

POINT 'N CLICK

Point and Click is the computer program that manages/stores patient information at the Klotz Student Health Center. As a PNC, you will need to use Point n Click to check in a patient, make and change appointments, and document your counseling session. Dr. Lisagor has access to Point n Click and will check student appointments on a daily basis.

I. CHARTING PROCESS OVERVIEW

An overview of the charting process is provided here. Detailed instructions are provided below.

Timeline

Per health center policy, PNCs are to write chart notes within 48 hrs of seeing a patient and all patient notes be completed and input into Point and Click within 72 hours of patient visits. *Although the PNC has 48 hours to write the note, to ensure that the chart gets into Point and Click within 72 hours, the Word document should be prepared immediately after the visit (or as soon as possible) and emailed to the professor.* This will give the PNC professor time to make corrections and send them back to you. Also, charting immediately after a session is easier because the session is fresh in your memory. Although not a HIPAA violation, delays in posting chart notes in Point and Click can result in citations by the AAAHC accreditor.

The following table illustrates the deadlines for completing the SOAP note to the PNC professor and for entering the corrected SOAP note into the Point and Click system.

Patient Appointment	Word Doc emailed to Professor by: (48 hours)	Final Version entered in Point and Click (72 hours)
Monday	Wednesday	Thursday
Tuesday	Thursday	Friday
Wednesday	Friday	Monday
Thursday	Monday	Tuesday
Friday	Tuesday	Wednesday

Remember, no information that can identify a patient may leave the Klotz Student Health Center or Living Well Lunge in any form: hard copy, email, CD, thumb drive, etc.

Overview of the Process

1. PNC sees patient.
2. PNC prepares and proofs a SOAP note (see Writing SOAP Notes below) using Microsoft Word software. (Note: the SOAP note must be written and emailed to the PNC professor within 24-48 hours of seeing the patient.)
3. *It is critical that no identifying information be included in the note.* Identifiers include first and last names, student/staff identification numbers, appointment date/time or any other information which could be used to identify a patient. To help identify patients, PNCs will use an alphanumeric code.
4. When the SOAP note (Word document) is complete, the SOAP note is saved to the PNC drive (N) on the PNC computers.
5. Using an official CSUN email address, PNC emails the SOAP note (Word document) to the PNC Professor as an attachment.
6. The PNC professor will make corrections to the SOAP note if needed.

7. The PNC Professor emails the corrected SOAP note back to the PNC. This will be the final SOAP note for entry into Point n Click. (NOTE: If extensive corrections are needed, the PNC professor may request the PNC to resubmit a second [corrected] SOAP note. If so, the PNC follows the same procedure for emailing the second SOAP note.)
8. The PNC enters the corrected SOAP note into Point n Click.

II. WINDOWS and POINT AND CLICK INSTRUCTIONS

To determine if the computer is on, press the “Enter” key. If no image appears on the monitor, turn on the computer.

Logging on and off Windows

The Windows logon screen is the first screen you will come to when you log on to the computer. This login information is case sensitive. (If you need help with your Windows login, see a Health Promotion staff member. If you need to remember your ID and password, contact the CSUN ITR Help Desk at 818-677-1400.)

To log in to Windows:

1. Enter your CSUN User ID. This is the ID you use to log on to the CSUN Web Portal.
2. Enter your password.
3. Be sure CSUN is selected on the third input line.
4. If you are away from the computer, it will lock. Use the logon procedure 1-3 to unlock the computer.
5. ***Remember to log off Windows when you are done using the computer. If you do not, the next PNC will not be able to use the computer.*** To log off, click on “Start” in the lower left portion of the screen then click on “Log Off.” Click “Logoff” to confirm logoff.

Logging on and off Point n Click (PnC)

You will be assigned the Login Name and a password so that you can access PnC. This login information is case sensitive. (If you need help with your PnC login, see a Health Promotion staff member.)

To log onto PnC:

1. From the Desktop, click on the PnC icon (Turquoise Arrow).



2. Enter your Login Name (first initial of your first name and last name).



3. Enter your Password.

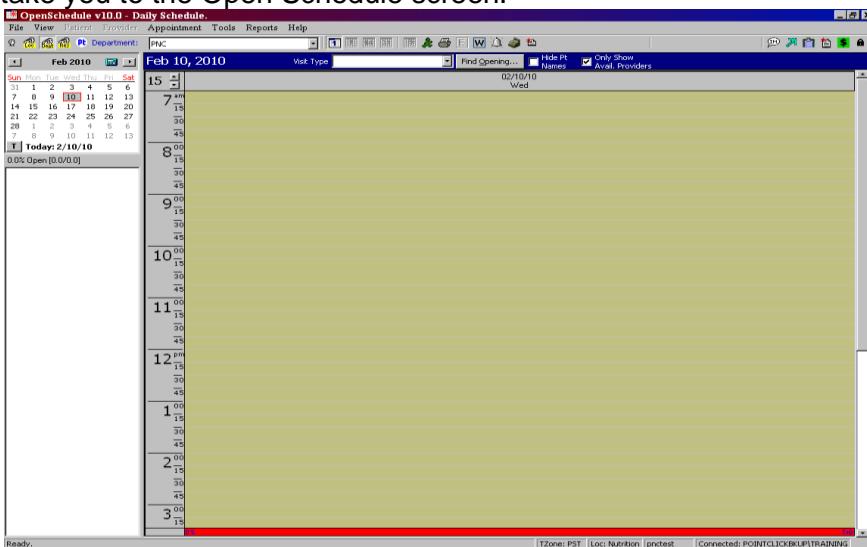
- The first time you log on to PnC, your Password will be: your first name, followed by the number “1”, followed by enough zeroes to reach 8 alphanumeric characters (minimum requirement). If your first name followed by the number 1 totals more than 8 characters, you do not need to add zeroes. This will allow access to change your password.
- Change your password. The system will ask for your old password, enter the Password you created in a) above. Create a new password (again, a combination of at least 8 alphanumeric characters). Click OK when done. Remember your password and keep it in a secure place. You are not to share your password with anyone.

4. Single click on “Enter.”

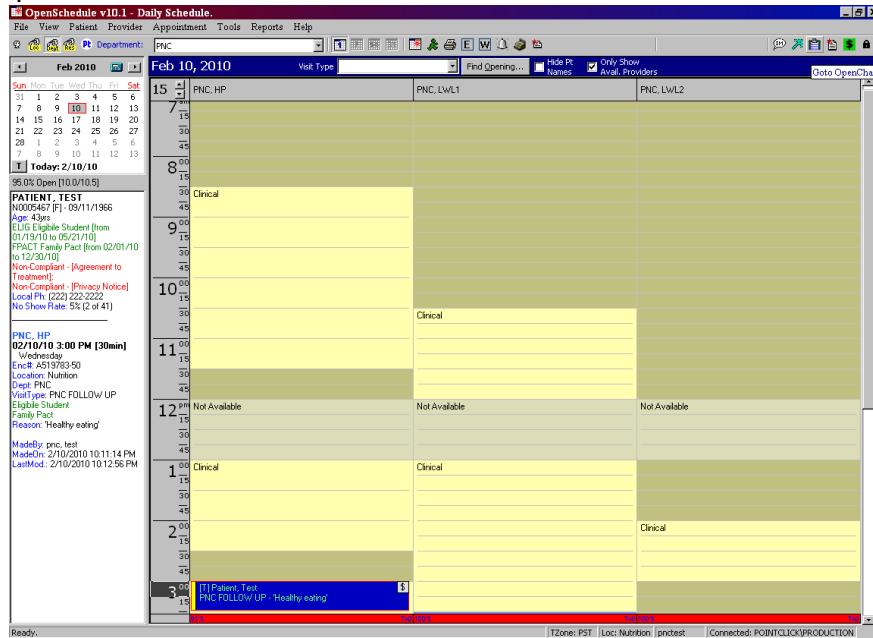
5. You will see a horizontal bar with icons.



