Starting a visit

Opening a note (from Tracking Window)

1. Working from 

2. Update the visit status for a patient using the **drop down arrow**
3. Assign a room by using the **drop down arrow**
4. **Right click on the patient's appointment**
5. **For Encounters:** Click **Open Encounter** with the left side of the mouse

For Well Exams: Click **Open Well Visit** with the left side of the mouse

Documenting Vital

Primary 

1. **Click** on the **green plus**
2. Enter in applicable vitals **(BP, Pulse, Resp. Rate, and/or Temp.)**
3. **Click** on the **green check** to **save**

Secondary Vitals

1. **Click** on the **green plus**
2. **Click** on the **secondary vitals tab**
3. Enter in applicable vitals **(Peak Flow, Pulse Ox, and/or Other Measurements)**
4. **Click** on the **green check** to **save**

Documenting Growth Measurements

1. **Click** 

2. **Click** on the **green plus** across from the Growth Measurements tab
3. Enter in **Height, Weight, and/or Head Circumference**
4. **Click** on the **green check** to **save**

Viewing 

1. Along the top of the screen click 

2. The radio buttons in the upper right under **Chart type** toggle between the different growth charts
3. Clicking on the  will allow you to print up to 4 growth charts per page

Updating CC/HPI/ROS

1. **CC:** Will come from the appointment reason; type additional complaints if needed
2. **HPI:** Use the drop down boxes to describe the present illness
3. Type more **HPI** in the text box for items that can't be captured by boxes above* it
4. **ROS:** click on the **Pert** box one time to **report** or twice to **deny** the symptom**

NOTE:

For coding purposes: Make a list of HPI or separate the text by semi-colons*

Only **Red**/**Green** **ROS** will be seen in the summary of the note

Adding in-house labs (no task)

1. While in an encounter or well visit click 

2. **Click** on the **In-House** button
3. Fill out the left side accordingly (ordering provider, blood draw CPT etc..)
4. Fill out the dx if it has not been pre-filled from the ICD pop up
5. **Check** all applicable tests
6. Fill out results if they are already received then click **save**
7. *If results are not ready*, then click **save** so the test(s) are **PENDING**
8. Return to the patient's chart and click 

to fill out results.

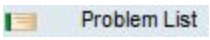
NOTE: Only one user can be in the patient's visit at a time, however multiple users can access the patient's chart.

Exit and Save Notes

1. **Click** 

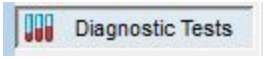
in the upper right corner of the note
2. **Click** the **save** button on the pop up
3. Return to the tracking screen to update **visit status** using the **drop-down arrow**

Updating Problem List

1. **Click** 

2. You may update the Status, Onset/Resolved Date, and Sort Number
3. If notes need to be added to the Diagnosis in the Problem List you may either double click to open the Problem List or click once on the Problem and then click on the edit pencil icon

In-house lab tasks

1. Click  in the **CheckList** column
2. Locate any tasks starting with **In House Diag Tests:**
3. **Double click** on the task, a new screen will pop up
4. Fill out the left side accordingly (blood draw CPT etc..)
5. Fill out/verify the ICD code associated with the in house lab(s)
6. All ordered tests will be **checked**
7. Fill out results if they already saved then click **save**
8. *If results are not ready,* then click **save** so the test(s) are **PENDING**
9. Return to the patient's chart and click 

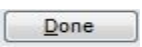
to fill out results.

NOTE: Only one user can be in the patient's visit at a time, however multiple users can access the patient's chart.

Send-out lab tasks

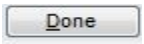
1. Click  in the **CheckList** column
2. Locate any tasks starting with **Quest Diag Tests:** ***(Lab name may vary)***
3. **Double click** on the task, a new screen will pop up
4. Fill out the left side accordingly (flag date, service, fast etc...)
5. Fill out/verify the ICD code associated with the in house lab(s)
6. All ordered tests will be **checked**
7. Verify the Req status is **Pending**
8. To Print: Place checkmark in **Print** box, Click on **Save** to print
9. To Save: Click on the **Save** button

Vaccine Tasks (one vaccine)

1. Click  in the **CheckList** column
2. Locate the task starting with **Imms:**
3. Double click on the task
4. If 1 lot, OP will automatically populate lot information
5. If more than 1 lot, select correct lot number and click on Continue with Highlighted Lot
6. Fill out body site, route, etc...
7. Verify Vaccinator/Counseling Provider then **click Save**
8. Click 

in the lower left corner

Vaccine Tasks (multiple vaccines)

