Document Quick Links:

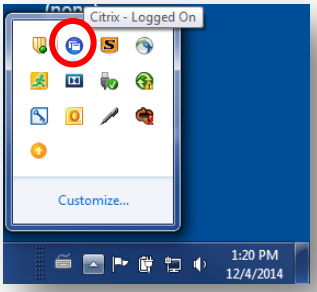
The intention of this Start Up Guide is to help you as a physician, nurse practitioner, resident or medical student get your day started quickly and easily, even if this is the first time using the MOIS program. Only the essentials are noted here. As you become more comfortable with the program, you may not need to reference this guide again.

WHAT IS MOIS?

- The Medical Office Information System or more simply "MOIS", is an Electronic Medical Record (EMR) designed for managing data and used as a tool to provide quality patient care.
- Key functionality of MOIS includes documentation of patient medical records, scheduling, billing, evidence-based patient review, auditing, clinical calculators, and other reporting.
- Northern Health carefully selected MOIS as the standard EMR to be used in their clinics.
- Each clinic has their own "instance" of MOIS (i.e. the patient list and information in the Masset instance differs from the patient list and information in the Valemount instance).

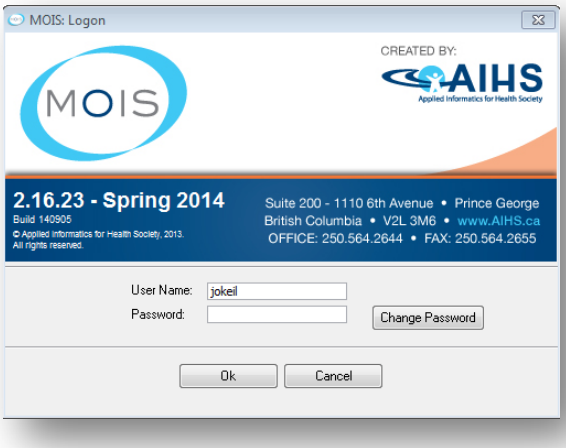
ACCESSING MOIS FROM YOUR DESKTOP

- Locate the Citrix icon on your desktop taskbar. (*Note: You may need to expand what icons are shown on your taskbar.)*
- Select MOIS from your Citrix program list.



Signing in the First Time

- A logon screen will appear.



- Your **User Name** will auto-populate with your Windows user name (i.e. Northern Health user name).
- Enter your temporary **Password**, you will be prompted to change your password at this time.

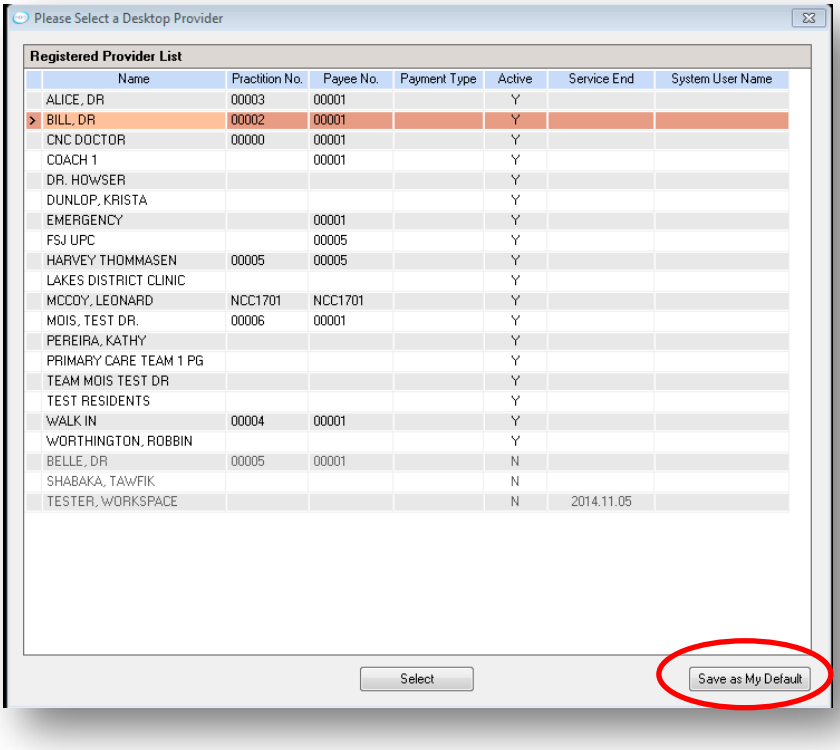
- Your **New Password** must fit the following criteria:
  - Minimum 8 characters
  - Contain at least one capital letter
  - Contain at least one number
- Select **Change.**

Forgot Your Password

- Contact your site manager/site administrator, they can re-set your account and give you a new temporary password.
- You will be prompted to change your password the next time you sign in.

Set Default Desktop Provider

- The Desktop Provider name fills into requisition forms and other areas of the program, it is important to ensure the correct Desktop Provider is displayed when you are logged in.
- If prompted on your initial sign in, **select** your name from the list of providers and choose "**Save as My Default**".
- Note: Medical students should select the provider they are working with.



- The Desktop Provider can be changed at any time by left-clicking in the "Desktop Provider" field in the top right of the screen – a window will pop-up and you can select a new provider name from that list.

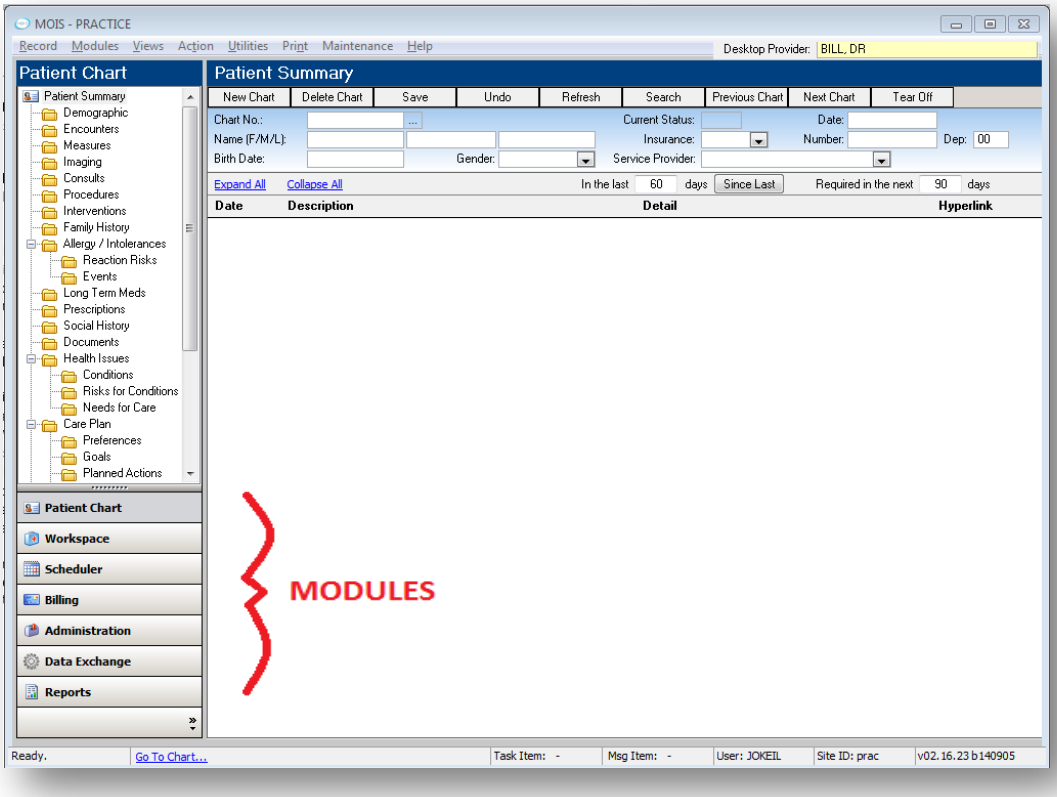
MOIS MODULES

MOIS contains the following modules to enable increased patient care and manage work flow:

- Patient Chart
- Workspace
- Scheduler
- Billing
- Administration
- Data Exchange
- Reports

Modules are shown on the bottom left of the MOIS screen.

Note: Some modules may not show on your MOIS account. Access to each module is role-dependent.



General Tips

The ellipses indicates there is a list associated with the field. Click the three-dot symbol or click in the space beside and use F4 to prompt the selection list.

F2 – Save
Ctrl-T – Enters today's date
Calendar – Left click on the date field and use F4 to prompt a month-view calendar.
Ctrl-H – Prompts a patient-specific Health Maintenance Review

See the appendix for a complete list of Hot Keys.

