CHAPTER 3

Doctor/Registered Nurse/ Nurse Practitioner (DOC) Role

The Doctor/Registered Nurse/Nurse Practitioner role (DOC) has the most extensive permissions in the system, other than the system administrator. In general they can perform all functions the OFF and PM roles can, in addition to several patient medical records functions unique to the role.

Specifically the DOC role has the *unique* ability to add and edit records in the following **Patient Information** areas:

1. Problems
2. Labs
3. Procedures
4. Notes
5. Orders

In addition, she can add new values to some **Reference Information** categories:

1. **Medication Status**: The filled status of a medication prescription.
2. **Note Titles**: The standard titles for **Patient Notes**.
3. **Problem Status**: The status of a patient's medical problem.
4. **Specialty of Cust's Department**: Specialty areas within the ambulatory care clinic.
5. **Visit Types**: Types of patient visits.
6. **Vital Signs**: Different types of vital signs for patient orders.
7. **Rooms**: The names or numbers of actual rooms in the clinic for appointment management purposes.

8. **Primary Care Team**: Name and location of various teams within a clinic.

9. **Primary Providers/Primary Care Team**: Primary Provider assigned to a Primary Care Team.

Finally, the DOC can view her schedule and unsigned notes and orders from the **Doctor Desktop** screen.

In the following exercises you will learn to create and sign **Patient Notes** and **Patient Orders**. You will also learn to read and use the **Doctor Desktop** screen to plan your work day as a Primary Provider.

Exercise 6: Creating a Patient Note

Patient notes include a medical diagnosis and the Primary Provider's assessment of the patient. To be effective, the note must be signed by the Primary Provider.

This exercise uses the class assignment for the DOC role. Log on to EHR LP, select the class, then select the assignment for the DOC role.

6.1 Record a Note for Your Patient

1. Locate your patient and display the patient's individual record.

2. From the **Patient Information** menu, select **Notes**.

   The system displays the **Patient Notes** screen with an empty list.

3. Click **Add New Record**.

   The system displays an empty **Patient Notes** form with a **Note Date** having today's date and time.

4. From the **Selected Title** list, click the standard notes title "General Note."

5. For the **Subtitle**, type "Annual Physical."

6. For **Urgency**, click "Routine."

7. In **Diagnosis (or code) contains (3 chars min)**, type "V70."

8. From **Diagnosis (ICD-9)**, click the code "V700."

! Code "V700" corresponds to the nomenclature for a general exam, "Routine general medical examination at a healthcare facility." You can also locate this diagnosis by typing part of the descriptive title. The more unique the text you type, the shorter the list. Try the words "examination" and "routine," and compare the results.

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9. For the **Note**, type "Patient is in good general health."

10. Select yourself as the Primary Provider in the **Signed By** list.

11. For the time being, ignore **e-Signature**.

12. Click **Save**.

    The system displays the individual note record. (Fig. 12)

13. Write down the **Note Date** and **Entry Date** for later reference.

! **Signed?** is "No" because you did not sign the note. The default value of **Note Date** is the date and time you started writing the note. The **Entry Date** is the date/time the record saved. Since you created a new record, the **Last Changed** date/time coincides with the **Entry Date**.

Figure 12 Patient Notes Screen, Individual Record
When you create **Patient Notes**, you must select a standardized **Diagnosis (ICD-9)** diagnosis nomenclature and code and type the free-text **Note** content. The system automatically records the **Entry Date** and **Last Changed** date as part of the record audit process.

In Exercise 11, you will sign your note.

Exercise 7: Starting the Patient Order Process

Patient orders include a medical diagnosis and instructions from the Primary Provider regarding the patient's care. An order can include a prescription for medication, referrals for procedures or consultations, lab tests or radiology exams, or specialized vital signs. To be effective, the order must be signed by the Primary Provider.

This exercise uses the class assignment for the DOC role.

7.1 Start the Order Creation Process for Your Patient

1. Locate your patient and display their individual record.
2. From the **Patient Information** menu, select **Orders**.

   The system displays the **Patient Orders** screen with an empty list.
3. Click **Add New Record**.

   The system displays a blank **Patient Orders** form.

