

Errata for Electronic Health Records/Hamilton/2e

The SpringCharts EHR version posted to the OLC is currently undergoing some upgrades and fixes. Some exercises within the text need to be adjusted to work with the current version. Please use the following instructions and exercises as replacement to the corresponding ones in the text.

Chapter 3

Exercise 3.1 Setting Your User Preferences (LO 3.2)

Use the following illustration to complete exercise 3.1.

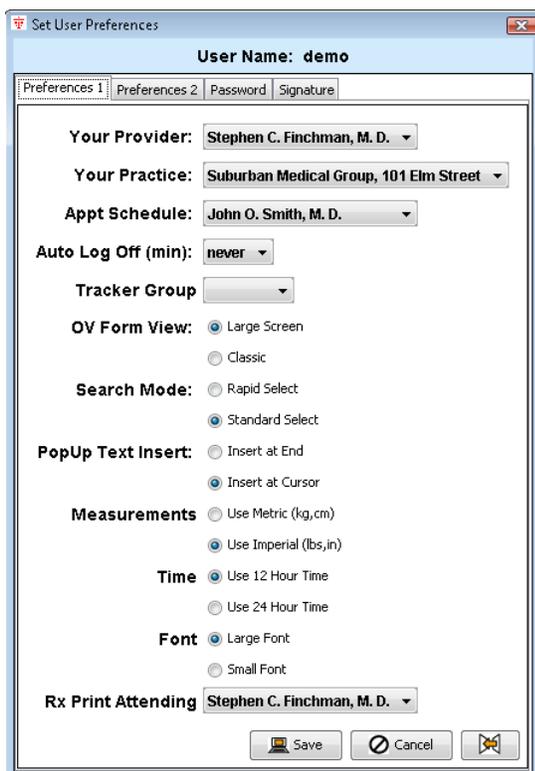


Figure 3.1 Set user preference window.

The following exercises in chapter five will need to be done using the chart of **Patti Adams** rather than the student's own chart.

Chapter 5

Exercise 5.3 Ordering an Imaging Test (LO 5.7)

1. Open the patient chart for Robert Underhagen. Dr. Finchman has recommended a magnetic resonance imaging of Robert's head.
2. Under the *Actions* tab select the *Imaging* submenu. Order Robert an *Imaging Test*, an MRI of the Brain – With & Without contrast. Click the [Done] button.

Exercise 5.4 Recording and Viewing Vitals (LO 5.8)

1. Open **Patti Adams'** chart. Under the *New* menu select *New Vitals Only*.
2. Record your vitals. Click on the *Note* tab in the upper right and select verbiage from the pop-up text. Click the [Done] button and *Save and Skip Billing*.
3. Close and reopen your chart by selecting your name from the *Recent Charts* menu on the Main menu bar.
4. Open the *Actions* menu within the patient's chart. Select *Graph Vital Signs* and view the various graphed vitals.
5. Open the Body Mass Index graph and print a copy. Write your name on the sheet and submit to your instructor.

Exercise 5.5 Creating a Letter About a Patient (LO 5.8)

1. Open **Patti Adams'** chart. Under the *New* menu select *New Letter ABOUT Pt*.
2. Select the referring physician, Dr. Harry Hart, from the [Get Address Book] button.
3. Choose the pop-up text that begins with: "Thank you for allowing me to participate...."
4. Click on the *Edit PopUp Text* icon.
5. Add the following sentence on an empty line: *Below please find a copy of the patient's recent lab results*. Click on the [Done] button.

6. Place the cursor in the letter body on a new line and select the newly added pop-up text sentence. Also, click on the sentence: *I will update you on this patient's progress after our next appointment.*
7. Click on the [Add Chart Notes] button and select the lipid panel results from the *Chart Entry* window. The lab test results will be added to the body of the letter. Select the Signature icon and select a signature (see marginal reference).
8. Print the letter on your letterhead and submit to your instructor.
9. Click on the [Done] button and select *Letters* as the category where the letter will be stored in the patient's care tree.
10. In your chart, click on the "+" expand symbol beside the *Letter* category in the care tree to see the saved copy of the letter.

