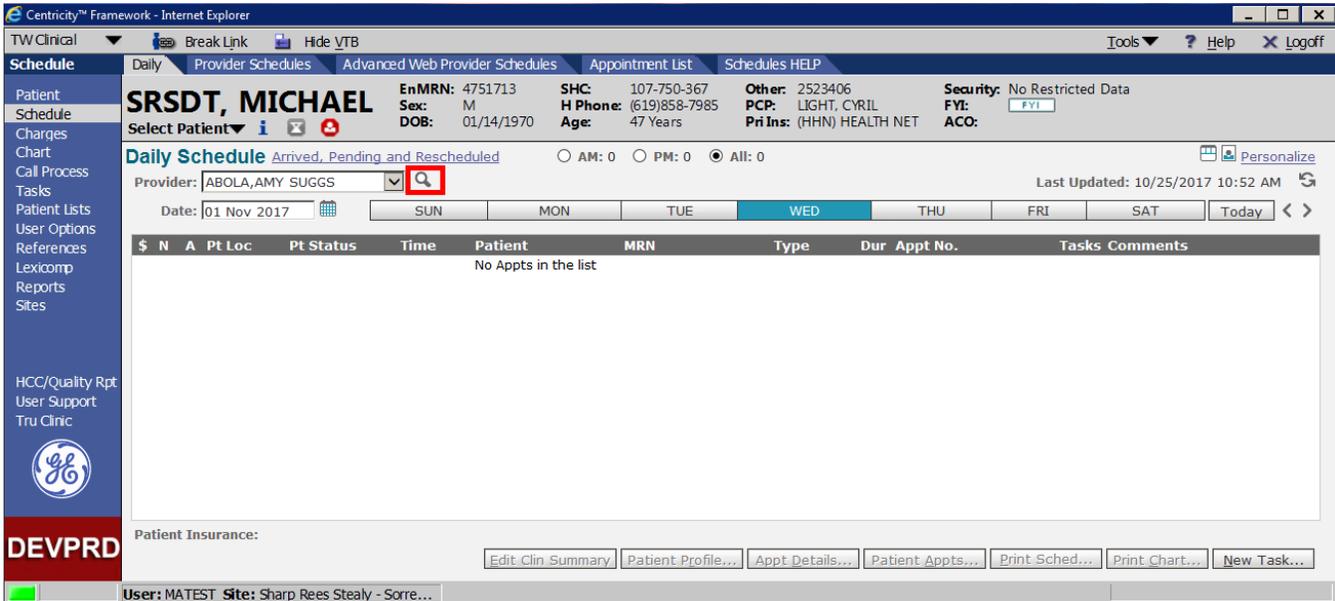


The HTB contains submenus across the top for the items listed from the VTB.

Schedules

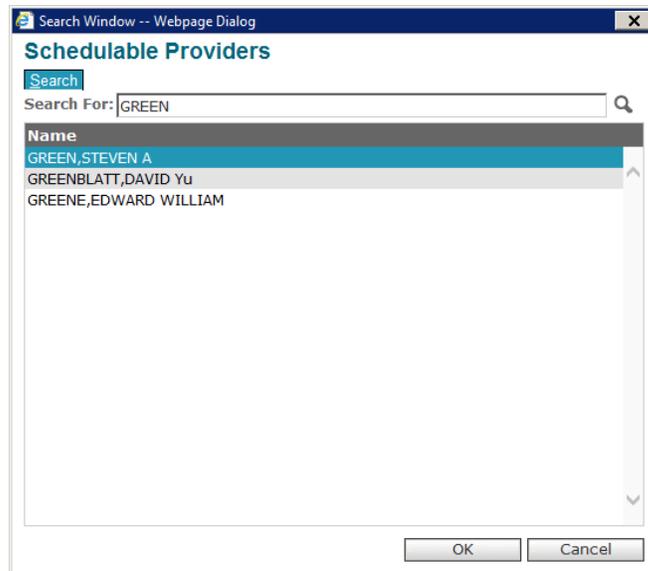
To select a Provider's schedule:

1. Click 



The screenshot shows the 'Daily Schedule' page for patient SRS DT, MICHAEL. The 'Provider' dropdown menu is open, and a magnifying glass icon is visible next to the search field. The search results show 'ABOLA, AMY SUGGS' as the selected provider. The page also displays patient information, including EnMRN, Sex, DOB, SHC, H Phone, Age, Other, PCP, Pri Ins, Security, FYI, and ACO. The 'Daily Schedule' section shows 'No Appts in the list' for the selected date (01 Nov 2017) and day (WED).

2. Type the provider's name in **Search For:** 
3. Click 
4. Highlight the provider and click

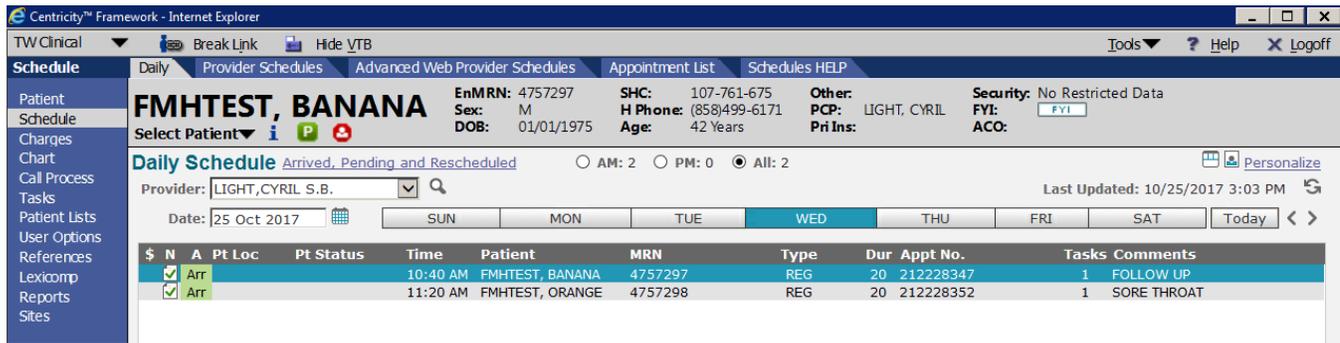


The screenshot shows a 'Search Window -- Webpage Dialog' titled 'Schedulable Providers'. The search field contains 'GREEN'. The results list includes 'GREEN, STEVEN A', 'GREENBLATT, DAVID Yu', and 'GREENE, EDWARD WILLIAM'. 'GREEN, STEVEN A' is highlighted. The dialog has 'OK' and 'Cancel' buttons at the bottom.

- The Providers Schedules tab allows the user to see up to 4 provider schedules.
- To select a default provider, click the [Personalize](#) hyperlink.

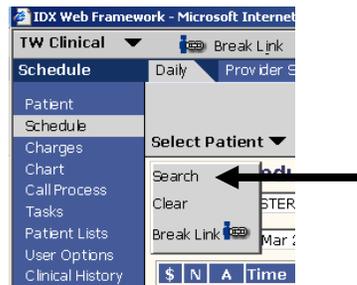
Patient Banner Bar

- The Patient Banner Bar populates by single clicking on a patient in the schedule or searching for a patient using the Select Patient Prompt on the Patient Banner Bar.



- To search for a patient not on the provider's schedule, click on

Select Patient ▼



- Click on Search.



- Search for patient by MRN, Name, Partial Name, Phone or SSN.
- When the Patient Banner Bar is populated with a patient name from the schedule, the buttons on the bottom of the screen will be enabled.

TW Clinical P4

Schedule Daily Provider Schedules IDX Sched

Tools Help Logoff

Patient **Vader, Darth** EnMRN: 50044401 SHC: 900-444-001 Other2: FYI
 Schedule Sex: M Age: 51 Years PCP: FAMILYPRACTICE, MD Pri Ins: MEDI-CAL
 Charges Select Patient i DOB: 12/23/1955 H Phone: (555)381-2436 Security: No Restricted Data

Daily Schedule Arrived, Pending and Rescheduled Personalize

Provider: RHEUMATOLOGY, MD All AM: 20 PM: 16 Total: 36 Last Updated: 10/15/2007 1:56 PM

Date: 15 Oct 2007 Sun Mon Tue Wed Thu Fri Sat

\$	N	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Appt No.	Task
		Arr			08:00 AM	Vader, Darth	50044401	CON	15	5004440168166800234	69
		Arr			08:15 AM	Krueger, Freddy	50044402	EST	15	500444026906800234	59
		Arr			08:30 AM	Vorhees, Jason	50044403	NV1	15	500444036996800234	75
		Arr			08:45 AM	Evil, Doctor	50044404	OFV	15	500444047086800234	54
		Arr			09:00 AM	Goldfinger, Auric	50044405	T1M	15	500444057176800234	45
		Arr			09:15 AM	Witch, Blair	50044406	OFV	15	500444067266800234	58
		Arr			09:30 AM	Meyers, Michael	50044407	CON	15	500444077356800234	50
		Arr			09:45 AM	Winters, Oldman	50044408	T1M	15	500444087446800234	59
		Arr			10:00 AM	Terminator, The	50044409	INJ	15	500444097536800234	55
		Arr			10:15 AM	Lecter, Hannibal	50044410	EST	15	500444107626800234	53
		Arr			10:30 AM	Gruber, Hans	50044411	CON	15	500444117716800234	50
		Arr			10:45 AM	Dracula, Count	50044412	OFV	15	500444127806800234	50
		Arr			10:45 AM	Voldemort, Lord	50044432	CON	15	500444327806800234	16
		Arr			11:00 AM	James, Jesse	50044433	OFV	15	500444337896800234	16
		Arr			11:00 AM	Bates, Norman	50044413	PE1	15	500444137896800234	45
		Arr			11:15 AM	Ratched, Nurse	50044414	T1M	15	500444147986800234	34
		Arr			11:30 AM	Nine, Hal	50044415	OFV	15	500444158076800234	16
		Arr			11:30 AM	Jones, Flattop	50044434	EST	15	500444348076800234	16
		Arr			11:45 AM	Ivy, Poison	50044435	NV1	15	500444358166800234	16
		Arr			11:45 AM	Torrance, Jack	50044416	OFV	15	500444168166800234	22

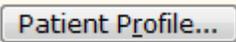
Patient Insurance: MEDI-CAL

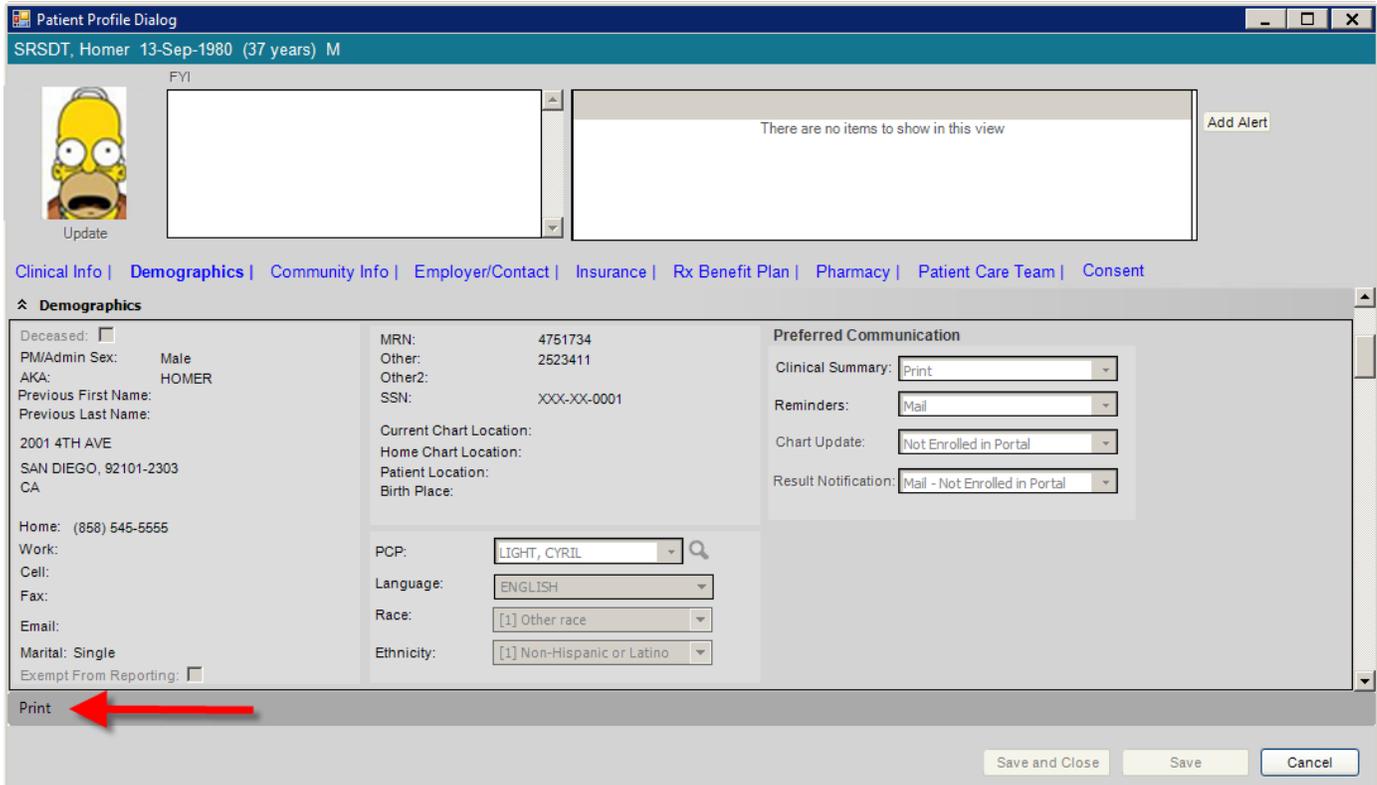
[Patient Profile...](#)
[Appt Details...](#)
[Patient Appts...](#)
[Print Sched...](#)
[Print Chart...](#)
[New Task...](#)



Patient Profile



- To view the Patient Profile, click on the  icon on the Patient Banner Bar -or- Click on the  button at the bottom of the screen



- The demographic page will appear and can be printed by clicking on <Print>.