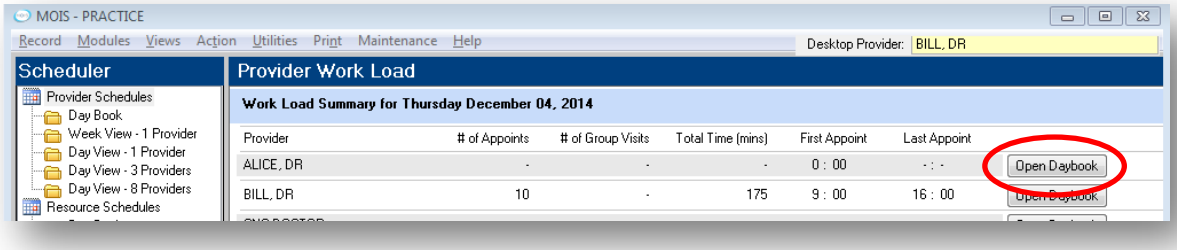
Scheduler Module

The Scheduler Module allows you to:

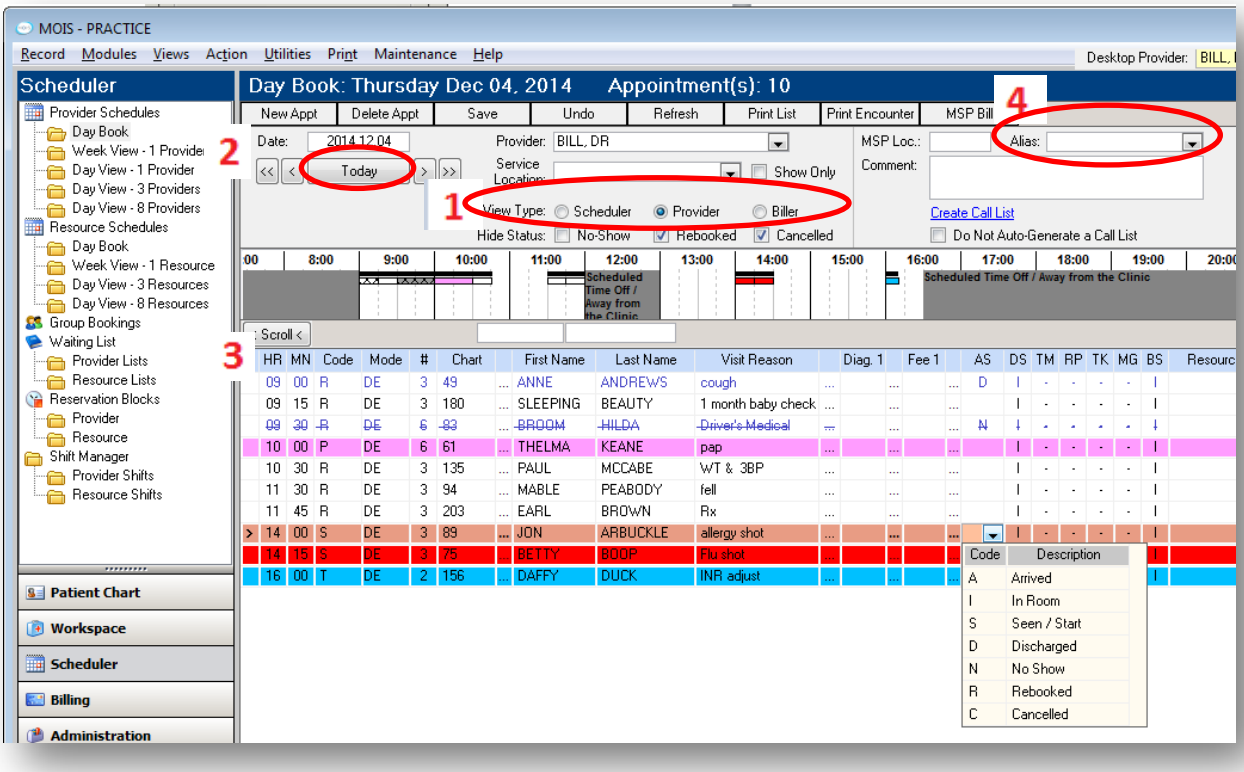
- View your schedule for current, past, and future appointments
- Manage patient appointments
- Track patient appointment status (Arrived, In Room, Seen, Discharged, No Show, Cancelled, or Rebooked)
- Quickly navigate to the patient encounter detail window – where you enter your progress note

View Your Schedule

- Click on the **Scheduler** Module.
- Find your name and select **Open Daybook.**



- Your daybook looks like this:

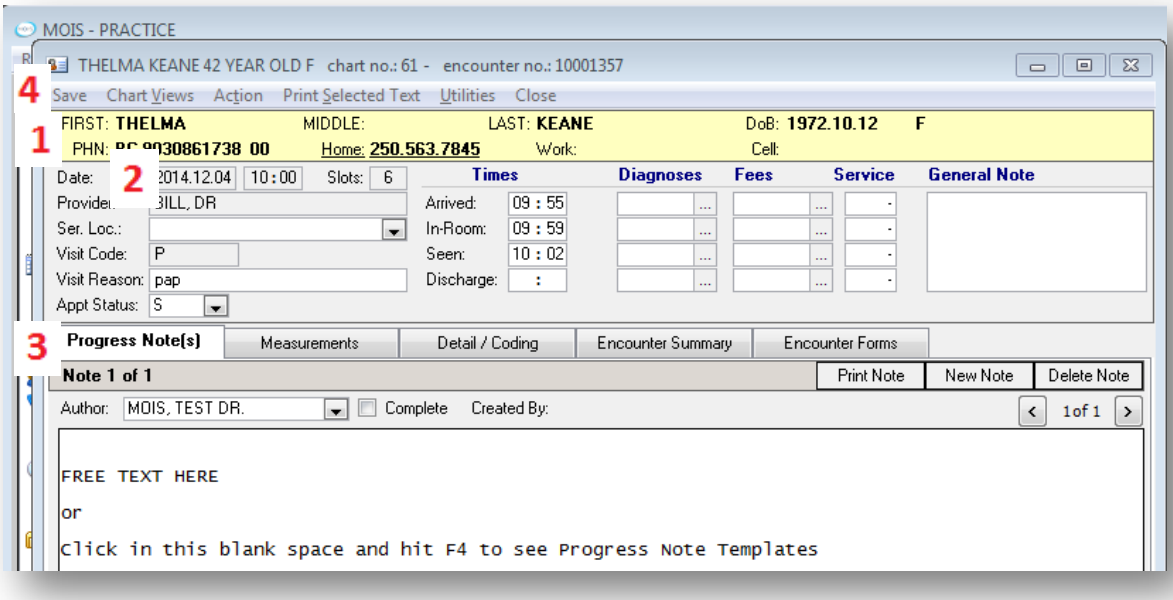


1. The view of your daybook can change – toggle between view types: Scheduler, Provider, Biller.
    - The "Provider" view is shown above.
    - The columns will show in a different order (and some don't show at all) in different views.

2. Use the "Today" button to look at the schedule for the current date.
    - << moves back 1 week at a time from the date shown
    - < moved back 1 day at a time from the date shown
    - > moves ahead 1 day at a time from the date shown
    - >> moves ahead 1 week at a time from the date shown
3. Each column in the daybook has a meaning:
    - HR MN = Hour Minute
    - Code = Visit Code (e.g. "R" usually means it is a Regular visit)
    - Mode = How the visit is carried out (e.g. Direct Encounter with the Patient)
    - # = Length of the visit in blocks (1 = 5 min, 2 = 10 min, etc.)
    - Chart = Chart number of the booked patient
    - First Name, Last Name = Legal name of the booked patient
    - Visit Reason = Why the patient is booked
    - Diag 1 = Diagnostic Code associated with the visit
    - Fee 1 = Fee Code associated with the visit
    - AS = Arrival Status of the patient (See dropdown on above screen shot. E.g. A = Arrived)
    - DS = Document Status (I for Incomplete Progress Note, C for Completed/Saved)
    - TM = Number of templates used in the visit
    - RP = Number of reports made from the visit (e.g. WCB)
    - TK = Number of tasks attached to the visit
    - MG = Number of messages attached to the visit
    - BS = Billing Status (I for Incomplete, B for Billed)
    - Resource = Resources needed for the visit (Site specific)
    - Room = Room number for the visit
    - M = A down arrow will populate if a General Note is added in the Encounter Detail window
    -  = Number of attachments associated with the visit
4. Locums choose the name of the provider they are covering for from the dropdown list by "Alias".

Document an Encounter (Progress Notes, etc.)

- **Double click** on a patient name in today's schedule to open their Encounter Window.
- The Encounter Window looks like this:

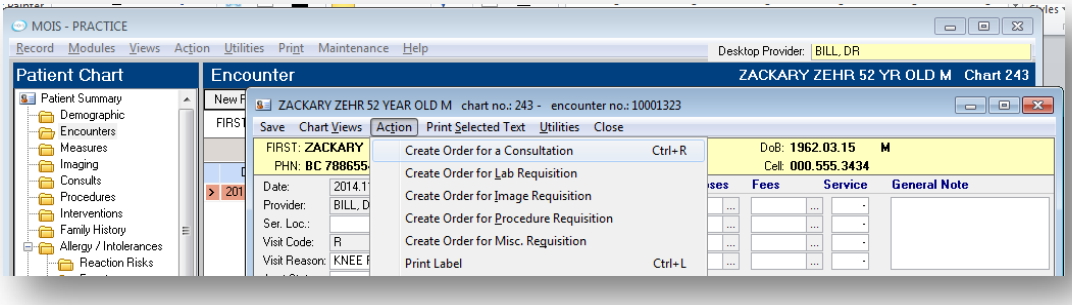


1. The patient's demographic information is shown on the top of the Encounter Window – **always check** to ensure you are working in the correct patient's chart.
2. Date and time of the patient's booked visit.
3. Navigation tabs to record information from the visit:
   - **Progress Note(s)** – free text area; templates to start notes are also available by clicking in the blank space and pressing F4.
     - Additional notes for the same visit can be added by selecting "New Note" (e.g. a patient is seen by a student and a physician – 2 separate notes for the same encounter).
     - There is a creator and author for each progress note – the creator has 7 days to edit and the author has 28 days to edit after the note is created.
   - **Measurements** – to enter values from the visit (e.g. BP, weight, smoking status); graphing, calculator and templates also available
   - Detail/Coding – to enter billing information
   - **Encounter Summary** – shows a read-only view of all items associated with the visit
   - **Encounter Forms** – access forms for chronic disease management visits, WCB, pain management, and others
4. Important Toolbar options:
   - Save – F2 is the Save quick key throughout MOIS
   - Chart Views – Drop down allows you to easily navigate to a section of the current patient's chart
     - E.g. view previous Encounters, Measures, Health Conditions, Medications, etc.
   - Action – Create an external service request, create tasks/messages within MOIS, print a patient label
   - Utilities – Access spell check, Health Maintenance Review

