

Medication Plan QRG

The Medication Plan (Med Plan) in NextStep Solutions is a type of Note used for documenting on medications prescribed for a client and can also be used to document client observations, similar to a Mental Status Exam (MSE). Med Plans are used in both Outpatient Agencies and Residential Care settings.

Access and Document in the Med Plan

After prescribing a client medication in <u>DrFirst</u>, you will want to document the prescribed medications in the Med Plan. It is important to note that the Med Plan Note type is <u>configurable</u>, and your Agency may or may not see some of the options listed in the steps below.

- 1. Navigate to Medication Management: Main Menu > Treatment Planning Menu > Medication Management.
- 2. Search for and select the client if not already displayed.
- 3. Click the **Medication Plan** button.
- 4. Upon entering the Med Plan, a message is displayed "Would you like to sync this client's meds from ePrescribe into NextStep?" Click the **Yes** button to pull in the information entered into DrFirst.

Note: If you already opened the Med Plan for the client prior to prescribing in DrFirst, click the **Update (Draft)** button and then click the **Sync Meds** button.

- 5. In the **Diagnosis (DSM-5)** section:
 - a. Review or add diagnosis information. To enter a new diagnosis, type into the search bar and click the **Search** button or click the **List All** button to list all available diagnoses options and select one from the list.
 - b. The **Effective Diagnosis Date** is defaulted to today's date, change if necessary.
 - c. Click the **Diagnosis Type** drop-down and select the diagnosis type.
 - d. Select Diagnosis specifiers from the list if applicable or click the Add Custom Specifier button.
 - **Note**: If adding a custom specifier an Information window is displayed, "Please note that anything entered here may not be officially sanctioned by the DSM-5. Please use responsibly." Click **Yes** to continue and enter the specifier.
 - e. Click the Add Diagnosis button.
- 6. In the **Persistent Notes** section:
 - Enter your clinical opinion in the Subjective and Objective Data field to justify the prescription written for the client.
 - Note: Click Fill with last to bring in previous text that was entered in this field for the client.
 - b. Enter the **Assessment and Plan** for the client.
- 7. The **Date of Service** field defaults to today's date. Type into the field if the date needs to be changed or click into the field and select from the calendar.



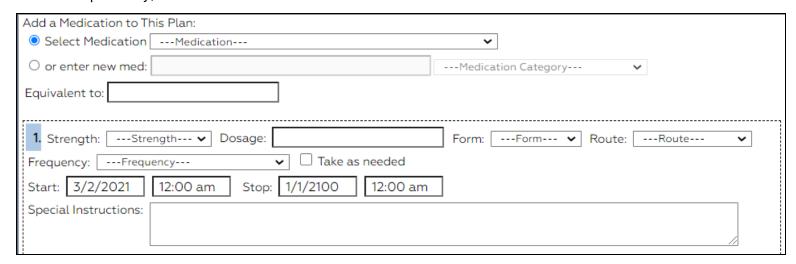


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- 8. In the **Medications** section, the following information is displayed for the client which is synced from DrFirst:
 - Prescribed Medications: A list of prescribed medications by your Agency as well as any other active
 medications they are taking that are not PRN. Click Show Discontinued Medications to view discontinued
 prescribed meds.
 - PRN: This section is collapsed by default. Click the drop-down arrow in the PRN header to display any
 prescribed/or active as-needed medications.



Note: If your Agency is not utilizing DrFirst/ePrescribing, you will be required to manually enter prescriptions into NextStep directly, as shown here:



- 9. In the **Allergies** section, review the client's allergies as entered into DrFirst.
- 10. In the **Side Effects** section, select the checkbox(es) that apply.
- 11. In the Vitals section, complete the fields as necessary.
- 12. The **Vitals History** section displays previously recorded vitals. Click on a specific **Vital** column header to view a line graph of that vital over time.
- 13. Complete the various evaluative criteria statements and checkboxes to document a complete evaluation, including components of a Mental Status Exam (MSE). Examples:



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☐ GENERAL OBSERVATIONS	
Appearance Well Unkempt Disheveled Groomed	
Build ☐ Average ☐ Thin ☐ Overweight	THOUGHT CONTENT
Demeanor Average Hostile Mistrustful Withdrawn Preoccupied Demanding Eye Contact	Delusions Grandiose Persecutory Bizarre Nihilistic None Reported
☐ Average ☐ Avoidant ☐ Intense Activity	Other
☐ Average ☐ Agitated ☐ Slowed	Autistic Obsessional
Speech Clear Slurred Rapid Pressured	☐ Guilty ☐ Ideas of Reference ☐ Preoccupied ☐ Guarded

- 14. If your Agency is set up for Meaningful Use, complete the questions in the **Meaningful Use ONC section**.
- 15. Complete the fields in the **Billing Data Box** as you normally would.
- 16. (Optional) Search pre-existing Notes via the **Search Notes** section using any of the filters described below.
 - From the **Service Provider** drop-down, search by Any User or select a specific user.
 - Populate the **Service Date on or after** and the **Service Date on or before** fields with a date range of pre-existing Notes to search.
 - From the **Chart Type** drop-down, select a specific Chart Type if you don't want to search by All Notes & Case Manager Summary.
 - From the Case Selection drop-down, select a specific Case if you don't want to search by All Cases.
 - Select the **Show Billing Info** checkbox if you'd like billing details displayed for past Notes.
 - Select the **Show Progress Indicators** checkbox if you'd like the progress indicators displayed for past Notes.
 - Select the **Show Dynamic Fields** checkbox if you'd like dynamic fields displayed for past Notes.
 - Select the **Show Note Updates** checkbox if you'd like to see a history of when past Notes were updated and by who.
 - Enter text into the **Keyword Search** field to search Note text.
 - Click the **Show Notes** button.
- 17. Click the **Update (Final)** button to sign/seal the Note.

Note: You can click the **Update** (**Draft**) button which allows you to save your note as a draft and come back to it later.