Exercise 5.6 Creating a Test Report for a Patient (LO 5.8)

1. Open **Patti Adams'** chart. Under the *New* menu select *New Test Report*.
2. Highlight the lipid panel in the *Select Text* window. You will notice that the program automatically adds the test description to the bottom of the test results.
3. Place your cursor in the body of the report under the section heading *Problems*. Select *Elevated Cholesterol* from the pop-up text in the lower right panel.
4. Click on the down arrow in the pop-up text category window to reveal the list of pop-up text categories. Select *Report-Recs*. Place your cursor under the section heading *Recommendations*. Now select the following pop-up text line items: *Low cholesterol diet. Regular exercise program. Please make an appointment to see the doctor as soon as possible.*
5. Print the test report and submit to your instructor.
6. Click on the [Done] button and store a copy of the report under the *Reports to Patient* category in the care tree. You will notice a "+" expand symbol has been placed beside the *Reports to Patients* header in the care tree. Click the "+" symbol to see the saved report.

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head measurements for developing infants. BMI (body mass index) is grayed out because the program will calculate this item from the height and weight measurements.

5. Click on the [Done] button in the OV screen. Click the [Save and Skip Billing] button. We will come back later, finish the note, and create a routing slip for this office visit. The OV note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.

Exercise 6.2 Building an OV Note (Part 2—Doctor) (LO 6.2)

Note: Now that the medical assistant has completed the initial assessment, the office visit is handed over to the physician. The physician will not start a new office visit note (as the medical assistant did), rather he/she will edit the existing office visit note.

1. Open your chart. Click on the "+" sign beside the *Encounters* heading in the care tree. Select the office visit entry you started in Exercise 6.1. Click on the [Edit] button at the bottom of the window.

Note: In the office visit screen the provider can view the information already collected by the medical assistant. SpringCharts has office visit templates for some of the most common ailments. This enables the provider to quickly select the appropriate template to populate the office visit note. All that remains is tweaking the notes for the specific patient.

2. Click on the [Template] button in the bottom right corner of the office visit screen. From the displayed list select: *Allergic Rhinitis*. Notice the entire note has been built very quickly.

3. The doctor will now complete the note for this patient. Click on the *PI* navigation tab on the right-hand side. The text from the template appears in the lower middle work area. Move the scroll bar to the top of this window and complete the following sentence: *Pt c/o red, itchy eyes, congested, itchy and runny nose (clear fluid), post-nasal drip, sneezing, itchy ears, scratchy throat and occasional cough for the past _ weeks*. Place your cursor in front of the word *weeks*, highlight the underscore mark and type 3.

Note: The physician will continue this way through the entire note making changes and additions where necessary for this specific patient.

4. A diagnosis will need to be added. Click on the *Dx* navigation tab on the right-hand side. Search for *Allergic Rhinitis* in the Diagnosis field in the upper right. Select *Allergic Rhinitis 477.9*.

5. Next the physician will prescribe a medication. Click on the *Rx* navigation tab on the right side. In the *Prescription* field search for and select *Allegra 180mg* and *Flonase 50mcg*.

6. The physician may want you to come back into the exam room and administer a subcutaneous allergy shot. He/she will order the injection by choosing the *Proc* navigation tab on the right side. Click on the drop-down arrow beside the *All* category on the upper right side. Select the category *InjectMed*. From the list displayed below, choose *Allergy Injection – 1*.

7. Click on the [Done] button in the OV screen. Click the [Save and Skip Billing] button. The medical assistant will need to re-open this office visit note and document the administration of the allergy injection. The OV note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.

Exercise 6.3 Building an OV Note (Part 3—MA) (LO 6.2)

Note: The physician will now communicate with the medical assistant regarding administrating the allergy shot. This may be done via the *Patient Tracker* by changing the *Tracker Status*.