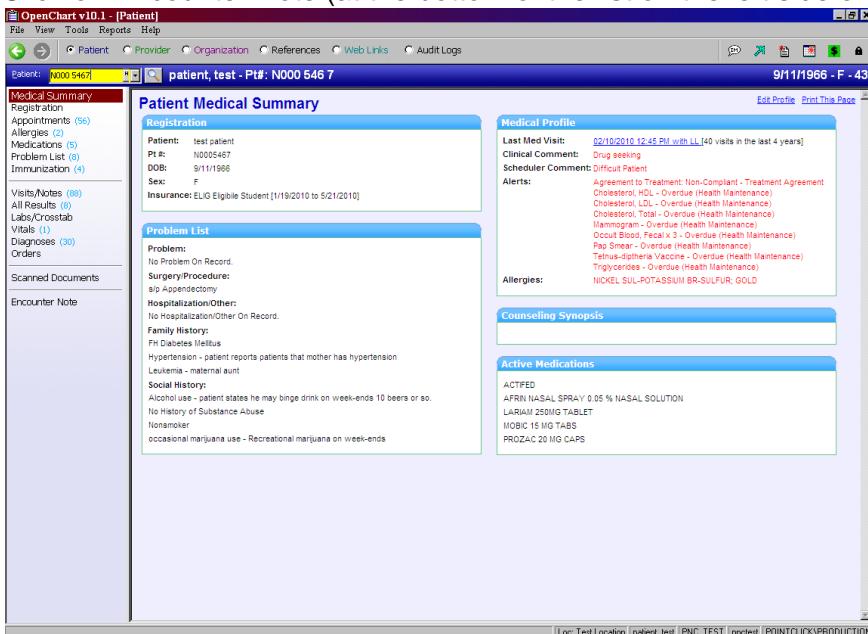
- If you will be viewing or scheduling appointments, click on the Scheduling icon. A box will appear in the center of the screen with a list of Departments. Choose Nutrition. This will take you to the Open Schedule screen.



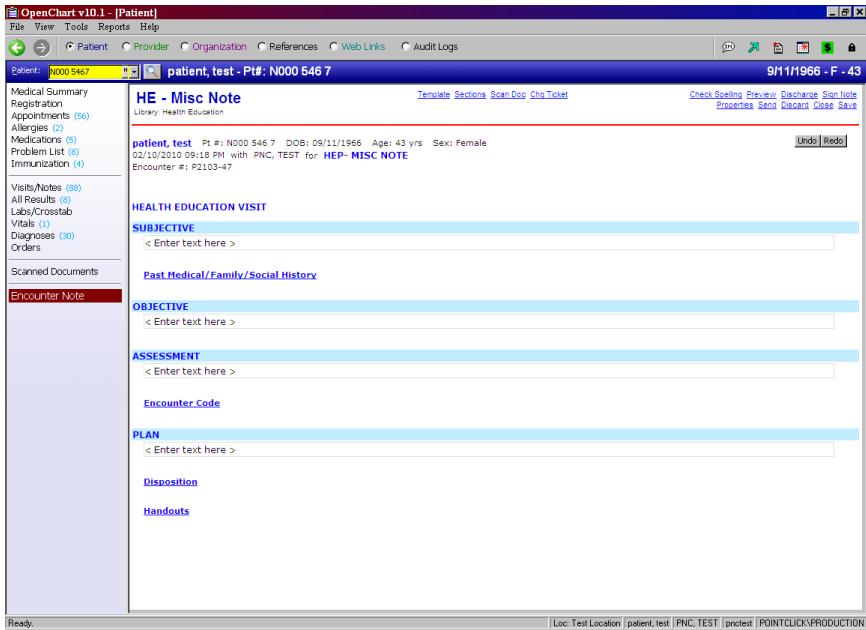
- If you will be cutting and pasting your final and approved patient notes from your Word document to the PnC system, click on the Chart icon (Clipboard); this will take you to the Open Chart screen.



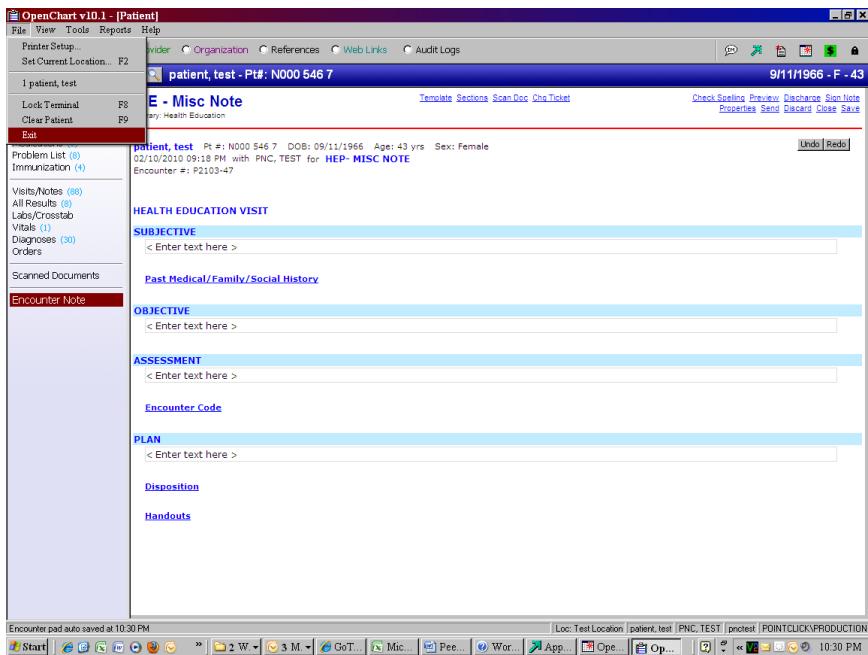
- At the top of the screen, select the bullet marked “Patient”. Enter the patient’s ID number. Click on Encounter Note (at the bottom of the list on the left side of screen).



- Click on Incomplete Documentation for PNC Provider on xxx Date. The charting template will appear. (Stop here and see “Charting Your Notes in PnC” below.)



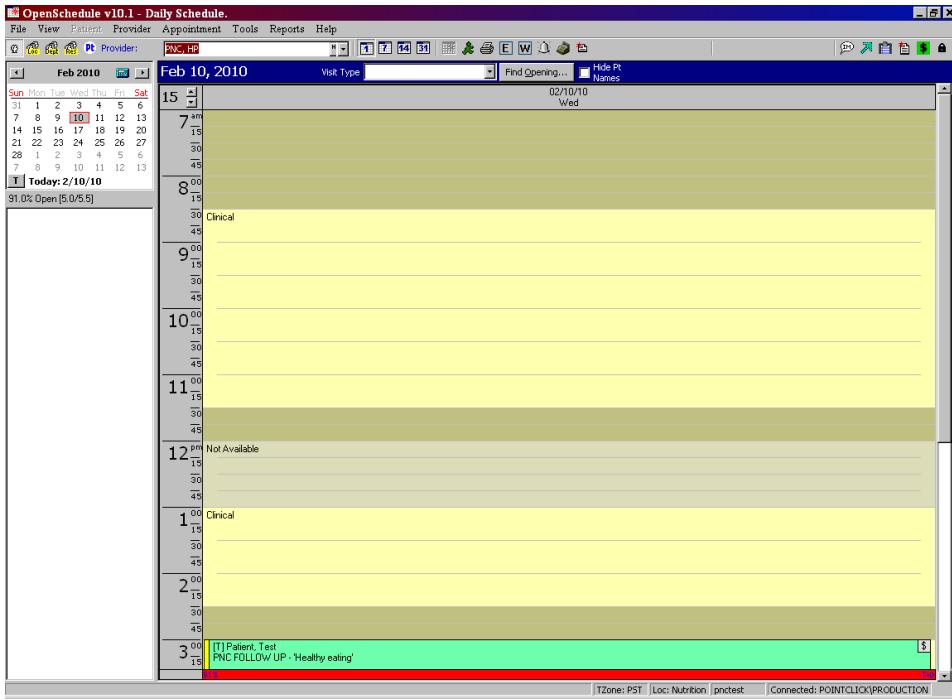
6. When you are finished with PnC, remember to log out, by clicking on “File” then clicking on Exit OR clicking the “X” (top right of your screen).



