

Specialists and Consultants Provider 101 Practice Exercises

Provider 101 The Patient Story

Patient is a 94-year-old lady who is referred to me for stroke.

PAST MEDICAL HISTORY:

1. Vascular dementia. At baseline, the patient ambulates with a walker. She does require assistance with ADLs. She lives in retire home. No concern regarding behaviors.
2. Previous TIAs.
3. Coronary artery disease, PCI 2005.
4. Bladder cancer surgery.
5. Hypertension.
6. Dyslipidemia.
7. Osteoarthritis.
8. Osteoporosis.
9. GERD.
10. Depression/anxiety.
11. Vitamin B12 deficiency.
12. Rectal bleeding secondary to diverticular disease as well as hemorrhoids in the past

HOME MEDICATIONS:

1. Acetaminophen 1000 mg t.i.d.
2. Amlodipine 5 mg daily.
3. Candesartan 8 mg daily.
4. Vitamin D 2000 units daily.
5. Prolia 60 mg every 6 months.
6. Fluoxetine 100 mg every other day.
7. 11. Nitroglycerin patch 0.4 mg on during the day.
8. 12. Pantoprazole 40 mg daily.

HISTORY OF PRESENT ILLNESS: Patient awoke this morning at around 0900 and was found to be incontinent of stool and urine. She was noted to have some left-sided weakness as well as slurred speech and difficulty with words. She was unable to ambulate and was brought to the Emergency Department for evaluation.

Over several hours being in the emergency department, patient symptoms have improved. The patient herself is unable to provide a history. She denies any symptoms and reports being quite well.

PHYSICAL EXAMINATION: Temperature on arrival was 36.6 degrees, heart rate 72, blood pressure 111/64, respiratory rate 16, oxygen saturation 95% on room air.

On examination, patient is alert but not oriented to time or place. Her extraocular eye movements seems intact. She has no facial asymmetry. She has no obvious cranial nerve abnormalities. Patient is moving all 4 of her limbs. She does have a slightly weaker left side compared to the right. Patient is

unable to cooperate with commands to have a more precise neurological strength exam. She has diminished deep tendon reflex. Cardiac exam reveals normal S1-S2 with a 2 out of 6 systolic murmur. Her JVP is not elevated. Her chest is clear with good air entry. Soft non tender abdomen. There is no peripheral edema.

INVESTIGATIONS: ECG shows sinus rhythm with LVH. Her CT head shows evidence of acute ischemic stroke in the right occipital and right cerebellum areas.

Her CBC is unremarkable. Her creatinine today is 111, previous creatinine we have is 75 from 2017.

SUMMARY AND PLAN:

In summary, patient is a 94-year-old lady who presents with a right-sided stroke with left sided weakness and dysarthria. Her symptoms are resolving. Patient woke with her symptoms and is therefore not a TPA candidate. She will be admitted and treated medically. She will be started on ASA and usual secondary stroke prevention medications. She will also undergo a repeat CT scan of the head in 48 hours, Holter monitor as well as an echocardiogram. A neurology consult has been placed.

Provider 101
Exercise One
Logging into Meditech Expanse and Navigation Buttons

Objective

In this exercise, you will practice the sign on process and explore the navigation buttons.

Signing On

1. Click on Meditech Expanse Icon
2. Enter Network Username and Password
3. Select 'Launch New Session'
4. Select HCIS: OAK.TEST
5. Select Job: Your Role
6. Click Sign On

Navigate to Web Acute Status Board

1. Once logged in, click on Clinical.
2. Select Web Acute Status Board.
3. Set up a Pin if prompted. If no prompt, follow these steps:
 - a. Click on the Menu button and select Change Pin
 - b. Enter Network Password
 - c. Enter New Pin and re- enter to verify then click OK.

Explore Navigation Buttons:

Click on the following buttons to get familiarized with their functions:

1. Return To: To switch between routines and charts.
 - a. Click and Select Main Menu
 - b. Click Return To again, and select Web Acute EHR to go back to the status board
2. Home & Chevron: To go back to home page.
 - a. Click on the Down Arrow to view list of other Status Boards available. You will only be able to click on those you have access to (ie. ED Tracker)
3. Middle Buttons:
 - a. Chart- To go to Chart
 - b. Document- To go to Documentation Tool
 - c. Order- To access Order Management Tool
 - d. Discharge- To access Discharge Routine
4. Sign Button: To view documents on queue to be signed
5. Menu: To access preferences and change pin function
6. Close: To close current Screen
 - a. This will close the status board and bring you back to the main menu.
 - b. Navigate back to your status board.

Provider 101
Exercise Two
Status Board and List Management

Objective

In this exercise, you will explore the acute status board. You will practice managing your rounds list; creating a personal list; viewing other lists; using the Patient Search bar; and navigating the patient rows and widgets.