1. Open your chart. Click on the "+" sign beside the *Encounters* heading in the care tree. Select the office visit entry you amended in Exercise 6.2. Click on the [Edit] button at the bottom of the window.

2. Click on the *Proc* navigation tab on the right side. Click on *Allergy Injection – 1* in the lower center work area.

3. In the *Edit Procedure* window you will need to document the injection administration that you just gave. Choose the pop-up text *Lot#* and type in a lot number. On the next line choose the pop-up text *Site: Left arm*. Click on the [D & T] button and the [Initials] button. Click on the [Save] button.

4. Click on the [Done] button in the OV screen. Click the [Save and Skip Billing] button. The doctor will now complete the routing slip and bill for the encounter. The OV note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.

Exercise 6.5 Activating a New Medication (LO 6.4)

1. The provider needs to add another medication that is not yet activated to the SpringCharts list. Click on the [Rx] navigation button. In the prescription field type: *deconsal*. It is not in the list. Once again, select *Database* on the OV menu bar, then *New Drug*. The provider has the option to fill out the details of the new drug or click the [Lookup] button and search for Deconsal in the drug database. Click on the [Lookup] button. In the *LookUp Drug* window type: *deconsal* search and select *Deconsal 60 mg – 200 mg Cap*. In the *New Drug* window type: *1-2 cap PO q12h* in the *directions* field and *30* in the *Quantity* field. Put *0* in the *Refills* field. Save the new medication.

2. In the prescription search field of the OV screen search for Deconsal again. Select the newly activated drug.

3. Click the [Done] button in the OV screen and *Save and Skip Billing* of the office visit. Close the patient's chart.

Chapter 7

Exercise 7.1 Creating and Conducting a Chart Evaluation (LO 7.1)

1. Open the *Administration* menu in the main *Practice View* screen. Select *Chart Evaluation*. Highlight the *Chart Evaluation Item* that deals with mammogram screening and click the [Edit] button. Look at the details of this wellness check item. Let's narrow down our screening criteria by linking this item to a family medical history diagnosis. In the lower portion of the window click on the radio button that deals with the FMHX. Select a diagnosis by clicking on the [Get FMHX Dx] button. In the *Rapid Select* window type: *breast* and select *Breast Cancer 174.9*. Click the [Save] button. This chart evaluation item will now only recommend an annual mammogram for female patients between 35 and 110 years if their chart shows a family medical history of breast cancer. Remember, the chart evaluation is activated manually in a patient's chart and will reveal only disease management items that are not up to date.

2. We will now add a new wellness screening item. Let's do some research and find the criteria we need to know in order to create the conditions for a Pap smear. In the opened *Chart Evaluation Items* window click on the [NGC] button. Once on the National Guideline Clearinghouse™ website, type in *pap smear* in the *Search* field and conduct a search. Locate the title for Cervical screening. Read through a portion of the article and note down the appropriate age that Pap smears should begin and end, who should get them, and how frequently they should be conducted. Close the web browser and click on the [New] button in the *Chart Evaluation Items* window. Fill out the details in the *Edit Chart Evaluation Item* window with the information you have gathered. **Note:** A Pap smear will be a test, not a procedure. We will not link a Pap smear to any specific diagnosis. Save the new item and close the *Chart Evaluation window*.

3. Because the *Chart Evaluations* are normally set up on SpringCharts Server in a network environment, you will need to close SpringCharts and reopen it. This will enable you to see the changes that were made on the server. Once the program is rebooted, open your patient's chart. Locate the *Chart Evaluation* icon on the toolbar and conduct a chart evaluation. Let's assume we recommend all the displayed criteria to the patient so we will check the *Mark this Completed* radio buttons. Record the patient's response. Perhaps the patient is declining the DT shot and will schedule on the next visit. If the Pap smear screening is displayed, go ahead and indicate the patient has agreed to have it done today. Click the [Done] button.