Appointment Details

Appointment Details

Patient Information

Patient: SRSDT, HOMER
MRN: 4751734

Appointment Information

Appt No: 212042602 Type: REG
Date: 09/28/2017 Duration: 20
Time: 02:40 PM Location: SORRENTO MESA
Status: Pen Department: FAMILY PRACTICE
Provider: LIGHT, CYRIL
Referring:
Reason:

Comment: BACK PAIN

Close

- Click on the **Appt Details...** button to see the details of the current appointment.

Patient Appointments

- Click to see a list of the patient's appointments.

Patient Appointments

Patient: SRSDT, HOMER

Date	Time	Status	Provider	Department	Type	Appt No
09/28/2017	02:40 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042602
09/22/2017	02:30 PM	Pen	ALBERTON,GREGORY	ORTHOPEDICS	IWC	212042524
09/21/2017	02:40 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042601
09/14/2017	02:40 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042600
09/13/2017	09:40 AM	Pen	GARAY,ALON	ORTHOPEDICS	IWC	212042515
09/07/2017	02:40 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042599
09/01/2017	08:40 AM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042447
08/31/2017	02:40 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042598
08/24/2017	02:40 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042597
08/10/2017	03:20 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042596
08/08/2017	09:20 AM	Can	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042783
08/07/2017	05:40 PM	Can	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042661
08/04/2017	10:00 AM	Pen	WRIGHT,CHERYL	RHEUMATOLOGY	CON	212042532
08/04/2017	10:00 AM	Pen	WRIGHT,CHERYL	RHEUMATOLOGY	CON	212042540
08/03/2017	03:00 PM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042595
08/03/2017	01:00 PM	Bmp	BROWN,DANIEL	INTERNAL	REG	212042477
08/03/2017	08:20 AM	Pen	LIGHT,CYRIL	FAMILY PRACTICE	REG	212042547

Appt Details... Close

For Your Information (FYI) Button

SRS DT, HOMER EnMRN: 4751734 SHC: 107-750-396 Other: 2523411 Security: No Restricted Data
Sex: M H Phone: (858)545-5555 PCP: LIGHT, CYRIL FYI:
DOB: 09/13/1980 Age: 37 Years Pri Ins: HEALTH NET ACO:

- The button in the patient banner bar can be used to communicate important information to other staff members viewing the patient.

Note: This information is not a part of the patient's chart

FYI -- Webpage Dialog

FYI

NOTE: Entries in the box below are not part of the patient's medical or billing record and should not be used as such. The current version is saved in the system and is accessible by other users.

Patient requires large room for wheelchair access

OK Cancel

- After clicking OK, the button will change from white to yellow on the Patient Banner Bar.

Examples of FYI Comments:

- Patient requires large room for wheelchair access
- Patient requires Spanish translator

FYI Standards – Rules and Guidelines

The FYI will be owned by the clinical staff. The nurse will notify the physician if there is information in the FYI button he/she should review. Information will be entered by the clinical staff using the IPC project tools used currently. Training involved for all clinical staff will be done by a clinical lead.

Information entered in the FYI is discoverable, do not use inappropriate content or language. Proper “task etiquette” should be used. Follow this basic rule:

“If you don’t have anything nice to say, don’t say anything at all”

What should the FYI be used for?

IPC (Individualized Patient Care) capturing specific data from the patient NOT related to his/her medical condition. This information is used to increase Patient Satisfaction.

- Patient doesn’t like to be left alone in the exam room
- Patient recently returned from Italy
- Patient recently lost mother
- Patient just bought a new car
- Patient will need a wheelchair
- Patient is a great golfer

What should it NOT be used for?

1. Anything related to the patients medical condition
 - Patient is due for a pap smear
 - Patient is allergic to sulfa medications
 - Patient is HIV positive
2. Inappropriate comments
 - Patient was very annoying
 - Patient smells horrible
 - Patient is weird

How should info be entered?

1. Information should be entered as seen below (date, info, user name):
 - 05/04/07 “Patient...” RAZCR
2. Items will be in chronological order, most recent updates to be at the top

Who to contact if the information entered is questionable?

Staff should contact their supervisor or manager. Staff should provide:

- Patient name
- Patient MRN

Chart

Centricity™ Framework - Internet Explorer

TW Clinical

Chart

SRSDT, HOMER

EnMRN: 4751734 SHC: 107-750-396 Other: 2523411 Security: No Restricted Data

Sex: M H Phone: (858)545-5555 PCP: LIGHT, CYRIL FYI: FYI

DOB: 09/13/1980 Age: 37 Years Pri Ins: (HHN) HEALTH NET ACCO:

Clinical Staff View

Medications

Active

- Aspirin 81 MG Oral Tablet Chewable; CHEW AND SWALLOW 1 TABLET DAILY; Therapy: (Recorded:08Nov2017) to Recorded
- Lasix 20 MG Oral Tablet (Furosemide); TAKE 1 TABLET DAILY AS DIRECTED; Therapy: (Recorded:08Nov2017) to Recorded
- ProAir HFA 108 (90 Base) MCG/ACT Inhalation Aerosol Solution; INHALE 1 PUFF EVERY 4 HOURS AS NEEDED; Therapy: (Recorded:08Nov2017) to Recorded

Unauthorized - Requires Signature

- Montelukast Sodium 4 MG Oral Tablet Chewable; CHEW AND SWALLOW 1 TABLET DAILY; Last Rx:08Nov2017 Ordered

Allergies

Medication

Penicillins ; Rash;

Chart Viewer

Progress Note (Office Visit) - LIGHT, CYRIL S.B.; Enc: 28-Sep-2017 - Appointment - LIG

Encounter Forms

Encounter Form - LIGHT, CYRIL S.B.; Enc: 28-Sep-2017 - Appointment - LIGHT, CYRIL S.

User: MATW18 Site: Sharp Rees Stealy - San D... Enc Date: 28 Sep 2017 03:00 PM Enc Type: Appointment

- The Clinical Desktop is comprised of 3 panes in one workspace.
- There are tabs within each pane.
- To view one full screen pane at a time, click on the  icon in the upper right corner.

Double click on an item in the chart to display the selected information.

Note Viewer

SRSDT, HOMER 19 YO M DOB: 23Dec1994 Appointment 6/11/2014

Type: Progress Note

Owner: GRANT,JOHN J Status: Signed

Patient

BRENEN SRSDT DOB: Dec 23 1994 Gender: M

SHC#: 107118082

Provider: JOHN GRANT

DOS: 06/11/2014

Current Meds

Lasix 20 MG Oral Tablet (Furosemide); TAKE 2 TABLETS DAILY.; RPT

Tropicamide 1 % Ophthalmic Solution; USE AS DIRECTED.; RPT

A-D Prevent External Ointment; APPLY AS DIRECTED.; RPT.

Allergies

Ambien CR TBGR; Ataxia

Latex

Nuts

Penicillins; Bradycardia.

Med/Allergy Rec

Medications and allergies reconciled, including those medications given at discharge where applicable. The patient's medication list has been updated accordingly.

Vital Signs

Vital Signs Recorded by TESTMA, MATW7 Z on June 11,2014 10:16 AM

BP: 128/42 mm Hg LLE Sitting

Blood Pressure Not Obtained: Refused;

HR: 88 b/min Apical;

Resp: 19 /min ;

Temp: 98.5 F Axillary

Height: 73 in, Weight: 250 lb, BMI: 32.98 , BSA: 2.37 ; BMI Percentile 98 %; 2-20 Weight Percentile 99 %; 2-20 Stature Percentile 89 %

Signature

Electronically signed by :MATW7 Z TESTMA MA; 06/11/2014 10:20 AM PST; Author.

Edit Print Fax Sign Task Attach To Result Enter in Error Copy Fwd Copy Sel. Fwd Copy Doc CB Copy Sel. CB Document Hx

PATIENT INTAKE FORM

<i>INTERNAL USE ONLY</i> *BMI: _____		
BP: _____	T: _____	Ht: _____
P: _____	R: _____	Wt: _____

At Sharp Rees-Stealy, it is important that your concerns are heard.
Please complete the information below to assist us with your visit today.

My major concern today is:

If time permits, other issues I would like to discuss are:

	YES	NO	
Do we need to update your address or phone #?			New #/Address:
Do you need a note for work/school or any other form?			
Do you need medications refilled?			Name of medication(s):
*Do you use any tobacco products?			Type of tobacco:
*Have you recently received care such as inpatient hospitalization, ER visits, Urgent Care visits, nursing home stays, or visits with other physicians?			Which facility:
You can now get a summary of today's visit through our patient portal. If you aren't already signed up, would you like more information?			

If you are 64 years of age or younger, STOP here.



If you are 65 years of age or older, please complete the two questions below:

***Question #1: Fall Screening**

	YES	NO
1. Have you fallen in the last calendar year?		
a. If yes, how many times? _____		
b. Were you injured?		

***Question #2: Depression Screening**

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the day	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3



INTERNAL USE ONLY

FOR OFFICE CODING ONLY ADD QUESTIONS 1 & 2 FROM PAGE 1	_____ + _____ + _____ + _____ = TOTAL SCORE: _____
---	---

	Not at all	Several days	More than half the day	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

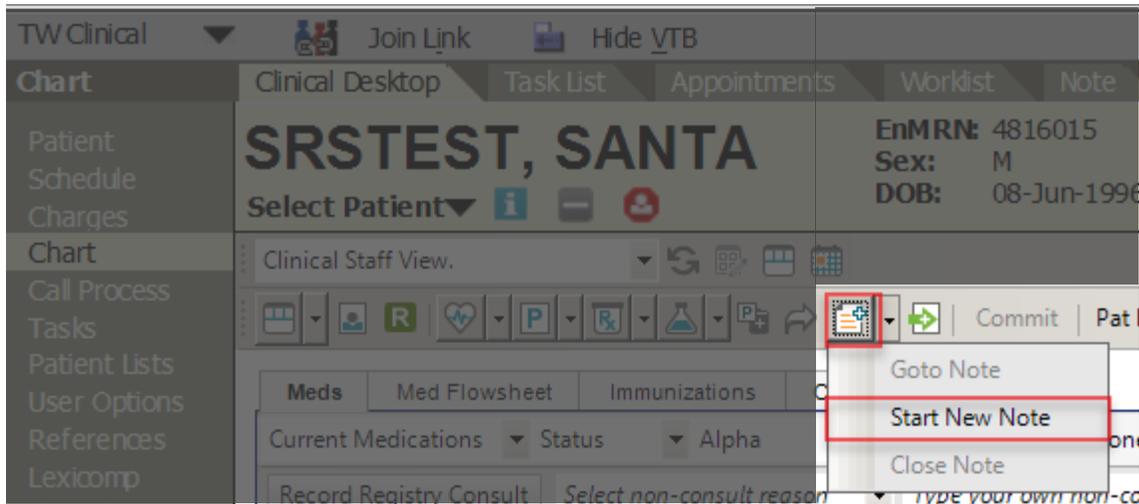
FOR OFFICE CODING ONLY ADD QUESTIONS 1-9 FROM PAGES 1 & 2	_____ + _____ + _____ + _____ = TOTAL SCORE: _____
--	---

INTERNAL USE ONLY	
<u>Pain Scale (Provider use only):</u> _____	
<u>Depression Screening:</u>	Provider action needed?
Depression on problem list? (YES/NO) If yes, skip question <i>(Document once a calendar year)</i>	YES NO
<u>Fall Screening:</u>	
Criteria 65+: If 2 or more falls or 1 fall with injury <i>(Document once a calendar year)</i>	YES NO
<u>BMI Screening:</u>	
18-64 years: If <18.5 or ≥25 provider action needed <i>(Document Wt & Ht every 6 months)</i>	YES NO
65+ years: If <23 or ≥30 provider action needed <i>(Document Wt & Ht every 6 months)</i>	YES NO
<u>Transitions of Care 65+:</u>	
Patient outside SRS or doesn't share same E.H.R.	YES NO
<u>Social History:</u> Smoking status documented changed or unchanged <i>(Document once a calendar year)</i>	YES NO
Patient education material provided <i>(Document once a calendar year)</i>	MD CS

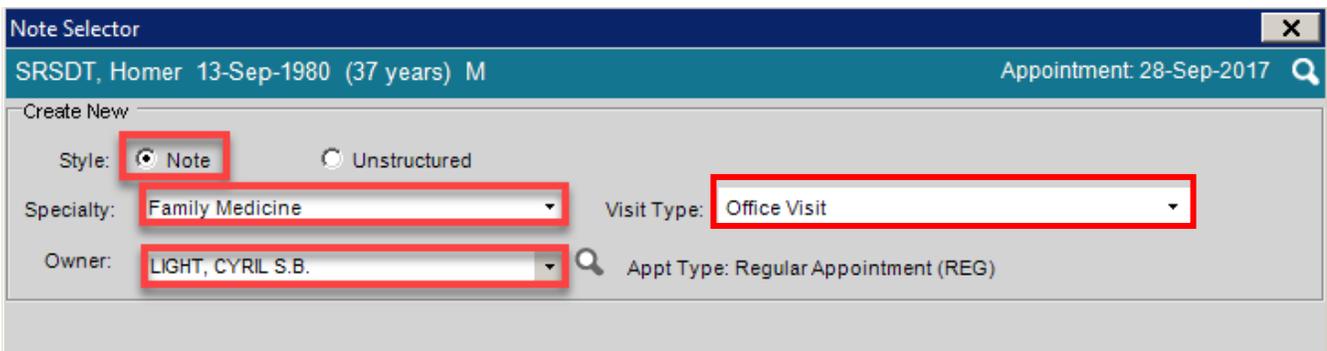


Starting a New Provider Note (V11 Note)

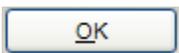
- To begin a note, start by **double-clicking**  on the patient from the schedule.