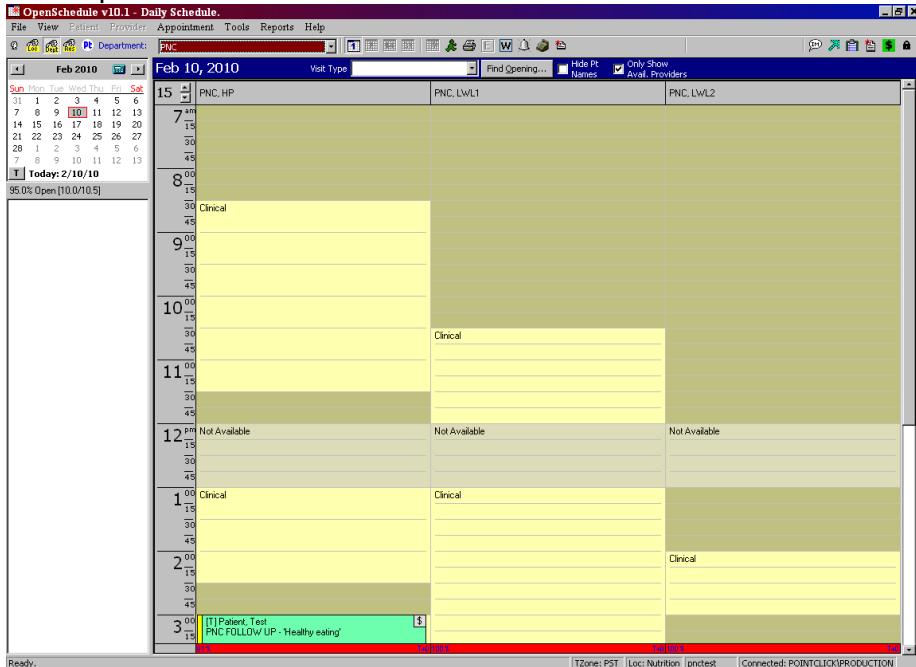
Viewing/Scheduling a Patient Appointment

To schedule an appointment, you can ask the patient to call the health center at 818-677-3666 to schedule the appointment. Or, if it is convenient, you can schedule the appointment yourself in PnC.

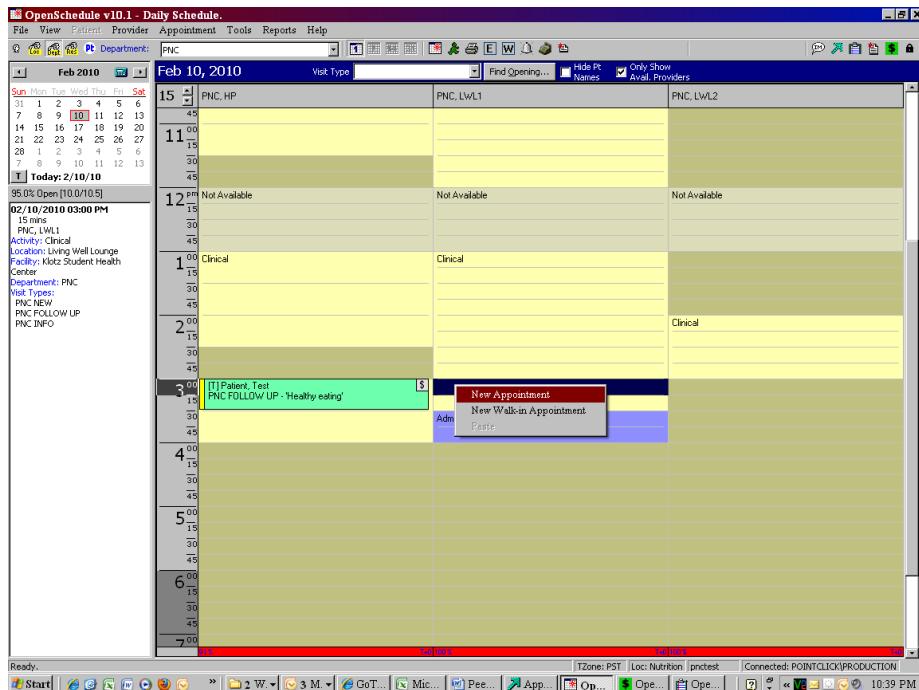
1. You might see a Tip of the Day. Please read the tip and click OK or X to close.



2. You are now on the Open Schedule page. From here, you can make, change or cancel appointments.
3. In Open Schedule, click on the “Dept” icon in the upper left corner of the screen. Click on the drop-down box next to “Department:” and select PNC. You should see PNC in the box next to “Pt Department:”
4. Check the schedule to determine when a PNC is available. Be sure you are checking the correct provider.



5. You will see the current day's schedule for each PNC (HP, LWL1 and LWL2). Select the correct date of the appointment from the calendar to the left. The calendar defaults to the current date.
6. Select the time of the appointment. Note: the red bar designates current time. Right Click on the blue bar that corresponds with the time of the appointment. Select New Appointment.



7. The Appointment window will display.
8. Enter the patient's student ID number on the Patient field and select enter. (The text field will initially be Yellow). If you entered the correct ID number, the field will turn White.

OpenSchedule v10.1 - New Appointment

Appointment Type: Patient Non-Patient Class

Patient Details

Patient ID # or first 3 letters last name, 3 letters of first:

Patient #: DOB: Future Appts Provider

Coverage: NoShow Rate: % (0 of 0) Schd Cmnt:

No Appointments on record.

Print Appts Appt. History

Ref/Case# New Edit

Appointment Details

Provider(s) PNC, LWL1 Visit Type Instructions

Location Living Well Lounge Double Bookable

Dept. PNC Early List

Date/Time 02/10/2010 Wed 03:00 PM Find Openings Recurrence...

Reason Code (none) Call Back #

Reason Procedures...

Additional

Private Help Save Appt Cancel

9. Click on Visit Type and select the appropriate Visit. A PNC New appointment will automatically default to a 60 minute appointment and a PNC Follow-up appointment and Information Session will automatically default to a 30 minute visit.

OpenSchedule v10.1 - New Appointment

Appointment Type: Patient Non-Patient Class

Patient Details

Patient patient, test Clear Patient Edit Patient

Patient #: N0005467 DOB: 09/11/1966 Future Appts Provider

Alerts: Non-Compliant - [Agreement to Treatment]; Non-Compliant - [Privacy Notice]

Coverage: ELIG Eligible Student [from 01/19/10 to 05/21/10]

NoShow Rate: 5% (2 of 41)

Schd Cmnt: Difficult Patient

02/10/10 12:00 PM LANDETA, LYNNE ...
02/10/10 12:45 PM LANDETA, LYNNE ...
02/10/10 03:00 PM PNC, HP

Print Appts Appt. History

Ref/Case# New Edit

Appointment Details

Provider(s) PNC, LWL1 Visit Type Instructions

Location PNC FOLLOW UP
PNC INFO
PNC NEW

Date/Time 02/10/2010 Wed 03:00 PM Find Openings Recurrence...

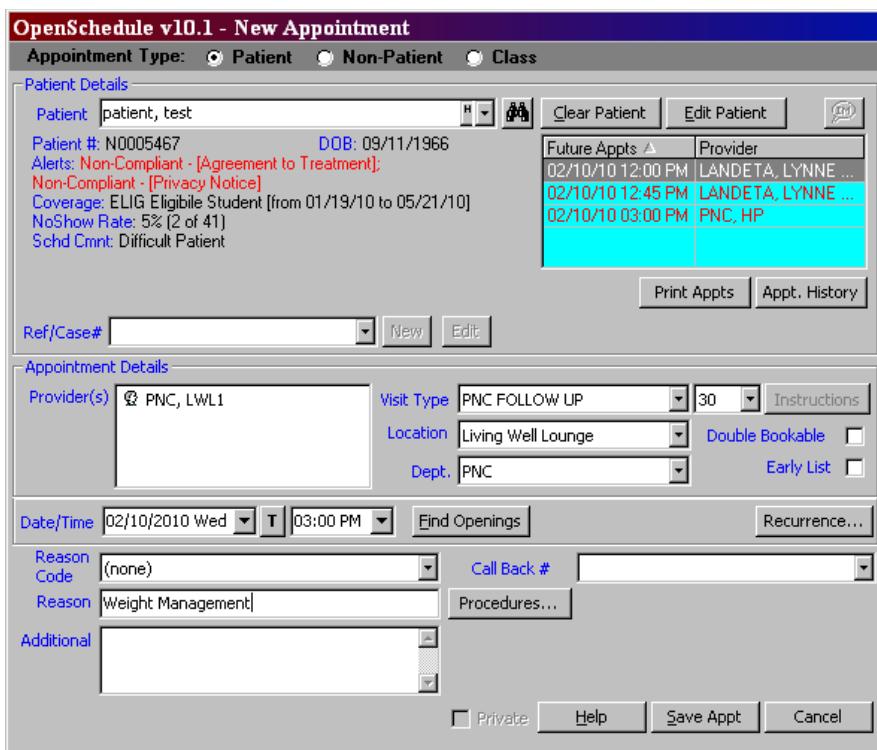
Reason Code (none) Call Back #

Reason Procedures...