The orders process is designed to help the Primary Provider and Practice Manager filter information and track their patients' health more easily by categorizing the information. Based upon the **Order Type** you select in the **Patient Orders** screen, you can generate more than half a dozen different types of orders, each with their own criteria.

Let us explore what is common to all patient orders, the different types of patient orders, and their characteristics.

Exercise 8: Exploring Patient Orders

This exercise is a continuation of Exercise 7. It uses the class assignment for the DOC role.

8.1 Explore Patient Orders in General

1. The top section of **Patient Orders** contains information common to all orders (Fig. 13):
   - **Order Type** designates which order the record is and determines what detailed information to require.
   - **Urgency** indicates how promptly an order must be completed.
   - **Order Date/Time** is the date and time the user began to fill the order.

- **Instructions** are the specific order directions. *Any details in the specific order sections must be entered in this area.*
- **Ordering Location** is the location at which the patient was seen and the Primary Provider is placing the order.
- **Historical Visit?** checked indicates this was recorded after the fact.
- **Primary Provider** is the designated signer of the order.
- **e-Signature** is the field the **Primary Provider** types her secret code for signing orders.

2. Scroll down to the bottom of the screen. The screen ends with **e-Signature**.

3. Select "V (Vitals)" from **Order Type.**

   The bottom of **Patient Orders** changes, displaying the specific fields for that type of patient order.

! Each **Order Type** has custom information displayed at the bottom of **Patient Orders**.

Patient Orders

Patient Information

Code	Prefix	First	MI	Last	Suffix	DOB	Gender	SSN
College12021971	Mr.	William	J	Montgomery		12/02/1971	Male	9711

Patient Orders

[Save] [View List]

* = Required Field

Patient	Montgomery, William J.
SSN	9711
Order Type*	
Urgency*	M (Medication)
Order Date/Time	C (Consultation)
	L (Lab)
	P (Procedure)
	V (Vitals)
	T (Text only)
Instructions*	I (Imaging)
Ordering Location*	
Historical Visit?	
Primary Provider *	
e-Signature	[Sign]

Figure 13 Patient Orders Screen, Add New Mode
Each order has common information, listed directly beneath **Patient Orders**. Every **Order Type** has additional information unique to its category. In this screenshot, the **Order Type** list displays all order selection options.

8.2 Explore Patient Orders for Medications

1. From the **Order Type** list, select "M (Medication)."
2. Scroll down to see the fields for medication orders.
3. A medication order is a prescription for a drug using the chemical name, such as "ACETAMINOPHEN," not the trade name "Tylenol."
4. Type "ACETA" in **Medication Chemical Name contains (3 chars min)**.

    Drug's Chemical Name (NDC) contains the drug "ACETAMINOPHEN" in the list.
5. A medication order also contains detailed prescription information, including the **Schedule** for taking the medication and pickup information. The select lists for **Dosage Form**, **Dosage**, and **Route** vary based upon the **Drug's Chemical Name (NDC)**.

8.3 Explore Patient Orders for Consultations

1. From the **Order Type** list, select "C (Consultation)."
2. Scroll down to see the fields for referrals to specialists.
    -   **Disease Specialty** is the specialist's practice type to whom the patient is being referred.
    -   **Attention** is the name of the specialist.
    -   **Consult Location** is the physical location of the specialist, such as his or her clinic or practice name.
    -   **Provisional Diagnosis (ICD-9)** is the ICD-9 diagnosis code that the patient's Primary Provider assigns to the patient—the reason for the patient consultation referral.

8.4 Explore Patient Orders for Lab Tests

1. From the **Order Type** list, select "L (Lab)."
2. The lab test fields available depend upon the **Collection Type** of the specimen.
3. Both **Collection Types** require the following fields:
    -   Lab test (and number) LOINC
    -   **Collection Date**
    -   **Schedule**

4. If **Collection Type** is "Collect Locally," the Primary Provider types a **Specimen Description** and **Sample ID** for tracking. The **Specimen Date** defaults to today's date and time.