4. Click on the “+” sign to the left of the *Encounter* category in the care tree and notice the addition of the chart evaluation screenings. The details will be seen below.

Exercise 7.2 Ordering a Test in an Office Visit (LO 7.2)

1. Let's go ahead and order the Pap smear screening. Open a new office visit in your patient's chart. In the OV screen, select the *Routine Well Visit* pop-up text under the [CC] navigation button.
2. Record some routine well vitals under the [Vitals] navigation button.
3. Select the diagnosis code for a *Well Woman* under the [Dx] Navigation button.
4. Now let's order the Pap smear test. Choose the appropriate navigation panel button for tests and type *pap* in the search field. Selecting the test will place it in the lower window. Click the [Order Selected test] button at the bottom and the test is added to the OV note.
5. To print the order for the test, click on the printer icon *below* the [TEST] button in the lower left text panel. You will notice the diagnosis added to the *Orders* window from the OV note. Add the patient's insurance information to the Order form by clicking the [Add Pt Ins] button.
6. Print the order note, electronically sign it, and submit the printed Order Form to your instructor.
7. Click the [Done] button inside the *Orders* window and chart the order form under the *Encounters* category in the care tree.
8. Record a 3-year follow-up for the patient from the [F/U-Rem] navigation panel. If you do not have *3 years* in your pop-up text then you need to add it by clicking on the edit pencil icon. Remember to choose the appropriate category in the *Edit PopUp Text* window, add the new text, and then move it up to the most suitable position. Return to the OV screen and refresh the pop-up text panel.
9. Send a *New ToDo/Reminder* to the front desk to *Schedule appointment in 3 years*.
10. Close the office visit and create a routing slip. Choose the recommended E&M code in the *Routing Slip* window.
11. Print the *Routing Slip* and submit to your instructor.
12. Click the [Send] button to send the *Routing Slip*. Close the patient's chart.

Chapter 8

Exercise 8.1 Creating an Office Visit Template (LO 8.2)

1. Open your patient chart. Open the office visit note that you created dealing with the *allergies, runny nose, itchy eyes, and congestion* complaints. Select the *Database* menu and choose *Copy OV To Template*. Name the new template: *Adult Allergies* and [Save] the template. Close the *Office Visit* screen, skip billing, and close your patient chart.
2. Click on the main *Edit* menu and select *Templates*. Locate your *Adult Allergies* template under the office visit templates list. Click on the *CC* navigation tab on the right. Remove all the chief complaints: allergies, runny nose, etc. in the lower section. Click on the *F/U-Rem* navigation tab. Remove the verbiage in the F/U-Rem segment dealing with the patient returning to the clinic as needed. Save the edited template.

Exercise 8.2 Activating an Office Visit Template (LO 8.2)

1. Open Patti Adams' chart. Open a new OV note screen from the *new* menu.
2. Click on the *CC* navigation button. Patti mentions that she has a runny nose and congestion. She believes she has allergies again. You notice in the lower right hand window that Patti was in your office on 12/21/2004 with the same complaints. With your mouse highlight *Allergies, runny nose, congestion*. (Do not highlight the date.) Click on the *copy highlighted text to note* button and the previous chief complaints are added into the new OV note.
3. Enter some vitals in for your patient. Remember she doesn't have an elevated temperature.
4. Knowing that you have a template for adult allergies, click on the [Template] button at the bottom of the window and choose the *Adult Allergies* template. The template will be added into the OV note augmenting the chief complaints and vitals that you have already added.
5. Patti mentions that her cough started about 7 days ago and she tells you she does not have a headache. Click on the [PI] navigation button. This brings the PI text to the lower center text box where it can be edited. Change the cough onset time to 7 days. **Remember to use the [Delete] key on your keyboard, not the [Delete] button in the OV screen.**
6. Perhaps you decide not to give her Flonase, which is in the template. Click on the [Rx] navigation button and highlight *Flonase* in the lower center window and delete the medication.
7. Print the prescription and submit to your instructor.