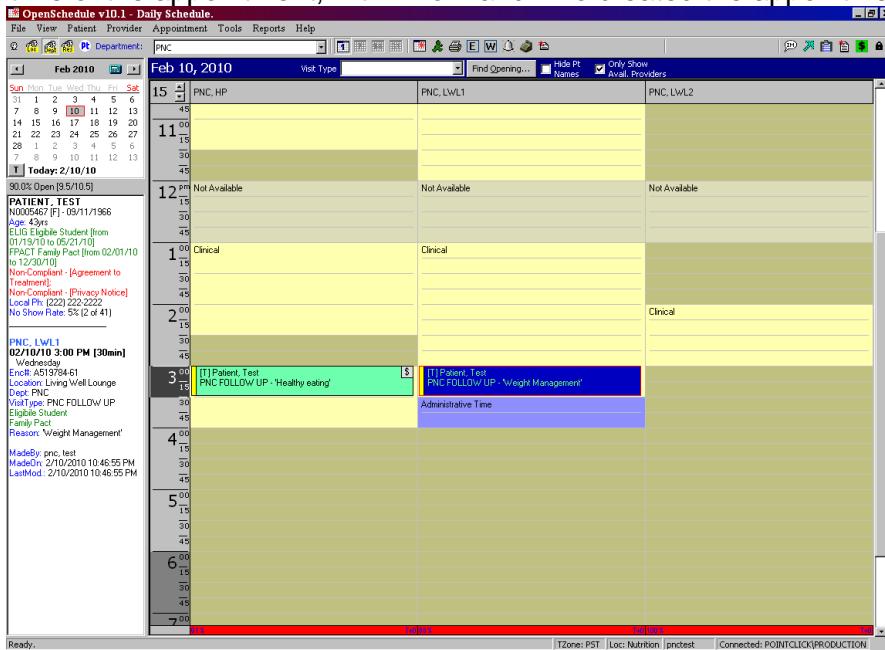
Additional

Private Help Save Appt Cancel

- Enter a Reason in the "Reason" box (e.g., Weight Management).
- Click on Save Appointment. Confirm the appointment information and select OK. After saving the appointment, you will return to Open Schedule and see the patient's name on the schedule.



- In Open Schedule on the left side of the screen, you can view the history on this specific appointment on the left side of the screen. You will see information on the visit type, date and time of the appointment, with whom and who created the appointment.

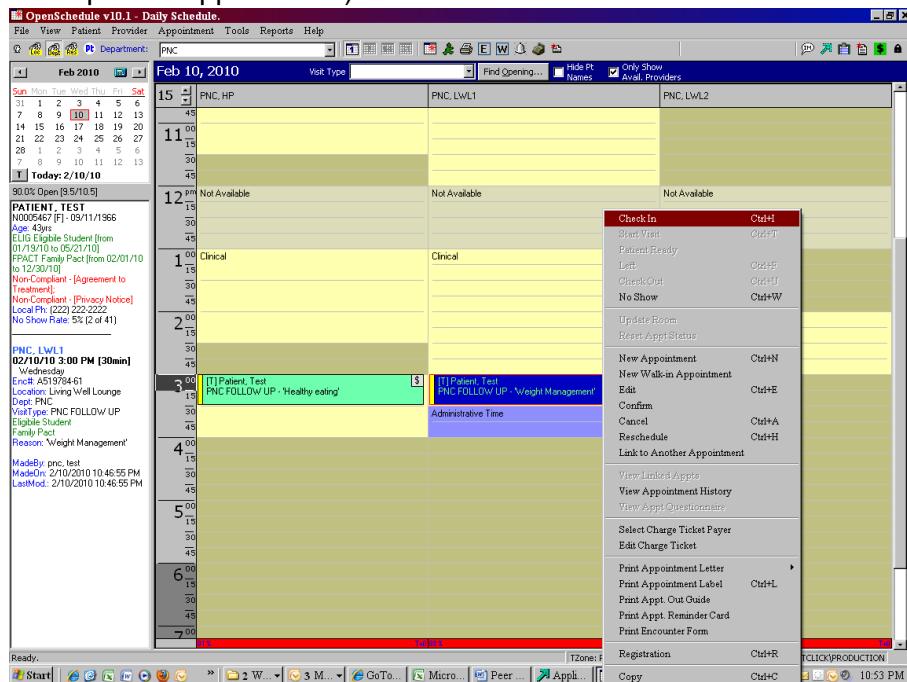


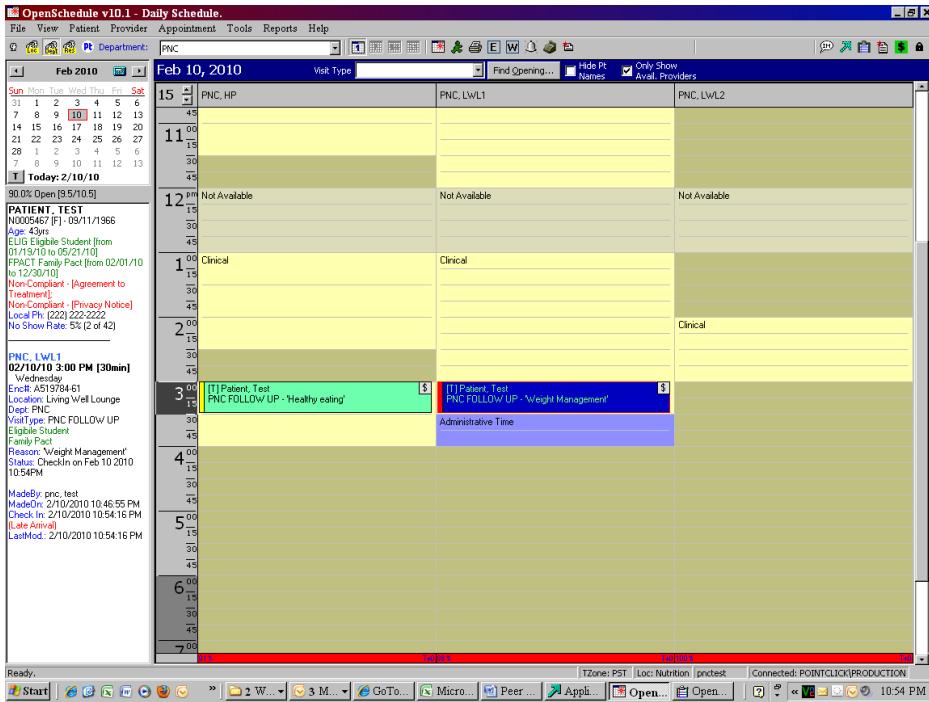
13. If your PnC session is complete, click on the X in the upper right portion of the screen or select File, Exit to log out.

Checking in a Patient

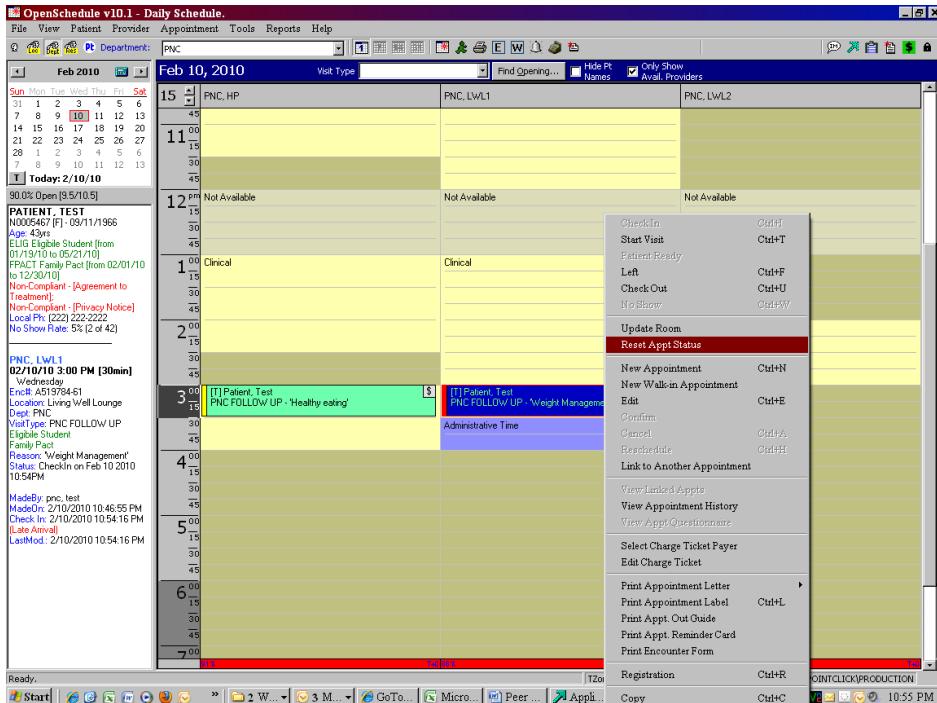
In the Lounge, you will check in your own patient and escort them to the office. At the health center, all patients must check in at the front desk and be directed to the second floor waiting room where you will greet them. If your patient has checked in the bar to the left of the patient's name will change from yellow to red. If your patient was not checked in, check the patient in using the following procedure.