- Click the arrow beside the Note icon  and select Start New Note

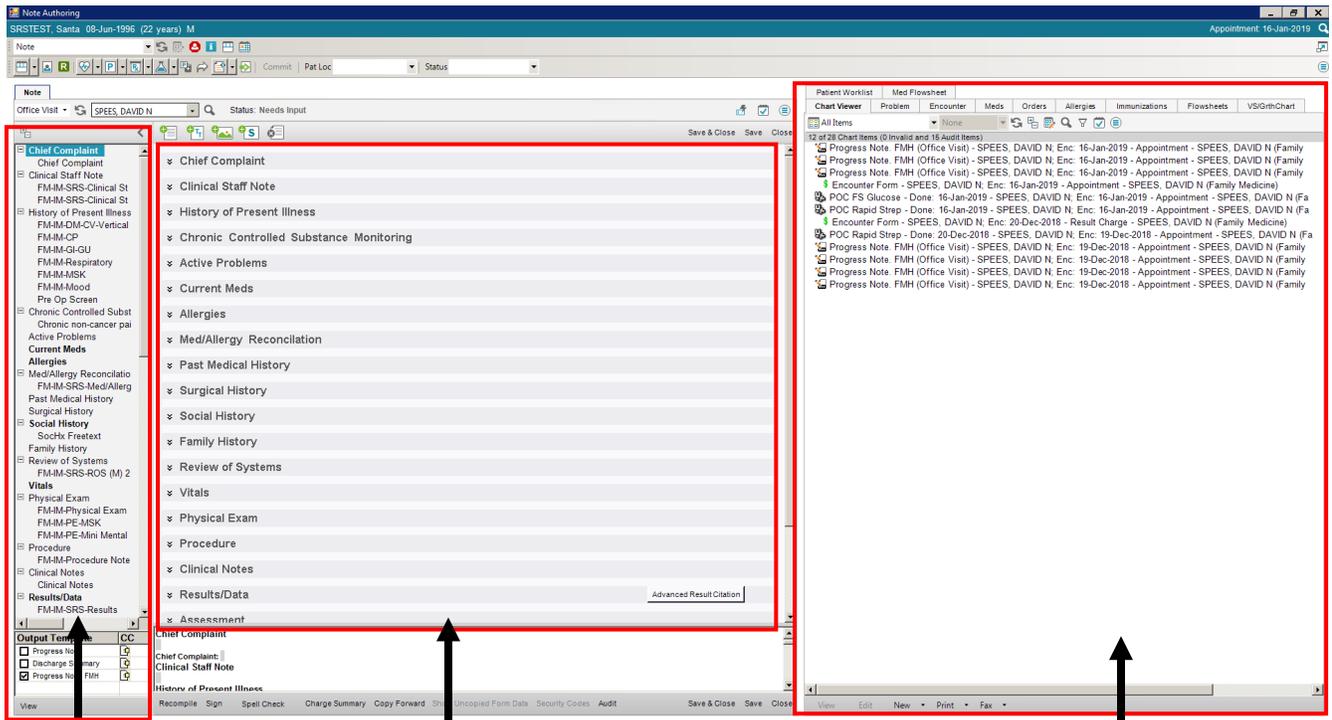
The screenshot shows the 'Note Selector' dialog box. The patient information is SRSDT, Homer, 13-Sep-1980 (37 years) M, and the appointment is on 28-Sep-2017. The 'Create New' section has the following fields: 'Style' is set to 'Note' (radio button selected), 'Specialty' is 'Family Medicine', 'Visit Type' is 'Office Visit', and 'Owner' is 'LIGHT, CYRIL S.B.'. The 'Appt Type' is 'Regular Appointment (REG)'. Red boxes highlight the 'Style', 'Specialty', 'Visit Type', and 'Owner' fields.

Select the correct fields in Note Selector:

- Select "Note" if not defaulted
 - Select Specialty
 - Select Visit Type
 - Select Owner
- Click 

Note Authoring Window

- A separate window will pop-up called 'Note Authoring'



Note Contents
(Same info in each box)

Patient's Chart

Complete Note by completing designated fields

- **Clinical Staff Note**
- **Medications**
- **Allergies**
- **Med/Allergy Reconciliation**
- **Pharmacy**
- **Height/Weight/Vitals**
- **Meaningful Use Guidelines**

Note: Review at your site which fields to populate. Some departments may be required to complete additional fields

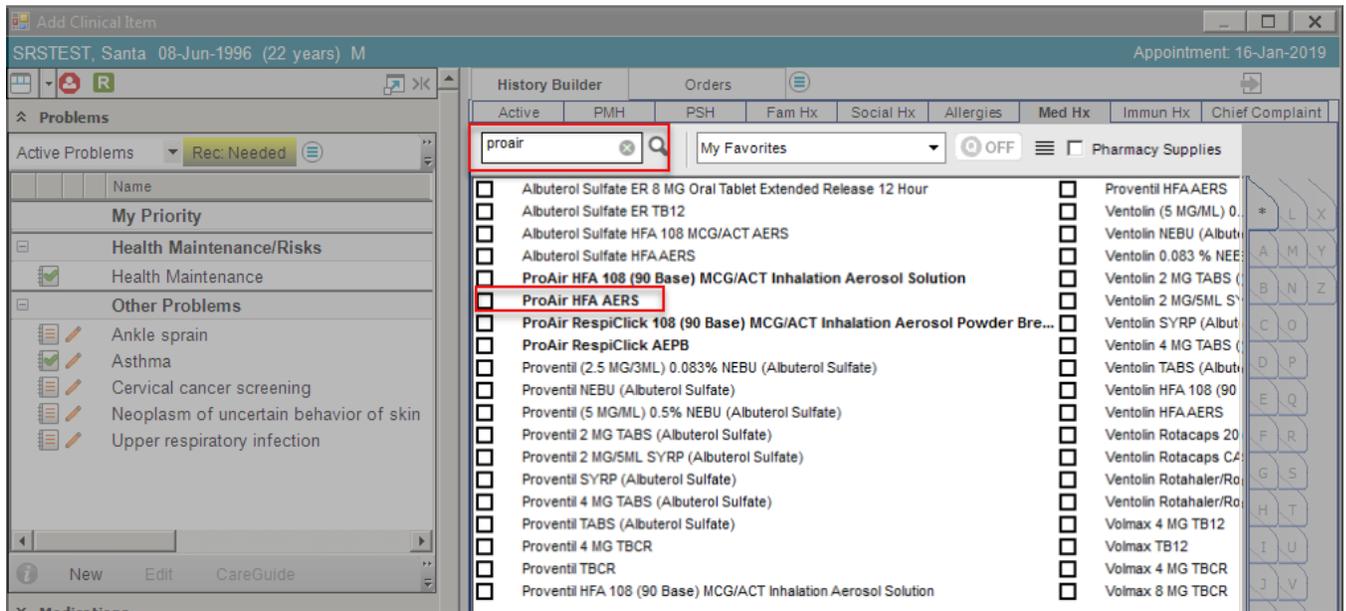
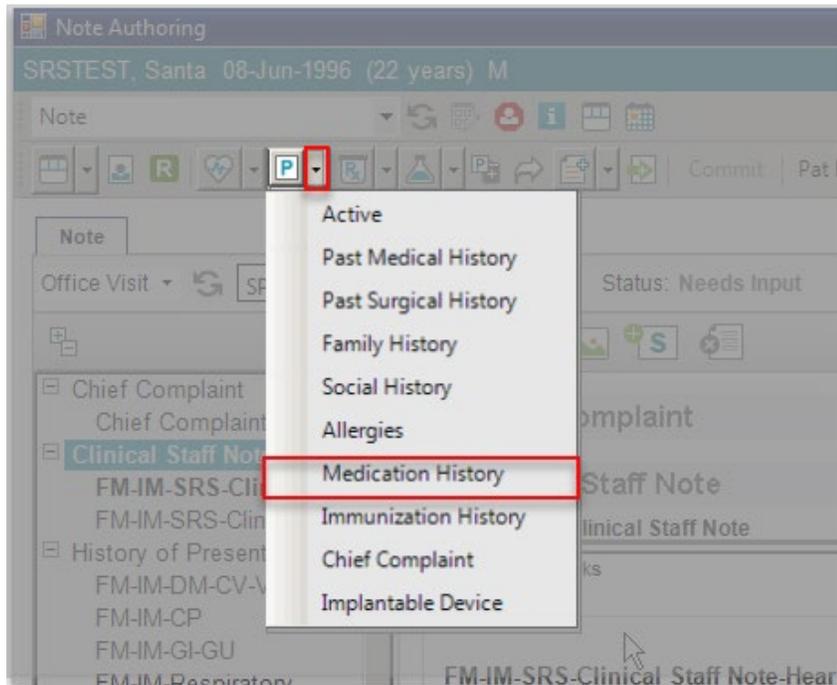
Reason for Visit

The screenshot shows a medical software interface for note authoring. At the top, the patient information is displayed: SRSTEST, Castle, 18-Jun-1976 (43 years) F. The note title is 'Office Visit' and the author is 'SPEES, DAVID N'. The status is 'Needs Input'. The left sidebar contains a list of medical categories, including 'Chief Complaint', 'Clinical Staff Note', 'History of Present Illness', 'Chronic Controlled Subst', 'Allergies', and 'Past Medical History'. The main content area shows a 'Chief Complaint' field with the text 'Cough x2 weeks'. An arrow points to this field.

- Click into the free-text **Chief Complaint** field and enter the patient's chief complaint(s)

Medication History

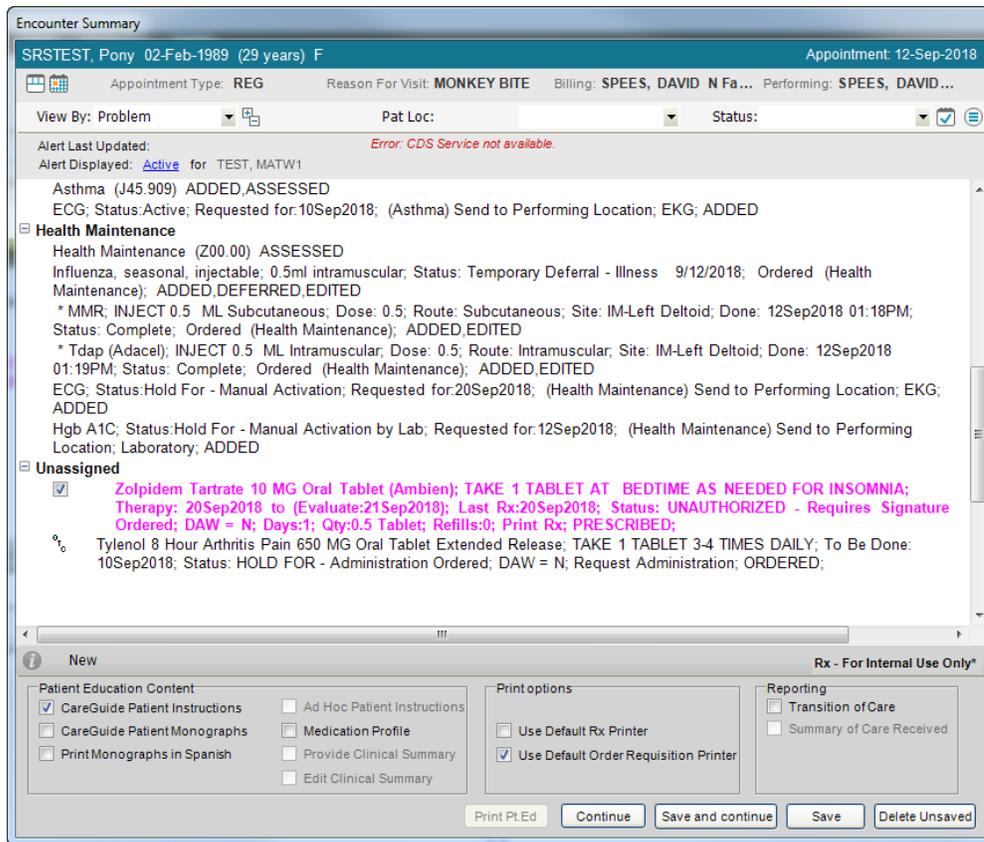
- Click the arrow beside the P (Problem)  icon
- Select **Medication History**



- In the search text box. Type in all or part of the medication name.
- **Double-Click**  on the medication name.

- Select the appropriate Sig and click the **Save and Close ACI** button.

- The added Medication History will be pink until it is saved.
- To save the information, click on the **Commit** button.
- Once you click **Commit**, you will get an “Encounter Summary” pop-up window
- Click **Save and Continue**



This allows you to verify the information that was entered before it is saved in the patient's chart.