1. Click  in the **CheckList** column
2. Locate the task starting with **Imms:**
3. Double click on the task
4. Immunization Order Management will open, double click on vaccine under **Status: Ordered, Not Yet Given**
5. Vaccine Administration page will open
6. Fill out body site, route, etc...
7. Verify Vaccinator/Counseling Provider then **click Save**
8. Click 

in the lower left corner

Survey Tasks

1. Click  in the **CheckList** column
2. Locate the task starting with **Survey:**
3. Double click on the task
4. Once the survey is displayed, fill out the informant
5. Answer the survey according to the patient/parent's input
6. Click **Save**

Resources/Handouts Tasks

1. Click  in the **CheckList** column
2. Locate the task starting with **Handout:**
3. Double click on the task
4. The handout linked to the task will display on the screen
5. Click the **print** button (Location may vary)

Sending Messages

1. Click  on top toolbar or  from schedule and practice workflow
2. Search for the patient using the **Patient Look-up**
3. Update return phone number
4. Select who you **spoke with** from **drop down**
5. Select who you are sending the message **To: individual or department**
6. Type in the **Subject** of the message
7. Enter the message
8. **Click** 

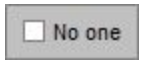
Note: Act Req=someone needs to take care of the message. Send= FYI, CC (no one needs to do anything with the message).

Replying to Messages

1. **Highlight** the message you want to reply to
2. Select one of the three buttons:

3. The message will open, at the top type in reply to the message
4. **Click** 

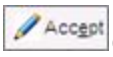
Documenting Advice Given

1. Click  from top toolbar
2. Search for the patient using the **Patient Look-up**
3. **Check this box :** 
4. Type in advice given to the patient in the message body
5. **Click** 

Medication Refills

1. **Click** 
2. **Click**  on the left side of the chart
3. Locate the medication being refilled and **check** the box before the date
4. **Click**  to refill the medication
5. Verify **Dosage**, **Sig**, **Qty**, **Refills**
6. Select one of the following:

Refills from e-Rx center

1. Click  on the schedule and practice workflow
2. Once in the e-Rx tab click 
3. Select a request then click  or 
4. If  is clicked, verify information, add refills and click **Submit**
5. If  is clicked, you must fill out  then click **Submit**

Medication Favorites

1. Write a prescription from the patient's note or chart
2. Prior to **Saving** the medication **click** 

3. Choose or create a Category Name
4. Add a Prescription Template Title
5. **Check** Allow proxy use by non-prescribers if applicable
6. **Click** 

Proxy Medications

1. **Click** 

tab from the patient's chart
2. **Add** a new prescription
3. Use the **drop-down** to make the purpose **Med-to dispense**
4. **Click** on ellipsis box 

5. The address book will pop up; **double click** on the authorizing prescriber
6. Type in the first few letters of the drug and click the ellipsis box
7. **Double click** on the medication from the matching favorites
8. Verify **dosage, sig, quantity, and refills**
9. Click on **Send** or **Print**

NOTE: If you are unable to locate a medication you are trying to fill on the doctor's behalf; it will need to be added to the favorite's list as a proxy med.

Importing Medications

1. **Click** 

on the left side of the chart
2. **Click** 

3. Input how many months you would like to search. The system will automatically have 3 in the text box. Click **Ok**
4. Place a checkmark next to the prescriptions that you would like to import
5. **Click** 

to import the selected medications into the patient chart
6. The medications will now appear in the patient chart. If the patient is still taking the medication you may edit the prescription and update the end date or make it a chronic medication
7. You will also need to update the Sig (Directions)

To View Extra Notes on Medications

1. **Place** a checkmark in 

to see the prescriber/pharmacist notes
2. Notes will appear below the medication

on how the patient takes the medication

Refilling Multiple Medications

1. Click on Med Review
2. Place a check marks next to the medications to refill
3. Click on to refill the medications. Note that this will copy the medications exactly how they were previously prescribed
4. Make changes to the Prescriptions if needed and Send.

Printing Medication List

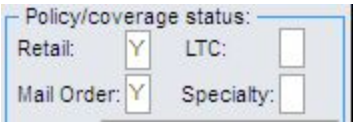
1. Click Med Review
2. Click to print the patient medication list

Printing New Prescriptions

1. Click Med Review
2. Place a checkmark next to the New Prescriptions to print
3. Click on the printer icon to print an individual prescription, or click on the drop down arrow to choose format

Checking Pharmacy Benefits

1. From the Medications **tab**
2. Click on Validate
3. Go to the Patient's Insurance and click Pharmacy Benefits
4. The benefits will show in Policy/Coverage Status if the Insurance gives that information



Lookup Medications Guidelines

1. Highlight a medication in the patient's medication list and click on 0 lookup medication guidelines
2. Lexicomp will open in an internet page and give you medication information (Brand Name, Pharmacologic Category, Dosing Information, Patient Education, Contraindications, Adverse Reactions, Drug Interactions, Dosage Forms, etc.)