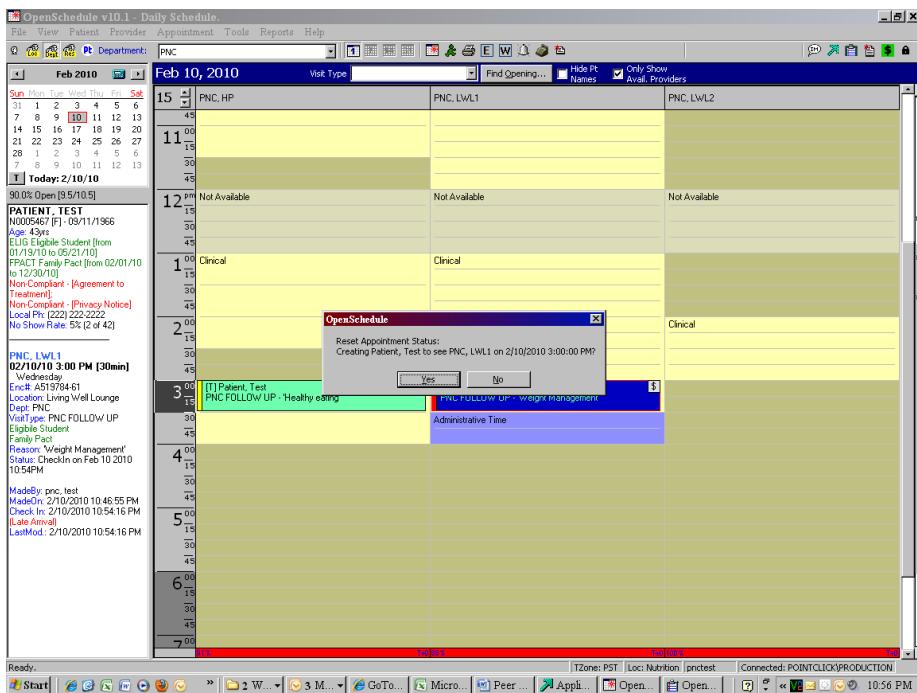
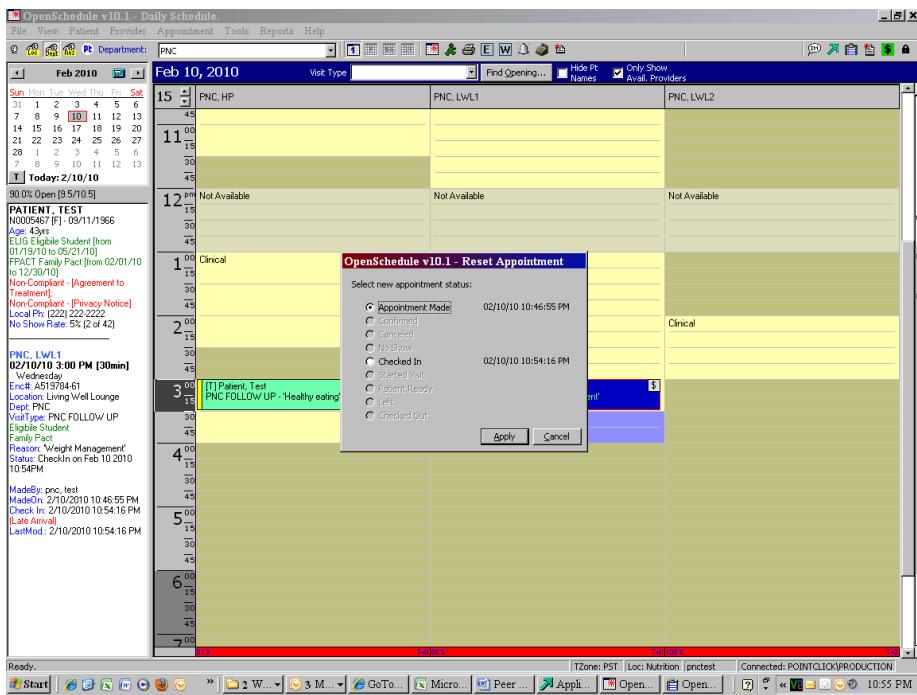
- In Open Schedule, on the date of the appointment, right click on the patient and select "Check in". The Check in box appears. Confirm the appointment and click OK. The yellow side bar (next to the patient appointment) will turn red.

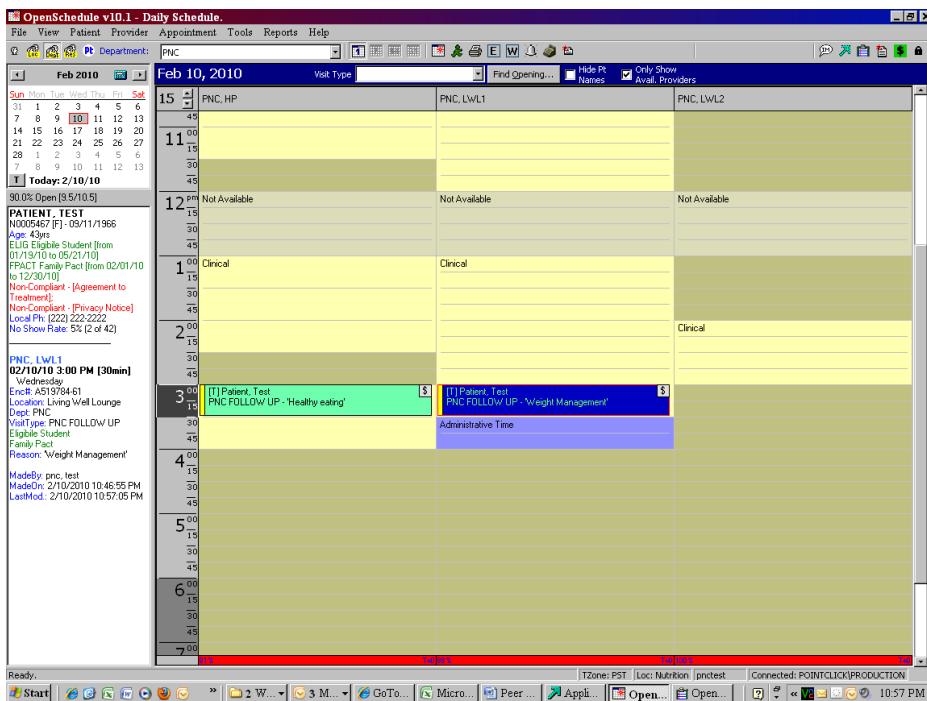




- If you check in the wrong patient, right click to on the patient appointment and select Reset Appointment Status and click on Appointment Made and click apply. Click on Yes. The red sidebar will turn back to yellow.







III. CHARTING YOUR PATIENT VISIT NOTES

Charting your patient notes is a two-part process. First you will create a Word document that contains your patient (SOAP) notes. This document must be approved by your instructor. Once approved and final, you will cut and paste these notes into the Student Health Center Point-n-Click electronic health record.

Creating your Word Document Notes

Follow these procedures to create your Word document.

1. While you are seeing your patient, it is good practice to take notes on a notepad or laptop.
2. To help PNCs identify patients, an alphanumeric code will be used and should be included at the very beginning of the “Subjective” portion of the SOAP note written in Word. The code will be divided as follows: four digit appointment time (in military time), patient initials, and four-digit appointment date. *For example*, if John Doe had an appointment at 9:30 on February 15, the code would read 0930jd0215. If Susan Smith was seen at 12:00 on February 6, the code would read 1200ss0206.
3. For your Word document, use the new SOAP template provided on the class website (www.csun.edu/~lisagor), This template is also located at the end of this document. Weekly Printouts, Week Two. It is strongly recommended that you write complete notes when you see your patient, using the SOAP template that is provided. Make sure all sections are filled out.
 - a. ***Subjective***
Document information that is relevant to the current visit that you obtain by talking to the patient. This may include patient identification, main complaint, history of present illness, past medical history, family history, systems review, social and/or sexual history information.

b. Objective

Record your **physical** findings, including general appearance, vital signs and findings of system exam. Only record what you can see, hear, touch, smell or taste along with age, etiology, chart, family information and lab tests. (This is **objective** data.)

c. Assessment

Asses the patient condition based on subjective and objective findings including your diagnosis or presumptive diagnosis, health maintenance issue and other observations.

