Northwoods Virtual Epic Training –

Ambulatory Clinical Support (Nurses and Medical Assistants) Lesson Plan

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## Introduction

### ****Welcome****

Hello and welcome to Aspirus Outpatient Clinical Support Epic training. I am excited to walk with you through this information to give you a basic idea of how the system functions. Class layout will include instructor lead demos and individual exercises.

### ****Administrative Notes****

Before we get started, I would like to go over some administrative notes. Please silence cell phones for the entirety of the class. Feel free to stand and stretch during class if you need to. We will have routine breaks throughout the class as well as a lunch break at around the mid-mark of the class.

### ****Questions****

I welcome questions as we go through the material. If there are any questions that I am unable to answer they will be added to the parking lot. Feel free to shout them out as we go through the material. Or, since we will be reviewing each individual lesson plan upon completion, you can feel free to save them until that natural break in the action.

### ****Materials****

The binder contains exercises and a classroom information sheet that will be used throughout class to guide you through some hands-on practice. There is a training companion at the end of the binder that we will reference during class. At the end of class, we will show you where to find all these materials, as well as tip sheets on the intranet. The job aid is there for you to take notes and use in your clinic.

### ****Environment****

Class is led in a training environment with fake patients and end users. Our class focuses on teaching you Epic functionality. We attempt to create scenarios with rich patient data that are as realistic as possible, but there are some instances where the environment we are using and the scenarios we are going through are not completely accurate/complete from a clinical standpoint. However, feel empowered to make these scenarios your own so that they are reflective of your clinical specialty.

### ****Meaningful Use****

Another thing we will discuss throughout this training as it relates to workflows in Epic is the term “Meaningful Use.” Meaningful Use is a government mandated program controlled by the Centers for Medicare and Medicaid which defines criteria for ‘Meaningfully using’ an Electronic Health Record or EHR. Aspirus must report on certain criteria to qualify for reimbursement. There are several training points we will make through the curriculum that relate to “Meaningful Use.”

### Pre-Requisites

### Epic - Overview of Hyperspace in an Outpatient Setting

### Epic - Finding Patient Information

### Epic - Office Visit Demonstration

### Epic - Ambulatory: Ordering in an Outpatient Context

### Epic - Clinic Administered Medications

### Epic - Ambulatory: Wrapping up a Visit

### Epic - Introduction to Communication Workflows

### Epic - Overview of In Basket

### Epic - In Basket: Telephone Encounters

### Epic - In Basket: Following Up on Results Messages

### Epic - In Basket: Handling Refill Requests

### Classroom Materials = 480 minutes (8 Hours)

* Introduction PowerPoint (15 minutes)
* Explain Classroom Materials (Login Sheets, Guided Practices etc.)
* User Guides and Tip Sheets for Playground Login post-class

### Departments and Patients Used for Training

* Department: Weston Clinic Family Practice
* Patients: Rick, Isaac, Fred, Heather, Nancy, Linda, Luke, Sophie and Olivia

## ****Logging In/Orientation to the Epic Workspace****

1. Log in using your **User ID** and **Password** on the provided Login Sheet.
   * User ID: trn####
   * Password: logins
2. Keep the **WESTON CLINIC FAMILY PRACTICE** department and click **Continue**.
   * If you need to log into a different department, you can change it here.
     + Click the magnifying glass icon to change the Department if you are working in a different clinic, or in an inpatient department at the hospital.
   * Epic remembers the last place you logged into and will store it on the **Recent** tab.
     + Otherwise, use the **Search** tab to locate your clinic.
3. Click **OK on the Message of the Day** and click **Remind Me Later** for the pop-up window that appears.
   * The system defaults to the **Schedule.**
   * The **Schedule** provides an overview of all the patients scheduled to your clinic as determined by your Login Department, arranged chronologically by appointment time.
   * The Schedule will always default to today’s date, but as you can see, users can navigate to different dates using the Calendar on the top left side of the activity to review different dates of service, moving both forward for to review future visits, or backward to review past visits.
   * Notice that there are several tabs just beneath the Epic Button in the top left portion of the screen. These are referred to as Home Workspaces.
     + Let’s quickly explore some of your other Home Workspaces in Epic.
4. Graphical user interface, application, website

   Description automatically generatedHover over the tab containing a bar graph.
   * What does it say?
     + **My Dashboards**
5. Click on it to open your Learning Home Dashboard.
   * The My Dashboards tab will contain a host of information containing various reports, references, clinic metrics, as well as Tip Sheets which users can access to review both basic and advanced workflows.
   * My Dashboards will also be used to disseminate details about Epic upgrades, outlining cosmetic modifications to the user interface as well as workflow changes that may been made to the system.
   * Point out the **Patient Lists** workspace – Inpatient users will find all admitted and Emergency Dept-based patients within Patient Lists. If outpatient or Ambulatory users are keen to review information pertaining to any admitted patients that they also see in the clinic, they can go to Patient Lists, or they can simply go to Chart Review which we will discuss shortly.
6. Let’s return to the Schedule for further review of our primary workspace. Find the green calendar icon in the tab just below the Epic button and click on it.
   * Let’s review some additional landmarks and baseline utilities within Epic to ensure that we can effectively navigate, exploit basic functionality, and even customize our experience within the system.

### Hyperspace Title Bar

* + At the very top of our screen is the title bar. 
    - This shows what time zone, environment, department, and who is logged in to the workstation, representing a great way to ensure we are not stepping on each other’s toes in shared workspaces.
      * If things ‘don’t look right’ in Epic, check the Title Bar to ensure you are in the correct department, and also that you are the one logged into the system.
    - **Note:** It is very important that you log into the correct time zone when you are using the live system.
      * If you log into the Central Time zone and are working in Eastern Time zone, you may not be able to document because it is “Read only.”

### Main Hyperspace Toolbar

* + The Epic button is out Lighthouse, anchoring us in the system. It will always be visible.
    - Think of the Epic button like a “File” button in a Word document containing all the necessary tools that can be used within the software.
  + On the same bar as the Epic button, you’ll see a series of frequently used tools or buttons on the main toolbar. These will be referenced throughout class.
  + At the end of the Toolbar, we can see some very useful tools:
    - **The Wrench** icon – Allows users to edit the activities we can quickly access
    - **Log Out** button – Which users should click when they are leaving the system for an extended period of time, either for lunch or at the end of the day.
    - **The drop-down arrow next to Log Out** contains two additional items.
      * Secure: If you plan to shortly return to your workstation but are briefly leaving, Secure the workstation to save time when logging back in, protecting patient data as well as your own work.
      * Change Context: Allows users to switch Login Departments without needing to log out completely.

### Schedule Toolbar

* + Each Home Workspace will also contain a set of tools that are specific either to the patient population housed there, or the specific utility that is being offered.
    - The primary button we will user here is the Review function. Before we go into a patient’s chart, we will explore a few other tools available on the schedule.
      * Hover over the **Review** button to see Epic’s Hover to Discover functionality.
      * Notice that most of these items are greyed out and inaccessible. Before they are available, we will need to tell the system whose information we would like to review.
    - Let’s talk about that next.

## Finding Your Patients

**Scenario: Because** patients are generally not assigned to Nurses and Medical Assistants, we will want to look for our provider’s schedule(s) to review our list of patients for the day. Your provider(s) are listed on your Log In Sheet**.**

1. Beneath the Calendar on the upper left side of your screen, notice the folders: My Schedule and your Login Department (in this case, Weston Clinic Family Practice):
   * Text

     Description automatically generatedCurrently we are looking at the entire Weston Clinic FP’s patients for the day.
     + But since we will not be caring for the entire department’s patient population, at least not today, we want to narrow that down.
2. Expand the Weston Clinic Family Practice Department folder by clicking the black arrow, or carrot, beside it.
   * Notice that all the providers in the clinic now display.
   * To see your provider’s schedule for the day click their name.
     + Notice how the Schedule gets much less cluttered.
   * Let’s now associate the Providers from our Login Sheet to our own schedule so that we do not need to go digging through the Department folder each time we want to review our patients each day.
3. Click on your Nurse name just beneath where it says, “My Schedule”. The **Gears** icon just above illuminates. Click on it.
   * A Schedule Editor appears where we can edit the contents and layout of our visible schedule.
4. Click on the Configuration tab toward the top left side of the screen.
   * On the left side of the screen you see a list of Providers, Nurses, and other clinic resources.
   * On the right side you should see your Nurse’s name.
5. Scroll through the list of Providers on the left side of the screen and find your “car” doctor (Bentley, Cadillac, Corvette, etc.). When you find them, click once on them, then click the **Add** button in the middle of the screen.
   * Note: you can also double-click to add them.
6. You also have a “rock” doctor (Amethyst, Coral, Diamond, etc.) on your Login sheet. Add them to your folder, as well using the same steps above.
7. Click **Accept** on the bottom right side of the screen.
   * These providers are now associated to your schedule and will remain there until you remove them.
   * Back on the Schedule screen note that you now have about a dozen patients.
   * Find the **Provider** column on the Schedule and note the provider that is assigned or scheduled to each patient.
     + Note: users can edit (Add or Remove) these columns by using the same Gear icon that we used to add providers to our schedule folder.
       - Columns are editable in the General tab.