8.5 Explore Patient Orders for Procedures

1. From the **Order Type** list, select "P (Procedure)."
2. **Procedure (CPT)** uses CPT codes and nomenclature for referring patients to specialists for further treatment. **Procedure (or code) contains (3 chars min)** narrows the list.
3. **Provisional Diagnosis (ICD-9)**, **Consult Location**, and **Disease Specialty** serve the same purpose as they do for "(C) Consultation" orders.

8.6 Explore Patient Orders for Vital Signs

1. From the **Order Type** list, select "V (Vitals)."
2. A **Vital** is one of the vital signs listed under the **Reference Information** menu option **Vital Signs**.
3. The **Start** and **Stop** dates, combined with the **Schedule**, indicate the duration and frequency with which to conduct the vital sign test.
4. **Special Instructions** could include more specific directions, such as what equipment to use or what range of vital sign readings to record.

8.7 Explore Patient Orders for Images

1. From the **Order Type** list, select "I (Imaging)."
2. In the **Imaging Type** list, click "General Radiology."
3. The **Imaging Procedure (CPT)** contains the CPT imaging code groups primarily in the 7X000 series, including but not limited to the 75,000 and 78,000 series.
4. Type either a partial code ("781") or phrase ("xray") in **Imaging Procedure (or code) contains (3 chars min)** to limit the list in **Imaging Procedure**.

8.8 Explore Patient Orders for Free Text Instructions

1. From the **Order Type** list, select "T (Text Only)."
2. Free text orders have a limited number of fields—a large **Description**, a required **Start** date, and an optional **Stop** date.

> **!** **Description** in the free text order offers the most flexibility for Primary Providers to create orders. However, free text order types also require the least specificity, making it difficult to systematically categorize and track these orders.

Now that you have seen the various types of orders for a patient, you can complete an order for your patient.
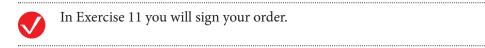
Exercise 9: Completing a Patient Order

9.1 Write and Save an Order

1. From the **Order Type** list, click "I (Images)."
2. From the **Urgency** list, click "Next Available."
3. Select an **Ordering Location**.
4. Select *yourself* as the **Primary Provider**.
5. Select "General Radiology" as the **Imaging Type**.
6. In **Imaging Procedure (or code) contains (3 chars min)**, type "ultrasound."
7. Select "76977" from the **Imaging Procedure (CPT)** list.
8. Type the **Exam Reason**.
9. The **Request Date** defaults to today's date and time.
10. Type **Instructions** to the radiologist. Include the **Request Date**, **Imaging Type**, **Imaging Procedure (CPT)** code and name, and the **Exam Reason**. Add anything else you think pertinent, such as the patient's **Gender** and **DOB**, shown at the top of the screen.
11. Click **Save**.

If you completed all required fields (Fig. 14), the system displays the saved record. **Signed** will display "No," and **Signed Date** will not have a value.

Figure 14 **Patient Orders Screen, Add New Mode**
The screenshot shows the completed fields for a patient **Order Type** "I (Imaging)" before you save the record. **Imaging Procedure (or code) contains (3 chars min)** contains "71111" to limit the list of choices in **Imaging Procedure (CPT)**. The **Instructions** contain the actual order to the radiologist, including the CPT code and possible diagnosis.

In Exercise 11 you will sign your order.

Exercise 10: Using Doctor Desktop to Manage Your Patient Care Load

As a primary provider, you do many tasks, including seeing patients (patient encounter) and signing orders and notes.

This exercise uses the class assignment for the DOC role.

10.1 Read Doctor Desktop

1. Click the **Doctor Desktop** menu.

    The system displays the **Doctor Desktop** screen. (Fig. 15)

✅ **Doctor Desktop** displays records for a user who is logged on to the system using the "DOC," or Doctor, role. Each category of information lists only records where the user is either the assigned Primary Provider for appointments or the assigned Primary Provider, or signer, for notes and orders.

Figure 15 Doctor Desktop
When you log on using the "DOC" (or Doctor) role, **Doctor Desktop** provides you access to a list of patient appointments where you are the Primary Provider, as well as unsigned notes and unsigned orders where you are the designated signer.

2. There are three sections to the work area:

- **Patient Appointments for [Day], [Date]**, showing the Primary Provider's appointments for a specific date.
- **Patient Notes**, listing all unsigned notes where the user is the Primary Provider named in **Signed By**.
- **Patient Orders**, listing all unsigned orders where the user is the **Primary Provider**.