Continue – will **close** the Encounter Summary window **without saving** the information. The information will remain pink

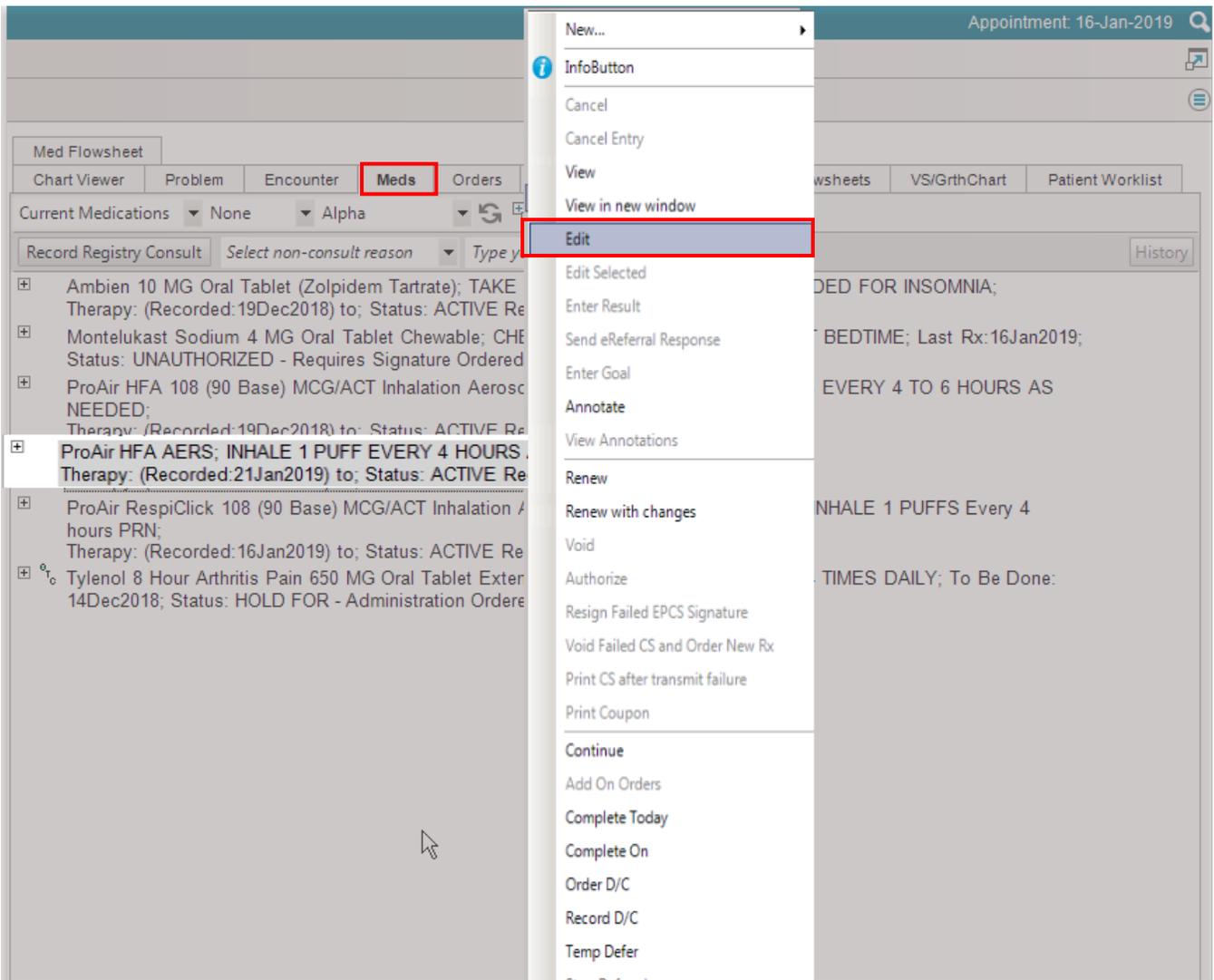
Save and continue – will **save** the information and **close** the Encounter Summary window. The information will no longer be pink

Save – will **save** the information and keep the Encounter Summary window **open**. The information will no longer be pink.

Delete Unsaved – will **delete** the information without saving and **close** the Encounter Summary window. The information will be removed from the patient's chart.

Edit Medication

- Right click on the medication and click **Edit**



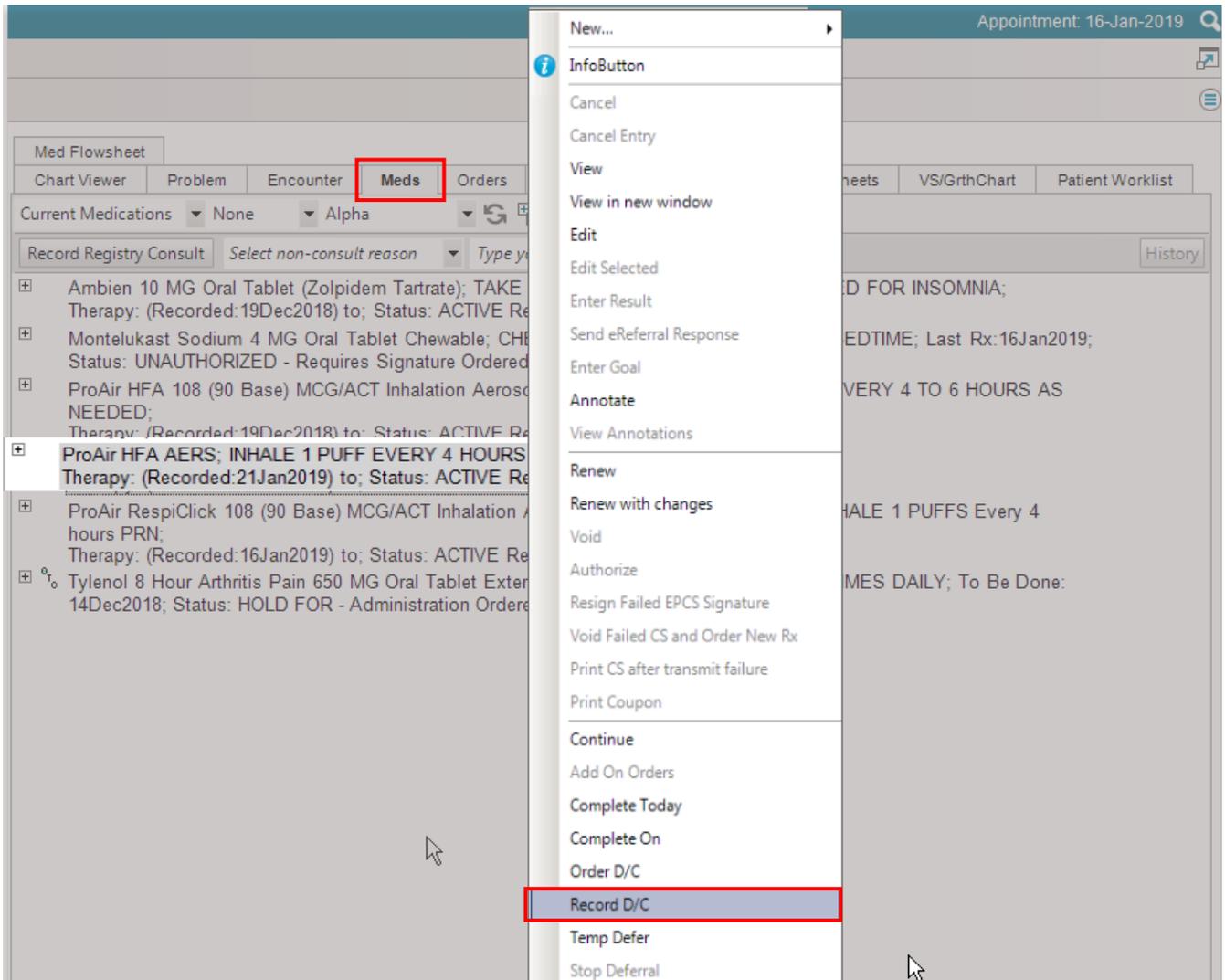
- The edited Medication will be pink until it is saved.
- To save the information, click on the **Commit** button.
- Once you click **Commit**, you will get an “Encounter Summary” pop-up window
- Click **Save and continue**

Remove Medication

Inform the provider if the patient is no longer taking a medication that is on their medication list. **DO NOT** remove the medication unless instructed by the provider.

The provider will consult with the patient and either remove the medication or instruct you to remove it.

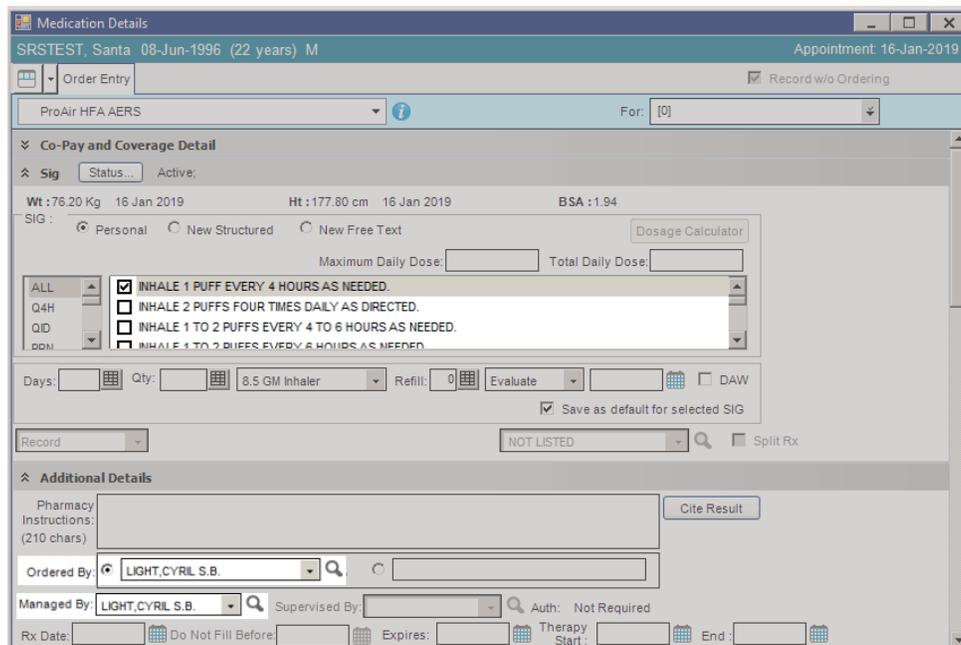
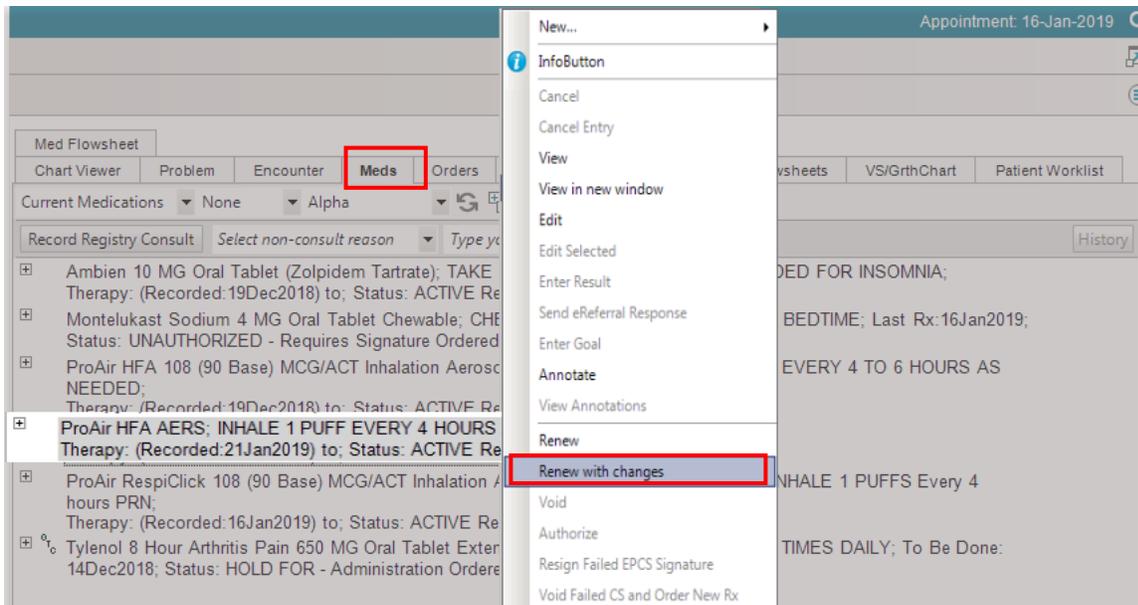
- Right click on the medication and click **Record D/C**

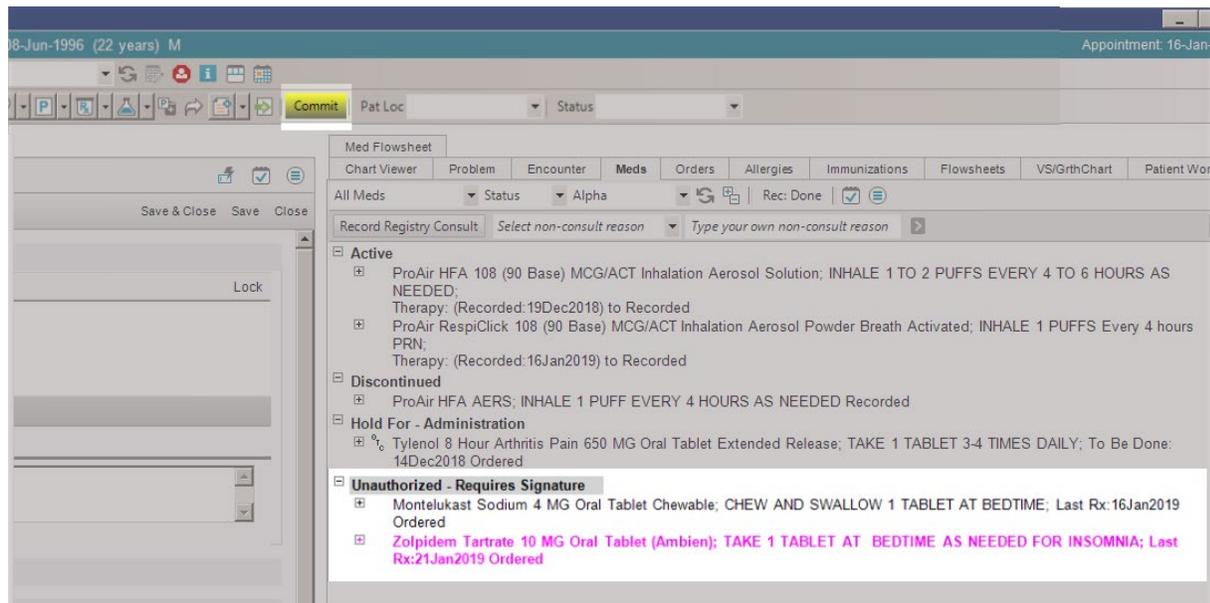


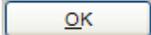
- To save the information, click on the **Commit** button.
- Once you click **Commit**, you will get an “Encounter Summary” pop-up window
- Click **Save and continue**

Renew Medications

- Right click the name of the medication to refill and click on **Renew with Changes**.