**Tip Sheet Available!** - *How to Create and Modify Your Schedule*

* + Before reviewing our patient’s information, let’s review some additional components of our schedule screen

### Status

* + Notice the **Status** column on the schedule. Most of your patients will have a status of Scheduled and perhaps have a comment about their Check-in Time beneath it.
    - Note: Until a patient is checked in for their appointment, users cannot begin documenting patient care.
      * When a user attempts to access the chart, a **Pre-Charting** activity will appear where users can edit documentation ahead of the patient’s arrival.
  + Review the list of additional Schedule Statuses in the table below:

|  |  |
| --- | --- |
| **Scheduled** | Patient has not arrived at the clinic yet |
| **Arrived** | When the patient is checked in for their appointment by Front Desk staff |
| **Rooming in Progress** | Nursing staff is logged in and started documenting |
| **Waiting** | The time between nursing staff and provider logging in |
| **Visit in Progress** | Provider is logged in and started documenting |
| **Checked Out** | When the patient checks out of the clinic |
| **Signed** | All required documentation has been completed and the encounter has been Signed. |

### Type

* + Informs us as to the nature of the visit.
    - i.e. Worker’s Comp., Office Visit, Wellness Exam, OB Visit, etc.

### Notes

* + Allows us to see the free text reason for visit that the scheduler recorded when making the appointment.

### Calendar

* + To the left of the Schedule is the calendar
    - When looking at the calendar, today’s date is automatically selected and displays the patients who are scheduled for today.
    - You have the capability of navigating to a future, or past date, by clicking on the desired day on the calendar. 
      * Note the **Today** button just above the calendar which will always bring you back to the present day.
  + Epic has a functionality called **Date Conventions** which are essentially shortcuts to documenting dates and times in the system
    - For example, to see a month into the future, type in “M+1” and press “Enter” or “W-1” to go to back one week.
      * T = Today
      * W = Week
      * M = Month
      * Y = Year
    - And elsewhere in the system, Time can be documented in the same manner:
      * N = now
      * H = hour

**What questions do you have about Finding Your Patients?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## Reviewing Patient Information

**Scenario: Prior to our first patient’s (Rick) arrival, we are hoping to gather information about their historical as well as their most recent care, whether it was received at our clinic, or at a different facility.**

1. Graphical user interface, text, application, chat or text message

   Description automatically generatedClick once on Rick’s appointment.
   * Clicking twice, opens the patient’s encounter for charting to begin.
     + If you did this, use the “X” on the patient’s tab to close their chart.
   * On the Schedule workspace, in addition to our list of patients for the day, we should also see a report on our selected patient either in the bottom, or right half of our screen.
2. Find the **Preview** box in the top right corner of our screen, just above the Schedule.
   * Ensure the Preview box is checked off.
3. Click the carrot, or black arrow beside Preview and select either *Auto-position*, or *Right* depending on where you want your patient report located on the screen.
   * Wherever you place the report, you should be able to see that you are able to review basic patient data including Demographics, Current Meds, Allergies, among other key health indicators.
     + Can anyone tell me the name of this report?
       - *Amb Patient List Report*
   * Notice the Search box to the right of the report button.
     + Users can search for other reports using the magnifying glass icon and even *wrench in* those reports, creating new buttons for quick access using the available Wrench icon.
4. To gather more data about your patient we can use Chart Review. Ensure you are reviewing details relating to your Rick patient and click the **Review** button on the Schedule toolbar.

### Chart Review

* + A “Welcome” screen may appear highlighting Epic’s new **Storyboard** functionality. Click “Let’s Go” to bypass it.
    - We will discuss this in more detail in a moment.
  + **Chart Review** is a gateway to your patients’ complete medical history.
    - Imagine an old paper chart that would contain a myriad of notes, lab results, x-ray images, prescriptions, signed consents, surgical details, etc.
      * Chart Review organized this method of patient data storage.
    - Chart Review is broken down into tabs containing details pertaining to specific medical categories.
      * Take a moment to orient yourself to the screen.

Graphical user interface, text, application, email

Description automatically generated

* + First note the list of tabs at the very top of the screen. There are known as Activity tabs, a common theme within Epic.
    - Notice that the Chart Review tab is lighter in color than the rest. That tells us where we are in the system. We are in **Chart Review**.
  + Within Chart Review, there are additional tabs such as Labs, Meds, Notes/Trans, etc.
    - Notice the Encounters tip has a pink box around it. That tells us where we are within Chart Review, on the **Encounters** tab.

### Encounters tab

* + Epic is an Encounters-based system. Every time patient care is delivered in some instance, an encounter will be or must be created.
    - Different types of encounters include an Inpatient admission, an office visit, a telephone call at the clinic, a procedure (e.g. a Colonoscopy), or a visit to the Emergency Dept.
      * Note: Users do have the ability to Edit or Addend encounters from this screen by right-clicking on the desired encounter.
    - Single-clicking on an Encounter will allow users to review the high-level details of that encounter, including the Provider’s note, orders that were placed

### Lab

* + Click the Labs tab.
  + This tab displays current, standing, future, and final lab/pathology orders along with the associated results, if available. Single-click any Lab to view the associated results.
  + Filters are a good way to narrow down the available information within Chart Review, isolating the most pertinent details regarding your patient’s care.
    - Timeline

      Description automatically generated with low confidenceClick the Filters button on the left side of the screen just beneath the Encounters tab.
      * We recall from the Schedule report that Rick has a history of High Cholesterol. We want to focus on those labs.
    - In the list of Orders, check off *LDL* and *Lipid Panel*, and click **Save as New Filters**
    - Type “Cholesterol Labs” in the Capton space and click **Accept**.
      * You should see a Cholesterol Labs check box at the top of the Labs tab which will now be available for all of your patients in Chart Review.

### Imaging

* + This tab displays information related to XR, CT, MRI (MR), DEXA, VAS, and US images and studies.
  + Single Click an imaging study to view results report.

### Cardiology

* + Contains results and reports related to EKG, Echos, Stress Test, Holters, and Cath Reports.

### Procedures

* + Displays information related to Sleep studies, PFTs, and Biopsies

### Other

* + Displays information related to Discharge instructions, diet orders, DME orders, and consult orders.

### Meds

* + Contains a list of the patient’s current and historical medications.
    - Current Meds Only filter is always checked by default
      * So if you want to locate the origins of a prescribed medication, this check box will need to un-checked.

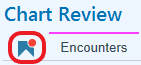
### Letters

* + If any letters were written on behalf of the patient to another provider, employers, school, or any other institution, those will be stored here.

### Notes/Trans

* + Contains all dictated, transcribed, or typed notes and instructions.
    - Make note of the “Me” filter at the top of the tab.
      * Note that only notes that have been Signed will appear in this tab. Notes that are in a Draft status will exist only within the Encounter until signed.

1. A picture containing Word

   Description automatically generatedFind the patient’s visit with Dr. Lahren from 6 months ago. This is the encounter when the patient was first diagnosed with COPD.
2. On the far left side of the encounter row, you should see a Bookmark icon. Click on it.
   * ****Notice that at the left end of your Chart Review tabs, the Bookmark tab now has a red dot indicating that a new item has been added to that section.

### Blood

* + Past blood administrations

### Media

* + Displays information related to Aspirus based scanned documents and annotated images (for example: scanned consent or HIPAA forms).
    - Handwritten notes, pictures drawn by a child, or other pertinent paper-based documents may be stored here upon scanning into Epic.

### Episodes

* + Pregnancies, Worker’s Comp visits, Psychiatric Care often user Episodes of Care to track ongoing care across a period of time.

### Misc Reports

* + External med lists, Code Status, coverage-related info, and Immunization Summary

### Hx/Off Premise Rec

* + This tab displays information related to medical records from outside organizations that are not on Epic. Users bring these details into Epic using **Care Everywhere**.

### Referrals

* + This tab displays information related to both external and internal referrals.

### LDAs

* + Lines, Drains & Airways (LDAs).
    - Additional information includes wounds, pressure ulcers, burns, incisions, etc.

### Consents

* + Consents that are completed and signed within Epic.
    - Release of Information (ROI), Transfusion consents, Adolescent Informed Consents, etc.

1. When you have completed reviewing the patient’s chart, exit out of the workspace by clicking on the ‘x’ beside their name on the tab in the upper left corner of the screen, below the Epic button.
   * Back on the Schedule screen, we see that Isaac has Arrived (is **checked in**) for their appointment
     + Text, email

       Description automatically generatedLocate the column on your Isaac patient’s appointment that is just to the left of the Time column.
   * When you hover over it, a circle outline appears.
2. Click on that circle to reveal a list of colors.
   * Red Dot = Rooming in Progress
     + To be done just after the patient is taken to the exam room
3. Select the red dot.
4. On the Schedule toolbar, click the **SnapShot** button.
5. On the far right side of the screen, locate the search bar and type ‘rooming’
6. Press Enter.
   * The Rooming report appears allowing users the opportunity to print in case the provider likes to have a paper copy handy while examining the patient.
7. Right-click anywhere in the report to reveal a print option which will delivery a copy to the nearest printer.