Set Prescription Lines to show in Chart

1. From the Medications **tab**
2. Click on the arrow to change the Lines: 4
3. Changing the lines to 3 or 4 will allow you to see the medication name and complete instructions. This will take away the need to hover over a medication to see the instructions

Vaccine Quick Entry

1. **Click** on 

2. Search for patient using the **Patient Look-up**

3. **Click** on the 

tab

4. **Click** on 

5. On the Grid use the **drop down arrows** to choose the vaccine and date given

6. On the Right side list click  and fill out vaccine and date given

7. For multiple vaccines, repeat steps for updating Grid/List

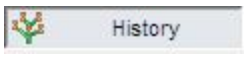
8. **Click** 

to save and update vaccine information

Past Medical/Social Hx

1. **Click** 

2. Search for the patient using the Patient Look-up

3. **Click** 

tab

4. Click on the + to open the list or double click on the bold heading

5. Click once to report +, twice to report -

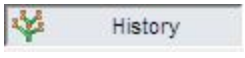
6. To open all sections check off the box:

Note: To add an item to the problem list see “Adding to the Problem List Quick Reference Guide”

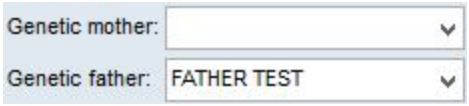
Family Hx

1. **Click** 

2. Search for the patient using the **Patient Look-up**

3. **Click** 

tab

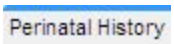
4. Select the genetic mother and father if not already generated 

(this pulls from the contact being selected as the role/reason of mother or father)

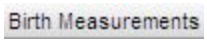
5. Click  to add a new family member
6. Search for the Problem (i.e. hypertension)
7. Enter in the DX Age if applicable and any Notes
8. Copy To will have the siblings listed, you may remove the checkmark if this Family Hx shouldn’t transfer to that child
9. **Click**  to save the history

Newborn Hx

1. **Click** 

2. Search for the patient using the Patient Look-up
3. **Click** 

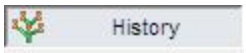
tab, then each tab thereafter


4. Fill out the boxes utilizing the drop down arrows
5. Under the 

tab, enter all applicable measurements
6. **Click**  to save the history

Maternal/Pregnancy History

1. **Click** 

2. Search for the patient using the **Patient Look-up**
3. **Click** 

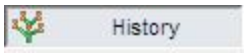
tab
4. **Click** 

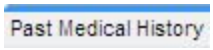
tab
5. Fill in all pertinent information.
6. **Click**  to save the history

Note: This is where you can document mom's maiden name

Adding to the Problem List

1. **Click** 

2. Search for the patient using the **Patient Look-up**
3. **Click** 

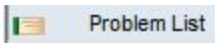
tab
4. **Click** 

tab, then click + to open the list or double click on the bold heading
5. Click once to report a + and then click on the  to add a diagnosis to the Problem List if needed


6. Fill in all pertinent information and ensure that you save the Problem List

Editing/Updating the Problem List

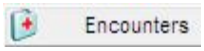
1. **Click** 

2. Search for the patient using the Patient Look-up
3. **Click** 

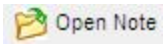
tab and update the Status, Onset Date or Resolved Date, if applicable fill in the Stage/Severity, Quality of life and any Notes
4. Before saving this problem ask yourself who this should be visible to

Opening Encounter/Well Visit

1. From Tracking update the patient's **Visit Status**
2. **Click** 

3. **Click** on 

or 

tab
4. Highlight the current visit being documented and click on 

or double click on the Date to open up the note

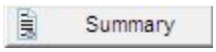
Interval Hx/ROS (Well Visit)

1. The 

box is pre-populated based on the well exam template
2. Update the text as necessary by typing directly in the box
3. **ROS:** click on the **Pert** box one time to mark it as Confirms or twice to mark it as Denies

Only **Red**/**Green** **ROS** will be seen in the summary of the note

CC/HPI/ROS (Encounter)

1. On the 

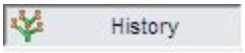
tab, the clinical documentation can be reviewed
2. **Click** 