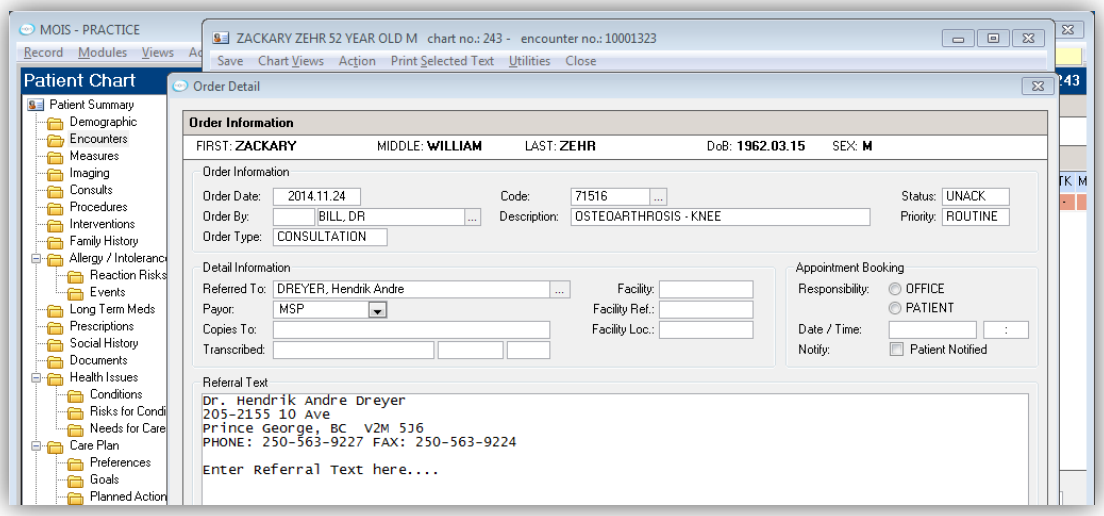
Create a Service Request (Referral)

(Note: This section will need to be edited for CDX EMR to EMR Referrals.)

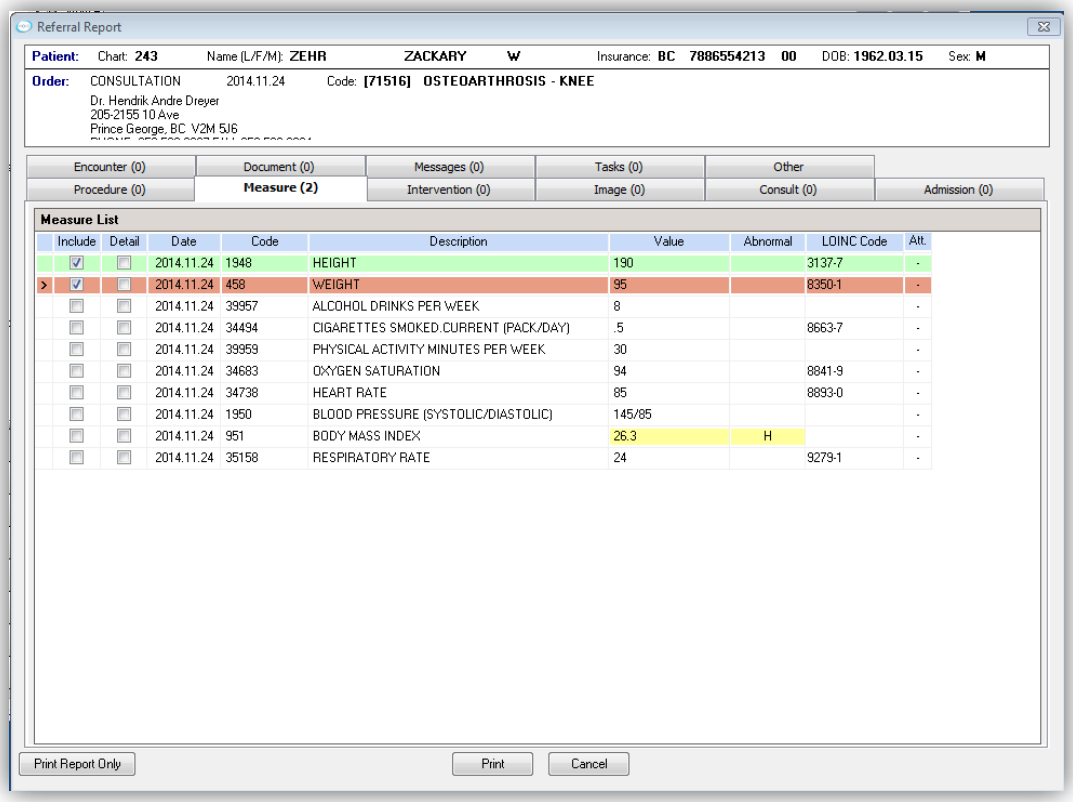
- Click on the **Scheduler** Module.
- **Double click** on a patient name in today's schedule to open their Encounter Window.
- Select **Action** from the toolbar, a drop down will appear.



- Select the type of service request from the list – e.g. **Create Order for a Consultation.**
- An Order Detail window will pop up, fill in the information as appropriate.



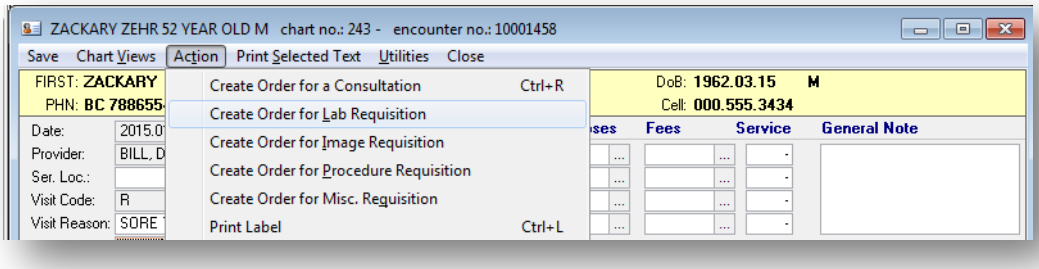
- To navigate to the next screen, select **Print**.
- Here you can choose to include different aspects of the patient chart in the service request.
    - Note: All tabs say (0) until you choose an item from the tab. The number will change to reflect how many items you've added to your letter.



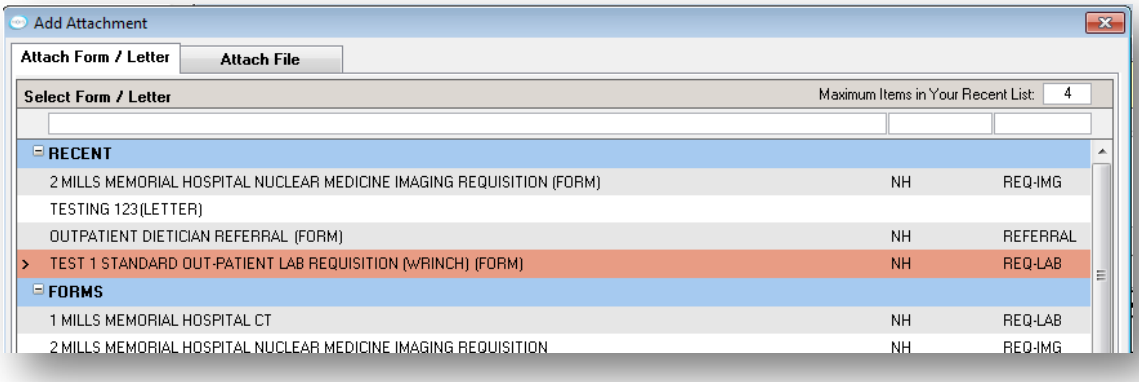
- To create the report, select **Print.**
- The service request is sent – this is usually via printing and faxing the final copy.
- The service request remains part of the patient chart – it can be accessed via the **Orders** folder.

Create a Service Request (Order/Lab Requisition)

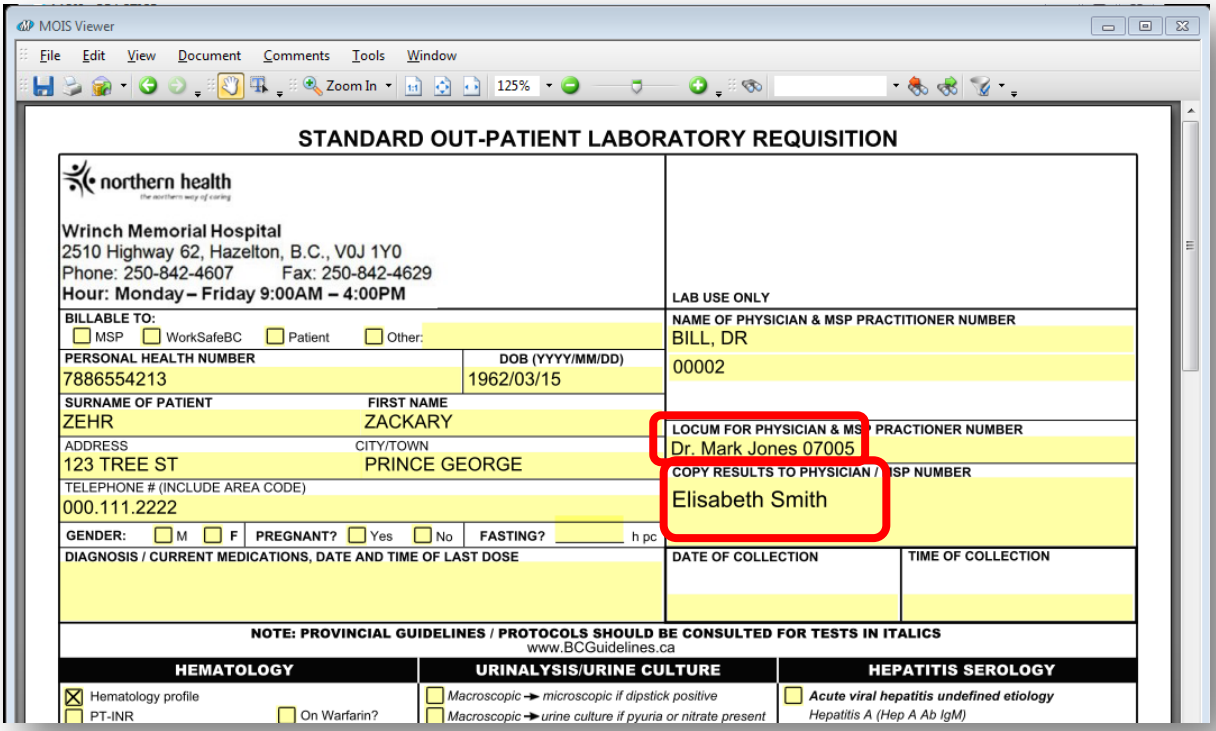
- Click on the **Scheduler** Module.
- **Double click** on a patient name in today's schedule to open their Encounter Window.
- Select **Action** from the toolbar, a drop down will appear.