**What questions do you have about Chart Review?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Rooming Your Patient****

**Scenario:** Isaac has arrived and checked-in with the front desk. Isaac is here complaining of a Sore Throat and accompanying Cough. He is ready to be roomed. We quickly collected the patient’s weight and are now in the exam room **ready to document their additional care.**

1. Double click your **Isaac** patient from the schedule.
   * A **Best Practice Advisory** (BPA) pop-up may appear upon accessing the chart.
     + BPA’s inform providers about suggested treatments for patients based on several variable background checks about the patient’s medical and treatment history.
   * Bypass the BPA by selecting “Patient Declined” on the top portion of the screen and by also clicking “Do Not Open” on bottom half of the screen.
   * Click **Accept.**
   * Upon accessing a patient’s appointment, you will be brought directly to the **Rooming** activity
     + Notice the tabs at the top of the patient’s chart. The Rooming activity tab is a lighter shade than the rest which orients users to where they are in the system, orienting us to where we are physically located in Isaac’s chart.

### Storyboard

* + On the left side of the screen, you should see a sidebar containing an assortment of patient information. This is called the patient’s Storyboard.
    - Hovering over the data in Storyboard will reveal additional data about that specific aspect of the patient’s condition.
      * Hover over the patient’s Demographics. What happens?
    - Clicking on a segment of data will allow a user to edit that aspect of the patient’s condition.
      * Click on Allergies. What happens?
    - Navigate back to the **Rooming** activity.
      * If you get a pop-up about reviewing allergies, click Not Now.
  + Storyboard contains additional items such as the patient’s Problem List (patient diagnosis list), MyAspirus status, Covid-19 status, PCP, upcoming or overdue screenings/immunizations (Health Maintenance), as well as the clinical Sticky Note.
  + **FYI Flag** - If a patient has an active FYI the background above the patient name in Storyboard will be bright green.
    - A flag badge will display. Hover to discover more information.
    - There will be a number next to the flag to denote how many FYIs are present.
      * This area can be used to enter information that is not part of the patient’s permanent medical record but will help communicate with other clinicians.

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### Rooming Activity

* + Back in the Rooming Activity, make note of the of the links at the top of activity (aka the toolbar). These links allow you to quickly access points of documentation and information:

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1. Click the **Visit Info** link.
2. Document:
   * **Chief Complaint**: Cough
     + Add a comment – Began about 10 days ago
   * Add a second Chief Complaint below: Sore Throat
3. Click the **Vital Signs** link on the Rooming toolbar and document:
   * BP: 118/76
   * Pulse: 68
   * Temp: 96.8
   * Source: Oral (you can just type ‘O’ and select “Oral” when it appears)
   * Weight: 188 lb
     + You must either type the unit of measurement, or #
   * Height: 6’6
   * Resp: 20
   * Tobacco Use:
   * Click the **Edit Tobacco Use** link toward the right side of the screen
     + Are we still in the Rooming activity? Notice that the **History** tab is now a lighter color indicating to where we have moved.
   * Document:
     + E-Cigarette Use: Never User
     + Smoking Status: Never Smoker
     + Smokeless: Never Used
     + Scroll down past Alcohol, Substance Abuse and Sexual Activity and click **Mark as Reviewed**
       - Notice how your name now appears beside the button.
       - Marking the patient’s Tobacco Use. History, Allergies and Medication List as reviewed is a Meaningful Use requirement, allowing clinicians to confirm that these vital aspects of patient care have been discussed with the patient directly.
4. Click back into the Rooming tab above and select **Allergies**.
   * Notice that **Pollen (Hayfever)** is already documented.
5. In the “Add a New Agent” field type ‘Cipro’ and hit Enter. Select Ciprofloxacin.
   * Reaction: Rash
   * Severity: Medium
   * Reaction Type: Allergy
   * Click **Accept**
   * Click **Mark as Reviewed**
     + Note that Storyboard has updated the Allergies section in real time.
       - Hover over the Allergies section.
6. In the Rooming activity and click **Medications.**
   * We confirmed Isaac is still taking the medications listed here.
7. Click **Mark Unselected as Taking** toward the top of the section.
8. Click the **Select the patient’s pharmacy** button
   * On the Pharmacy screen, unclick “Patient and clinic’s nearby…”
   * Then, type ‘Toms’ in the **Name** field and hit Enter.
   * Select “Tom’s Drugs” and then click **Accept**
     + Note the Pharmacy above the Med List now says “Tom’s Drugs”
   * Click **Mark as Reviewed**
9. On the right side of the screen, notice there is a blank note. Click into it and document the following:
   * “Patient is here today for a severe cold that has produced a dry cough and a sore throat. Dr. [your car provider] would also like to have his iron levels checked.”
   * Click **Accept** at the bottom of the sidebar.
     + Note that there is also a **Nursing Notes** section with the Rooming activity. Your note can be written in either location, as necessary.

### Screening Activity

1. Still in the Rooming activity, click **Screenings.**
   * Note which tab you are now in.
2. Click **Adv. Directives**:
   * Click the magnifying glass in the “Do you have an Advance Directive on File?” field and select **Yes, it is on file**
3. Click **Depression Screening**:
   * Answer **Yes** to the initial question.
   * Select the **Not at all** option for both additional questions that appear.
     + Note that the **Depression Risk** score calculates automatically.
4. Click **Learning Assessment**:
   * Preferred Method of Learning: Demonstration
   * Barriers to Learning: None
   * Person Responding Relationship To Patient: Self
5. Click **Safety and Abuse Screening**:
   * Select **No** to the first two questions
   * Click **Close**
     + Note: For Peds patients, this screening should be performed every visit.
   * Note: There is an Aspirus policy regarding Depression Screening, Learning Assessment, and Safety and Abuse.
     + The Gender Identity/Sexuality section is only addressed when applicable
   * Make note of the additional screenings available including the ADL, Fall Risk, Gender Identity/Sexuality, as well as the Add’l Screenings section which will open the Nursing Flowsheets activity where users can access other screenings.
6. Click on **MyAspirus Signup** (MyChart)
   * A picture containing text, clipart

     Description automatically generatedMyChart gives patients web access to information in their Epic chart.
   * We can see if a patient is currently signed up for MyAspirus by checking the top portion of Storyboard.

### Other Pertinent Items in the Rooming/History/Screening Activities

***Trainer Note****: These sections can be quickly reviewed without extensive data entry.*

* + **Verify Rx Benefits** (Rooming) -A nightly process checks and displays any coverages and prescription benefits. If there are multiple coverages, check with the patient regarding which coverage is active. If the patient was an add-on appointment you must run the query manually. In this instance you will click “Check Again” in the Verify Pharmacy Benefits section.
    - When the providers are ordering medications, they will be prompted to select medications that are on the patient’s formulary.
  + **Medical, Surgical, and Family History** (History) - Document any past information that is pertinent to the patient. Be as specific as possible when documenting historical information.
  + **Substance and Sexual Activity (History) -** Documentation regarding alcohol, drug use, and sexual activity.
  + **Goals** (Rooming) -The PCMH (Patient Centered Medical Home) coordinator and physician use this area to add or update patient goals.
  + **Social Determinants of Health –** Beyond documenting essential medical history, users are now being asked to also document the social environment within which our patients are presently living. By documenting items such as financial strain, housing insecurity, among other social indicators help inform us about the totality of our patient’s health situation and can help clinicians respond in the most effective way possible.
  + **Care Everywhere –** Allows clinicians to ping non-Aspirus organizations that also use Epic, who may contain recent records of care for the patient we are seeing in the clinic.
    - For example if a patient visited St. Luke’s in Milwaukee, we could theoretically pull in the record for that visit or admission.

**Scenario:** We’re checking on Isaac’s **status regarding several topics we are seeing in their Health Maintenance report. We ask about a colon screening, and he reports that he recently had this done a few months ago at a different clinic.**

### Health Maintenance

* + On the Storyboard, scroll down to the **Health Maintenance** section and hover over it.
    - Health Maintenance informs users about upcoming or overdue vaccinations, screenings and other periodic health checks that might be needed for our patients.
    - Let’s document the details that Isaac provided to us:
  + Click on Health Maintenance on the Storyboard.
    - Note the tab that you are now in.
  + Select **Colon Health** and click **Address Topic**.
    - The Address Topic window appears:
      * Click **Add Completion**.
      * Completion Reason: **Patient reported already completed outside of Aspirus**.
      * Completion Date: **m-3**.
      * Enter the procedure location in the Comment section: **GI Associates**.
      * Click **Accept**.
  + Note: This information would likely be presented to users in a red box called “Reconcile Outside Information” which can then be confirmed with the patient upon viewing.
  + We will talk more about completing Health Maintenance-related items in the next lesson.

1. Close Isaac’s chart.
   * Back on the Schedule tab, locate the column on your Isaac patient’s appointment that is just to the left of the Time column.
2. Click on that circle to reveal a list of colors.
   * Green Dot = Patient ready to be seen by provider
     + To be done just before exiting the exam room.
3. Click the green dot to let your Provider know the rooming is complete.

**What questions do you have about the Rooming Activity?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Placing Orders, Administering Medications, and Immunizations****

**Scenario:** We’ve now turned our attention to Fred who we examined earlier today. Dr. Rock looked at Fred and would like certain labs and medications ordered. Additionally, based on a review of Fred’s Health Maintenance report, they would also like us to administer a tDap jab.