3. **CC:** Will come from the appointment reason; type additional complaints if needed
4. **HPI:** Use drop down boxes to describe the present illness
5. Type more HPI in the text box for items that can't be captured by boxes above it
6. **ROS:** click on the **Pert** box one time to mark it as Confirms or twice to mark it as Denies

Note: For coding purposes: Make a list of HPI or separate the text by semi-colons

Only **Red**/**Green** **ROS** will be seen in the summary of the note

Reviewing Hx

Click 

tab in the patient's encounter. **The hx will be counted toward billing a few different ways:**

1. **Click** on the check box in the Pert column for the respective hx being reviewed
2. Check off the following boxes to indicate an entire section was reviewed:

3. The **Past Medical** box will also be checked if the  or  is clicked on the Problem list tab

Note: Only options 1 and 3 will populate the patient note with specific information about their problem(s)

Developmental Milestones

1. **Click** 

2. The top boxes default to NORMAL; use the drop-down arrows to change

3. **Click** 

4. Update Informant and age achieved, if there are any developmental delays

5. Use the  or  to indicate if the milestone was achieved or not

6. **Click** on if you want this to show in the summary of today's note

7. **Click** 

Med Review

1. **Click** 

2. **Click**  to review an individual medication and add it to the summary

3. **Click**  to indicate the medication list was reviewed

4. To add a new reference medication click the 

5. Change the purpose type to **Med-Reference Only** using the drop down arrow

6. If the Prescribing Provider needs to be noted click on 

7. Type in the first few letters of the drug and click the ellipsis box

8. Double click on the medication from the matching favorites/Master List

9. Verify dosage/sig (if applicable)

10. **Click** 

Applying Exam templates

1. Once the patient's exam is complete click on 

tab

2. Click on the drop down arrow or begin to type the diagnosis template that you want to apply

3. Select a template that matches that diagnosis

4. Confirm the checked off sections for the template are all needed

5. **Click** Ok

6. Click on NL or ABNL to change it to the opposite or skip the exam point

7. Click on the Body System heading to expand and have access to more questions

8. Use the Findings column to type in additional documentation

AG/Counseling

1. **Anticipatory Guidance** is pre populated based on the template selected

2. Type directly in the AG box to make changes if needed

3. Counseling is typically blank; type directly in for any counseling documentation

4. The visibility on the **counseling** box is the only place to restrict use. Click on the **drop-down** arrow to restrict so only certain users can view the documentation.

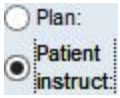
Assess/Plan

1. Additional dx can be added by typing the description in the dx box

2. Push Enter on your keyboard and then double click on the correct ICD

3. The assessment can be used for a different dx; type directly in the box

4. The plan can be edited or typed directly in the box

5. Click the radio button 

to access patient instructions; the plan can be copied by clicking 

Note: All of the above areas can be pre-populated by utilizing templates

Assess/Plan Med tab

1. The 

tab may have a pick-list associated with it based on the dx

2. Double Click on the medication to be prescribed

4. Verify dosage, sig, refills

5. Click 

or 

If there is no pick list:

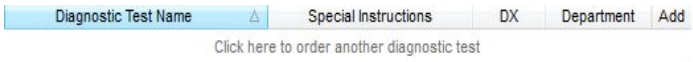
1. Type the first few letters of the medication
2. Click the ellipsis box to bring up the med finder
3. Double click on the medication being prescribed
4. Verify dosage, sig, refills
5. Click 

or 

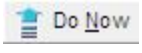
Assess/Plan Lab tab

1. For routine orders, the box in the add column will be pre-checked
2. If there are Alternate orders in the template place a checkmark in the box to select these orders

3. To add any additional labs, click in the blank area at the top:



4. Begin to type the test name and click on the test you want to add to the order
5. Add special instructions/DX if applicable, then verify the department
6. Repeat if necessary, once all tests are selected click  or click on  next to Do Now to create the orders and send the tasks to the proper department

7. If you are completing the order click 

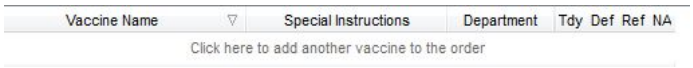
to complete the order

Assess/Plan Imm

1. For routine imms, the radio button will be selected under the **Tdy** column

2. Change the radio button from **NA** to **Tdy** for any additional imms

3. To add any imms that are not already listed click in the blank area at the top:



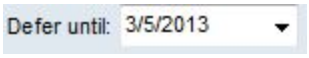
4. Begin to type the imm name then click on the one you would like to order

5. Add any **special instructions** and verify **department**

6. Repeat if necessary, once all imms are selected click  to save the orders OR you may click  next to Do Now to create the orders