- Select the type of service request from the list – e.g. **Create Order for Lab Requisition.**
- An Add Attachment window will pop up.
- **Double-click** the form name to select the desired requisition form from the list.



- The form will pop up, pre-filled with the patient's demographics, the Desktop Provider's name and MSP practitioner number.



- Type directly onto this form, boxes can be selected using a left-click.
- **Important:**
  - LOCUMS: In order for results to be distributed electronically to the correct EMR, be sure to enter the name of the provider you are covering for in the "Locum For" section.
  - **Additional provider names** (and in some cases the clinic name) can be added in the "Copy Results To" section.
- **Print** & **Save** the form.

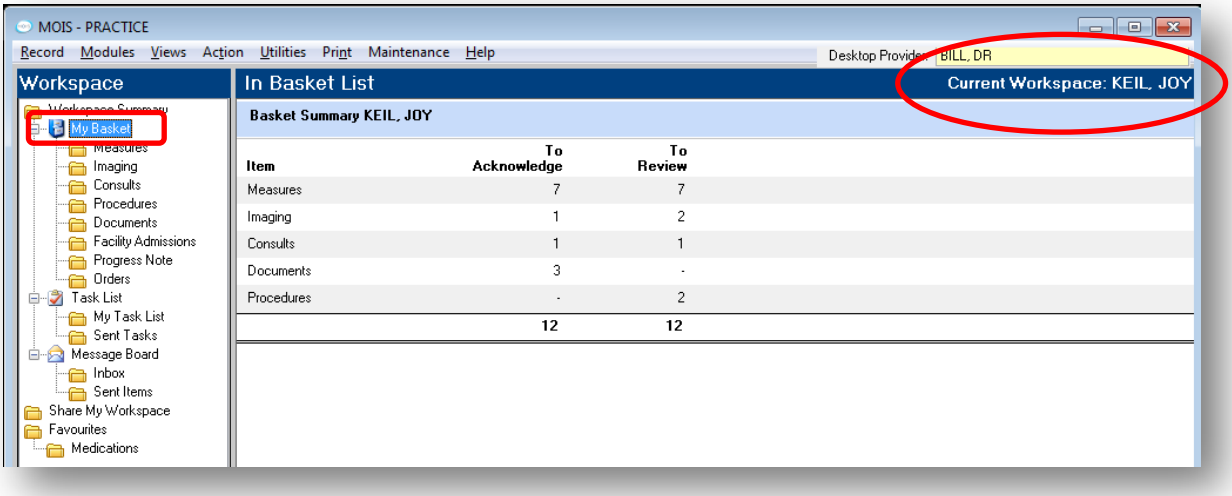
Workspace Module

The Workspace Module allows you to:

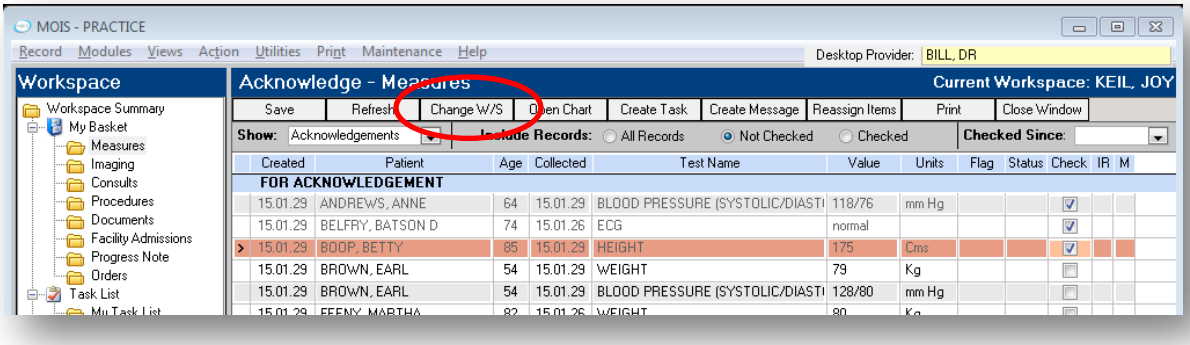
- View and acknowledge patient results that are downloaded through CIX, CDX, or manually entered
- Manage your task list
- Manage your messages
- Share your workspace and access the workspace of the provider(s) you are covering
- Manage your favourite medications list (user specific)

View Your Workspace

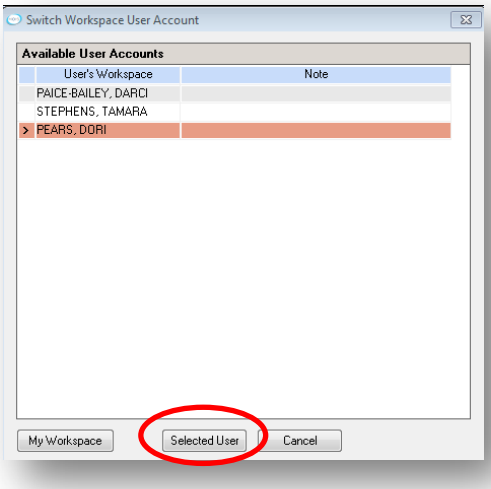
- Click on the **Workspace** Module.
- Click on "**My Basket**" to see a summary of items that need to be Acknowledged or Reviewed.
- **Note:** the name associated with the Current Workspace is displayed on the top right.

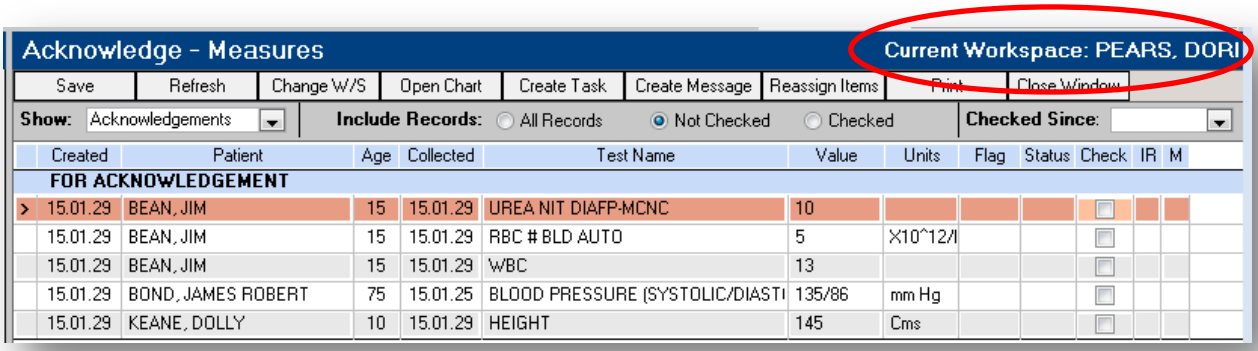


- **Select** any of the folders under "My Basket" to view the items in the current workspace.
- Details associated with the highlighted results are shown at the bottom of the screen.



- To change workspaces, select **Change W/S.**
- A prompt listing the available workspaces pops up, click on the correct name and choose **Selected User** to switch to their workspace. *(Workspaces must be shared in order to show on this list.)*
- Results can now be acknowledged from their workspace (your username is associated with the acknowledgement, even if results are checked in another user's workspace).