1. Enter the Stage of Change at which you assess your patient to be.
2. Enter the Complaint (reason why client made appointment for PNC):
 - Client desires to become a vegan/vegetarian: vegetarianism
 - Client is member of athletic team on campus: sports nutrition
 - Client wants to eat healthy diet but does not want to follow vegetarian diet: healthy eating
 - Client wants to change weight – gain or lose: weight loss/gain
 - Client wants to prevent further wt gain or weight loss: weight management
 - Client concerned about his/her high blood pressure: high blood pressure
 - Client is concerned about decreased frequency of stools: constipation
3. Enter the Diagnosis (ICD 9 or temp code^{1,2} - Use to categorize client's nutritional problems):
 - Recent unplanned weight loss likely due to medical problem: abnormal weight loss
 - Recent unplanned weight gain – cause not specified: abnormal weight gain
 - Client has BMI 30-39: obesity
 - Client has BMI >39: morbid obesity
 - Client states has anorexia nervosa
 - Client has a lack of appetite and does not want to eat: anorexia
 - Client appears to eat a variety of nutritious foods in needed quantities (based on Food Pyramid): healthy eating
 - Client needs to improve nutritive content of diet for sports performance: sports nutrition
 - Client is vegetarian and needs to change food intake to obtain nutritious diet: vegetarian
 - Client states has high cholesterol, triglycerides, LDL: hyperlipidemia mixed
 - Client states has high cholesterol: hyperlipidemia
 - Client states is anemic or has iron deficiency: iron deficiency
 - Client states has high blood pressure: hypertension, unspecified
 - Client states has heartburn or gastric ulcer: heartburn
 - Client states has lactose intolerance: lactose intolerance
 - Client states has Type 2 diabetes: diabetes with no complications

¹ ICD International Classification of Diseases, 9th edition

² For ICD9 code numbers, see: <http://www.medilexicon.com/icd9codes.php>

d. Plan

Formulate a plan including diagnostics, therapeutics, consultants and referrals, anticipatory guidance, patient education, health promotion, disease prevention and follow-up instructions.

Entering Your Approved Notes From Your Word Document Into Point n Click

Do not document your patient visit in the Point and Click system until your professor has approved your notes in the Microsoft Word document.

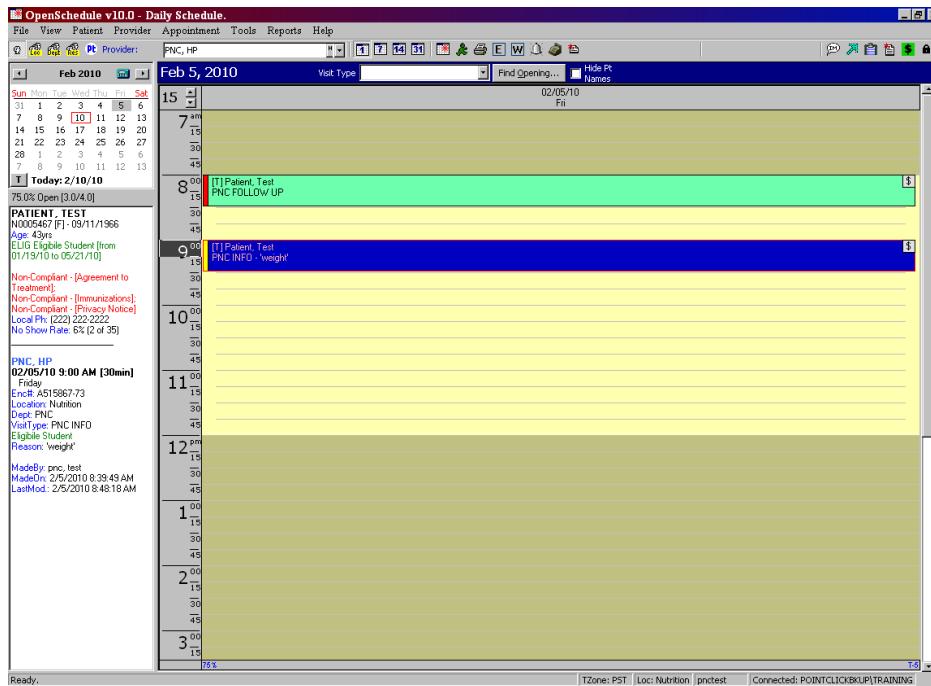
1. Enter Point n Click.



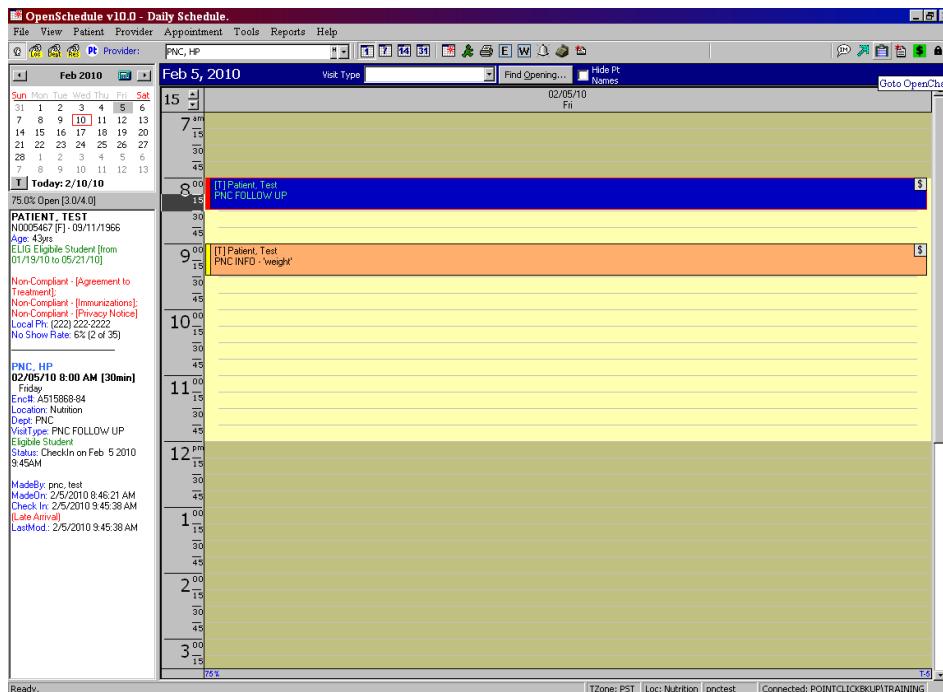
2. Click on Scheduling on the horizontal bar.



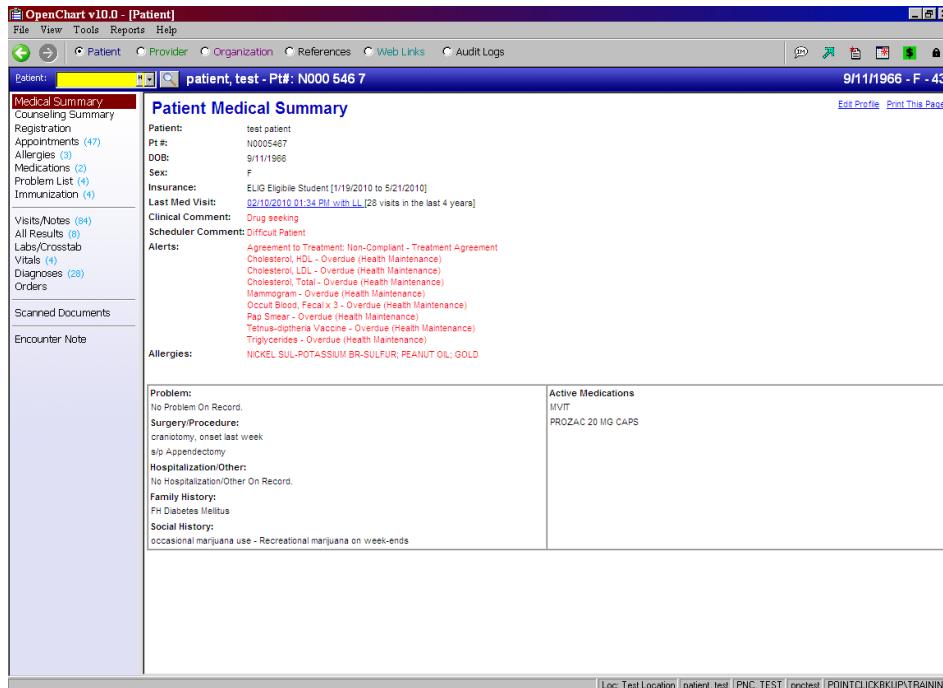
3. Locate the correct patient by date and time. Click on the correct patient appointment on your schedule. This will highlight the appointment.