### The Plan Activity

1. Find your Fred patient’s appointment on the Schedule.
   * Note: Fred has an 8am appointment.
   * The Rooming activity opens where we can review the Visit Information and Vital Signs that we documented earlier today. However, we are not going to be working in the Rooming activity during this lesson.
2. Navigate to the **Plan** tab.
   * The Plan tab is where your provider will perform most of the work, updating the patient’s Problem List, confirming the patient’s Visit Diagnoses and potentially, using a SmartSet to complete documentation, billing requirements, follow-ups and placing orders for the patient’s visit.
   * Take a few moments to scroll through the Plan activity for a window into the documentation that a provider might add to the patient’s chart.
     + We will review SmartSets a bit later during the exercise portion of class.
3. Click Meds & Orders from the links on the top portion of the Plan activity.
   * You are reviewing the Medication List from the perspective of the Provider.
   * Note that there is some expanded functionality in this list.
4. Find the Fred’s Lipitor prescription in the list and hover over the icon.
   * What does it say?
   * This is the **Reorder** option.
5. Click to Reorder Fred’s Lipitor
   * Notice in the bottom right corner of the screen we see the Lipitor order
     + Note that the order has not yet been placed. It is simply “queued up” for a signature.
   * Before we sign this order, let’s see how we can place other orders in the system.

### The Visit Taskbar

* + On the bottom left side of your screen, just to the right of the Storyboard, you should see a series of buttons.
  + Presented are two different methods for locating and placing orders in the system.

1. Click **Add Order**.
   * A box appears displaying the test “Search for new orders”
     + Here, users can type out the name of an order and search for it.

### Lab Orders

1. Type Lipid and hit your Enter key.
   * The **Search Order** window appears displaying the matching orders based on your search parameters.
     + Notice how we did not have to enter the full order for results to appear.
     + Epic allows for a myriad of methods when searching for order including completion matching, partial word, and synonym searches.
   * Make note of the 3-4 tabs in the top right corner of the screen:
   * We will discuss the **Browse** tab momentarily, but notice that we begin on the Preference List tab.
     + The **Preference List** is constructed based on the most commonly placed orders by the user that is logged into the system (based on their role), as well as the most commonly placed and available orders in the Login Department.
       - The Preference List will also contain your personalized **Favorite** orders.
     + If you do not find the orders on your Preference List, check the **Facility List**, which will allow for a wider search of less commonly placed orders at your clinic.
     + The **Database List** searches the Aspirus enterprise for additional orders.
       - Note: Use of the Database tab is discouraged because the orders you find there may not be available at your clinic to be administered, drawn, or acted upon.
2. Based on what the Preference List has returned, we see the order that we want; select the top **Lipid Panel (Px Code 330275)** order and then click **Select And Stay** in the bottom right corner of the window.
   * Clicking Select And Stay allows us to continue searching for additional orders.
     + If you only needed the one order, or found the order(s) you need, you would click Accept.
3. In the top left portion of the Order Search window, type CBC and hit Enter.
   * Graphical user interface, application

     Description automatically generatedNote that the first CBC is highlighted in purple, meaning that it is selected.
4. Click **Select and Stay** once more.
   * Notice that you now have two orders in the sidebar, or shopping cart of the Order Search window.
5. Click **Accept**.
   * Notice in the bottom corner of the screen on the Visit Taskbar, we now see a button indicating how many orders we have queued up.
     + The window will initially display all of the orders.
   * However, we want to place a few more orders.

### Medication and Immunization Orders

1. On the Visit Taskbar, click the Preference List icon  beside the **Add Order** button.
   * The Search Order window opens once again.
     + Which tab are we in?
   * The **Browse** tab display our Preference List in a different manner, allowing us to review our most commonly placed orders using individual order categories (on the left) in conjunction with a check box functionality for selecting orders (on the right).
   * Fred came to the office complaining of pretty severe back pain, so we are going to provide him with an NSAID.
2. Expand the Medication category on the left side of the window and select the “Others” sub-category.
   * A list of medications presents itself on the screen.
3. Scroll through the list and check off the ibuprofen (MOTRIN) order.
   * Notice the medication now appears in our shopping cart, but we still want to place more orders.
   * We noticed earlier while examining Fred’s Health Maintenance that he is due for a Tetanus shot. So let’s order one for him.
4. Expand the Order Panels category and select the Immunizations section.
5. Toward the top of the list you should see **Boostrix**. Click the box beside it.
   * We want to place one last order for Fred, who appears to be in serious pain, so we are going to administer a pain medication in the clinic to help alleviate some of that pain.
6. In the top left corner of the Order Search window, search for Toradol.
   * Available orders appear in **Facility List** tab.
   * Observe that there are two main types of orders that we are being presented with:
     + Orders and Prescriptions Medications
       - Outpatient orders that will be filled at a pharmacy and administered by the patient at home. Indicated by aicon.
     + Clinic-Administered Medications
       - Outpatient orders that will be administered while the patient is in the clinic. Indicated by a  icon.
   * Because we are going to be administering this medication, we want to choose from the latter option.
7. Select the 60mg/2 mL injection option and click Select and Stay.
   * That should cover what we need for Fred today.
8. Click Accept.

### Signing Orders

* + Often times, before we can sign off on our orders, the orders themselves will require additional information.
    - For example, the Motrin order should be presenting itself to you on the screen, seeking additional information as designated by the Stop Sign icons.
      * Stop Signs indicate required fields which cannot be ignored
      * Yield signs indicate recommended fields which can be bypassed.
    - This window is called the **Order Composer**.
  + Let’s take a closer look at the Motrin order to ensure that the order will be prescribed as desired.
  + **Dose:** 600 mg looks correct. If we wanted to change it, we could simply modify it using free text.
  + **Route:** Oral. We did order tablets, so this is correct.
  + **Frequency:** The order defaults to “q6h prn”, however we only want Fred taking this medication every 8 hours, as needed.
    - Click “q8h prn”.
      * Note that users can also use the magnifying glass icon if the Frequency of their choice is not presented in button form.
    - Note the available PRN reasons.
  + **Duration:** While not a required field, is available. You can select Doses or Days.
  + **Dispense:** Can take the place of Duration by limiting the patient to only taking a certain amount of the medication.
  + Enter:
    - Quantity: 90
    - Refill: 1
  + **Patient Sig:** Directions for administration will often be contained in the order already, but users can update the Sig within the free text box.
  + **Class:** How the order will be submitted to the Pharmacy.
    - **Transmit –** the medication will be ePrescribed to the patient’s pharmacy
    - **Print –** the prescription will be printed, and the patient will take it to the pharmacy to be filled.

1. Click Accept in the bottom right corner of the Order Composer.
   * We should not see any additional Stop Signs, or required fields, however we do want to make some additional edits to our orders.
2. Click the CBC order.
   * We can see that the order it ready to be drawn today. However, we want our patient to have the lab drawn while on an empty stomach sometime in the next 3 months.
3. Change the order **Status** to Future.
4. For the Expected Date, click the “3 Months” button.
   * Check of the Approx. box, also.
5. Click **Accept**.
6. Next, click the Lipid Panel.
   * The patient has high cholesterol, and we want this lab drawn quarterly to keep a close eye on it.
7. Change the order **Status** to “Standing”.
   * An **Interval** field appears.
8. Click the magnifying glass and in the lookup, select “Every 12 Weeks”.
9. In the **Count** field, enter “4”.
   * Over the next year, the patient will have a Lipid Panel performed about every 3 months.
10. Click **Accept**.

### Creating Favorites

* + Recall that we had to do some digging to find our Toradol order that we are going to administer here at the clinic. To reduce the time it takes in the future, we are going to save that order as a **Favorite**.

1. Hover over the Toradol order.
   * You should see a Star, along with an “x” icon.
2. Click the Star icon.
   * An “Add to Preference List” window appears which will allow us to specify the contents of our order, along with ‘where’ on the Preference List we would like the order stored.
3. In the top right corner of the screen, change the **Pref List** value to “Meds” using the magnifying glass.
   * We are telling the system we want this order to be placed in our “Medications” category on the Browse tab.
4. In the same corner, click the **New** button, next to “Section”.
   * Here we can create a brand new subcategory for our order.
     + We want to create a Clinic-Administer subcategory.
5. Graphical user interface, text, application, email

   Description automatically generatedWithin the New Section screen, enter “Clinic Admin” into the **Display Name** field.
6. Click **Accept**.
   * Back on the Add to Preference List screen, notice that we can also modify the **Display Name** of the order itself.
     + Here you can change the order to be simpler to understand or easier to quickly identify later on when searching for your order.

**TIP:** *For your favorite lab orders, change the Display Name to something like, “Standing CBC” or “Quarterly Lipids” or even “Monthly A1C” for easy identification.*

1. Change the **Display Name** to “Toradol 60 mg/2 mL inj. (Clinic)”.
2. Click **Accept** to close the window and create your new Favorite order.
   * A “Replace Order” window appears.
3. Click “No” to close the window.

### Diagnosis Association

* + When signing orders in an outpatient setting, Epic will always force users to associate a diagnosis to certain orders.
    - Primarily labs, referrals, procedures, but rarely medications.
  + Users can anticipate this requirement by associating diagnoses before clicking “Sign”.
  + In the bottom right side of the screen, your unsigned orders should be visible.
    - If not, click the Unsigned Orders button to make them visible.