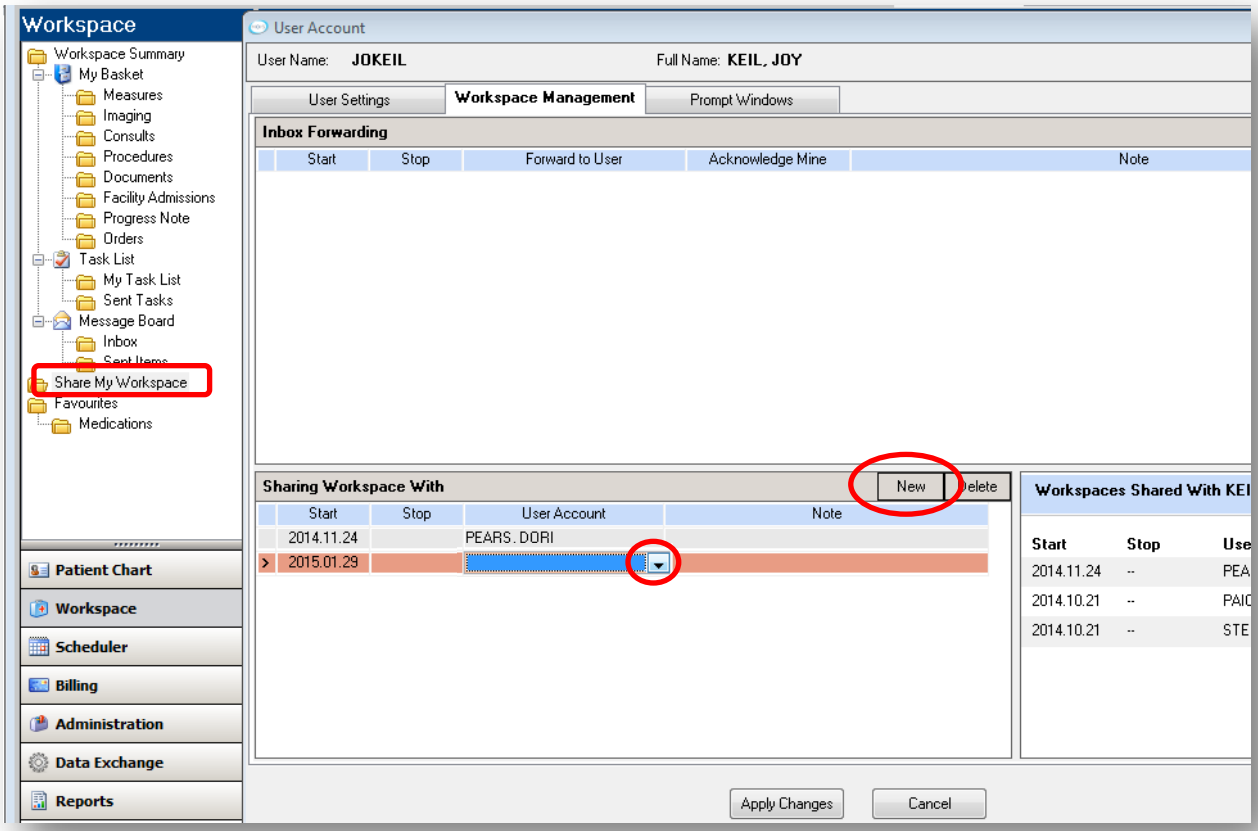




Share Your Workspace

- Click on the **Workspace** Module.
- Click on "**Share My Workspace**" to open your User Account Workspace Management settings.
- Under "Sharing Workspace With", select **New** to add a new line.
- Use the dropdown under "User Account" to find the name of the person who needs to share your workspace OR whose workspace you need to share (i.e. the person you are covering for).
- Select **Apply Changes.**

- **Note:** Workspaces must be shared both ways (i.e. Joe shares with Bill, Bill must also share with Joe).
- **Note:** If a provider did not share their workspace prior to leaving, an administrator can share their workspace with you.



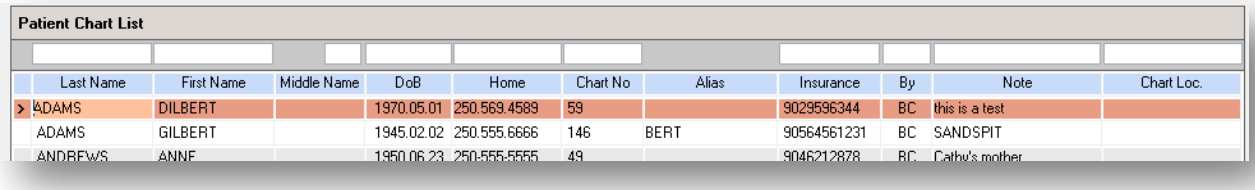
Patient Chart Module

The Patient Chart Module allows you to:

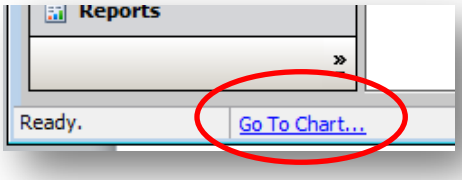
- Navigate the different folders of the patient's chart
- View previous encounters, lab results, medications, diagnoses, patient-specific care plan, consults, etc. and add to these folders as needed.
- For examples of what is found in each section of the patient chart, see the Consistent Data Entry document in the appendix – a Provider Reference version should be posted in the exam rooms in the clinic.

Finding a Patient

- Click on the **Patient Chart** Module.
- In either **Patient Summary** or **Demographic** folder, click on the ellipses by "Chart No" or click in any "Name" space and press F4 – a master patient list pops up.
- In the white search boxes, you can search by Last Name, First Name, Middle Name, Date of Birth, Home Phone Number, Chart Number, Insurance Number (PHN), short note or Chart Location to find exact matches.
- You can also type directly in the list (e.g. typing "Mouse,M" and hitting enter takes you to the area of master patient list by Mickey Mouse. It will show all names above and below the search characters.)
- **Best practice is to search first by PHN, then DOB, followed by Name.**



- Alternatively, you can click on **Go To Chart** from any module in MOIS. It prompts the same master patient list, which can be searched as above.



Long Term Meds & Prescriptions

There are two folders for recording and managing patient medications – "Long Term Meds" and "Prescriptions".

Most medications should be entered in the Long Term Medications folder. It is a "best possible medication history" that documents regular medications and natural health products that are expected to be taken over a mid to long term. In some cases, it should be used even for, what some would consider a short term medication - e.g. a prescription for antibiotics to be taken with a COPD exacerbation plan.

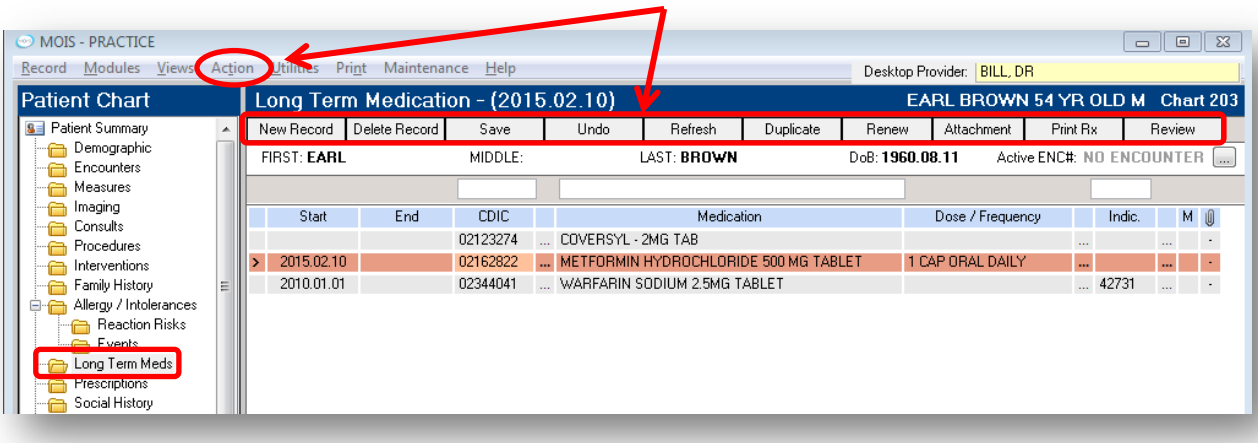
About **Long Term Medications**:

- They will print on the clinical summary and referrals.
- The list has the "Reviewed" functionality. (i.e. users check "Review"; this updates the date beside the folder name, indicating when the most recent medication review occurred.)
- Both current and discontinued items are listed.
    - End dates should be added for items that are no longer required; items should not be deleted.
- *When entering Long Term Medications for the first time, they must be renewed first before printing.*

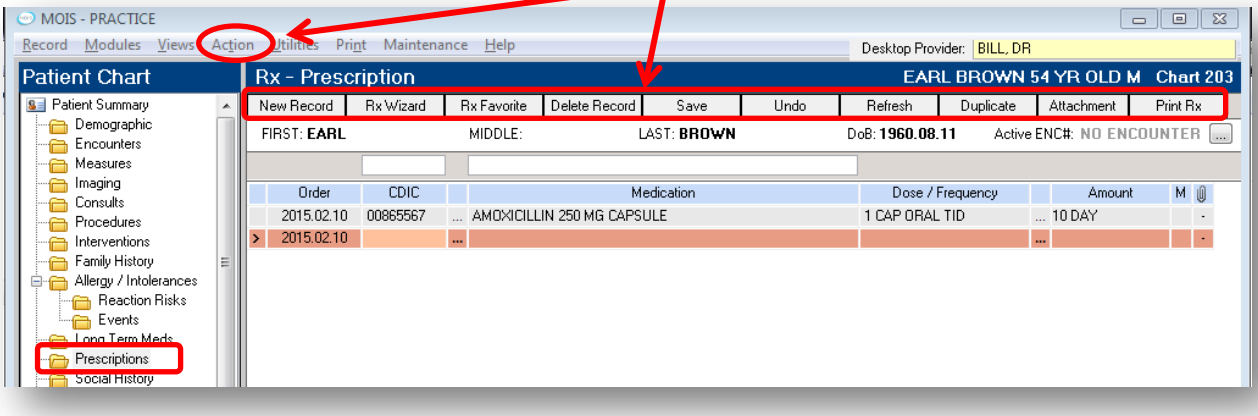
About **Prescriptions**:

- Record any short term, one-time, trial/sample medications and natural health products prescribed.
- Includes documentation of every product ordered.
- Items prescribed as a short term or trial will be recorded here.
- Items renewed from long term meds will also be recorded here.
- Medications recorded in this folder can be duplicated but not renewed. (note: duplicated is copied exactly to a new line with the current date)
- Items in Prescriptions will not be sent with referral letters nor listed on the clinical summary.
- Items in the Prescription folder can easily be added to the Long Term Medication list.