Add a Patient:

1. Click on the Hamburger button located beside your name.
2. Click on 'Add Patient' to take you to the Add Patient overlay.
3. Click on the 'Name' Field.
4. Type your patient's name and press Search or the Enter key on your keyboard.
5. Select your patient.
6. Select 'Rounds-Show Cover' then click 'Yes'
7. The patient should now appear in your Rounds List.

Remove Patient:

1. Click on an empty spot on the patient row to highlight the patient. Once highlighted, the row should be green.
2. Click on the Hamburger button
3. Select 'Remove Patient'
4. Click 'Yes' on the pop-up.
5. The patient should disappear from your rounds list.

Restore Patient on List

1. Click the Hamburger button
2. Select 'Restore Removed Account'
3. If there is a list, find the patient you would like to restore and click on the checkbox beside their name.
4. Click 'Save'
5. The patient should re-appear on your rounds list.

To Make a Personal List

1. Highlight the patient you would like to add to your personal list.
2. Click on the Hamburger button
 - a. NOTE: To add multiple patients to your personal list, you would click ' Select Multiple Patients' and highlight the desired patients before the next step.
3. Click the Hamburger and select 'Add to Personal List'.
4. The patient should now appear in your 'Personal list'

To View other lists:

1. Click on the 'Rounds Patients' button.
2. Click 'Show All Lists'
3. Click 'Personal List'. You should now see the patient that you added from Rounds List.

To use the Find Patient Search Bar

1. Click on the Search Bar.
2. Type in your patient's last name.
3. Look for the percentage bar beside the patient name and note the color.
 - a. Click on the blue 'I' icon located at the bottom of the overlay, beside "Best Match Results".
 - i. Blue Means Best Match
 - ii. Yellow means Probable
 - iii. Red means Possible.
4. To increase match:
 - b. Click outside of the overlay.
 - c. On the left-hand side, add the patient's first name and age. When adding first name ensure that you have a comma in between (ie. Last name, First name). Note the results and the percentage bar.
5. Click on your patient's name. This should bring you to the patient's chart.

Note: This is only to access the patient's chart. There is no way to add a patient to your list from here.

Explore Patient Row:

1. Use Sign Out View
 - a. Click on 'Sign Out'
 - b. Click on the textbox to enter a note to communicate to a covering provider.
 - i. A 'Sign Out Comment' overlay should appear.
 - ii. Enter your note, then click 'Save'.
 - c. Click on 'Rounding' to return to the Rounding view.
2. Use Yellow Sticky Widget
 - a. Click on the Yellow Sticky to enter a personal note (ie. Check Labs). Click 'Save' when you are done.
3. Use Result Widget
 - a. Click on the Result Widget beside the yellow sticky
 - b. On the right hand side, click on an item to review (ie. Outstanding Orders)

Provider 101
Exercise Three
Status Board and Chart

Objective

In this exercise, you will explore the chart tabs, patient header, and reference panel. You will practice adding a medical history and problem.

Patient Row and Information

1. Find the following information:
 - a. Patient name.
 - b. Admission date
 - c. Reason for admission
 - d. OT number
 - e. Location
 - f. Pink Alerts. Click to view information available.
 - g. Code status

Open the Chart:

1. Highlight the patient by clicking on an empty spot. Once highlighted, the row should be green
2. Click on the Chart button located in the middle of the navigation bar.
3. Alternatively, you can click on the Patient's Name.

Chart Tabs, Filtering, and Sorting:

1. Find and click on the following tabs:
 - a. Diagnostic
 - b. Provider Notes
 - c. Nurse/Allied Health
 - d. Medications
 - e. Summary

2. Go to Provider Notes
 - a. To view filtering options, click on 
 - b. To look at viewing/ sorting options, click on the button above filter. You can sort by subcategory, specialty, date, or activity log.

Add a medical history & problem:

Enter 1-2 of the patient's past medical history.

1. Click on Medical, Surgical, Family, and Social History
2. Click Medical History
3. Click Edit and the Problems & History List should pop-up.
4. Go to the search bar and type in a keyword
5. Options should appear and to the right are these buttons:
 - a. Active: To add it as a problem
 - b. History: To add it to the medical history list
 - c. Both: To add it to the medical history as well as the problem list.
6. Select History.
7. Click Save and you should return to the chart where the item should appear.

Explore the Patient Header:

1. Find  located on the upper right corner. Click on this to view more information. Find the contacts for this patient.
2. To view previous visits, click on Acc #.
3. Click on Code Status bubble to view, re-order, or change code status.

Explore the Reference Panel:

1. Click on  to collapse all sections
2. To Graph:
 - a. Select a value (e.g vitals or lab)
 - b. Right Click to view options
 - c. Select Graph
 - d. Click on  to view graph
Note: You can select 'Graph Favorites' if this is a value you often like to trend.
3. To Add to Saved Data:
 - a. Select a value (e.g vitals or lab)
 - b. Right Click to view options
 - c. Select 'Add to Saved Data'
 - d. Click  to view saved data

Provider 101
Exercise Four
Document Types and Favourites

Objective

In this exercise, you will explore different document types and selecting favourites.

Open Documentation Tool

1. If you have remained in the chart, click 'Document' from the navigation bar
2. If you returned to the rounds list, highlight the patient, then click 'Document' from the navigation bar.

Explore Note Types and add to Favourites

1. Find the following document types, relevant to your specialty:
 - a. History & Physical
 - b. Consult Note
 - c. Progress Note
 - d. Procedure Note
 - e. Discharge Summary
2. For each document type, click the Star to add the document type to your favorites.
3. Click on the Home button to navigate away.
4. Return to the Documentation tool again.
 - a. Note the difference? You should only see your favorites now.
 - b. To see ALL document types again, click on 'Show All' checkbox
 - c. To search for a specific document type, enter a keyword in the search box (e.g Progress Note).

Explore Document Features:

1. Select Medical Consult Note.
2. Find the following buttons:
 - a. Menu to find Cancel or Switch options
 - b. Preview
 - c. Recall and Typicals
 - d. Sign and Save
3. Click on the  to collapse sections.
4. Click on the > chevron to expand an individual section. Now expand a section by selecting from the section bar.
5. Cancel this document by clicking  and select cancel or delete.

Provider 101
Exercise Five
Working With Notes

Objective

In this exercise, you will practice entering and editing a note. You will complete a Medical Consult Note using the scenario provided.

Complete a Medical Consult Note

1. To Enter the document:
 - a. Select from your Favorites **OR**
 - b. Click the 'Show All' checkbox to select from the list of document types **OR**
 - c. Use the Search Bar
2. To use a Pick List:
 - a. Ensure you are on Rapid Entry to expand picklists.
 - b. Under Exam section , go to subsection Const (Constitutional)
 - c. Click on the bubbles to document patient is **not cooperative, in distress, and confused**.
 - i. For affirmative, left click on the mouse. The bubble should appear green.
 - ii. For negative, right click on the mouse. The bubble should be green, with text crossed out.
 - d. Click on the down arrow button beside 'in distress'. Select additional details using the pick list or type in the comment bar.
 - e. Click on the menu button beside 'confused'. There should be a textbox to enter additional comments.
3. To add problems:
 - a. Go to Assessment and Plan section
 - b. Click Add Problem
 - c. Search for Stroke and select Active.
 - d. Change the status to Inactive in the R/I/R column.
 - e. Expand the R/I/R section. Change the status back to Active.
4. To add problems to the documentation:
 - a. Ensure a checkmark is placed on Stroke then click Save.
 - b. Enter details in the Assessment and Plan textbox.
5. Click on Preview button to preview output, located at the top of the page.
6. To sign, click on the 'Sign' button.
 - a. If you would like to send copies to another provider not automatically listed, click on 'Other' to search for the provider. Once finished, click 'Sign' and enter your pin.

Provider 101
Exercise Six
Progress Note, Documentation Tools, and Addendum

Objective

In this exercise, you will explore Medical Consult Progress Note and practice the use of recall and the documentation tools we looked at. You will also practice the use of Addendum.

Open Medical Consult Progress Note

1. Select from your Favorites **OR**
2. Click the 'Show All' checkbox to select from the list of document types **OR**
3. Use the Search Bar

To use Formatted Data:

1. Click on a textbox
2. Click  and select 'Formatted Data'
3. Search for a formatted data (ie. Last Response Vitals or lab)
4. Select desired item
5. Click 'Insert'
6. Data should appear in a table format

To use Saved Data:

1. Click on a textbox
2. Click  and select 'Saved Data'
 - a. If this option is not available, you would have to add an item. Please refer to Activity #3 (Reference Panel, Item 3).
3. An overlay should appear. A checkmark should appear beside the item you would like to add.
4. Click 'Insert' and your data should appear in a table format.

To use the Recall function

1. Click on the Recall button. A pop up should appear.
2. You should see the Assessment and Plan you entered from the previous note.
3. Click Apply and the data should now appear in the note.
4. Enter details in the Assessment and Plan textbox (e.g Continue current management).

Adding an addendum:

You want to add an addendum to your Medical Consult Note that you spoke to the patient's son and POA. He is aware of the plan and agrees with goals of care.

1. Go to Chart.
2. Select 'Provider Notes'
3. Find your document and click on the paper icon beside the status.
4. Click on 'Addendum' located at the top left corner of the note.
5. Click on the textbox and type in your addendum.
6. Click Sign, click sign on the overlay, then enter your pin.
7. Go back to chart and find the same note. Click on the paper icon and find your addendum.