8. Save the office visit and edit the routing slip. Use the recommended E&M code and [Send] the routing slip. See how the introduction of a template into the OV notes greatly enhances the speed of documentation. You will see the completed OV note saved under the *Encounter* category in the care tree of Patti Adams' chart. Close the chart.

Exercise 8.5 Using Pop-up Text (LO 8.5)

1. Open up your patient chart. Locate the office visit note regarding the Pap smear exam and open the OV note. Click on the [CC] navigation button and select the text: *Routine Pap smear exam* from the *S Panel* pop-up text.

Note: When a user selects a series of pop-up text, the text wraps by default. If the user wants to have each new category of text on a new line, he/she will have to click at the end of the previous line of text in the lower center window and hit the *Enter* key. This will place the cursor on the next line. When selecting new pop-up text it will go to where the cursor is positioned.

2. Click on the [ROS] navigation button. Select all the *ROS-Normals* text starting with *GENERAL:* down through *GU/GYN (female)*.

3. Click on the [Exam] button. Again, select all the *O(Normals)* text starting with *GENERAL:* down through *GU/GYN (female)*. Start each new section on a new line and be sure to use the heading names. Your text in the lower center window should finish with *Pap smear performed*.

4. While performing the physical exam, the physician notices several benign lesions on the skin. Start a new line in the lower center text box and then drop down the pop-up text category list and choose *O (Abnormals)*. Locate the *Skin* heading and select *SKIN: + maculopapular lesions* and add them into the text box.

5. Notice the enormous amount of text that was effortlessly compiled detailing the patient's review of systems and the physician's exam. Click the [Done] button and the [Save and Edit Routing Slip] button. Notice in the *Routing Slip* window that the E&M code recommendation is now 99215. Even though your diagnosis code and text code remained the same, a great volume of documentation was added to the OV note to indicate the thoroughness of the exam. This is now indicated by pressing the [Details] button.

6. Let us assume this patient is a Medicaid recipient. Rather than choosing the recommended E&M code, you will choose a preventive E&M code that we listed in the superbill earlier. Highlight the *EP 18–39 yrs old* for an established patient wellness visit.

7. Print the routing slip and submit it to your instructor.

8. [Send] the routing slip and close your patient chart.

Chapter 9

Exercise 9.2 Processing a Reference Lab Result (LO 9.2)

1. Under the *Edit* menu on the *Practice View* screen, locate the *Reference Lab* option.
2. Open the *Imported Reference Lab Tests* window and locate the complete blood count lab for Patti Adams. Highlight the test to open the *Imported Lab Data* window. The imported lab shows the patient's results both in range and out of range.
3. Click on the [Match] button to match this test to a SpringCharts patient. Type in Patti's last name and select this patient.
4. You will be presented with a window displaying Patti Adam's pending tests. Select the CBC to link the imported complete blood count to this test. Drag the smaller window in front to the side and you will notice in the larger comparison window that the imported lab on the right has already placed the analyte results into a SpringCharts pending test. The lab item in gray on the right side indicates an unmatched test analyte. The smaller *Match* window is asking you to match the *Platelets* to an item in the pending test. Select *Platelet* to complete the match. Confirm the match. You will notice that there are additional items that are listed on the imported test that are not listed on the pending test. Many times lab companies will test for more or less items than what the physician needs. This is based upon the lab companies' protocols. Click on the [Ignore] button to ignore the additional items on the imported lab.
5. Click the [Make ToDo] button and send a *ToDo/Reminder* to the physician alerting him or her to the completed test. Use your pop-up text.
6. Click the [Done] button and the CBC is removed from the reference lab list.
7. Close the *Imported Reference Lab Test* window. Open the *Pending Test* window. You will notice the pending CBC test for Patti Adams is missing. Once the match was completed with the imported reference lab the test was sent automatically to the patient's chart.
8. Open Patti's chart. Locate the newly added lab in the care tree.
9. Print out the lab and submit to your instructor.