1. Graphical user interface, text, application

   Description automatically generatedClick the Dx Association button on the top left portion of the window.
   * A window will appear containing all the orders that will require a diagnosis to be associated prior to signing.
   * Within the window, note that users have access to a **Problem List** drop-down.
     + Presumably our provider will have updated the Visit Diagnoses along with the Problem List prior to writing orders. However, non-providers still will have the ability to add problems/diagnoses and associate them to orders on their own.
   * In the window, Hyperlipidemia may already be associated on the list.
2. Associate the Lipid Panel and the CBC to the Hyperlipidemia diagnosis.
3. In the search for diagnosis prompt, type ‘back pain’ and hit Enter.
4. In the pop-up window, select the **Low back pain** option and in the bottom section, click **Acute**.
5. Click **Accept.**
6. Associate the Motrin, Toradol and Boostrix vaccine to the Low back pain diagnosis.
   * Graphical user interface, text, application

     Description automatically generatedNote – Immunizations will likely be associated to an “Annual Visit” or “Physical” diagnosis, but we can bypass it for now.
   * Once all orders have a pair of colorful linked rings  associated we are good to go.
7. Click **Accept**.
8. In the bottom right corner of the screen, locate the **Sign Orders (#)** button and click on it.
   * The system will perform background checks against known allergies and other prescriptions to ensure patient safety.

### Reviewing Orders

* + Next to the **Sign Visit** button in the bottom right corner of the screen, you should now see a clipboard icon which will display a report showing each of our Signed orders.
    - But what if someone else placed orders for the patient, such as our provider? Is there anywhere else, outside of the chart, where we can be made aware of which orders were signed?

1. Leave Fred’s chart open and navigate back to the Schedule activity by clicking on the Green Calendar workspace tab just below the Epic button.
   * One of the immediate places where we can see potential clinic-administered medication orders is the Schedule itself.
     + Generally, your patient will have a “mortar and pestle” icon associated to your patient’s appointment, indicating the need for an administration to be performed.
       - Users can simply click the icon and it will bring them directly to the **MAR** (Medication Administration Record) activity in the patient’s chart to administer the medication(s) in question.

* Note: users will need to add the **Meds Due** column to their Schedule configuration to have this functionality available.
* See *How to Create and Modify Your Schedule* tip sheet
  + However, users can also leverage their Schedule reports to view additional orders, beyond just medications.

1. In the bottom half (or, right-side, depending on where your screen is configured) of your Schedule, click the report search field, type “orders” and click the magnifying glass.
   * The **Visit Orders** report may open automatically. Otherwise, select it from the list.
     + This report will give us additional details about lab orders that were ordered during the visit, medications that need to be administered, point-of-care tests that need to be performed, and immunizations that need to be administered.
2. Wrench this report into your Schedule screen by clicking the Wrench icon next to your report search field:
3. Select the “add or remove buttons from toolbar” option.
4. Graphical user interface, text, application

   Description automatically generatedAt the bottom portion of the pop-up window, select **Add Current** and click **Accept**.
   * Note that you now have a new report button on your Schedule screen called “Visit Orders”.

### Administering Immunizations

* + Recall that we ordered a Boostrix injection for the patient.
    - We will need to administer that jab prior to the patient’s departure.

1. Click back into Fred’s chart and navigate to the Immunizations tab.
   * If you cannot see the Immunizations tab, use Chart Search (the magnifying glass) in the top right corner of your screen, just below the Log Out button, to search for it.
   * At the top of the Immunizations activity, you should see the **TDaP** order that we placed earlier.
     + There should also be an **Administer** button associated to it.
2. Click the **Administer** button.
   * An administration window opens with a series of hard stops.
3. In the **Lot #** field, click the magnifying glass and select the first option in the lookup.
   * Notice how a host of other hard stops have been addressed by addressing the Lot # field.
   * The Time field has a Yield sign indicating the field is recommended but not required.
     + Let’s address it anyway.
4. In the **Time** field, type “n-15” and hit Enter.
   * A time of 15 minutes ago should appear.
5. In the **Site** field, select “Left Arm” from the lookup.
   * There is also a questionnaire section toward the middle of the Administration window asking about the VIS (Vaccine Information Statement)
6. Select **Yes** to this question and click **Accept** to complete the administration.
   * Make note of today’s Administration of the TDaP back on the Immunizations screen.

### Administering Medications

* + Recall that we placed an order for Toradol to alleviate Fred’s back pain before the leaves the clinic today.
    - All medications that are administered at the clinic will be documented on the MAR.

1. Navigate to the MAR tab.
   * You should see a Toradol administration.
   * We administered the injection just moments ago to a nervous Fred. Let’s document it.
2. Click the blue line that says **Due <date> at <time>** to begin the documentation.
   * An Administration window appears where we can document the specifics of the administration.
3. Document the **Site**: Right Deltoid.
   * Scroll to the bottom of the window noting the availability of a Pain Assessment.
     + If necessary, according to protocols, document this information in light of the Toradol being administered.
4. Once at the very bottom of the screen, click **Accept**.
   * Back on the MAR, note that the Toradol administration now has a status of **Given**.

**What questions do you have about Placing and Administering Orders?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Wrapping Up the Visit****

**Scenario: Now that we have administered Fred’s immunizations, medications and placed additional order for after visit care, we are preparing to send him home to pick up his prescriptions and rest according to the Provider’s orders. Before we do, we would like to finalize some information and provide some care instructions for his back pain.**

1. Navigate to the Wrap-Up tab.
   * This is a shared activity where both providers and clinical support staff can draw up patient instructions, write letters on behalf of the patient, enter billing details for the visit, provide follow-up instructions for the patient, as well as Preview and Print the patient’s discharge instructions (known as the After Visit Summary (or, AVS) in Epic).
2. In the **Patient Instructions** section, click the “Go to Clinical References” link in the top right corner.
   * Clinical References will recommend additional clinical guidance to patients based on the Problems and Diagnoses documented during the visit.
     + Users can select from the suggested topics, or they can search for additional documents to share with the patient.
3. From the **Relevant Documents** tab, select the Adult Advisor: High Cholesterol
   * A preview of the document appears on the right side of the screen.
4. Find the **Add to Patient Instructions** button and click on it.
5. Click the **Additional Search** tab and type “Back exercises” in the search bar. Press Enter.
   * A list of selections appears.
6. Select “Low Back Pain Exercises” and click the **Add to Patient Instructions** button.
   * Note: these instructions can be translated to a number of different languages.
     + Observe the multiple Language drop-down boxes.
7. Click back on **Wrap-Up.**
   * If you scroll through the note box within Patient Instructions section, you should see the documents that we intend to share with the patient.
     + Note: You can also free text instructions or draw on SmartPhrases that you have created previously to provide information to your patient regarding their condition, maintenance or treatment.
8. Click the **Communications** link at the top of the Wrap-Up activity.
   * This section allows us to generate letters and other communications on behalf of the patient.
     + We could be sending correspondence to the patient’s PCP, their school or work, or to some other organization that requires documentation of a test, condition, or other medical detail.
   * Users will first select the recipient
     + PCP, other provider, patient him/herself.
   * Then, they will select the type of correspondence.
     + Referral, work/school excuse, waiver, etc.
       - A template will then generate where the user can modify existing documentation, or free text the necessary details.
   * Letters and other communications generated in this activity will be stored in **Chart Review** on the **Letters** tab.

**Tip Sheet Available!** – ***Send a Letter to a Patient or Another Clinician***

1. Click the **Follow-up** link at the top of the Wrap-Up activity.
   * Here we can document when the provider wants to see or hear from the patient.
     + Users can either use the available speed buttons or document their own timeline manually.
2. **Return in**:
   * Enter “2” and then click the Weeks button.
     + The **Return on:** field should now display a date that is 2 weeks from now.
3. Check off the **PRN** box.
   * You can leave the defaulted text or replace it with more specific information.
4. **For**
   * Check off the **In-Person Visit** box indicating that the patient should set up an appointment should things not improve.
5. Click the **Preview** button in the **After Visit Summary** section.
   * Spend a few minutes reviewing the contents of the AVS noting all the details included and recalling where we documented or entered that information in the chart.
     + The AVS can be printed by the nurse, provider, or reception.
       - Check with your clinic to determine preferred workflow.
6. Close Fred’s chart.
   * The Provider is ultimately responsible for Signing the Visit.
     + They will likely do this later in the day after they complete their visit note.

**What questions do you have about Placing and Administering Orders?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## Specialty Workflow Lab – Well Child Visit

**Scenario:** Sophie is a 10-month-old coming to the clinic for a routine Well Child exam.

* + On the Schedule workspace, find your Sophie patient’s appointment.