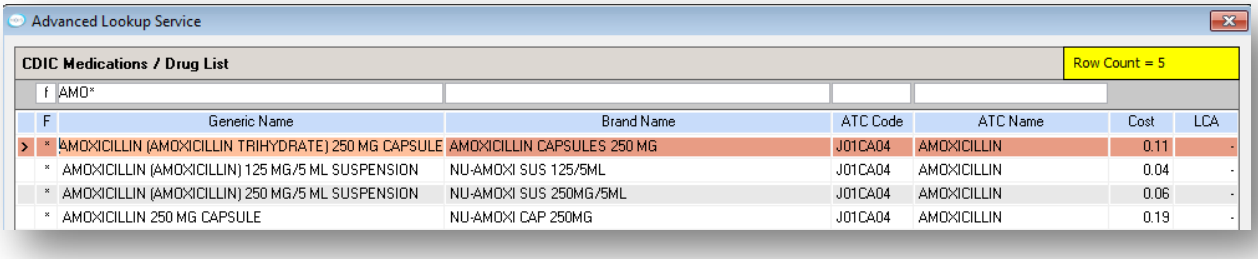
- From the **Patient Chart** Module, navigate to the correct patient chart as above.
- Or from the **Encounter Note** window, select **Chart View** from the toolbar.
- Select the **Long Term Meds** folder.
- Complete the desired action using the **Action** drop-down or the action buttons under the folder name.



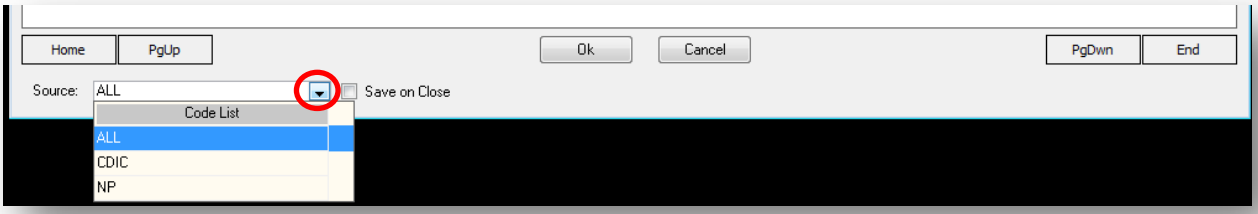
- Select the **Prescriptions** folder.
- Complete the desired action using the **Action** drop-down or the action buttons under the folder name.
  Note: the choices in Prescriptions are slightly different than in Long Term Meds.



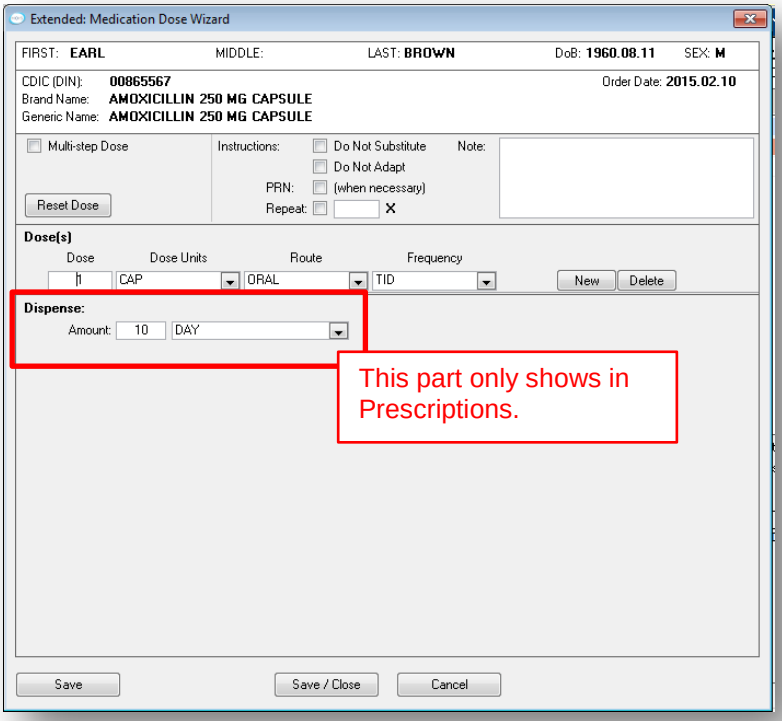
- In either folder, search for medications by:
  - Using the white “search” boxes to show only items that match the text, add an (*) to indicate any letter combination can follow the text. (Otherwise, items with the text anywhere in word will be shown.)
  - Put any character in the “F” field to pull only formulary items.
  - Search by Generic or Brand Name.



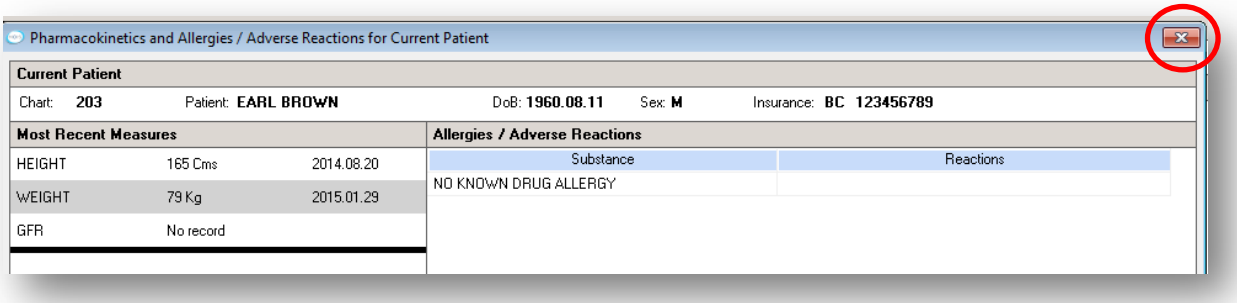
- The searchable list source can be changed between All, CDIC only, or NP only.



- Select the item to be prescribed/added to the Long Term Med list.
- Fill in the **Dose/Frequency** by clicking on the ellipses. A new window will pop up.

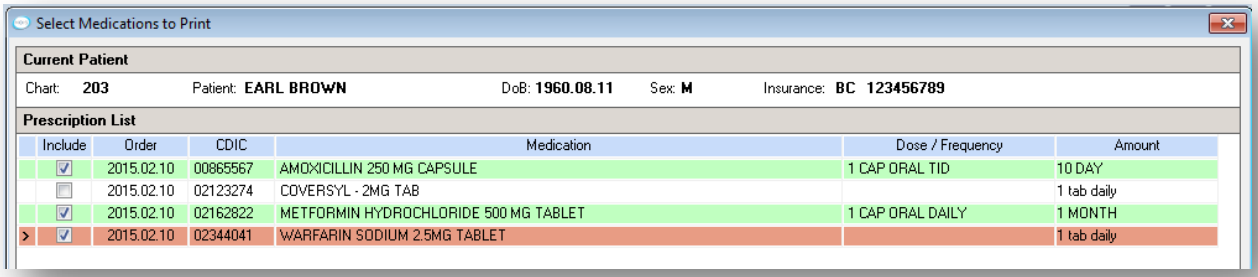


- Select **Save/Close**.
- Select **Print Rx** to print the prescription.
- The patient's allergies will pop-up. (If no allergies are listed, the patient may have allergies that are not entered correctly into their chart.)

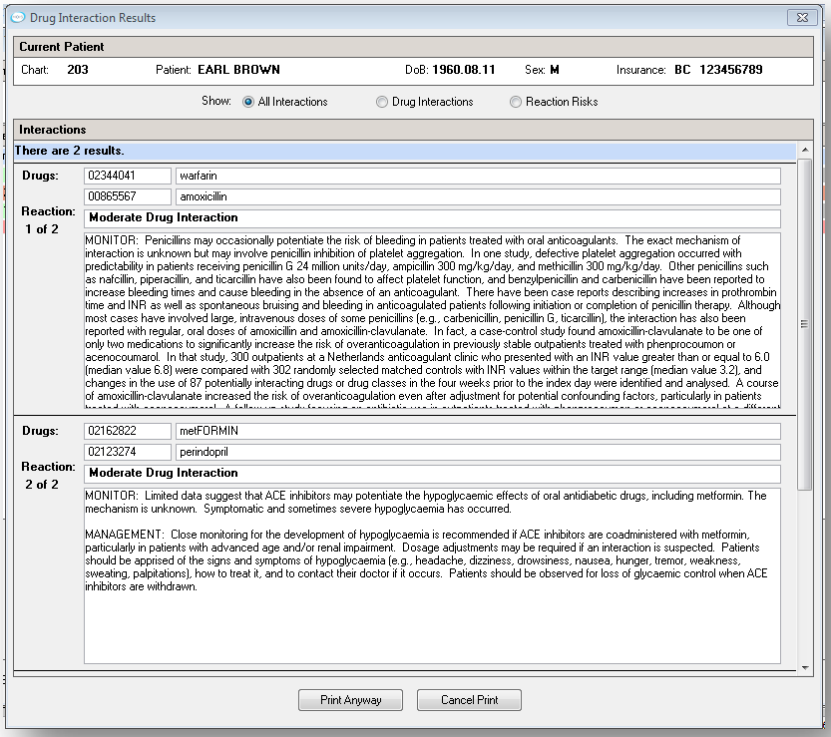


- Select **X** to close the "Pharmacokinetics and Allergies" pop-up.

- Select the items to include.



- "Drug Interaction Results" will pop-up, if applicable.



- Select **Print Anyway** to print the prescription or **Cancel Print** to change your selection.
- Or if no interactions, simply select **Print (F2)** to print the prescription.