Exercise 9.7 Creating a New Imaging Test (LO 9.6)

1. Open the *Tests* window in the main *Edit* menu. Click on the [List Imaging Tests] button. Examine the list of imaging tests that are in SpringCharts. Check to see if a test for an x-ray of the larynx with contrast was activated. Close this window.

2. In order to add this imaging test, click on the [New Imaging Test] button. You will notice the [Lookup] button. This will access the CPT dictionary database of SpringCharts. Press *Lookup*.
3. In the *Lookup CPT Code* window type the code: 70373 and hit the search icon. When the new code has been located, highlight it. The description and code are added to the *New Imaging Test* window. Delete the term *Laryngography* and replace it with *Xray Larynx*. Click [Save] and the new code will be added to the list of activated imaging tests. Click on the [List Imaging Tests] button again to view the new test.

Chapter 10

Note: In order to fax directly out of SpringCharts you will need to activate the *Interfax* feature. Complete the following steps before beginning Exercise 10.2.

1. Click on the *Administration* menu and select the *InterFax Setup* option.
2. In the *InterFax Setup* window check the *Enable* box. Enter the Username *mnti* and the Password *springmedical*.
3. Click on the [Fax Web Service Key] and enter the number 2036. Click the [OK] button and the [Done] button.
4. Close down SpringCharts and reboot the program.

Exercise 10.2 Faxing a Prescription Electronically (LO 10.2)

1. In the *Productivity Center* menu open the *Address Book* option. Change the search criterion on the right side to *Category*. In the *Find* field type: *pharmacy* and conduct the search.
2. Select the *Walshop Pharm*. In the *Address* window add a fax number to the *Work Fax* field and click the [Save] button. Close the *address* window.
3. Open your patient chart. Select the office visit note under the *Encounter* category of the care tree that deals with the adult allergy symptoms. Click on the [Edit] button to open the OV screen.
4. In the OV screen click on the [Rx] navigation button to display the three prescriptions that were ordered. Click on the printer icon in the lower center section of the screen.
5. In the *Prescription Printing Options* window select *Use Digital Signature* and *Print License No on Rx*. Click on the [Fax] button.

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6. In the *Fax* window conduct a search for a pharmacy by clicking on the search icon. In the *Fax Number Lookup* window choose *Category* as the search criterion. In the search field type: *phar* and click the [Search] button. In the list of displayed pharmacies select the Walshop Pharmacy. On the right side the fax number will be displayed that you typed in earlier. Click the radio button beside the fax number and click the [Select] button.

7. Back in the *Fax* window type in the *Subject* field: *Prescription*. Check the box to *Send InterFax Header* and click the [Send] button. The fax will now be transmitted to the pharmacy.

Exercise 10.3 Processing an Inbound Electronic Fax (LO 10.2)

1. If the medical facility had an account set up with InterFax, all inbound faxes to the clinic would be listed in the *Inbound Fax List* of the *productivity Center*. Because we are not currently interfaced with this Web service we will retrieve our fax from the *EHR Material* folder on the desktop. Within this folder, locate the document regarding an *MRI of the Ozarks* and open it.

2. With the left-click of your mouse held down, highlight the document. Or you may simply select the [Ctrl] + [A] buttons to highlight **all** the document. Right-click inside the highlighted area and select *Copy*. Or you may simply select the [Ctrl] + [C] buttons to **copy** the document. Close the fax image and close the *EHR Material* folder window.

3. Open the *Pending Tests* window under the *Edit* menu, locate and open the MRI of the brain test for Robert Underhagen. Click in the *Results* text box and press [Ctrl] + [V] on your keyboard to **paste** the document. The MRI evaluation will appear in the pending test.