1. Double-click to open her chart
2. In the **Rooming** activity – click **Visit Info**:
   * **Chief Complaint**: Well Child
3. Right-click on the Well Child entry and select “Add to speed buttons”
   * Notice the new button that is now available for all future visits.
4. Click **Vital Signs**
   * Pulse: 118
   * Temp: 98.6
   * Source: Temporal
   * Weight: 21 lb
   * Height: 2.5
   * HC (Head circumference) 39.5cm
   * Resp: 22
   * Click the **Edit Tobacco Use** link and scroll down to the Tobacco > Smoking Status question.
     + There should be a caution symbol within the field, indicating that it is Recommended for users to address.
   * Click the magnifying glass and select **Never Smoker.**
   * Select **Never Used** for the Smokeless Tobacco question.
   * Scroll to the bottom and click **Mark as Reviewed**
5. Navigate to the **Growth Charts** tab at the top of the activity.
   * Make note of the Print All button in the top right corner of the screen, but do not click it.
6. Click back on the **Rooming** tab.
7. Click **Allergies**
   * Enter **Soy Allergy**
     + Reaction: Hives
     + Severity: Medium
     + Type: Allergy
   * Click **Accept.**
   * Click **Mark as Reviewed.**
8. Click **Medications**
   * Graphical user interface, text

     Description automatically generatedIn the Add Medication field type ‘Flint’ and hit Enter.
     + The search may yield no results, so click the **Database Lookup** tab toward the top of the window.
     + Select the **Flintstones Gummies PO Chew** option
     + Scroll down and document:
       - Dose: 1 tablet
       - Frequency: Daily
       - Click **Accept**
   * Also add: **Zyrtec Children’s Allergy po**
     + Remember to use the Database Lookup
     + Click **Accept**
       - Dose: 5mg
       - Route: chew and swallow
       - Frequency: once daily as needed
       - Click **Accept**.
   * Click **Mark Unselected as Taking**
   * Click **Mark as Reviewed**
9. Click the **Plan** tab
   * Go to **SmartSets** (you may know these as “Encounter Plans”)
10. Click the suggested **ACI – WELL CHILD** SmartSet
    * SmartSets allow users to open note templates, place orders, add visit diagnoses, associate billing codes, and add follow-up details all in one location.
      + Providers may ask their nursing staff to open various SmartSets for them.
11. Click **Open SmartSets**
    * Choose the following under each section:
      + Documentation:
        - Select: **Well Child 1 Year**
      + Leave any orders that are already selected as selected
      + Modify the Diagnosis by clicking “Select Specific Diagnosis” next to “Routine infant or child health check”
        - Click either with or without normal findings
      + Go to **Infant-Child Immunizations**
        - Select: Pediarix
12. Click **Sign.**
    * Associate the order(s) with the “Routine infant and child health check” diagnosis
      + Notice how a new note template appears in the right sidebar.
        - You will learn more about Epic’s note writing templates during training.
13. **Cancel** the note
14. Select **Discard**.
15. In the top right corner of the screen, you will see a magnifying glass. Click it.

Graphical user interface, text, application

Description automatically generated

* + This is Epic’s **Chart Search** utility which can help users find anything from patient diagnoses, past lab results and even other Epic functions, such as the Immunizations activity.

1. In the search box, type ‘Immun’ and wait for options to appear (Do not hit Enter!).
   * Click **Immunizations** under “Jump to”
2. The Immunizations activity opens (note the tab you are now on).
   * Note the Pediarix (DTaP-HebB-IPV-Combo) vaccine is available for administration.
3. Click **Administer**
   * Lot: Click magnifying glass and choose first option.
   * Time: n and hit Enter. (‘n’ equals “now” in Epic)
   * Site: Left arm
   * Route: Intramuscular
   * Questions below: click Yes for the first two questions and indicate that the Patient is not VFC eligible
     + Stop Signs indicate that a field is required!
4. Click **Accept**
5. Click **Mark as Reviewed**
   * + Make note of the **Administered On** date for the DTaP-HepB-IPV-combo.
6. **Close Sophie’s chart.**

## Specialty Workflow Lab – Writing a Note

**Scenario:** Sophie is a 10-month-old coming to the clinic for a routine Well Child exam.

1. Find Sophie on the schedule and double-click to open her chart.
2. On the right side of the screen, find the **Insert SmartText** field above the blank note.
   * Note: Notes can also be opened via **SmartSets** which are found within the **Plan** activity.
3. In the **Insert SmartText** field, enter ‘AGC well child’ and press Enter.
4. Select the **AGC - Well Child 9 months** option and click **Accept**.
   * SmartTexts are note templates that feature a combination of tools to help providers quickly and exhaustively document patient care.
   * SmartText enlists several tools to accomplish this:
     + **SmartLinks**
       - Areas of the note highlighted in blue that contain details pulled directly from the patient chart.
     + **SmartLists**
       - Blocks of information that gives users the flexibility to make choices about what information they want to include in their note
         * Yellow backgrounds = Single-select lists
         * Blue backgrounds = Multi-select lists
     + **Wild Cards** (\*\*\*)
       - Wild Cards seek free text information from the user
       - Either replace the 3 asterisks with additional information or delete them.
     + **Note:** Wild Cards and SmartLists are required fields and will need to be addressed for the note to be signed.
5. Click into the note at the upper most point
   * Note that the patient’s demographic details appear toward the top.
   * To make your note space bigger you can click on the blue line to the left and drag it further to the left.
   * You can also click the **F3 key** to open the note in a larger window.
   * Note how the vitals that appear in the note automatically.
     + These are **SmartLinks.**
   * To address all required fields (SmartList and Wild Cards), press your **F2** key, or use yellow forward button up on the note toolbar.
6. Make your choice now.
   * We see that the first **SmartList** is a multi-select option.
     + How do we know?
       - The background is blue.
7. Left-click on the Mom option and press Enter.
   * You are immediately sent to the next SmartList.
   * It is once again a multi-select option.
     + Notice that there are Wild Cards built into the lists that will require free text clarification of the selections that you make.
8. Select the Breast Milk option by left-clicking on the selection and pressing Enter.
9. Address the Wild Card by either entering text to replace it, or by deleting it if no additional details are necessary.
10. Once again, press the F2 key or use the yellow forward arrow
11. In the next field, select Cereal and Fruit.
12. For the Wild Card, type “At daycare and for dinner at home”
13. Press F2 or click the yellow forward button once again to get to the Stool/Void SmartList.
    * Note that the background is yellow.
      + Single-select SmartList
14. Select any number by left-clicking and pressing Enter.
15. Continue to use your F2 key/yellow arrow to address all remaining SmartLists and Wild Cards.
16. When you get to the **P** section (for Plan), locate the green plus button on the note toolbar and click on it.
    * SmartPhrases allow users to generate their own blocks of text that can be saved and quickly accessed within notes, as necessary.
      + If you find yourself repeatedly documenting the same information, create a SmartPhrase to save it and recall it with just a few short keystrokes instead of typing it all out.
17. On the left side of the SmartPhrase Editor, type the following:
    * “Recommended mom give the baby more veggies, as possible. Encouraged her to give the baby more tactile toys, and “play games” where she gives and receives them to mom/dad/etc.”
18. On the right side of the window, is where you name the SmartPhrase.
    * It is recommended that you develop a naming convention.
      + If your SmartPhrases are for you alone, then use your initials as an identifier.
      + If your SmartPhrases will be shared throughout the clinic, perhaps use initials to identify the clinic.
19. Name your SmartPhrase ZZZBABYPLAN
    * Use your initials instead of ZZZ
    * SmartPhrase names will be all caps and one word.
20. Note how you can share this SmartPhrase with colleagues toward the bottom of the window.
21. Graphical user interface, text, application, email

    Description automatically generatedClick **Accept**.
22. Back in your note, if the Wild Card below the P: is already highlighted, type .ZZZ to trigger the system to search for your SmartPhrase
    * Again, use your actual initials from the SmartPhrase you created.
    * Highlight the Wild Card if not selected already.
23. In the pop-up window, single-click your SmartPhrase that appears, and press Enter.
    * You should now see the block of text we entered earlier appear in your note in the Plan section for Baby Sophie.
24. Address the final SmartList for Reach Out and Read age using F2/the yellow arrow.
    * A good way to check for completion is to return your cursor to the very top of the note and press F2/click the yellow arrow to see if you missed any required fields.
25. Click **Accept**.
    * The note will remain in a pended status and remain editable until the Visit is Signed and completed.
26. Close Baby Sophie’s chart.

## Specialty Workflow Lab – Prenatal Visit

**Scenario:** Olivia is here for her 4-week follow-up visit.

1. Double click **Olivia’s** appointment from the schedule.
   * In the Rooming activity, update the Visit Info
2. Chief Complaint: **Prenatal Care**
3. Access the **Vitals and Notes** section:
   * Document:
     + Blood Pressure: **140/88**.
     + Weight: **151 lbs**.
     + Albumin: **N**.
     + Glucose: **N**.
     + In the Notes section just below the vitals, type **Blood pressure monitored at home: Systolic 120 to 140. Diastolic 70 to 90**.
4. Click the **Episode** tab at the top of the screen.
   * Verify that the visit is linked to that episode.
     + If you do not see an Episode, click **Episodes of Care** on the right side of the screen.
5. Click **Episodes of Care**.
   * Episodes of Care is a grouping of encounters for billing purposes.
     + Ex: OB, therapy plans, wound, behavioral health, etc.
6. Click the **Select Episode** button
   * On the next screen, check off “Resolved” in the top right corner.
   * Select the New Pregnancy episode that appears and click **Accept**.
   * In the Episode Details section, delete the **Resolved** date.
     + Note that today’s visit is now associated to the patient’s Pregnancy Episode.
7. Click back into the Episode tab and select **OB Providers:**
   * Olivia was just assigned a Perinatologist so we’re going to add them to the chart
8. Search for ‘Anderson,m’
   * Make sure the specialty is correct (OB/Gyn) and click **Accept**.
9. Graphical user interface, application

   Description automatically generatedPractice adding information to the OB Sticky Note:
   * Find the small pink icon at the top portion of the **Storyboard**.
   * “Boyfriend in the military, stationed overseas now, and he’s not going to be here for the delivery.”
   * **Close** the OB Sticky Note.
     + Hover over the icon to review what you wrote
10. Optional for this exercise:
    * If you would like more practice in the Rooming activity, you can review and document the following:
      + Results Console
      + OB History
      + Allergies
      + Medications
11. Close Olivia’s chart.