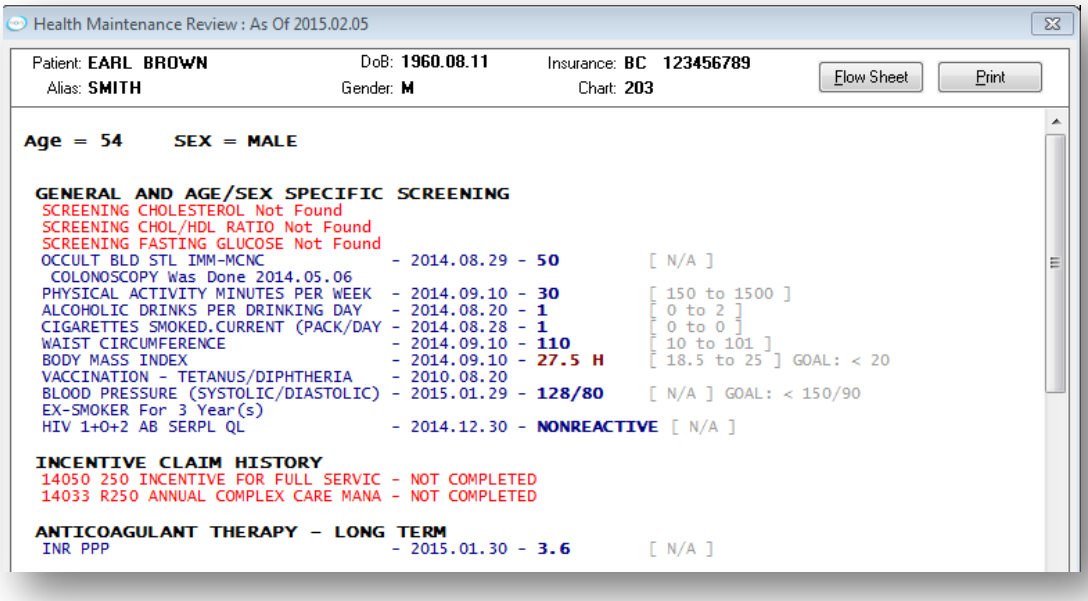
MAR (Medication Administration Record)

Information regarding this folder will be added when it is available.

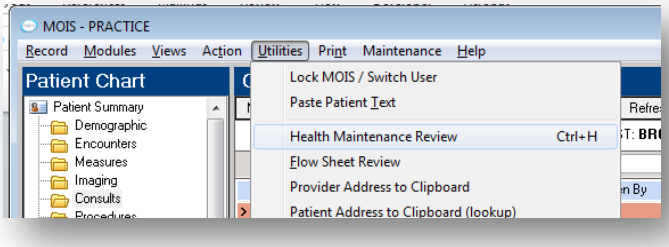
Health Maintenance Review (Ctrl-H)

The Health Maintenance Review, commonly referred to as the "Ctrl-H", is patient, age, sex, and condition-specific summary, as of the details in their chart at that moment. Common measures and interventions are shown along with their most recent date/value, the normal range (if applicable), and the patient-specific goals for each measure (if applicable and added to their Care Plan).

The Ctrl-H looks like this:



- From anywhere in the **Patient Chart** Module
- Hold the **Ctrl key** and type **H**, the Health Maintenance Review for the open patient chart will pop-up.
- The Health Maintenance Review can also be accessed from most folders by going to **Utilities** and selecting Health Maintenance Review from the drop-down.



APPENDIX

Hot Keys

Hot Keys are shortcut keys either to navigate to areas of the chart or to quickly complete a task.
The full list is given below. Please note that some hot keys might change depending on what module is active.

The most up-to-date copies will state **August 2014** on the bottom left.

MOIS Hot Keys

Commonly Used Hot Keys		Navigation Keys		Screen Specific Keys			
				Patient Chart		Billing - Unsent	
Save	F2	Patient Summary	ALT H	Swipe ID Card	ALT 1	Prompt Sent to MSP	ALT F1
Prompt	F4	Demographics	ALT 1	Audit Report	ALT 2	Prompt Unsent by Patient Name	ALT F2
Clear This Screen/Refresh	F5	Encounters	ALT 2			CTRL SHIFT R	
Skip to Next Section	F6	Measures	ALT 3	Prescriptions		Prompt Unsent by Provider	CTRL F4
Search Backwards	F7	Imaging	ALT 4	Duplicate Rx or LTM	CTRL D	Prompt Unsent by Service Date	CTRL F5
Search Forwards	F8	Consults	ALT 5	Print Prescription	CTRL P	Fee Code Option 1	F11
Find	F9	Procedures	ALT 6	Add to Long Term Medications	CTRL U	Fee Code Option 2	F12
Toolbar	F10	Family History	ALT 7	Select from Favorite Medication	SHIFT F4	Duplicate Claim - DOS	ALT F3
Superfind	SHIFT F9	Allergies/Intolerances (Reaction Risks)	ALT A	Long Term Medications		Duplicate claim diff Provider	CTRL F3
Superfind Previous	SHIFT F7	Long Term Meds	ALT C	Renew	CTRL R	Set as WCB Claim	CTRL W
Superfind Next	SHIFT F8	Prescriptions	ALT S	Patient Chart - Measures		Set as Pay Patient (PP) claim	CTRL P
Account Summary[1]	ALT F1	Social History/Risk	ALT O	Graph	CTRL G	Duplicate Claim - NOS	F3
Close Active Window	ALT F4	Documents	ALT K	Filter	CTRL F	Change Claim Provider	CTRL D
Open Chart	ALT F9	Health Issues (Conditions)	ALT P	Patient Chart - Orders			
Change Desktop Provider	ALT D	Orders	ALT F	Create Referral Report	CTRL R	Billing - Sent	
Free Text/Zoom (Voice Dictation)	ALT Z	Daybook	ALT 8	Encounters		Prompt Sent by Recon code	ALT F2
Bill MSP[2]	CTRL B	Unsent to MSP	ALT 9	Encounter Detail Window	CTRL Z	Prompt Sent for Chart	ALT F1
Copy	CTRL C	Sent to MSP	ALT 0	Text Zoom Window	ALT Z	Resubmit Claim	F2
Private Invoice	ALT I	Tab 1[7]	CTRL 1	Flow Sheet (Encounter Form)	ALT F	Debit Claim	CTRL F2
Health Maintenance Review[3]	CTRL H			Create Order for a Consultation	CTRL R	Duplicate Claim	F3
Create Task[4]	CTRL K	Printing		Close Encounter Detail Window	CTRL W / Esc	Toggle - Approve/Adjust	CTRL A
Print Labels	CTRL L	Patient Chart		Workspace		Toggle - Write off	CTRL W
Create Messages[5]	CTRL M	Print Demographics	CTRL D			Toggle - Mark for Delete	SHIFT F2
New Line	CTRL N	Encounter Care Form	CTRL O	Mark for Review	CTRL R	Detail Expl. Code	CTRL E
Current Date/Time	CTRL T					Detail Adjustment Summary	ALT Z
Paste	CTRL V	Billing - Invoices		Daybook			
Cut Highlighted Text	CTRL X	Print Statement	CTRL A	Daybook Bar - Multi	ALT F2	Billing - Invoice	
Family Summary[6]	CTRL F	Print Receipt	CTRL R	Daybook Bar - Single	ALT F3	Prompt by Recon Code	ALT F1
Undo	CTRL Z			Copy/Move Daybook Items	CTRL O	Prompt by Payor Code	ALT F2
Skip to Next Field	TAB	Letter Writer		Bill MSP ALL (All Encounters)	CTRL I	Prompt by Invoice #	ALT F3
Skip to Previous Field	SHIFT TAB	Print	CTRL P	Find Prescription	ALT F8	Pay Balance	CTRL P
Check off a Box	Space Bar	Print To... (Word Processor)	CTRL SHIFT P	Copy Encounter Data	CTRL SHIFT C	W/O Balance	CTRL W
Spell Check	CTRL F7	Redo	CTRL Y	Paste Encounter Data	CTRL SHIFT P		
Select All	CTRL A	Italics	CTRL I	Default Fee Code 2	F11	Data Exchange- Manual Entry Folders	
Print a Note/Print Select Text	CTRL SHIFT N	Delete	Del	Default Fee Code 3	F12	Link to Order	CTRL O
Open Drop-Down List	ALT ↓	Bold	CTRL B	Mark Appointment as Arrived	CTRL A	Save and Duplicate	F3
Delete	SHIFT F2	Underline	CTRL U				

1. Account Summary: Content of the summary will vary depending on the module and folder opened.
2. Bill MSP: Will bill the selected encounter record (Encounters folder, Daybook, Encounter Detail window).
3. Health Maintenance Review: Will open the Health Maintenance Review whenever a Patient's Chart is opened.
4. Create Task: Opens the 'Create New Task' window. This option is available from the Patient Chart module.
5. Create Messages: Opens the 'Create New Message' window. This option is available from most MOIS screens.
6. Available in the Patient Chart module - Demographics folder only.
7. When a MOIS screen has multiple horizontal tabs, use CTRL + the number of the tab to navigate to that tab without using the mouse (i.e. Patient Detail in Demographics is the second tab for hotkey CTRL 2).

Revised August 2014

Consistent Data Entry

The **Consistent Data Entry Guidelines** for data entry help to ensure that information is entered into the correct location in the electronic system so that those using the system can quickly and easily find the correct information when it is needed. Being able to rely on an electronic medical record for accurate data means better, safer patient care – a goal that is always at the forefront of our work. Copies of this document should be posted in the clinic you are working in for easy reference.
These guidelines include the most up-to-date placement for CDX documents, as well as CIX and Excelleris results that are downloaded directly into the patient chart. These interfaces rely on accurate patient data to ensure information is matched to the correct patient chart.

The most up-to-date copies will state **Version2** on the bottom left.