4. Click the [Tech Sign] button to add your initials and choose the appropriate testing facility. Select the interpreting physician.

5. Send a *ToDo* to Dr. Finchman (scfmd) notifying him of the completed MRI test that he will need to look at. Select the pop-up text: *Check XRay*. You will notice it is already linked to the patient and descriptive text is already applied. Send the item. Click in the *Complete* radio button and click the [Done] button. Close the *Pending Tests* window.

6. Now ask Dr. Finchman to open the *Completed Tests* window in the *Edit* menu. Select the MRI test for your patient. Send a *Message* to Jan to have her call the patient and schedule an appointment. Click on the *Dr. Viewed* radio button and the [Done] button.

7. Open the patient's chart and view the MRI test under the *Imaging* category in the care tree.

8. Click on the MRI item and select the [Print] button in the bottom right window.

9. Print the **MRI** report, write your name on it and submit to your instructor. Close the patient's chart.

Exercise 10.4 Working with the Time Clock (LO 10.3)

1. If the *Time Clock* submenu is not visible in the *Productivity Center* menu you will need to activate the feature in SpringCharts.
2. Click on the *Administration* menu on the main screen and select the *Time Clock Setup* submenu.
3. Check the *Enable time clock* box and select *demo* as the administrator. Click the [Done] button.
4. You will now need to close down the SpringCharts program and reboot it for this feature to be activated.
5. Access the *Productivity Center* menu and select *Time Clock*. In the *Time Clock* window click the *In* box and then confirm the click-in. Your time-in is stamped into the window.
6. You have clocked in after the hour. Let's say that you were actually in the clinic but had forgotten to clock in. Click the [Request Change] button and edit your existing time. Highlight your time and the *Edit Time Clock Item* window will open.
7. On the right-hand side, change the time back to the top of the hour. In the *Request Reason* text box state the reason why you clocked in so late and click the [Send] button.
8. The program has now sent your request to the office administrator as an item in the administrator's ToDo list, marking it with an orange bar. The administrator is able to open the item and either approve or deny the request. If the administrator approves the request, the user's time clock will be adjusted to reflect the newly requested time. Close the *Time Clock* window.

Exercise 10.5 Adding a New My Website Link (LO 10.4)

1. Under the *Productivity Center* open the *My Websites* option. In the *My Websites* window, click on the [Edit] button.
2. Enter the phrase, *Patient Instructions* in the first blank space on the left. Move your cursor to the far left. In the right side field place the cursor to the far left of the field and, following the same format as the other links, type in the web address: <http://www.familydoctor.org>. Save your website addition.

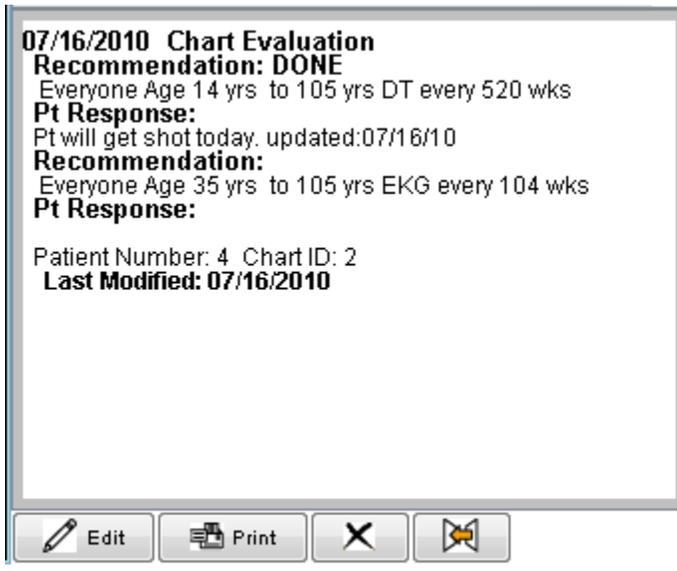


Figure 11.20