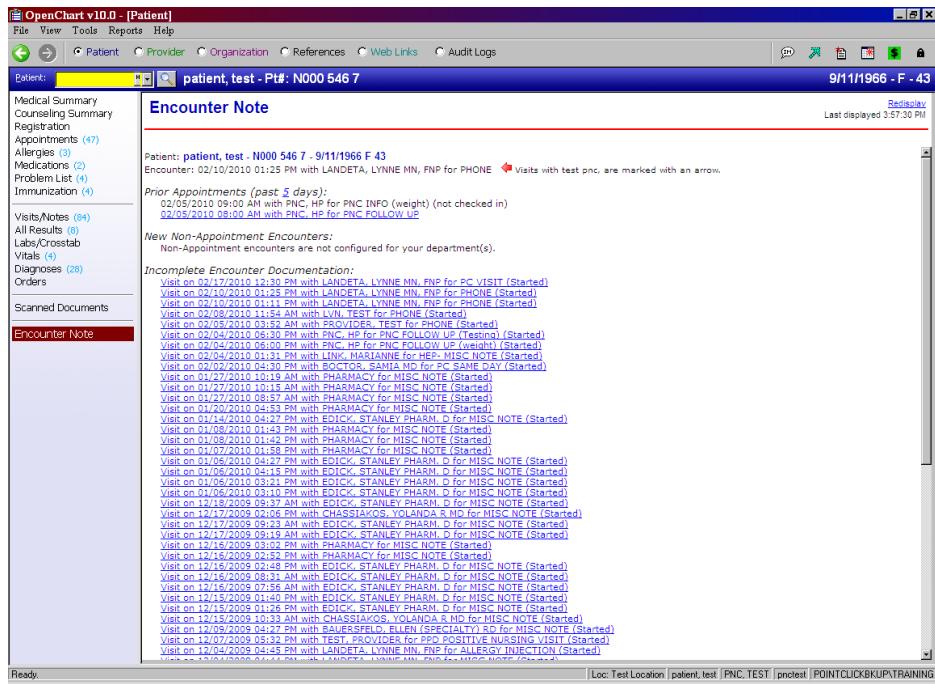
4. Click on Open Chart (clipboard) icon (top right of screen).



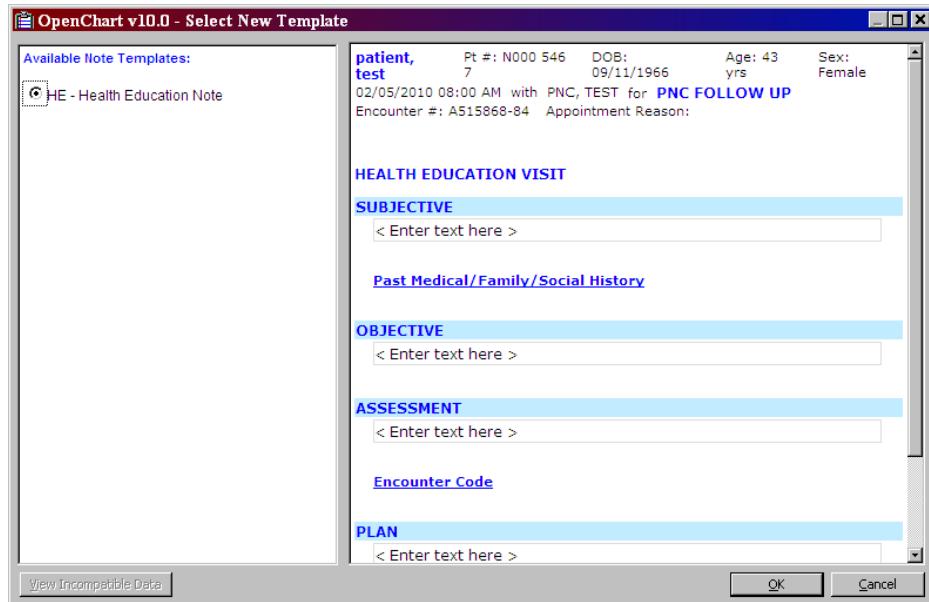
5. Click on Encounter Note (at the bottom of the list on the left side of the screen).



6. Click on the appropriate appointment under Prior Appointments (past 5 days).

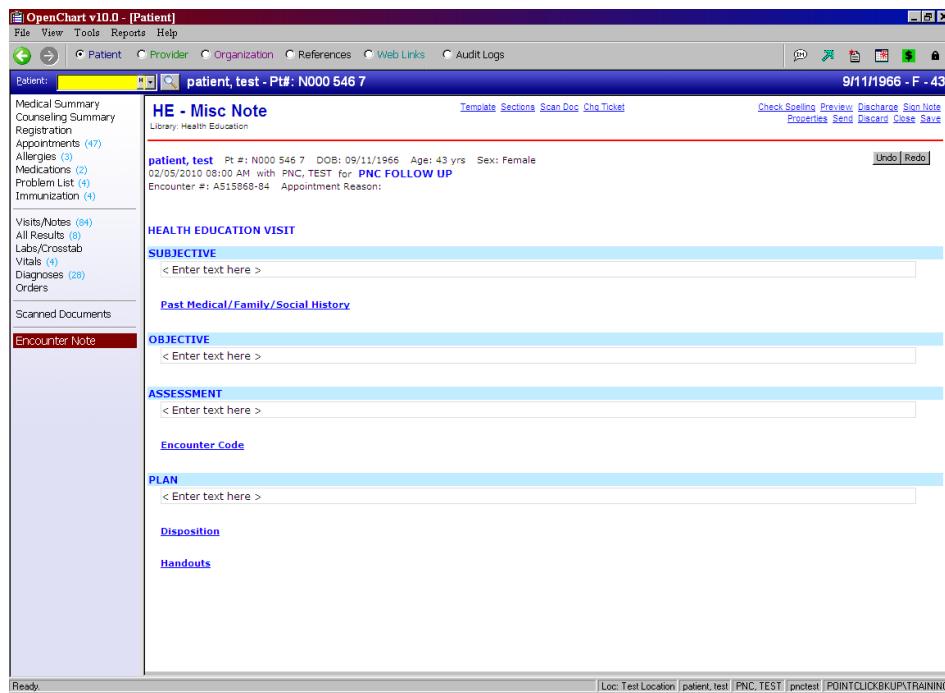


7. On the left side, select HE Health Education Note. Click OK.

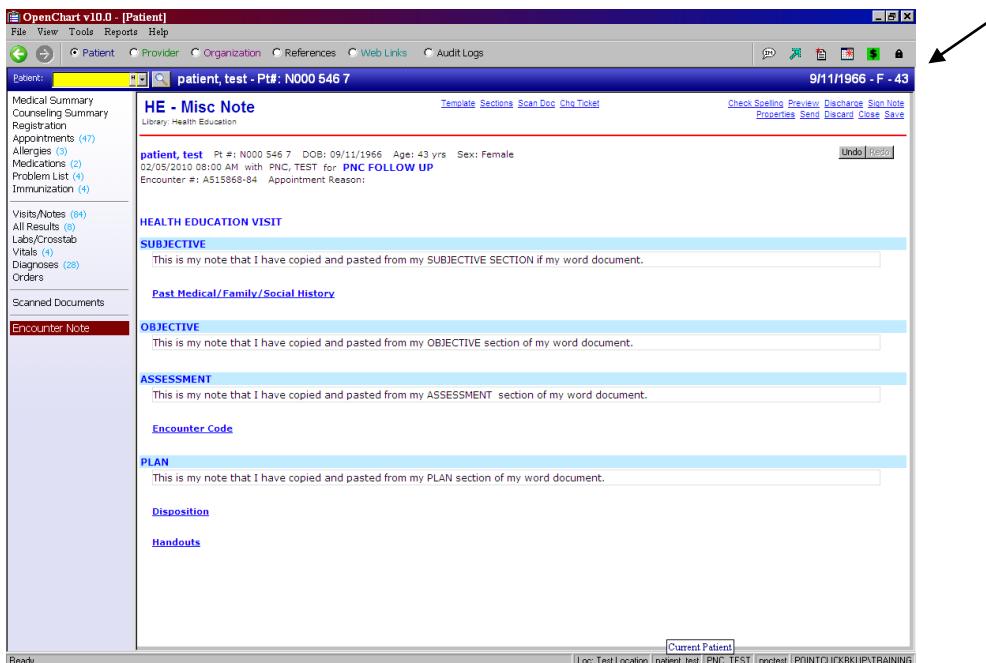


A template will appear in which you will complete all necessary SOAP (or PES) fields. Open your corrected Word document for the patient you wish to chart. Copy and paste your approved Word document into each specific field.