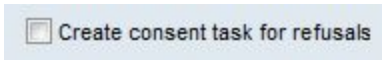
Assess/Plan Imms (Delayed/Refused)

1. If the imms are going to be delayed changed the radio button to **Def**

2. Update 

to be the date the patient should return

3. If there are imms that are refused change the radio button to **Ref**

4. Check the box 

5. Add any special instructions and verify the department

6. Click  next to Do Now to create the deferred and refused orders

Assess/Plan Patient Ed

1. For routine handouts, the box in the add column will be pre-checked

2. Check the box for any alternate handouts that need to be ordered

3. To add any additional handouts, click in the blank area to order them

4. Begin to type the name of the handout and click on the handout you want to add

5. Verify the task is going to the correct **Department**

6. Click 

Assess/Plan Survey

1. For routine surveys, the box in the **add column** will be pre-checked

2. Check the box for any alternate surveys that need to be ordered

3. To add any additional surveys, click in the blank area and begin to type the survey name, then click on it once it appears to select it

4. Add any **special instructions, DX, CPT** and **verify the department**

5. Click  next to Do Now to create the order

Assess/Plan F/U

1. If a routine follow up appt. exists in the template the **add column** will be pre-checked

2. If the follow up appt. needs to be added, click in the blank area

3. Choose a template as the appt reason or type in the reason

4. Update the **Timeframe/Instructions** and **Department**

5. Click  next to Do Now to create the order

Assess/Plan Other

1. If the other order is routine the box in the add column will be pre-checked

2. If there are any alternate orders check the box for them to be added

3. To add more click in the blank area and type the task you need

4. Select the **task type, due date** (if future task), **DX, CPT** (if being billed), **department**

5. Repeat if necessary, once all tasks are added click  next to Do Now to create the order

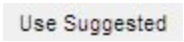
Coding (Well Exam) & Finalizing

1. Click on the 

tab

2. Add any additional dx if needed

3. There's a radio button to change the CPT to a new patient or Established patient

4. Once you have selected the radio button needed click on 

5. You can also double click on a CPT code from Categories or click on Lookup CPT to search for a CPT code

6. Click on 

tab when coding is complete

7. Review the note, make any necessary changes and click on **Finalize**

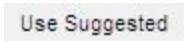
Coding (Encounter) & Finalizing

1. Click on the 

tab

2. Add any additional dx if needed

3. There's a radio button to change the CPT to a new patient or consult

4. Once you have selected the radio button needed click on 

5. You can also double click on a CPT code from Categories or click on Lookup CPT to search for a CPT code

6. Click on 

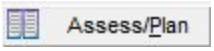
tab when coding is complete

7. Review the note, make any necessary changes and click on **Finalize**

Charting a Sick Visit with a Well Visit

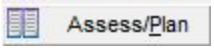
- Only one physical exam counts for this visit
  - Our best practice is to document the exam in well visit, including abnormalities
  - You always have the *option* to copy/paste abnormal exam sections to the encounter
  - Add a note to the Encounter to "See Well Exam for details"
  - OP will suggest a code reflective of the documentation
  - Typically, this code is one level lower than a stand alone sick encounter
  - Medical Decision Making must be documented based on complexity
  - Counseling/Coordination of Care must be documented, if applicable
  - Separate dx is not buried within the well exam (this makes it easier for colleagues to find information in the chart)
- Well Visit normally incorporates:
  - Interval Hx
  - ROS
  - Past Medical, Family and Social History
  - Exam (including any abnormal findings)
  - Assess/Plan
  - Orders
- Encounter (Sick) Visit normally incorporates:
  - CC (See Well Exam for Details) HPI
  - Pertinent ROS
  - Abnormal Exam Findings (optional, as this is documented in the Well Visit)
  - Counseling/Coordination of Care (including time spent)
  - Assess/Plan
  - Additional Orders

1. From within the Well Visit document the Well visit with the Exam findings

2. Click  to do a hard save
3. Click 

and click 

This will open a new Encounter

4. In the CC type in the patient's CC and type in (See Well Visit for Exam Findings)
5. Fill in the HPI since this is not available within the Well Visit and document any ROS findings
6. Click 

and pull in your diagnosis template (remove the checkmark for items that you do not need to pull in. Make any necessary edits and create any orders that need to be completed)
7. Click 

and select your coding for the visit (notice that it is already suggesting a CPT code along with the modifier) Keep in mind that OP will suggest a code reflective of the documentation.
8. Click 

and finalize the visit. You will now be taken back to your Well Visit to finish that documentation