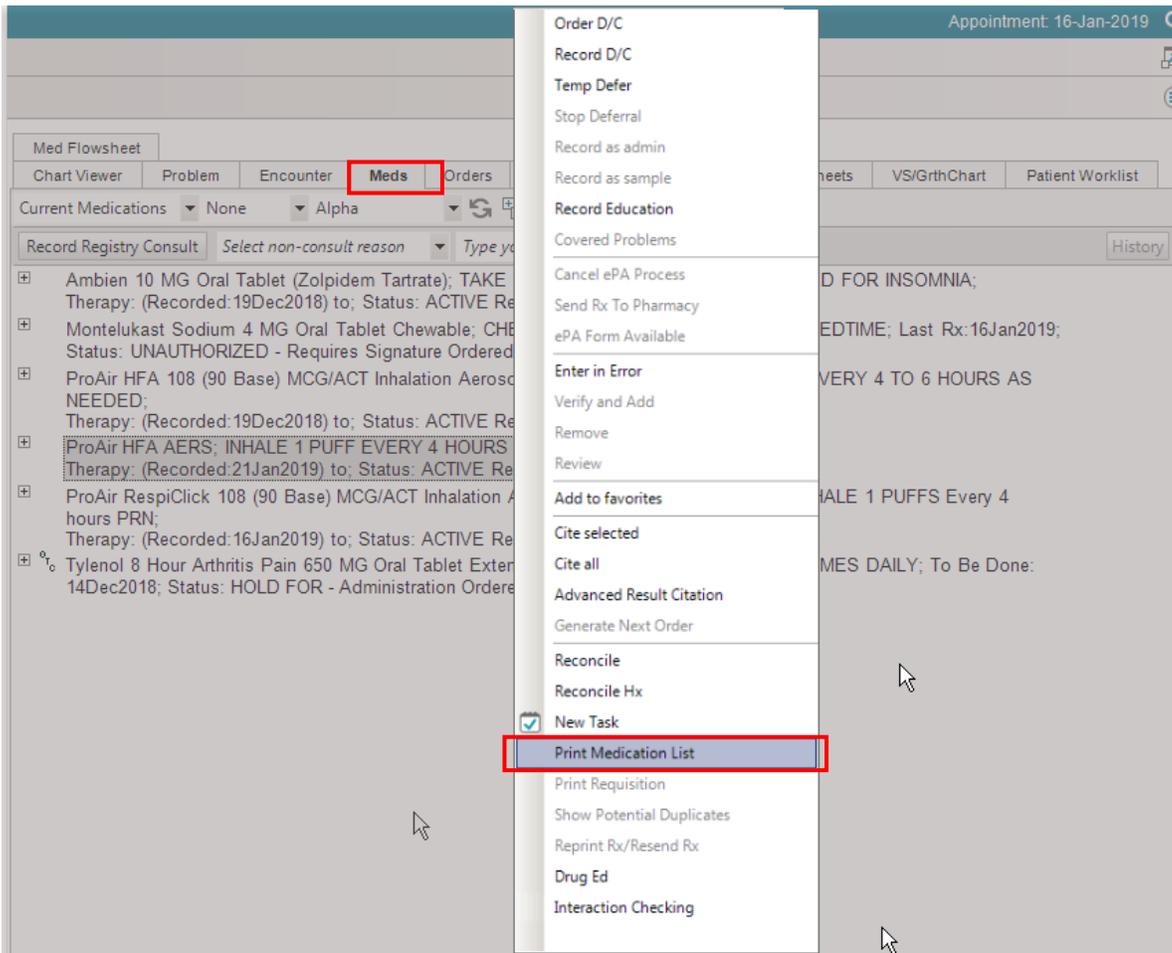
- Click 
- Click  to save
- Click 

What do the faces mean?

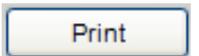
-  Medication is covered by insurance with a co-payment.
-  Medication is covered by insurance but requires a higher co-payment.
-  Medication is not covered by insurance.
-  Not reimbursable
-  Over the counter
-  Prior authorization required

Print Medication List

- Right click in the *Medication Pane* and click ***Print Medication List***



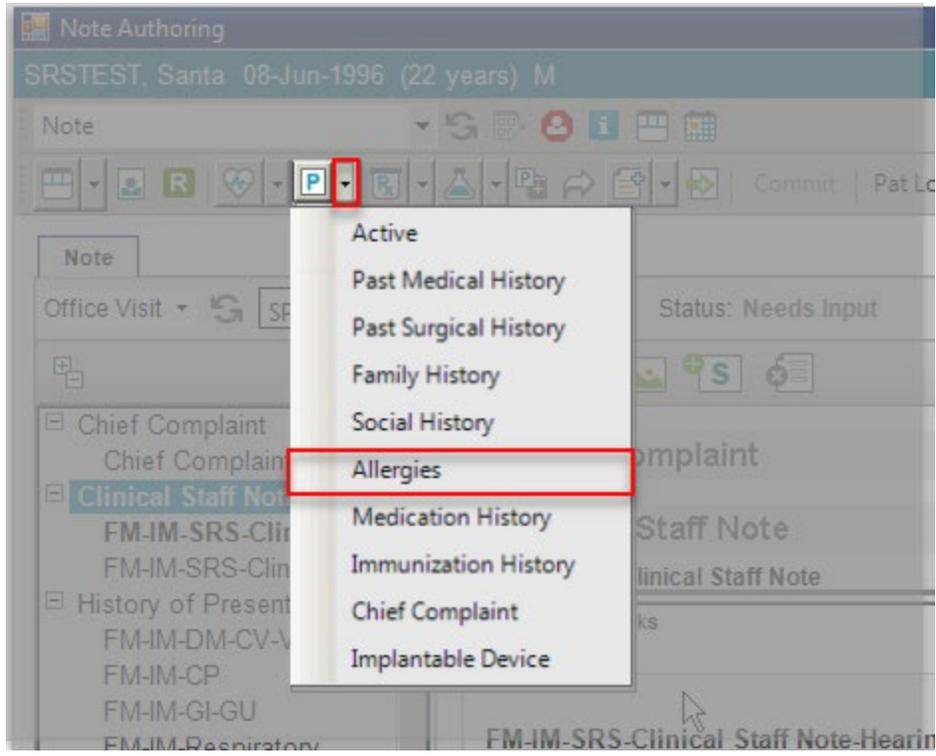
- Click 

- Click 

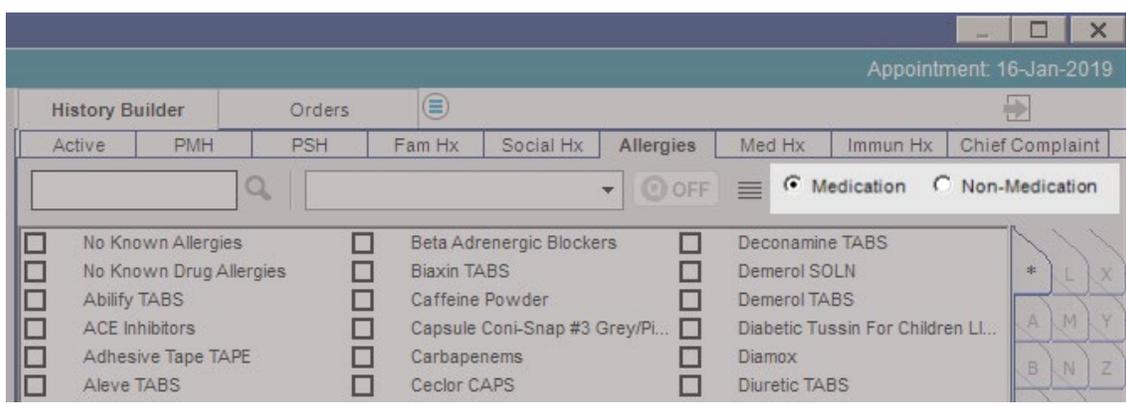
Allergies

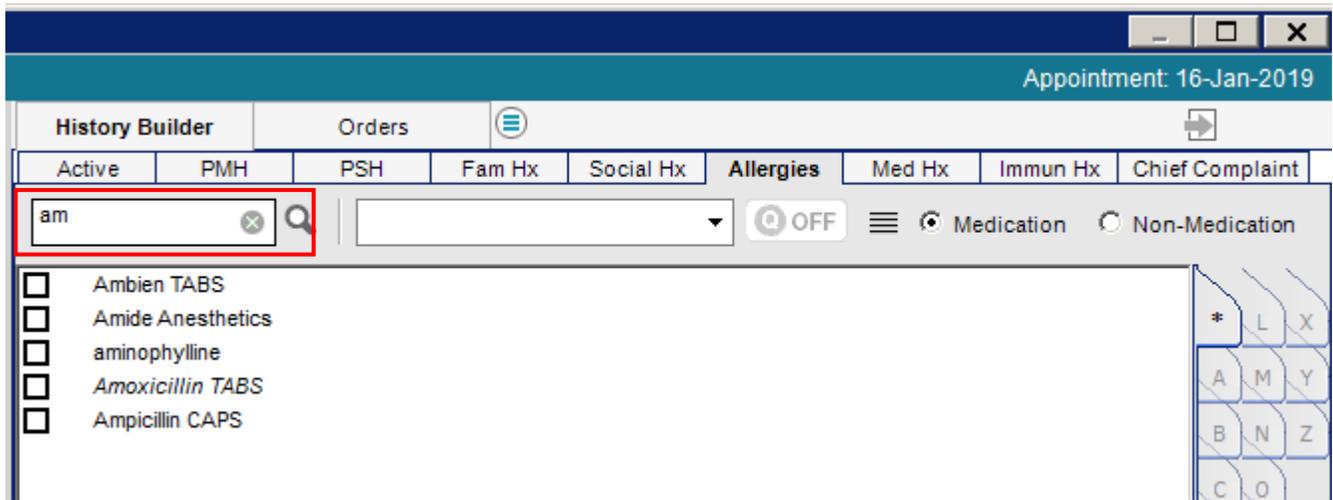
” Keywords: “For your safety...”

- Click the arrow beside the P (Problem) icon
- Select Allergies

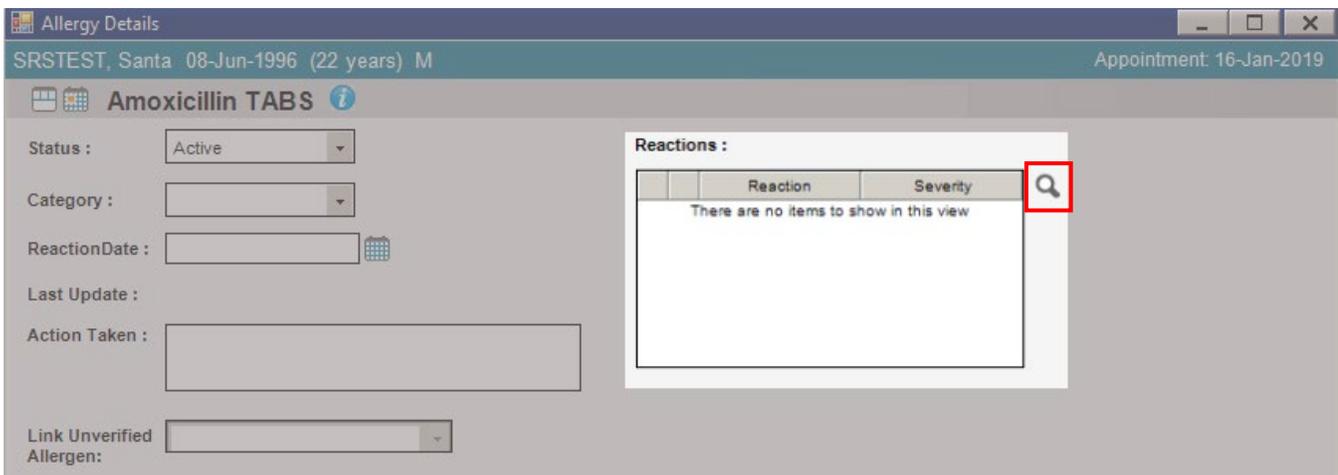


- Select **Medication** or **Non-Medication**.