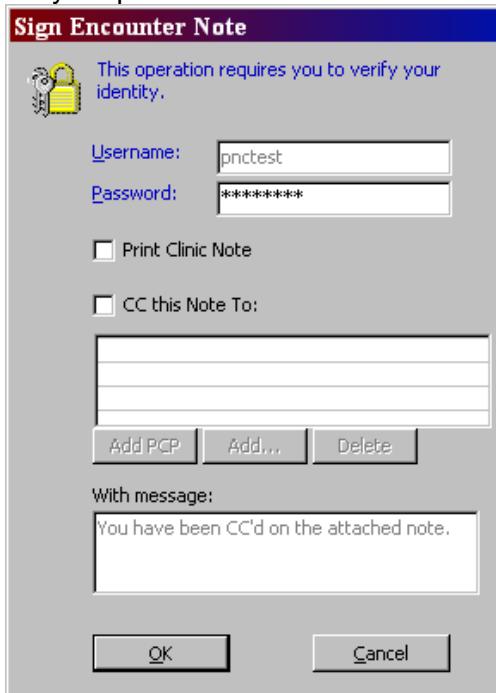
- Under Subjective, click on “Enter text here”. Copy and paste your Subjective information in the text entry field. Ignore the “Family/Social History” link.
- Under Objective, click on “Enter text here”. Copy and paste your Objective information.
- Under Assessment, click on Enter text here”. Copy and paste your Assessment information. Ignore the “Encounter Code” link.
- Under Plan, click on “Enter text Here”. Copy and paste your Plan information. Ignore the “Disposition” and “Handouts” links.



8. You are now ready to sign the note. Review your note! DO NOT SIGN THE NOTE UNTIL YOU ARE CERTAIN THE NOTE IS ACCURATE AND COMPLETE. BY LAW, NO FURTHER CORRECTIONS CAN BE MADE TO THE POINT AND CLICK DOCUMENT AFTER YOU HAVE SIGNED THE NOTE. Click on Sign Note (top right of Screen).

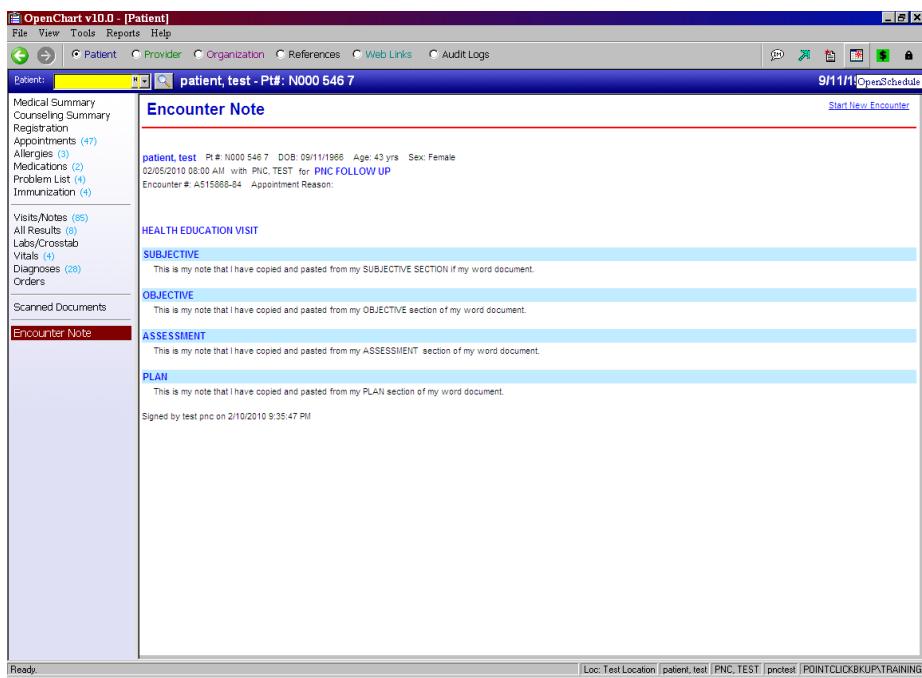


9. Enter your password. Click OK.

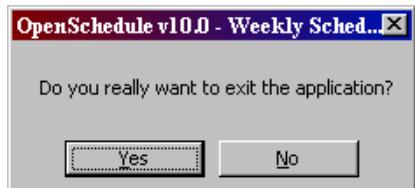


10. You will return to the Encounter Note screen and your completed note.

- If you want to enter notes for another patient, click on the Open Schedule icon in the top right corner of the screen to return to the appointment schedule. Highlight the correct patient and repeat the steps you have just completed.



- If you are done charting, click on the X to exit Open Chart. Click Yes.



- Click on Exit on the horizontal bar to completely exit Point n Click. Click yes.



SOAP Note Template

Date Patient Was Seen:

Client Code Number

PNC Name:

Patient:

ICD 9 Code:

Site of Visit:

Complaint/Reason patient stated for visit:

Pt. Visit: (New or Follow Up)

Subjective:

Food intake: In this box, comment on things that patient has talked about related to client's food intake. (Examples might be: eating patterns are stable, incorporating extra servings of vegetables per recommendations; reduced butter intake considerably; eliminated fatty afternoon snack, replaced with a vegetable/protein snack.)

Nutrition and health awareness/management: (E.g. nutrition knowledge has slightly increased, patient is feeling positive about progress thus far; patient wishes she had had more time for counseling, recommended she continue counseling next semester.)

Physical activity/exercise: Put information that patient has shared regarding this.

Food availability/access to food: Add any comments from or discussion regarding this, including who prepares foods, affordability, etc.

Client Self-Reported Health History and Lab Results: In the Subjective section, provide narrative comments patient reports regarding this: E.g. Patient reports she redid her lab tests per physician request but has not received updated results. E.g. Maternal grandmother has/had Type II Diabetes.

Educational tools/materials: List any handouts PNC provided and discussed with the patient.

Objective:

Patient age:

Gender:

Date of birth:

Height:

Weight:

BMI:

BF:

Estimated caloric needs: Show Harrison-Benedict Equation calculations, as described in PNC Handbook: E.g.:

$$\text{BMR female: } 655 + (9.6 \times \text{weight kg}) + (1.8 \times \text{height cm}) - (4.7 \times \text{age in years})$$
$$655 + (9.6 \times 58 \text{ kg}) + (1.8 \times 163 \text{ cm}) - (4.7 \times 53 \text{ yrs}) = 1255 \text{ calories}$$
$$\text{TEE: } 1255 \text{ BMR} \times 1.5 \text{ Activity Factor} = 1883 \text{ calories}$$

Labs: (Only documented results from the lab, not what patient may have told PNC)

E.g. GLUC: 115; Total Cholesterol: 214; LDL: 123

Assessment/Diagnosis:

E.g. Patient is obese, as evidenced by a BMI of 30.2.

E.g. Patient appears more focused on incorporating healthier habits. Has taken big strides toward accomplishing planned goals. Would benefit from further instruction and guidance.

Patient needs measurable goals and ongoing dietary journal to track progress.

Patient is in the *Preparation Stage*; intends to take action within the next 30 days.

PES

Problem: (E.g. Obesity as related to....)

Etiology: (E.g. Overconsumption of calories and poor nutrition knowledge...as evidence by...)

Signs/Symptoms: (E.g. BMI of 30.2; BF or 28.2%, pt interview.)

Patient is in the

Plan:

Patient agrees to try to:

- ✓ Concentrate on portion sizes
- ✓ Increase vegetable intake; reduce fat intake
- ✓ Consult with Fitness Center intern to plan regular exercise routine
- ✓ Schedule a follow up appointment