Northern Health MOIS/ICCIS Summary Guidelines for Consistent Data Entry – PROVIDER REFERENCE

Demographics (Alt-1)

Patient identification details
- Legal name and contact information
- Chart status (e.g. Active, Inactive)
- Next of kin, emergency contacts
- Connections (with allied services)

Family History (Alt-7)

- Linked family relationships – for those indexed within the MOIS instance
- Family history pertinent to care (with or without linking charts)

Encounters (Alt-2)

All patient interactions/appointments booked in the MOIS instance
- Progress notes include appointment status (e.g. arrived, no show), forms, calculators, measurements from visit
- On-site shared care provider notes
- WCB Reports & Encounter Forms

Previously contained:
Visits to Emergency & Walk-in Clinic Reports - now in Facility Admissions
Ambulatory Care Reports - now in Consults

Measures (Alt-3)

All ^lab results and manually entered measurements (including at point of care)
- Height, weight, BMI, BP
- Pap smears
- Tobacco/alcohol use, activity level
- PHQ-9, CSHA Frailty score
- Pulmonary function test, spirometry, overnight oximetry
- Cardiac Risk Assessment
- ECG & EEG *("normal" or "abnormal" result with report attached)*
- Exercise stress test

Imaging (Alt-4)

All ^diagnostic imaging reports *(may contain image attachments)*
- Bone Densitometry
- CT (Computed Tomography)
- Mammogram (Screening & Diagnostic)
- MIBI
- MRI
- Ultrasound
- X-ray

Consults (Alt-5)

All consultation letters received
- ^Ambulatory Care Progress Note
- Audiology Reports
- Diabetes Education
- ^Emergency Department Consult
- ^History & Physical Note
- ^Inpatient Consult/Progress Note
- Off-site Multidisciplinary Team Note
- ^Long Term Care Progress Note
- ^Oncology Consult/Progress Note
- Ophthalmology Reports
- ^Outpatient Consult Note
- Pharmacy Notes
- Prenatal Notes (from other providers)
- ^Specialist Reports
- WCB Consults

Procedures (Alt-6)

All medical and surgical procedures (in or out of clinic/office); *not minor office procedures*
- ^Angiogram, biopsy, colonoscopy
- Day Surgery Report
- ^Endoscopy Note
- Guided Biopsy
- ^Labour & Delivery Summary
- Nerve Block
- ^Operative Note
- Significant in-office procedures (e.g. excision biopsy, vasectomy, wedge resection)

Interventions (Alt-V-I)

Non-operative interventions
- Allergy Desensitization Summary
- Counselling (e.g. Tobacco Cessation, Exercise, Drug & Alcohol)
- Some Vaccinations *(MOIS only)*

Previously contained:
DNR/Level of Intervention & Contracts (e.g. Long Term Opiate)
- now in Care Plan – Preferences

Allergy/Intolerance (Alt-A)

Reaction Risks: Allergy status to drug or food *(include No Known Drug Allergy)*
- Drug, food or Environmental Reaction Risks

Events: Adverse events linked to related Reaction Risks, all adverse events related to Immunizations
- Contraindications due to adverse events

Long Term Meds (Alt-C)

Current list of regular medications and natural health products expected to be taken over the middle to long term
- Will print on clinical summary & referrals
- Shows on Patient Summary
- "Reviewed" functionality
- Current and discontinued are listed (add an end date as needed)

Prescriptions (Alt-S)

Short term, one-time, trial/sample medications and natural health products prescribed
- Include all dispensed samples
- Includes documentation of every product ordered
- Items renewed from long term meds will be recorded here
- Not sent with referral letters, not on summary

MAR (if available)

Medication Administration Record
- Documentation of all medications that have been given, omitted, withheld, and cancelled
- Immunizations (including historical)
- Medications provided at point of care
  E.g. Antipsychotics, Plan B, Rhogam, STI medications

Social History (Alt-O)

Socioeconomic details *(not diagnoses)*, Social Determinants of Health
- Diet information
- Family issues
- Sleep information

As needed, mark as sensitive so they do not appear in referrals

Documents (Alt-K)

All documents including forms and letters attached to other parts of the chart are viewable here. (Option to filter out these documents.)

All documents not attached elsewhere, such as:
- Band Letters
- Birth Records
- ^Cardiac Arrest Note
- ^General Letter
- Letters from clients
- Letters of Entitlement (e.g. BC Palliative Care Benefits Application)
- Previous Charts (scanned from paper or electronic)
- ^Physician Initial Assessment Note
- ^Sexual Assault Report
- ^Trauma Report

Health Issues (Alt-P)

Conditions: All past and present health conditions
- All should be coded entries
- One condition per entry/line
- Start and End dates must be listed
- E.g. Diabetes, depression, tobacco dependence, cancer, pregnancy, miscarriage, etc
- Smoking status *(for current smoker or previous smoker only)*

Risks for Conditions: Contains conditions the person is at risk for, but does not currently have
E.g. "Lung Cancer due to Asbestos Exposure"

Needs for Care: Needs that can be addressed by care
E.g. Socioeconomic deprivation

Care Plan

Consolidated view of shared patient data

Preferences: includes consent preferences for care (including refusals)
- Refusal of all immunizations
- MOST form (Medical Orders for Scope of Treatment)
- Pharmanet consent
- Contracts (e.g. Long Term Opiate)

Goals: Qualitative or quantitative patient & provider goals

Planned Actions: Actions to achieve goals

Barriers to Care: Obstacles preventing a patient from getting necessary care.
These usually spin off of Needs.
E.g. "English as a Second Language", "Transportation to Appointments"

Patient Resources: Personal resources/ what the patient "brings to the table"

Forms

Repository of Paper Forms, Dynamic Forms, and Encounter Forms

Encounter Forms: Read-only versions of Encounter Documentation Forms
- E.g. Insurance Forms – WCB Report
- E.g. Encounter Forms – CHF

Facility Admissions (Alt-V-Y)

All facility stays, including emergency visits, and other facility admission and discharge summaries

Orders (Alt-F)

All service requests for consultations, interventions, labs, procedures, images and other items sent
- E.g. Referral letters
- ^Referral Note

Alerts

Private alerts that never show up as a pop-up; entries have start and end dates

Notifications

Patient-specific notifications (show as pop-up when triggered)

Reminders:
- E.g. Risk of Violence or Restraining Order Against (ICCIS Only)
- Psychiatric care)
- Emergency Visits (attach ED reports)
- ^Emergency Department Note
- ^Transfer Note
- Off-site Walk-in Clinic Reports

Recalls: Notices for follow-up, coded
- E.g. for CDM, Complex Care, Pap, Immunization

Tasks/Messages: Patient specific tasks for providers/staff or patient-related messages between providers/staff

^ Downloaded through CIX, Excelleris, CDX (Clinical Document Exchange)

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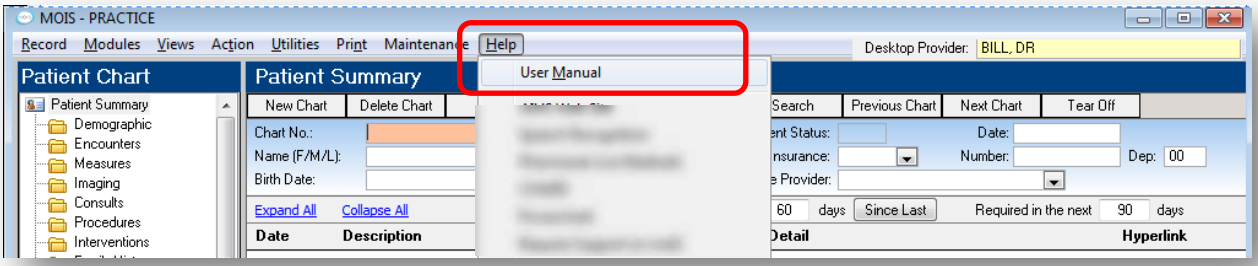
Where to go for Help

- From any Module in MOIS, select **Help** from the toolbar. Find the User Manual here.



- Online, the site on OurNH is currently being updated. NH-specific documentation will be found here.
  - ***Information regarding this website will be added when it is available.***

- For technical issues, contact ITS Service Desk
  - by email: servicedesk@northernhealth.ca
  - by phone: 1-888-558-4357

PRINT & POST – PROVIDER START UP QUICK REFERENCE

The following reference sheet is a quick reminder for the main items mentioned in this manual. Print & Post as needed.

PROVIDER START UP QUICK REFERENCE

For: **Physician (new or locum), Nurse Practitioner, Resident, Medical Student**

Accounts

Northern Health Username: jsmith Password: xxxxxxxx	**MOIS** Username: jsmith Password: aaaaaaaa

Note: Usernames should match, your password for MOIS does not correspond to your NH password (i.e. updating your NH password does not change your MOIS password and vice versa)

General Tips

The ellipses indicates there is a list associated with the field. Click the three-dot symbol or click in the space beside and use F4 to prompt the selection list.

F2 – Save
Ctrl-T – Enters today's date
Calendar – Left click on the date field and use F4 to prompt a month-view calendar.
Ctrl-H – Prompts a patient-specific Health Maintenance Review

A number below the paperclip indicates there is an attachment. Double-click to view it.

Scheduler

Scheduler – View patients booked for the day.

Enter a Progress Note – Double-click the patient's name to open the Encounter Window & type a progress note.

Create a Service Request (Consult/Referral/Lab or X-ray Requisition) – Open the Encounter Window, select "Action" from the Toolbar, select "Create Order for…".

View a patient's previous encounters – Open the Encounter Window, select "Chart Views" from the Toolbar, select "Encounters" or other chart area.

Create a Prescription – Open the Encounter Window, select "Chart Views" from the Toolbar, select "Prescriptions" or "Long Term Meds".

Patient Chart

Find a Patient – In Demographics, choose the ellipses beside "Chart No", or click in the name space and press F4 – always search using PHN, Date of Birth, Name. *Do not add a new patient MOIS without first searching by each of these fields*.
Or
Select "Go To Chart" on the bottom left corner from any screen.

Navigate the Patient Chart – Select the appropriate folder name in the menu on the left of the screen.

Workspace

Workspace – View and acknowledge patient results (labs, consults, etc.); manage tasks and messages. Note: The user's "Current Workspace" is shown on the right above the toolbar.

Change Workspaces – Select the Measures folder under "My Basket", select "Change W/S" from the Toolbar, click on the correct name from the pop-up and choose "Selected User" to view their workspace.

My Workspace – Go back to your own workspace by selecting "Change W/S" from the Toolbar, then choosing "My Workspace".