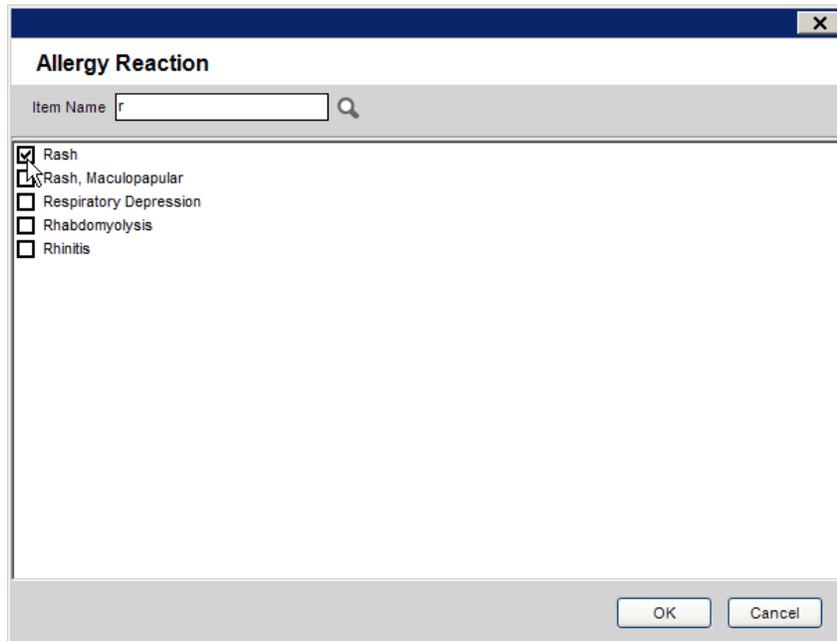


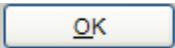


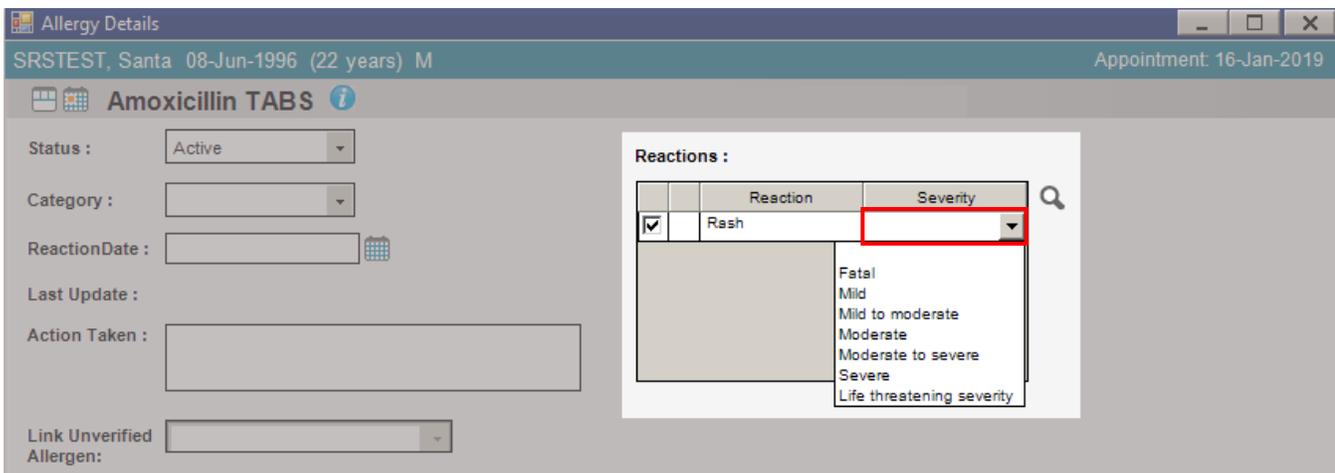
- Type in the name of the medication and press Enter.
- **Double-Click**  on the allergy.



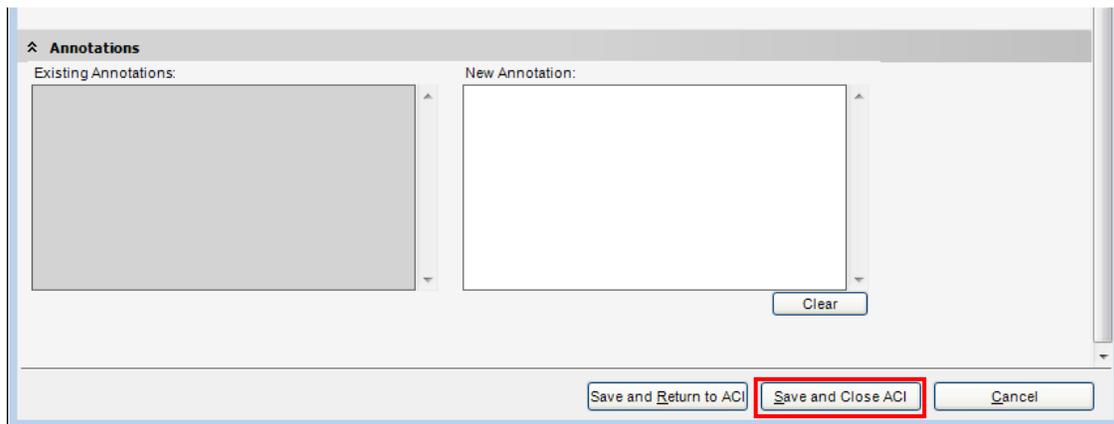
- Click on the magnifying glass icon  to add a reaction.



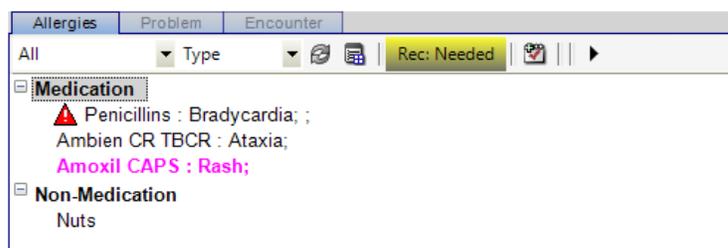
- Search and checkmark the correct allergy reaction.
- Click 



- Click on the drop-down arrow to choose the **Severity**



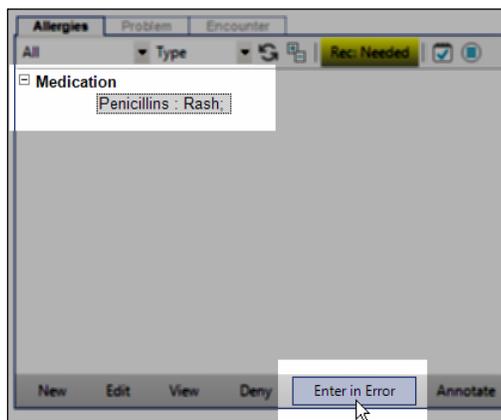
- Click the **Save and Close ACI** button.



- The new allergy will appear **pink**.
- Click **Commit** to save.
- Click **Save and continue**

Allergies Entered in Error

- If an allergy was entered in error, highlight the name of the allergy by clicking on it.
- Click on Enter in Error.



Note: This process must be done by the person who entered the Allergy in Touchworks AND it must be done within the same work day.

Med/Allergy Reconciliation

- Select **Med/Allergy Reconciliation** from TOC pane

Current Meds
Allergies

- Med/Allergy Reconciliation
- FM-IM-SRS-Med/Aller
- Past Medical History
- Surgical History
- Social History
- Sochtx Freetext
- Family History
- Review of Systems
- FM-IM-SRS-ROS (M) 2

Med/Allergy Reconciliation

FM-IM-SRS-Med/Allergy Reconciliation

Medications and Allergies Reconciled No Changes per Patient Per Patient Not Taking:

Comments

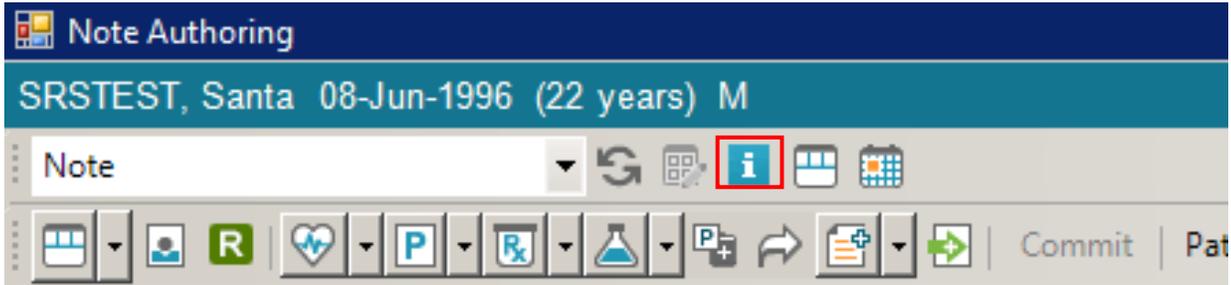
Plan
Unlinked
Renew: Montelukast Sodium 4 MG Oral Tablet Chewable; CHEW AND SWALLOW 1 TABLET DAILY

- Checkmark **Medications and Allergies Reconciled**
 - If there were no changes, checkmark *No Changes per Patient*
- Document any changes made to patient Medications or Allergies in **comments**

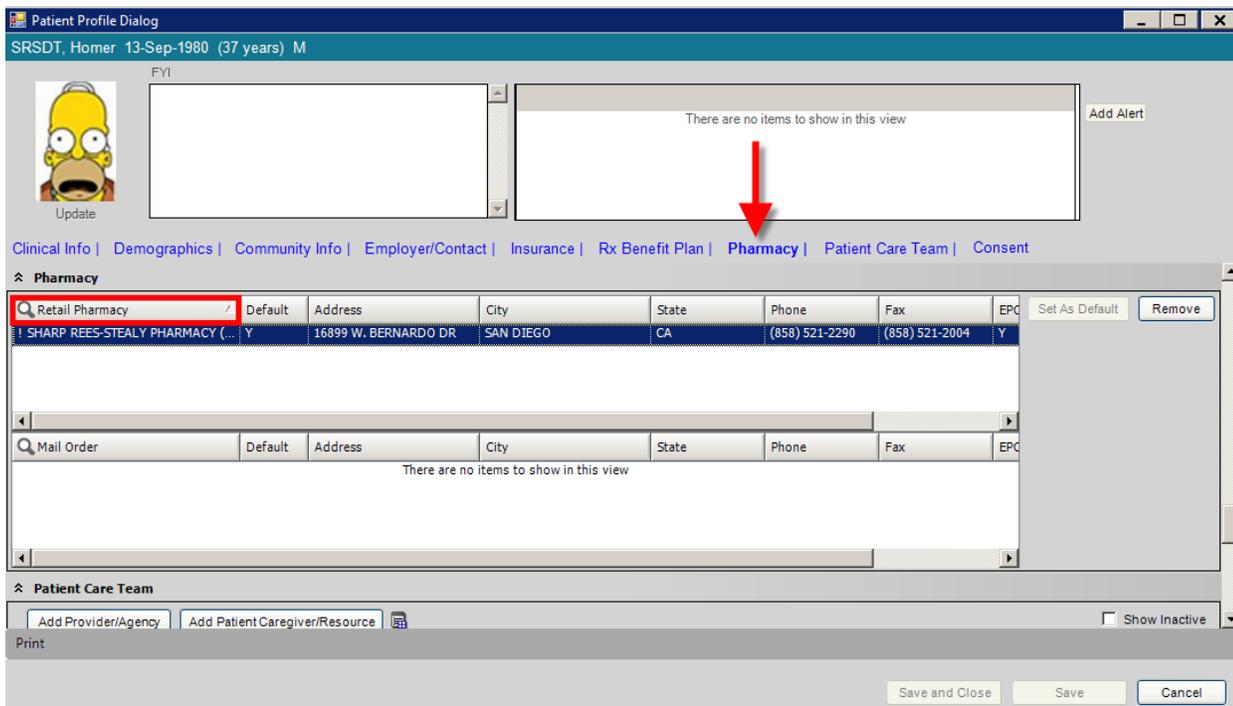
Adding a Pharmacy (in Patient Profile)

Suggested scripting: What **SRS** pharmacy would you like your provider to use for your prescriptions?”

- Click on the  icon to access the **Patient Profile**



- Click pharmacy



- Click on the Magnifying Glass 

- Type in the name and/or address of the pharmacy and click Search.

Detail Dialog

Select Retail Pharmacy

Personal
 Site List
 All

Alpha
 Frequency of Use
 Save as Default View

Name: Phone/Fax:

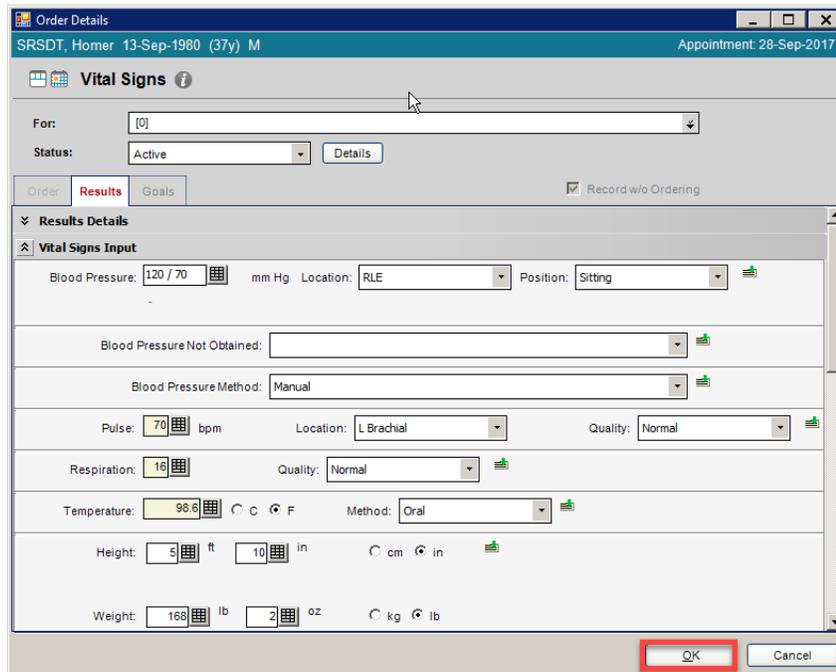
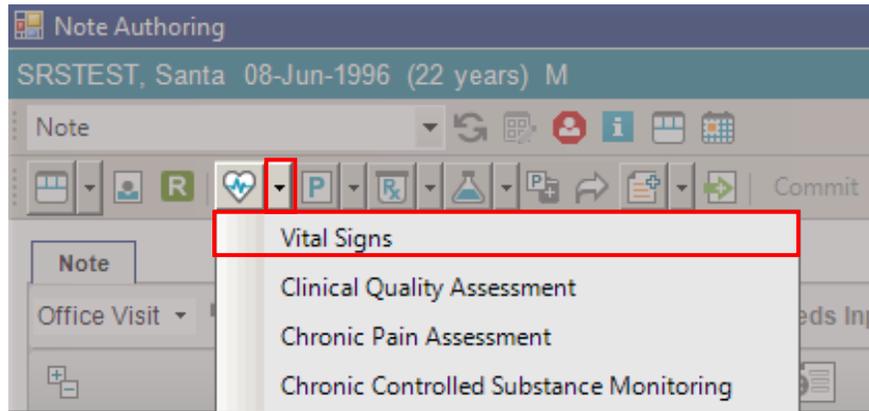
Address 1: Zip: -

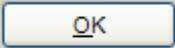
City: State: Include LTC and Specialty

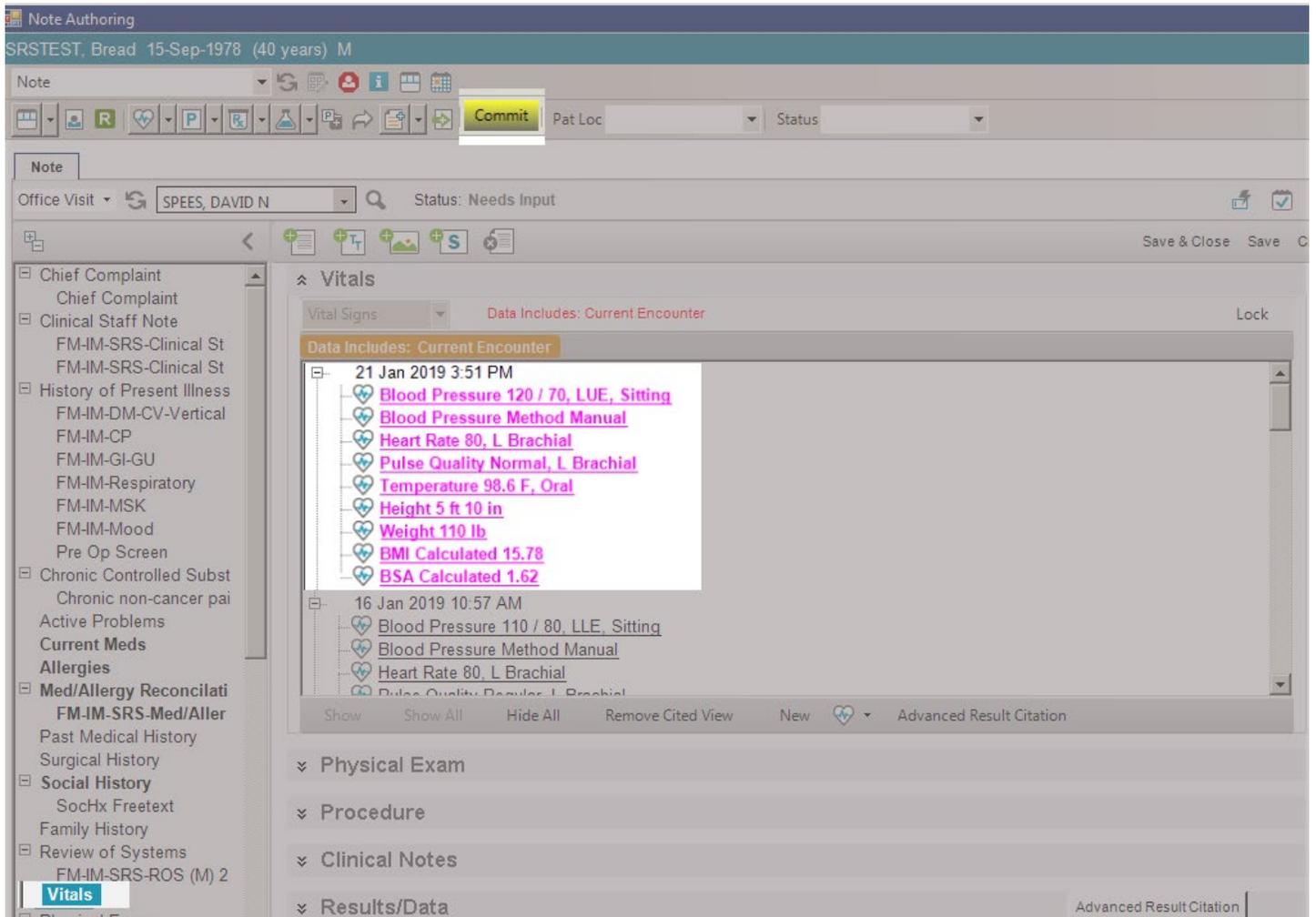
Name	Address 1	Landmar	City	State	Zip	Phone	Fax	Type	EPCS	Store Nu	Additional Info
CVS/PHARMACY #9177	8260 MIRA MESA BL...		SAN DIE...	CA	921...	(858)566...	(858)566...	Script	Y	09177	
TARGET PHARMACY #0...	8251 MIRA MESA BL...		SAN DIE...	CA	921...	(858)357...	(858)877...	Script	Y	16103	

Vitals

- Click on the drop-down menu next to the  icon



- Enter Vital Signs & Click 



- The new vitals will appear pink.
- Click **Commit** to save.
- Click **Save and continue**

Meaningful Use Guidelines

Screenings must be completed on patients **65 or older**

MEDICARE, ABN Select Patient ▼ i ▲	EnMRN: 12457896	SHC: 103-398-758	Other: SHARP, REES-STEALY	FYI: Security:
	Sex: M	H Phone: (619)555-4525	PCP: SHARP, REES-STEALY	
	DOB: 11/28/1969	Age: 43 Years	Pri Ins: (MED) MEDICARE	

Note: Check with your department lead or supervisor to determine if your department is participating in this workflow.

- **Depression Screening** (Annually): Provide patient with the PHQ Form, they will fill out the **first two** questions (PHQ-2). If the score of the first two questions equal 3 or more, ask the remaining questions with the patient. The sum off **all** the questions (including the PHQ-2 score) will equal the PHQ-9 score.
- **Fall Screening** (Annually): Ask patient if they have fallen within the past year, if they have, how many times and if there were injuries.
- **BMI Screening** (Every 6 months): Ensure you capture weight and height at the visit if this was not captured in the last 6 months.



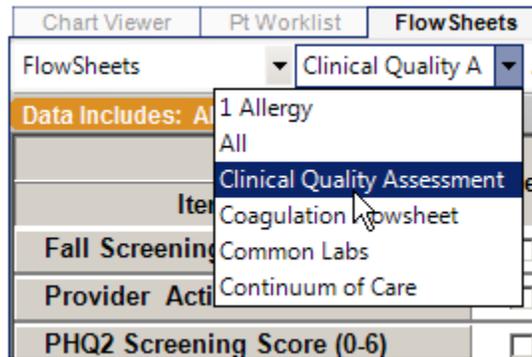
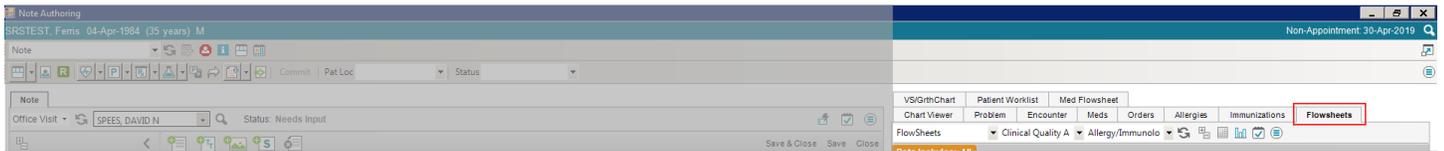
For staff use only

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please answer questions 1 & 2. (Use "✓" to indicate your answer)

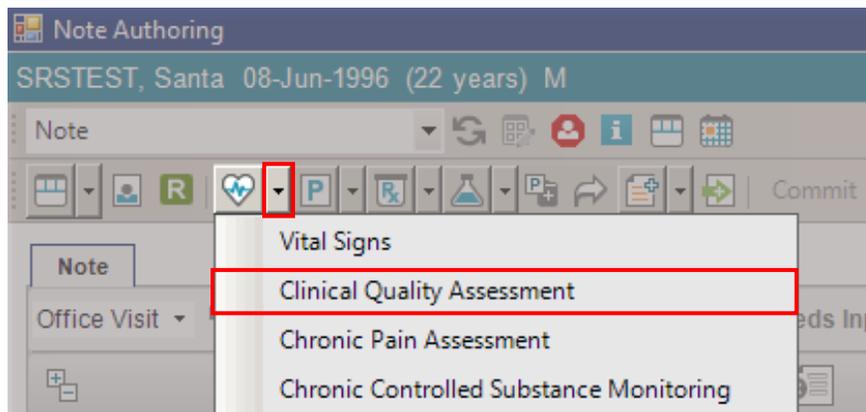
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
*****STOP HERE AND HAND FORM BACK TO CLINICAL STAFF*****				
FOR OFFICE CODING ONLY ADD QUESTIONS #1 & 2	_____	+ _____	+ _____	+ _____
		= TOTAL	SCORE:	_____
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3

Documenting Screening Results

- Click the **Flowsheets** tab and select **Clinical Quality Assessment** flowsheet.



- If no screenings have been completed, then capture the information.
- Click on the drop-down menu next to the  icon and select **Clinical Quality Assessment**.



Order Details

MEDICARE, ABN 44 YO M DOB: 28Nov1969 Non-Appointment 9/3/2014

Clinical Quality Assessment

For: [0]

Status: Active

To Be Done: 17Sep2014

Overdue: 22Sep2014 12:00AM

Order **Results** Goals Record w/o Ordering

Vital Signs Input

Fall Screening:

Provider Action Taken (Positive Fall Screening):

PHQ2 Screening Score (0-6):

PHQ9 Screening Score (0-27):

Provider Action Taken (Positive PHQ9):

Provider Comments - PHQ9 (Optional):

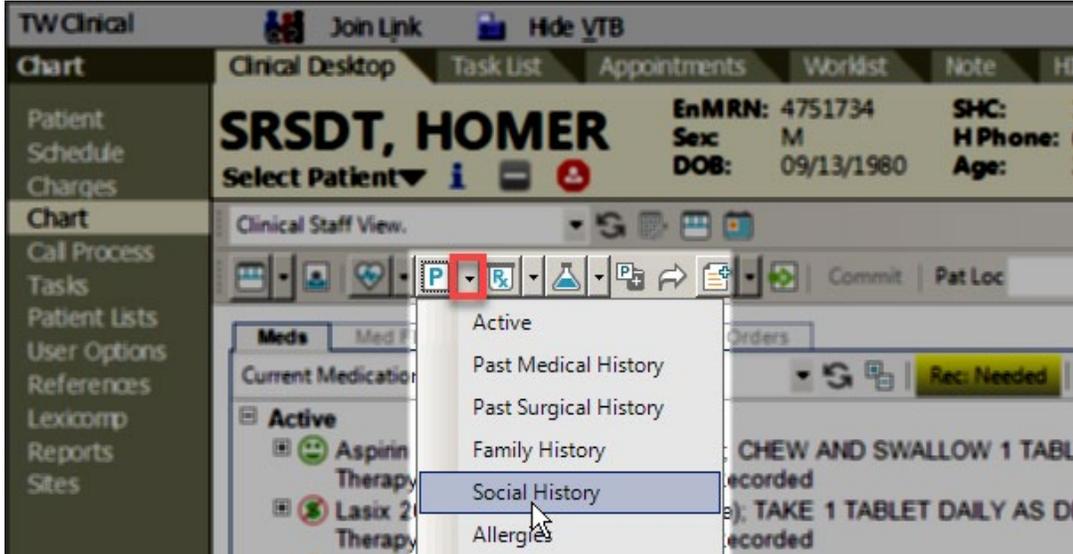
Provider Action Taken (BMI Outside Normal Parameters):

Provider Comments - BMI (Optional):

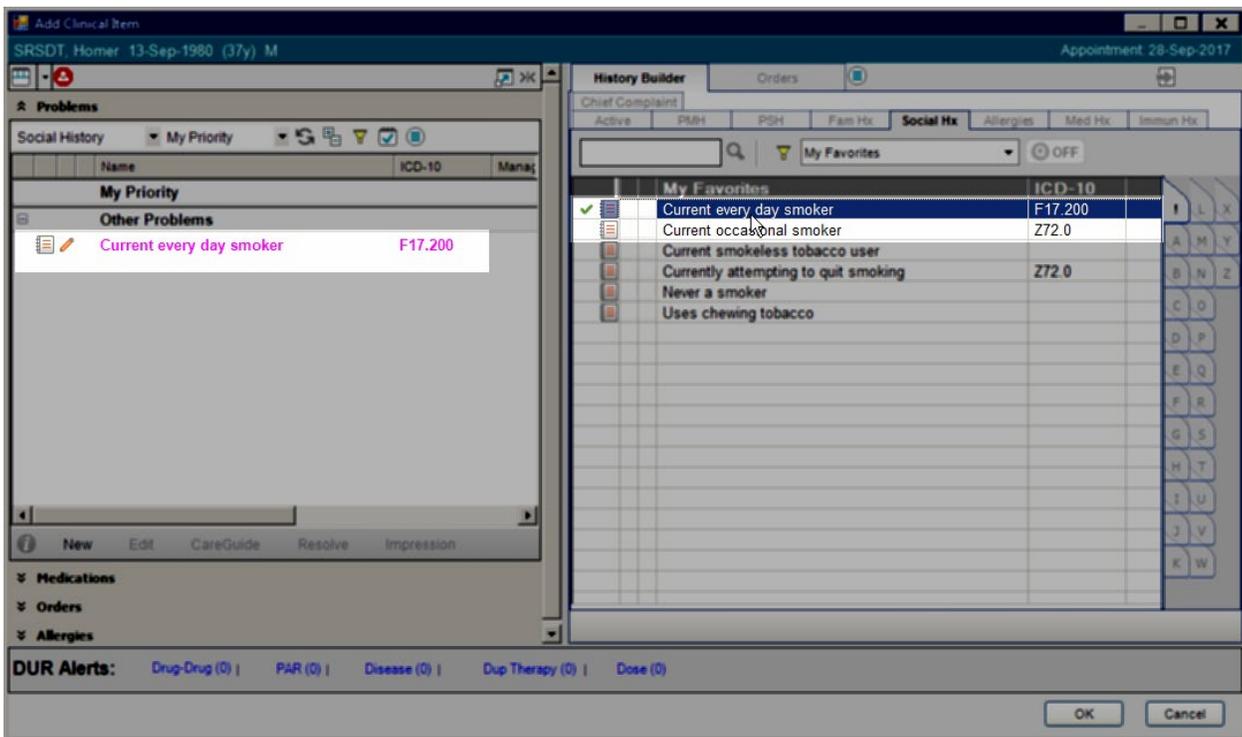
- Enter the Fall Screening information by selecting the drop-down
- Enter the PHQ-2 score.
 - If the score for the **first two** questions is **3** or more, you **MUST** ask the remaining questions and enter in the total PHQ-9 score.
- Click **OK**
- If BMI was also not screened, be sure to capture height and weight under **Vitals**.

Social History – Smoking Status

- Click the arrow beside the P (Problem)  icon



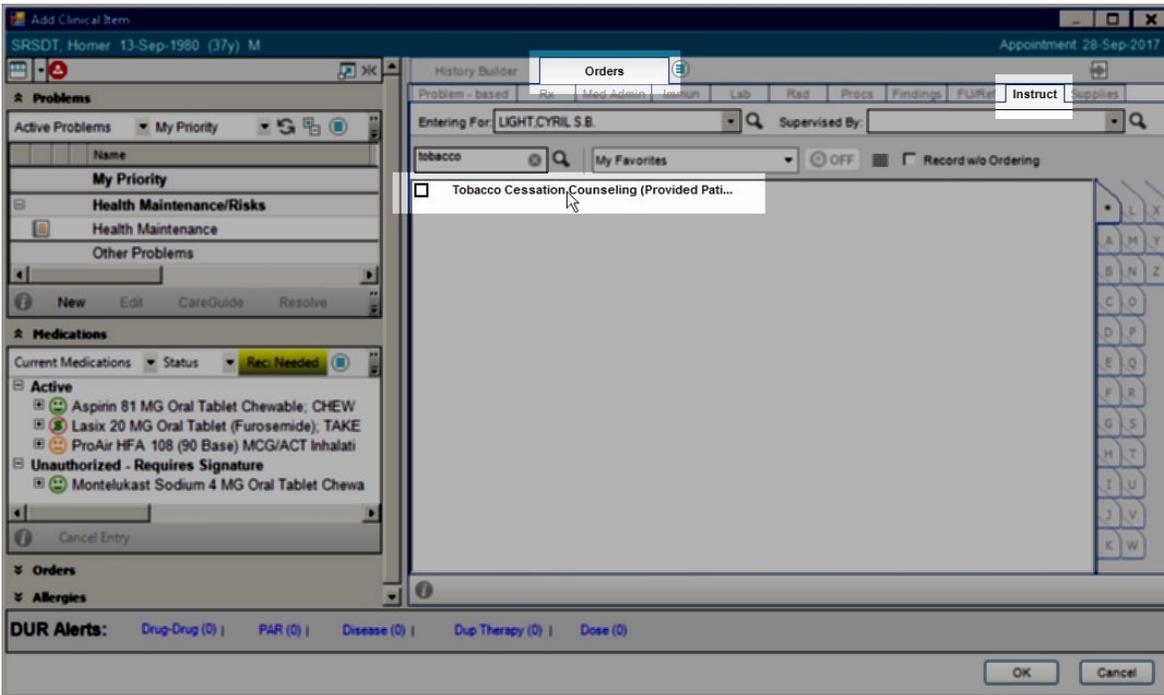
- Search and **single-click** to Select the correct Smoking Status



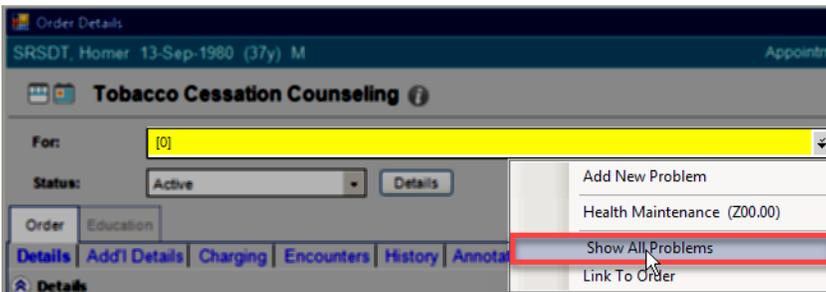
Patient Education - Smoking Cessation

- Select Orders tab

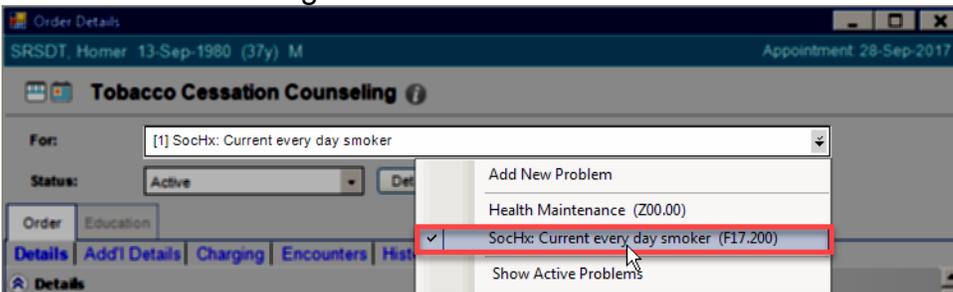
- Select Instructions tab
- Double click  'Tobacco Cessation Counseling...'



- Select Show All Problems



- Select Smoking Status SocHx



- Click the  button.
- Click 



Second Breath

A Comprehensive Smoking Cessation Program

If you're ready to quit smoking, Sharp Health Care's Second Breath program can help.

This small group program is designed to guide you through the process of becoming tobacco-free by addressing both the habit and addiction components of smoking. During the six-weekly sessions you will build skills in behavior change, stress management, weight control, and effective medication use and preventing relapse. Long-term support and follow-up is provided. Participants who experience a relapse are welcome to repeat the program within one year, free of charge.

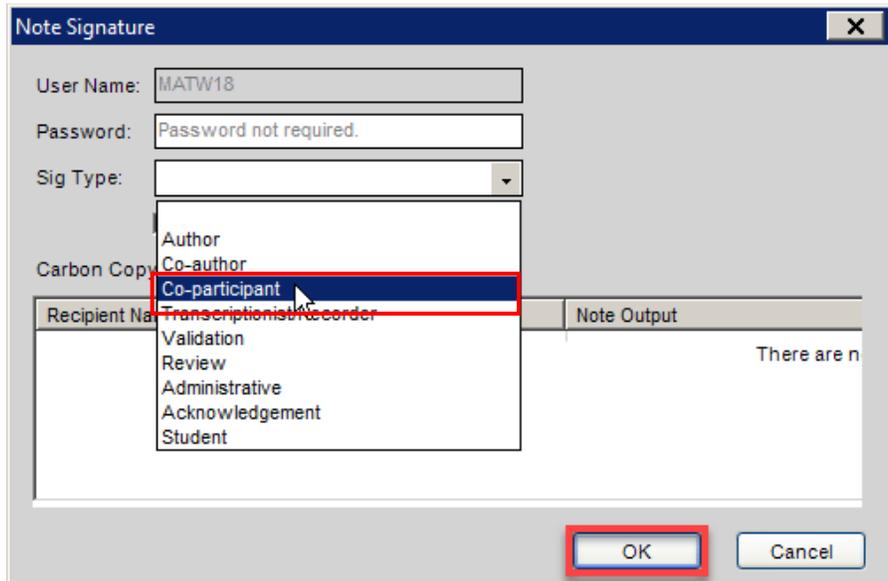
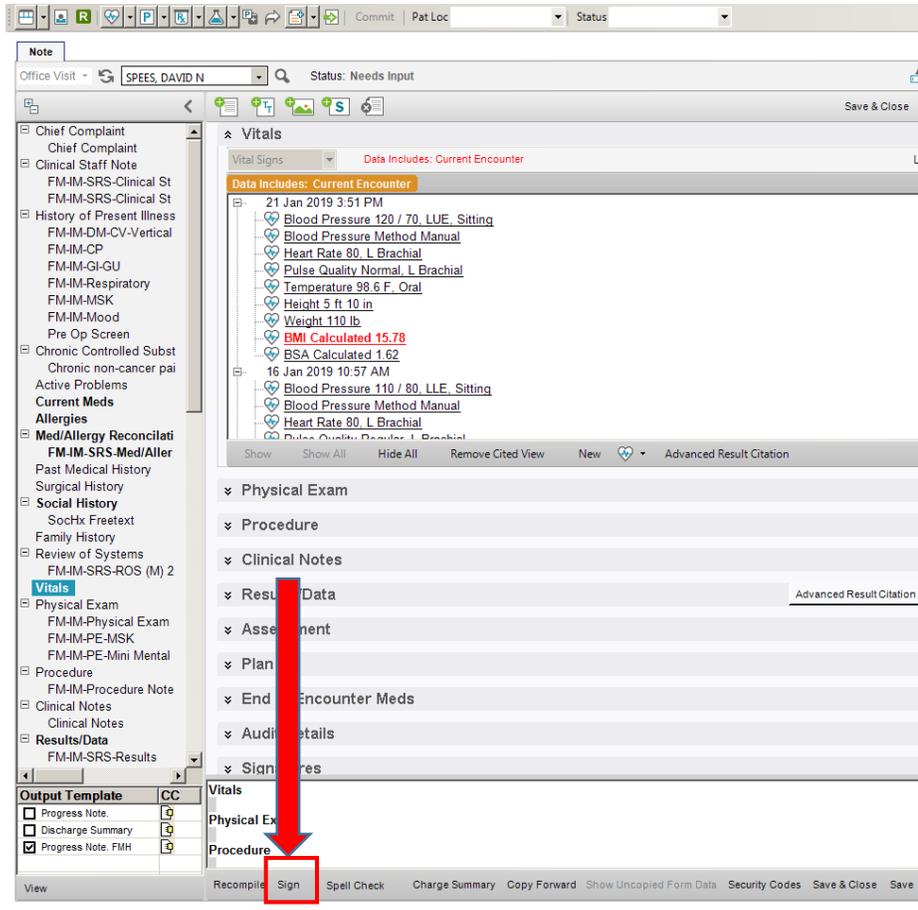
- Instructors are trained and experienced health care professionals who provide smokers with support they need to reach their goal
- Second Breath is based on clinically-proven therapeutic methods
- Classes consist of small group settings, and teach overall healthier lifestyles
- Each class meeting the importance of exercise, good nutrition, weight management, relaxation techniques and the use of effective coping skills are discussed
- Medication management is discussed and in some cases, may be prescribed to help alleviate the withdrawal symptoms associated with nicotine addiction.

Registration is required.

Payment options include cash, check or credit card (Some insurance plans may cover a portion of the program fee)

To schedule a free orientation, please call (858) 505-1400. Classes are held in the evening at various Sharp Rees-Stealy locations.

Sign the note (as Co-participant)



Once a note has been signed, a paper icon will appear on the provider's schedule



Break Link Hide VTB

Daily Provider Schedules Advanced Web Provider Schedules App

SRSTEST, BOB

EnMRN: 4873371
Sex: F
DOB: 01-Jan-1960

Select Patient [i] [minus] [trash]

Daily Schedule

Arrived, Pending and Rescheduled AM: 7

Provider: ABOLA,AMY SUGGS [v] [q]

Date: 16 May 2019 [calendar] SUN

\$	N	A	Pt Loc	Pt Status	Time
		Pen			08:20 AM
		Pen			08:40 AM
		Pen			09:20 AM
		Arr			09:40 AM
		Pen			10:00 AM

Note: Once you sign a note, you will be unable to go back into it.