## Specialty Workflow Lab – Protime Result Follow-Up

* + Anticoagulation encounters allow for tracking of Protimes.
    - Protime results will go to the AWC Protime Pool

1. Access your **In Basket**.
2. Click **Edit Pools**.
   * Verify there is a check in the box for AWC Protime Pool.
3. Click **Result Notes**
   * Note: ADS nursing staff will be finding these messages under Result Report.
4. Find the message for your Luke patient and click on it.
5. When the message appears, click the **Anticoag** button on the toolbar.
6. From the **New Encounter** window, enter Charger, Doc as the **Provider** from your login sheet and the Weston Clinic Family Practice as the **Department**.
   * ADS will enter the patient’s PCP and PCP Department location.
7. Click **Accept**.
   * If you receive a pop-up to add a problem to Encounter Diagnoses, click **Yes.**
     + Select **Longstanding persistent** and click **Accept**.
8. Click **Episodes** on the Anticoagulation toolbar.
   * If there is an episode already created verify it is linked to the current encounter.
     + If there were not an active episode, you would click the **New Episode** button.
       - Name: Anticoag
       - Type: Anticoagulation
       - Click **Accept**
9. From the Visit Taskbar, click Add Order and search for ‘anticoag’
10. Select for **Anticoagulation Therapy** and click Accept.
    * The order type will be Referral.
11. Complete the order details.
    * INR Goal: 2.0-3.0
    * Send INR Reminders to: AWC Protime Pool (ADS staff will send to ADS Primary Care Protime Pool).
    * Target End Date: Indefinite check box
    * First INR Date: t (press Enter)
    * Max Weekly Warfarin Dose (mg): 35
    * Click **Accept**.
    * Associate order with a diagnosis of A-Fib, Unspecified
      + Use the **Problems** drop-down to find it.
    * **Sign Order.**
12. Click **Contacts**.
    * Document an **Outgoing Call** to the patient.
      + Self: “Luke”
      + Home: ###
13. Click **Accept**
14. Click **Anticoag Track** on the toolbar.
    * We need to add a goal and dosing details.
15. Click the **No INR** button
16. In the Warfarin Dosing Instructions section, document:
    * Dosage of tablets the patient has on hand.
    * Update the maintenance plan with any dosage changes by clicking **Add Plan** or **Edit Plan.**
17. Document a priority using the speed buttons.
18. Document Date of next INR using the suggested date or free texting in a date.
19. Click **Close**.
20. Click **Sign Encounter**.
    * FYI: If a patient is taken off Coumadin, you would resolve the Anticoagulation Episode by opening a new Anticoagulation Therapy encounter.
      + Steps:
        - From Anticoag Track, click **Resolve Episode**.
          1. Reason: Therapy completed
          2. Place a check in the Resolve linked problems box if that diagnosis is no longer applicable.
          3. Click **Accept**

## Specialty Workflow Lab - Worker’s Comp Visit

**Scenario: Tim fell at work and injured his left knee two days ago and the pain has not improved.**

Note: Before starting a Worker’s Comp visit, ensure that the appointment is scheduled as a **Work Comp** visit type. If not, this will have to be canceled and rescheduled by registration.

**Note:** Much of the documentation is already documented for this patient. Do your best to ignore it and create your own visit documentation. Feel free to change the nature of the injury if it makes it easier to focus on the documentation.

1. Double click to open Tim’s encounter.
2. Document Vital Signs as well as a Pain Score and Location.
   * Since vitals were documented earlier, click the **New** tab to document a new set.
3. Click **Quick Questions**.
   * Modify:
     + Date of injury? **T-2**
     + Employer? **Wal-Mart**
     + Click **Close**.
   * Episodes of Care is a grouping of encounters for billing purposes.
     + Ex: OB, therapy plans, wound, behavioral health, etc.
4. Click **Episodes**.
5. Click the **New Episode** button.
   * Document:
     + Name: <Laterality> <Body part>
       - i.e., **Left Knee**
     + Type: **Workers Comp** 
       - (Type ‘Work’ and press Enter)
6. Click **Accept**.
7. Verify the box under Linked is checked.
   * **Episode** information can be found in Chart Review in the Episodes tab.
     + Future office visits, telephone encounters, and other encounters can be linked to this one episode.
     + Providers are responsible for resolving an Episode.
8. Close out of Tim’s workspace.
   * The Rooming and Screening documentation remains the same as an Office Visit.

## In Basket

**Scenario: We have wrapped up our appointments for the day and have some downtime to clean up our In Basket by responding to messages from colleagues, viewing correspondence with patients, and reviewing messages that may have been sent to our Nurse Pool from a Provider or someone at the front desk.**

* + **In Basket** is Epic’s internal messaging system that not only allows us to communicate interpersonally with our colleagues, but also provides enhanced security and supportive functionality that allow us to track the progress of our patients who will require additional care and communication outside the confines of the routine appointment-centered workflow.
    - Let’s review some of the functionality and benefits it provides.

1. On your Schedule screen, use any of the are several ways that exist to access In Basket.
   * You can:
     + Use the Epic Search utility to find In Basket.
     + Click one of the “Cards” on the far right side of the Schedule workspace which displays individual messages from In Basket.
     + Click the In Basket button from your Hyperspace Toolbar.
2. Graphical user interface, application

   Description automatically generated“I will select the In Basket button from my Toolbar”
   * Notice that a new Workspace tab appears displaying a yellow/golden envelope.
   * When you first open In Basket, you will see a list of folders on the left side of your screen.
     + Think of these like folders in Outlook or Gmail storing different types of messages.
       - Note: A folder only appears if there is a message within it.
         * Otherwise, it will not be visible in In Basket.
       - Bold folders = New message(s) are present
       - Un-bolded = Previously read messages are still present in the folder.
   * There is also toolbar that appears across the top, from which we can edit various settings, while also allowing us to send messages to colleagues, as well as patients.

### Sharing Your In Basket

1. Let’s begin with a fun exercise – Everyone click the **Attach** button on your In Basket toolbar.
   * Ask your neighbor for their username (e.g. Macarena, Linedance, Salsa).
2. Click the **Grant Access** tab in the “Attach Other In Baskets” window.
3. Enter your neighbor’s Login ID at the bottom of the screen and then click the **Grant** button.
   * Wait a few moments for everyone to catch up.
4. Now, click the **Attach** tab at the top of the “Attach Other In Baskets” window.
5. At the bottom of that window, once again add your neighbor’s Login ID and click the **Add** button.
   * This is how you can share In Baskets with colleagues, or your provider
     + First your neighbor needed to grant you access to their In Basket (and vice versa).
     + Once they did, you were able to attach their In Basket to yours in case one of you went out on leave, vacation, etc. or, if the event that you simply share a workload.
   * Look on the left side of your In Basket. At the bottom of the screen you should see a folder called “Attached In Baskets”
6. Click on it to view your neighbor’s In Basket messages.

### Staff and Patient Messages

* + As stated in the introduction, In Basket helps facilitate conversations between colleagues and staff at the clinic (and beyond), as well as with patients who come to the clinic.
  + Graphical user interface

    Description automatically generatedOn the In Basket toolbar, notice that just to the right of the In Basket banner are buttons for a **New Msg** and **New Patient Msg**.

1. Click **New Msg.**
   * This is where users can send a message to other users or colleagues either at your own clinic, or to another Epic shop.
     + Users can either send a message directly to a single user such as a Provider, Nurse, Medical Assistant, Front Desk user, or they can send a message to a Pool.
       - Pools are essentially distribution lists that contain like users.
         * There may be several pools at your clinic for nurses alone, broken down by specialty or coverage area.
         * Pool access is granted by the clinic manager.
         * You can see which pools you are assigned and/or checked in to by clicking **Edit Pools.**
     + Note that the messages can be patient-specific, or they can simply be logistical communications between users at the clinic.
       - Staff messages typically are not part of a patient’s permanent medical record. However, staff messages can be copied into Telephone Calls which will make them part of the patient’s medical record
   * Messages sent from the New Msg activity will appear in the Staff Message folder of the Recipient(s).
2. Send a message to your neighbor in class using their Login ID in the **To:** field, then adding a **Subject** and a quick message in the body of the note.
3. Click **Send**.
   * Note: every message you send, whether it be to a patient or colleague, will be stored in the **Sent Messages** folder at the bottom of your In Basket.
4. Click the **Refresh** button and go down to your **Staff Message** folder to see if you can find the message.
   * Note: Staff Messages referencing patients are not a part of the patient’s chart.
5. Click **New Patient Msg**.
   * Because we are not within a patient’s chart, or selecting a patient’s appointment on the Schedule, the system does not know who we are trying to communicate with.
     + Users can search for patients using their MRN (Medical Record Number), or by searching for their name.
       - Note: It’s good practice to include additional demographic details about your patient when searching for them by name to avoid selecting the wrong patient.
   * You will only be able to send messages to patients who have been signed up for the MyAspirus patient portal (aka MyChart).
     + Responses or direct messages from patients will appear in the **Pt Advice Request** folder.
   * Users can create templates called **QuickActions** that they can use as shortcuts when communicating with patients through In Basket.