3. If there are no patients listed under **Patient Appointments**, select another date using the calendar to locate appointments.

4. Under **Patient Appointments**, click the name of a **Patient**.

   The system displays that individual's **Patient Information** record.

5. Navigate back to **Doctor Desktop**.

6. Under **Patient Appointments**, click a date and time under **Start Date/Time** for an appointment.

   The system displays the individual appointment record.

Exercise 11: Signing Notes and Orders

Patient Notes and **Patient Orders** are not permanent until the signing caregiver, or Primary Provider, electronically signs the record using her eSignature.

This exercise uses the class assignment for the DOC role.

11.1 Sign a Note

1. From **Doctor Desktop**, click your patient's name next to his **Patient Note**.

   The system displays the unsigned note.

   ! An unsigned note has **Signed?** marked "No." **Signed** has no date.

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2. Click **Edit**.

3. Type your **e-Signature**, and click **Sign**.

   (Your e-Signature for purpose of this exercise will be the words **MySignature**. Simply type **MySignature** in the space provided once you have clicked on the **Edit**)

The system returns to the individual note record. **Signed?** now contains "Yes," and **Signed** has a date. (Fig. 16)

4. Observe a few intricacies about the note's dates:

    - **Note Date** is still the original date the note was first started (unless you deliberately changed it before signing the note).

    - **Entry Date** (the date the note was first saved, not signed) has remained the same.

    - **Signed** and **Last Changed** dates have the same date and time stamp.

5. Scroll down to **Patient Note History** to read the signed note's record.

6. Scroll up and click **Edit**.

7. Type some additional text in **Note**. Type your **e-Signature,** and click **Sign**.

    Signed and **Last Changed** dates and times reflect the current time stamp. **Patient Note History** contains a second record.

8. Return to **Doctor Desktop**.

    The patient note you signed is no longer listed in the **Patient Notes** list.

Every time you sign a note or order, the system creates a record in the history section of the screen, serving as a continuous audit trail and becoming part of the patient's care history.

Figure 16 Patient Notes Screen, Signed Individual Record
The signed **Patient Notes** has "Yes" and a date and time stamp for **Signed**? and **Signed Date**, respectively.

The same process applies to a **Patient Order**.

11.2 Sign an Order

1. From **Doctor Desktop**, click your patient's name next to his **Patient Order**.

    The system opens the unsigned order. **Signed?** is marked "No," and **Signed Date** has no date.

2. Click **Edit**.

(Your e-Signature for purpose of this exercise will be the words **MySignature**. Simply type **MySignature** in the space provided once you have clicked on the **Edit)**

3. Type your **e-Signature**, and click **Sign**.

    The system returns to the individual order record. **Signed?** now contains "Yes," and **Signed Date** has a date and time stamp.

4. Observe a few intricacies about the order's dates:

    - **Order Date** is still the original date the order was first started (unless you deliberately changed it before signing the order).
    - **Created** (the date the order was first saved, not signed) has remained the same.
    - **Signed Date** and **Last Changed** have the same date and time stamp.

5. Scroll down to **Patient Order History** to read the signed order's record.

6. Scroll up, and click **Edit**.

7. Type some additional text in **Instructions**. Type your **e-Signature**, and click **Sign**. (Your e-Signature for purpose of this exercise will be the words **MySignature**. Simply type **MySignature** in the space provided once you have clicked on **Edit.)**

    Patient Order History contains a second record with an audit history of the second order signed. (Fig. 17) These audit records become part of the patient's case history.

8. Return to **Doctor Desktop**.

    The patient order you signed is no longer listed in the **Patient Orders** list.

Figure 17 Patient Orders Screen, Individual Record with History List
Each time you log on to the system using the "DOC" (or Doctor) role, you can sign **Patient Orders** for which you are the listed **Primary Provider**. The system creates an audit record so Primary Providers have a **Patient Order History**, or case history, for each order.

You have completed all exercises through the DOC Role!

NOTE TO USER: YOU MUST COMPLETE ALL PRIOR EXERCISES BEFORE CONTINUING