**Tip Sheet Available!** – *Send Messages from In Basket Using QuickActions*

1. Click **Cancel** to close the Search pop-up.
   * Let’s explore some additional functionality and messages within In Basket.

### Patient Calls

* + The **Patient Calls** folder is where **Telephone Call encounters** will be routed either directly to your attention, or to a Pool.

1. Click the **Patient Calls** folder and find the message for your Heather patient listed on your Login Sheet.
   * When you select a message, a few things happen:
     + The original message is no longer bold
     + The Status changes from New to Read.
     + The message itself appears for us on the right side of the screen.
   * Notice one more thing about the message – it contains a icon indicating that it was sent to a Pool.
     + You can confirm it was sent to a pool by reviewing the message itself where the Provider sent a follow-up message to a Pool
     + Users that are reviewing a Pool message must take responsibility for any messages they intend to take action upon.
2. Above the message itself, on the toolbar, find the **Take** button and click on it.
   * Back in the folder, what happened to the “green dot” icon?
     + It’s now a  icon indicating that you have claimed responsibility.
   * Review the message to get an idea for how the conversation began and what needs to happen next.
     + Nurse Ballet initially received the call about Heather’s migraines and Dr. Automobile has since responded with advice.
     + We are now ready to take action.
3. On the toolbar above the message, click **Encounter**.
   * The original Telephone Call encounter that was created by Nurse Ballet opens.
     + Graphical user interface

       Description automatically generated with medium confidenceNotice that we are on the **Call Intake** tab.
4. Because we are going to complete the encounter by providing information to the patient, let’s instead click on the **Take Action** tab.
5. In the **Contacts** section, select **Outgoing Call**.
   * Many of the details may default in based on the initial phone call. Feel free to make changes as necessary.
6. Click **Accept**.
   * Note some of the other sections of this tab, including “Meds & Orders”, the “Problem List”, “SmartSets” and “Routing”
7. In the Sidebar on the right side of the screen, click **Create Note**.
   * We are going to document the discussion that we had with the patient based on the Provider’s feedback.
8. Document: Informed the patient that their Imitrex is available for pick up at the pharmacy. Reminded them that NSAIDs should not be taken on an empty stomach. Told them to call back in a few days if symptoms do not subside.
9. Click **Accept.**
   * If additional follow-up was required, we could send the encounter back to the Provider, or we could even route it back to a Front Desk pool for them to facilitate a follow-up appointment.
10. No follow-up is needed, so click **Sign Encounter** in the bottom right corner of the screen.
    * This will remove the message from our In Basket and into the Completed Work folder which is available on the bottom left side of the screen.

Graphical user interface, text, application, email

Description automatically generated

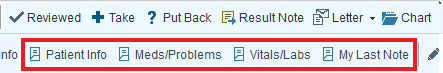
### Telephone Call Encounter - Refill Request

* + Often patient’s will call in between their visits to the clinic to request a prescription be refilled. Sometimes they can be refilled without any additional actions. Other times the patient may need to schedule an appointment or have labs drawn before a script can be refilled.

1. Find the **Telephone Call** button on your Hyperspace Toolbar and click on it.
   * Nancy called to get her Lexapro and Metformin refilled.
2. Search for your Nancy patient by typing out their full name and hitting Enter.
3. On the next screen, find your Nancy patient’s name and click **Select**.
4. In the Provider field input your provider’s name in place of your own username.
   * The Weston Clinic department should default in.
5. Click **New**.
   * You should be in the **Call Intake** tab.
6. Click **Contacts**.
7. Then:
   * Click **Incoming Call**.
   * Relationship: **Self**.
   * Phone: **Home**.
   * Click **Accept**.
8. Click **Reason for Call** and type **Refill Request**.
9. Add the medications being requested as a comment: **Lexapro and Metformin.**
10. Then, click the **Take Action** activity.
11. In theMedications & Orderssection,click **Load Meds** in the right corner of the section.
12. Click the **Reorder** icon  for the following meds:
    * escitalopram (Lexapro) 10 MG tablet (the Order Composer will open)
      + Dispense: **30**.
      + Refills: **3**.
      + Class: **No Print**.
      + Click **Accept**.
    * metformin (Glucophage) 500 MG tablet (click the med in the bottom right corner of the screen to open the Order Composer)
      + Leave defaulted details.
      + Class: **No Print**.
      + Click **Accept**.
13. Change the preferred pharmacy to the **Walgreens** in Antigo.
14. In the bottom right corner of the screen, click **Pend**.
    * **Note:** All medication refill requests must be routed to the In Basket to trigger a medication protocol. Protocols are in place to check patient information against certain criteria (scheduled appointment, lab results, etc.) without provider intervention.
15. Click the **Routing** section.
    * Note that the “Route as” field says **Rx Request**.
16. In the Recipient field type **p** **AWC NURSING POOL B**.
    * Note that you can add multiple recipients.
17. Add **p AWC Nursing Pool A**, also.
18. Click **Send and Close Workspace**.
    * The encounter tab will close, and you will be sent back to the screen you were on previously
      + Likely, either In Basket or the Schedule.
19. In not already there, navigate to In Basket.
    * You should have a new **Encounters** folder.
20. Click the **Encounters** folder.
    * Because you created this Encounter, the system will make you aware that it is open and still in progress.
      + The Encounter message will be completed once the Encounter is Signed.
    * You should also have an **Rx Request** folder.
21. Click the **Rx Request** folder and select your Nancy patient’s refill request.
    * Be careful! There should be several Nancy’s in the folder. Be sure to select your Nancy.
    * Based on what we can see in the message, the medication protocol was completed, and both the Lexapro and Metformin have failed.
      + We will have the Provider take a closer look
22. Click Approve and Routeon the toolbar above the Refill Request message.
    * Note some of the other available responses:
      + **Approve All:** Approve all requested medications, sign the orders, and automatically send a response to support staff.
      + **Approve and Route:** Approve all medications in the selected message and display notes and routing form.
      + **Edit Rx:** Approve or refuse requested medications and change any of the medications' order details. If necessary, you can add a note to the patient's chart, send a response to staff, and close the encounter.
      + **Refuse All:** Refuse all medications in the selected message.
      + **Refuse and Route:** Refuse all medications in the selected message and display notes and routing form
    * The system may require you to associate diagnoses to the meds**.**
      + Click Problems and select Hyperlipidemia**.**
        - Bypass the next screen by clicking **Accept.**
      + Click **Accept** once again.
    * You may also get an **Order Validation** pop-up screen.
23. Review the details and click **Accept**.
    * A pop-up screen appears where you will enter a quick note and route the details of the refill request to the appropriate party. In this case, the provider.
24. In the **Notes** section, type “Patient will need labs for upcoming visit”.
25. In the recipient field, enter the name of your Dr. Automobile.
26. Click **Sign and Route**.
    * The **Rx Request** message will automatically be marked as *Done*/*Complete* and disappear from your In Basket.
      + Note that the original **Encounter** message also disappears because it was Signed (and therefore completed) when we *Signed and Routed* the request.

### Result Notes

* + Because we are working in an ambulatory setting, we most often receive lab results for patients that are not presently at the clinic.
    - Each time a new lab is resulted, a message will be sent back to the provider’s In Basket, whether normal or abnormal.
    - Depending on the nature of that result, the Provider may route a Result Note message to a Nursing Pool to pursue potential follow-up with the patient.

1. Click the **Result Notes** folder and find your Linda patient.
   * Be cautious to select the correct Linda patient from your Login Sheet.
2. Above the message on the right side of the screen, click the **Take** button take ownership of this message.
   * The question mark icon will change to a plus (+) sign.
     + Spend a moment reviewing the message itself:
       - The provider’s message is listed at the top.
         * In this case, the patient does not require a follow-up visit, just a quick phone call.
       - The results for the lab(s) appears below.
         * Is the result normal or abnormal?
         * The exclamation mark indicates that there is at least one abnormal result present.
   * Just below the Toolbar above the message, notice that there are a series of report buttons.
3. Click the **Meds/Problems** report button.
   * Users can leverage these reports to make clinical decisions about patients without needing to go all the way into the patient’s chart.
4. Click back on the **Message** report button.
5. On the message toolbar, click **Telephone Call** to start a Telephone encounter.
   * Note: You may have to look under the **More** button to find it.
6. Change the **Provider** field to your [Rock] physician and click **New**.
   * A pop-up window appears asking “Do you wish to copy the message text to the encounter notes?”
7. Click **Yes**.
   * This includes the provider’s note from the In Basket message to the Notes activity of the telephone encounter.
   * A Telephone Encounter opens.
8. Within the Call Intake tab, click **Contacts**.
9. Document:
   * Outgoing call
   * Relationship: **Self**
   * Phone: **Home**
   * Click **Accept**.
10. Click **Reason for Call**.
11. Document:
    * Type: **Results**
    * Add a Comment: **Lipid Panel**
12. **In the sidebar on the right, click Create Note.** 
    * Notice that the result note is included in the documentation section of this encounter.
13. Type “Called patient with normal results.”
14. Click **Accept**.
15. On the bottom right side of the screen, click **Sign Encounter**.
    * Note: you are taken back to the In Basket where you can complete more actions, if necessary, or ‘done’ the message.
16. Click **Done** to remove from the message from your In Basket.

**What questions do you have about In Basket?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson