Lesson 4: Completing a Basic Office Visit

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By the End of This Lesson, You Will Be Able to...

- Open a patient chart or office visit from EMR Desktop
- Review and add vital signs
- Select a “working BP”
- Record Nutritional Counseling given
- Review or add MU demographics
- Review point-of-care test results
- Review medications and decide about renewals
- Document elements of the history of present illness (HPI)
- Verify and Amend problems, medications and allergies (P-M-A)
- Enter P-M-A provider comments
- Review/edit past medical and surgical
- Review/edit family history, social history and risk factors
- Review the Review of Systems
- Record a physical examination
- Add a new problem/diagnosis
- Complete a problem assessment and plan
- Write and transmit a prescription for a new medication
- Associate a problem with a prescribed medication
- Print a system-identified, patient-specific handout
- Find and print additional informational handout
- Record and print patient instructions and a clinical summary of the office visit
- Sign the office visit note

Office Visit Workflow Fundamentals for Providers
The flow diagram below depicts the common workflows a provider might complete during an office visit. This can vary significantly based on the specialty, reason for visit, chief complaint, time available for the visit, staff assistance, the number of problems to be addressed, patient acuity, and other factors.
For this basic office visit, we will focus on getting familiar with the “core forms” by navigating through them and entering data related to the reason for today’s visit. As in all lessons, we will recommend workflows and approaches to information reviewed and clinical documentation that promotes a team approach to accurate and efficient completion of tasks needed to ensure quality care and EMR Meaningful Use.

Office Visit: Provider Workflow Diagram
Open Chart / Office Visit from EMR Desktop

In most cases, office visits will be started by the Nurse or Medical Assistant who is rooming the patient. Upon completing their tasks, they place the visit on hold and route the document to the Provider’s EMR Desktop.

- Log in as Dr. Harry Winston (User ID: hwinston, Password: AsdfAsdf123)

In this lesson, you will use the Desktop toolbar to locate the patient’s office visit document.

- From the EMR Desktop toolbar, click on Documents.
Beneath the All Documents folder, in the Documents window, click on Office Visit. Notice the list of documents shortens to include only office visits.

- **NOTE:** If you see the All Documents folder without any subfolders, click the + symbol to the left of the All Documents folder to expand the folder tree.

In the documents list, click once on the document for Catherine A. Mattson's office visit to select it.

- Review the Comments field to be sure there are no special Routing Messages that need your attention.

- Double-click Catherine Mattson's document to open the visit.

- **Note:** the Care Alert Warning Popup, that reminds the clinic to schedule the patient for a mammogram does not execute when returning to the chart. Care Alerts can be reviewed from the Chart Summary or by following the workflow in Lesson 3 to add pertinent Care Alerts to comment field on the Vital-Signs-4-CCC form.

You are taken directly to the document which has opened in an active Update. The document Text displays and you can review the information entered by the rooming staff quickly by scrolling the Text viewing pane. Information is to be added using the forms as structured data whenever possible.

To access a desired form, click the Forms button or double-click in one of two places:

- On the form name in the Forms List or
- On the colored Text (green or blue) of the form in the Text viewing pane.
Tips and Tricks...

Opening an Office Visit from the Calendar: Instead of going right into the document from the desktop, if the provider would like to view the patient Chart Summary or other information in the chart in preparation for documenting their office visit, an efficient way to navigate to the patient’s chart is to double-click the patient’s appointment within the appointment book and then navigate to chart documents.

Review and Add Vital Signs

- Navigate to the Vital Signs 4-CCC form.
  - After reviewing the information recorded by the Nurse, you choose to take an additional blood pressure.
  - In the middle right of the form, click Serial Assessments button. The Serial Assessments – CCC form opens.

- At the top of the form, click the Time of Assessment.

- In the Vital Signs line, click the radio button indicating you took a Standard reading.
- In the BP fields, enter the new blood pressure of 148/86. Notice that the Record button has turned yellow.
- Click the Record button.
At the bottom of the form, notice the blood pressure reading is now displayed in the Vital Signs this Visit area.

At the bottom of the Serial Assessments-CCC form, click the VS navigation button to return to the Vital Signs-4-CCC form.

Select a “Working BP”
The “Working BP” is the blood pressure reading the Provider feels most accurately reflects the patient’s resting blood pressure for today’s visit. Selecting a “Working BP” means that you would like that BP reading to inform any quality reporting and decision support (e.g., BP goals for hypertension or diabetes mellitus).

On the Vital Signs-4-CCC form click the View Today’s BPs button.
  - The Select Working BP form opens and displays all blood pressure readings recorded today.

Click the checkbox next to 148/86 (BP 2nd Reading).

At the bottom of the form, click the Close button
  - Notice when you return to the Vital Signs form that the Working BP field is now populated with the blood pressure you selected.
Record Nutritional Counseling Needs

On the Vital Signs-CCC form, notice the Nutritional Counseling button has turned yellow to encourage nutritional counseling with your patient. This is a BMI driven button that turns yellow if the patient’s BMI is >25 kg/m², which is the Centers for Disease Control and Prevention threshold for “overweight.”

☐ Click the Nutritional Counseling button to indicate you discussed this with the patient
  o A pop up explains that this action pushes information to the note and Flowsheet.
☐ Review the pop up information then click OK to return to the form.

Meaningful Use Matters...

<table>
<thead>
<tr>
<th>Clinical Quality Measure Title (Core #1)</th>
<th>NQF Measure Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension: Blood Pressure Measurement</td>
<td>NQF 0013</td>
</tr>
</tbody>
</table>

Meaningful Use Matters...

<table>
<thead>
<tr>
<th>Clinical Quality Measure Title (Core #3)</th>
<th>NQF Measure Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Weight Screening and Follow-up</td>
<td>NQF 0421</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Quality Measure Title (Alternate Core #1)</th>
<th>NQF Measure Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
<td>NQF 0024</td>
</tr>
</tbody>
</table>
Review or Add MU Demographics

- Click the **VS-1 Additional Information** tab or button.
- Review the **MU Demographics** area and edit information as needed.

### Review Reason for Visit and Comments

Several forms in the system provide for additional free-text comments. MSU HealthTeam is advocating the use of 2 Comment fields for communication between rooming staff and Provider of important facts about the patient or visit that don’t have identified standard fields. One such field is on the **Prob-Meds-Allergies-CCC (PMA)** form and will be discussed when you reach that point in the lesson. Here on the **Vital Signs-4-CCC** form the Comments field at the bottom of the **VS-1 Additional Information** tab will automatically be included in the note and the information in the field stored as an observation. The provider should take care to edit any comments as necessary prior to signing the note into permanent record. The **View/Insert Prior** button above the field allows the comments from prior visits to be brought into subsequent visits and edited as applicable.

- Review the nurse’s **Reason for Visit (Nurse/MA)** and Comments.
- **Note:** the **Care Alert Warning Popup**, that reminds the clinic to schedule the patient for a mammogram, has been added by the nurse in the comment field.
Review Point-of-Care Test Results

- At the bottom of the Vital Signs-4-CCC form, click the Lab Entry button.
  - The Lab Entry-POC form opens.

- Review the results of the Urinalysis-dipstick test that was performed by the nurse earlier in the visit.
- Click the VS button to return to the Vital Signs form.
Review Medications and Decide about Renewals

☐ Navigate to the **Prescriptions** form.

![Prescriptions form](image)

The patient confirms she is no longer taking POTASSIUM CHLORIDE so you will be refilling the HYDROCHLOROTHIAZIDE only. We will confirm that the nurse has removed the POTASSIUM CHLORIDE from the medication list later.

☐ To the right of the HYDROCHLOROTHIAZIDE prescribing information, click the **Refill?** checkbox.
  - The **Quantity** and **#Refills** fields auto-populate with the values from the last prescription.

☐ Click the **Sign Rx** button.

☐ A popup informs you that your Prescription is complete.

☐ Click the **OK** button.

**Efficiency Tip**

Prescription is complete popup: We recommend that you check the Don’t show me this message again box to avoid having to see and dismiss the Prescription is Complete message in the future. Since the system alerts you whenever your attempt to record, print or transmit a prescription is not successful, this message adds little if any value.
Complete the History of Present Illness: HPI-ROS-CCC

Review or Record a Chief Complaint

Ultimately, Providers are responsible for the accuracy and completeness of the Office Visit note. When nurses, medical assistants or other health professionals contribute to the note, the Provider reviews their chart entries and verifies, modifies or amends the entries as needed before signing.

☐ Navigate to the HPI-ROS-CCC form
☐ Review the Visit Type and the Chief Complaint entered by the nurse.
☐ There are three ways to document HPI
  o Click on the Specialty-Specific tab and use a Problem template
  o Click the View Prior HPI button which allows the Provider to insert and edit the prior HPI
  o Click in the History field on the General HPI tab and free text the HPI

Review and Record Specialty-Specific HPI

Today we will be using the Specialty Specific tool for only one chief complaint but the same form can also be used for multiple complaints by committing the history of each problem separately.

☐ Click the Specialty-Specific tab at the top of the HPI-ROS-CCC form
In the **GU History** text box enter “UTI 2 years ago resolved with Sulfamethoxazole. Patient reports developing a rash near the conclusion of the antibiotic therapy.”

In the **Complains of/Denies** area you will be asking about all of the listed symptoms so click the **All Heg** button. Notice that all symptoms in the **Denies** section are now checked.

In the **Complains of** area, click the checkboxes for dysuria, frequency and urgency. Notice that the corresponding boxes in the **Denies** section uncheck. Notice that the list scrolls down and contains more entries. You choose not to ask about genital lesions; therefore uncheck that box in the **Denies** area.

In the **Past GU Hx** section, check the box next to **no significant past GU history**

In the **Risk Factors** section, check the box next to **recent sexual intercourse**

- Notice that the **Click to Insert Text** button has turned yellow.

Click the **Click to Insert Text** button. Note that the information you check is added to the Final Text field.
Note: Entering HPI on the Specialty Specific tab creates both free text and protected text. The protected text section is shown as `<C/O AND DENIES PROTECTED TEXT>`. This should not be deleted – it is important to record the patient’s symptoms correctly. If you want to change recorded protected text, use the Clear All button and then reenter the accurate information. The remaining text is freely editable by clicking inside the text box and typing.

Clicking the General HPI tab you will see the recorded Chief Complaint, Onset, Intensity and History.

Important!
- When using the All Neg button, be sure you have either: Asked about ALL of the items in the list, or uncheck any you did not ask about.
- In the Chief Complaint field, do not use general statements such as “Follow-up” or “Refills”. For billing purposes, the chief complaint must refer to one or more specific problems or symptoms.

For Your Information...
- Documenting a History of Present Illness using the Specialty-Specific tab automatically counts the elements in HPI indicating the extent of the history (brief vs. extended), and carries the information to the E&M Advisor form to assist in determining the appropriate billing level for the visit.

Review and Verify Problems, Medications and Allergies (PMA)
The PMA form is a convenient place to add, delete and amend clinical lists and choose whether or not to include the prior values from the list in your note.
- Navigate to the Prob-Meds-Allergies-CCC form.
Document Transition of Care and Medication Review

For Meaningful Use it is a requirement to document Transitions of Care (TOC). Additionally, during a transition of care visit, medications must be reconciled and that reconciliation documented. The most efficient way to accomplish the documentation of the transition of care and medication reconciliation is on the Prob-Meds-Allergies-CCC form. Support staff often participates in recording Transitions of Care and review of the Medication list. For Transition of Care Medication reconciliation both the Verified Meds and TOC buttons must be clicked. Please refer to MSU HealthTeam policy # CP-6 for Transitions of Care guidelines.

- In the middle of the form locate and click the TOC button. If the support staff performs this function, then the button will read Undo.
- If the Provider clicks the TOC button a popup informs you Transition of Care is recorded. Click OK

- If either the TOC or Verified Meds buttons were pushed in error, the observation terms can be removed by using the Undo or Clear buttons.
- The updated medication list will display in the Current Medications (verified) field.
**Edit Medications (Medication Reconciliation)**

- Review the **Current Medications (verified)** field on the PMA form. If the Provider needs to edit or amend an unsigned entry, they will click the **Edit Medications** button.

![Image of the Update Medications window open]

**Edit Medications:** The Update Medications window opens. The Provider can delete, add or amend the medication list.

- The Provider notes that the **Effects of this update** field indicates that the staff has removed MICRO-
  K...(POTASSIUM CHLORIDE) as indicated by the patient. The Provider approves this entry and clicks the **OK** button.
- If the Provider would like the change to be amended, they can click on the medication in the **Effects of this update** field and click the **Change Back** button.
Review and Verify Allergies

As we covered in lesson 3, because of the additional safety features in Centricity EMR 9.5, during the upgrade allergies and adverse reactions were assigned levels of Criticality by the system. In order to avoid false override requirements, the criticality of each allergy needs to be reviewed for accuracy. The recommended workflow is to have the rooming staff, with the assistance of the list of criticality criteria, review all allergies and make adjustments to Criticality as needed. The provider will also review and ultimately sign off on the assigned Criticality level.

Note: Criticality criteria is available for review by using quick texts .allergysev and .allergysev2

- Notice that the Allergies Verified button on the PMA form is no longer yellow, indicating allergies have been reviewed by the Nurse.
- Review the Updated Allergies field on the Prob-Meds-Allergies-CCC form or click on the Edit Allergies button.
  - The Update Allergies or Adverse Reactions form opens.

- Review the Reaction and Criticality listed for each allergy.
  - Discuss items with patient for clarification if needed.
If you are comfortable with the information, click the **OK** button to return to the **PMA** form.

If you feel a change is needed, click on the allergy you wish to change and click on the **Change...** button to edit the entry as needed.

**Enter PMA Provider Comments**

Earlier we discussed two Comment fields suggested for use by the rooming staff to communicate with the provider. The **Comments** for **Nurse/Medical Assistant** here on the **PMA** is another place for this purpose. This field differs from the comments on the **VS** form as they do not display in the note unless the provider chooses by checking the **Add to Note** box. You can also click the **Insert Above Comments** button to pull the rooming staff notes into the **Provider** comment field. In this exercise you will insert the nurse’s comments into the **Provider** field and amend as necessary.

- At the top of the PMA form, click the **Comments** tab
- In the center of the page, click **Insert Above Comments** button. This adds the nurse comments to the Provider field; amend as necessary.
- Click the checkbox next to **Add to Note**
- To the right, check the boxes indicating **Meds & Allergy reviewed by provider- with patient**.
- Above the check list, click the **Click to Enter** button to add the review to the text translation.
- Click the **Signature** button to enter your soft signature.
Review/Edit Past Medical and Surgical Histories

- Navigate to the **PMH-PSH-CCC** form.
- Review the information on the **Past Histories** tab.
  - The Nurse has already entered the documentation that the histories were reviewed.
  - Notice the dates in parenthesis included with each observation indicate when the entry was made.
    - This can help you determine if the Nurse has also recorded elements of **Past Medical History** and **Risk Factors** as part of this visit.
  - Additional entries or edits made by the Provider will be saved as an observation and display in the office note.

### PMH-PSH-CCC Form

**Past Medical History**

- Appendectomy: Fall 2010
- Dorsal meniscal tear: Divided (1/20/2014) (1/21/2014)

**Risk Factors**

- Smoking Status: Never smoked (01/21/2014)
- Passive Smoke Exposure: yes (01/21/2014)

Review/Edit Family History, Social History and Risk Factors

- Navigate to **FH-SH-CCC** form.
- Checkboxes for **reviewed —no changes required** are checked by default because we **Inserted All Histories** on the **PMH-PSH-CCC** form.
- On the Additional Hx tab, review the nurse’s entry. Record any other additional history as desired.
- Also notice that smoking Risk Factors have been completed by the system as a result of entry on the VS form.
Enter a Review of Systems

- Navigate to the ROS-CCC form.
- Click each of the radio buttons that have a – or + above them (indicating information has been entered) and review the information recorded by the nurse.
- Edit the ROS-1 and ROS-2 tabs and record any additional information as desired.

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Record a Physical Exam

- Navigate to the PE-CCC form.

As always, use only those sections of PE-CCC you need to complete the physical examination elements that you deem to be medically necessary for the evaluation of the patient’s reason for visit and problems to be assessed today.

Note: this form is Specialty Specific and allows for use of other specialty PE forms.

- On the Gen HEENT tab, use the check boxes in the General section to select “alert, well-developed and well-nourished.”
Efficiency Tip

Note that this specialty has elected to organize its PE-CCC form in a manner that lists all of the
- normal findings in the left column for each section
- abnormal findings in the right column for each section

This is an efficient way to find and record your specialty’s common normal and abnormal physical
examination findings without having to manually type information into the form. Work with your EMR
Team to customize your specialties CCC forms.

- On the Neck Lung Heart tab, in both the Lungs and Heart fields, click the Normal button.
  - Notice a specialty-specific default text is entered indicating all normal findings. The translation may or
    may not be identical to the list of normal findings in the checkboxes.
On the Abd GU tab, in the Abdomen field, use your keyboard to record findings with the free text method.

Add a New Problem/Diagnosis

Navigate to the Problems-CCC form.

The Problems-CCC form displays a Custom List up to 140 of the most common diagnoses you see in your specialty. You can use this form to efficiently add problems by clicking the adjacent checkbox. Notice, some of the selections are labeled List, not just a single problem. Using a List will take you to a custom problem list and allow you an efficient way to add more specificity without cluttering the Problems-CCC form with several closely related problems. If a problem is not present in the list, you can use the Problems button to add to or update the patient’s active problem list.

In the upper right column, click the check box next to UTI to add it to the problem list. This fulfills one of the Meaningful Use Core Criteria by entering a problem as structured data.
Efficiency Tip

Use the Problems-CCC form whenever you can to add a new problem. It saves several clicks and keystrokes and allows for problems that are self-limited to fall off the active problem list automatically.

This form can also alert you to the fact that a problem you are about to add is already on the Problem List. This way you don’t accidentally end up with a duplicate problem entry on the Problem List.

The form also alerts you when the problem you are about to add is on the list of inactive problems, so you can document whether you want to reactivate the problem or document a recurrence.

Next, click the [Problems] button on the Problems-CCC form. This will allow us to update the patient’s active problem list or add a New problem.

- The Update Problems form opens.
To update a problem click on the **Problem Description** and then utilize the Change or Remove buttons on the lower portion of the **Update Problems** form.

- **Adding a Problem**
  - Click the **New** button on the **Update Problems** form.
  - This will open the **New Problem** window.
  - There are three ways to add a new problem from this window.
    1. Place the cursor in the **Search for** field and type the problem or code you wish to search. If the problem you are searching is contained in the custom problem list in the **Using** field the problem will auto populate as you type, called **Quick Search**.
    2. You can also click the magnifying glass to do a full problem search, called **Full Reference Search**. You can also search by **Code type**: ICD-9 or ICD-10. If the search results in >60 problems, it provides folders and subfolders for selecting the most accurate description and code, called **Guided Navigation**.
    3. There is also a custom problem list called **Smart List**. This is a custom list that recognizes the Providers’ most commonly-used codes. Select **Smart List** in the **Using** field and type the problem or code in the **Search for** field. If this is a common problem the Provider uses, it will auto-populate.
QUICK AND FULL REFERENCE SEARCH

GUIDED NAVIGATION
SMART LIST

The CPOE A&P-CCC form is used to document the assessment and plan portion of an office note. CPOE stands for “Computerized Provider Order Entry”. This form has powerful tools designed to assist you in reviewing relevant past and current problem-specific information, documenting your assessment and plan for each problem you addressed at the visit, and pulling in medications and medication changes, test results, instructions, new orders, patient instructions and printed handouts.

The form allows you to assess a total of 12 problems, two problems per tab. Each problem is selected from a dropdown list of the patient’s current problems, including any newly added problems (which appear at the top of the list). If the problem being assessed has not previously been added, clicking the Prob List button in the right hand corner; it will allow you to add a problem to the list and subsequently be able to choose it from the dropdown.

- Under Assessment #1, select UTI from the dropdown list.
  - Notice that it includes the associated ICD-9 and ICD-10 code because it is a coded problem.
  - Click the appropriate Assessment radio button (in this case it is a New problem)
Notice that the **Insert Template** button is now bold. The bold type indicates that there is additional information that can be inserted and may be helpful, either by inserting relevant test results, typical management plans, patient instructions, or other information. If you find that the inserted information is not something you would like to have in the note, you can click the **R** next to it to remove it.

### Enter and Transmit a Prescription for a New Medication

You have determined that you will prescribe an antibiotic to treat your patient’s UTI.

- On the CPOE A&P-CCC form, at the lower left of the **Assessment #1** section, click the **New Meds** button.
  - The **New Medication** window opens.
  - Use the **CCC-Antibiotics-UTI** Custom List or do a full search using the **Reference List...** button.
- Click to select **AMOXICILLIN 250 MG CAPS** Take one (1) by mouth three times a day.
Notice the icons that appear:

- , indicating that this medication is on the patient's formulary and preferred.
- , indicating interactions messages. Hover over it to see what it means.
- , indicating dosing messages. Hover over it to see what it means.

You will be prescribing medication for 7 days. Enter today as the **Start Date** then enter the **Duration** or **End Date**. Notice if you enter a value in the **Duration** field, the end date populates automatically. This is desirable for medications that will not be used chronically, as the medication will automatically become “inactive” after the end date.

Enter **Quantity**: 21 and **Refills**: 0

Confirm the **Pharmacy** is correct – in this case Ideal Pharmacy.

Confirm the **Authorized By** field lists the correct provider – Dr. Winston

Confirm the **Prescribing Method** to be used. Here you will use Telephone but remember in production to use **Electronic** whenever permissible. Pharmacy’s with an (*) after the name accept e-prescriptions.
**Associate a Problem with a Prescribed Medication**

Associating problems with prescribed medications can be beneficial for internal reference and insurance companies are now starting to require the diagnosis be identified for the medication or supplies. Before completing the prescription, associate the Problem for which the medication is being prescribed.

- On the left of the New Medication form, click the radio button to view the **Current/Associated Problems**.
- In the **Description** list that displays, click to highlight the problem we just added – **UTI**.

**Print a System-Identified, Patient-Specific Education Handout**

At this time, the only handouts that are certified by GE for Stage I Meaningful Use incentive Menu Measure #6 are the handouts that are generated from the **New Medication** form. The measure requires that the handout be identified by the technology based on patient information entered into the system. The medications handouts that are generated by checking the **Print Pt. Handout** checkbox will meet the criteria and will print when the clinical list change has been signed.

- At the lower right of the New Medication form, check the box to **Print Pt. Handout**.
- Click the **OK** button to return to the **CPOE A&P-CCC** form.
- Clicking the OK button will associate the problem you have selected to the prescribed medication.

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**Efficiency Tip**

- Remember to enter the **Duration** or **End Date** for medication you do not intend to use chronically, so the medication will become “inactive” after the end date and does not need to be removed later.
- Remember to leave the **Duration** and **End Date** blank for **chronic medication**. Doing otherwise can present a risk to the patient and also creates waste and inefficiency as providers and staff try to figure out what happened to the medication, whether the patient is supposed to be taking it or not, and what to do next. They then have the additional work of prescribing it again rather than just renewing it.

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**Important!**

- **Never add a medication, change a name, strength or formulation by typing** it into the **Medication** line on the **New Medication** Form. Doing so adds it as an “uncoded medication” meaning that it is unstructured data that cannot be checked for drug-drug, drug-disease or drug-allergy interactions. Entering medications this way also does not count for Meaningful Use. If you are unable to find a medication on a custom list, use the Reference List to find it.
Uncoded medications are noted in the system with an asterisk (*) before the name of the drug (e.g., *AMOXICILLIN). Whenever you see this for a medication, you should make sure that it gets corrected promptly. NOTE: some compounded medications or durable medical equipment may have to be entered in an uncoded manner – these can be left as is.

### Meaningful Use Matters...

<table>
<thead>
<tr>
<th>Objective</th>
<th>Core Measure #4 – Meaningful Use Stage 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain active medication list</td>
<td>More than 80% of patients have at least one entry recorded as structured data</td>
</tr>
<tr>
<td>Generate and transmit permissible prescriptions electronically</td>
<td>More than 40% are transmitted electronically using certified EHR technology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
<th>Core Measure #9 – Meaningful Use Stage 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</td>
<td>More than 10% of all unique patients seen are provided patient-specific education resources.</td>
</tr>
</tbody>
</table>

### Find and Print Informational Handout

Though the above system-identified handouts are the only handouts that currently are certified by GE for the Meaningful Use incentives, the system has a wealth of informational handouts that you can provide to your patient as is appropriate. In this instance, you decide to provide Catherine with an informational handout about Dysuria.
On the CPOE A&P-CCC form at the lower right corner of the Assessment #1 section, click the Print Handout button. The Print Patient Education Handout form opens.

- Use the Custom List dropdown to select [None] at the top of the list.
- Notice this makes the search/binoculars button active.

Click the search/binoculars button. The Find Handout form opens.

- On the Search tab in the Search field enter “Dysuria” and click Search.
- Select a handout and click OK.

On the Print Patient Education Handout form, click the checkbox to Record handout printing in Chart.
Click the Preview button to review the handout you have generated.

Click Close to return to the Print Patient Education Handout form.

Click Print to send the document to the printer and record in the chart that you have printed it for the patient.

Click Close again to return to the CPOE A&P-CCC form.

Efficiency Tip

Reviewing the Patient Education Handout with the patient using the computer in the exam room can be an efficient way to reinforce your patient education goals.

At the top right of the CPOE A&P-CCC form, click Commit Assessment button. Notice that once you have done this “Committed” is displayed next to the button.

Efficiency Tip

Clicking Commit Assessment may seem like an unnecessary step but it pushes your Assessment and Plan to the Problem List where you can quickly see how the problem was assessed from visit to visit. This functionality can be a great help for chronic disease management.
Provide a Clinical Summary for Each Office Visit

☐ Navigate to the **Patient Instructions-CCC** form.

☐ Check any pertinent instructions that you would like the patient to receive. In this case, the patient instruction about **Increase fluids, Cranberry juice** and **1 week follow-up** seems pertinent.

☐ Click the **Click to Enter** button. This pulls the information to the text box. Edit or add to the text as desired.

☐ Click the **Print Pt. Instructions** button to print the Clinical Visit Summary required for Meaningful Use.

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**Meaningful Use Matters...**

**Objective**
For individual professionals, provide patients with clinical summaries for each office visit

**Core Measure #7 (2011)**
Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
Signing the Office Visit Note

- In the Update toolbar, click the **End…** button. The **End Update** form opens.
- Confirm the Summary line and Provider field.
- At the lower right of the **End Update** form click the **Sign clinical list changes** check box. This will sign any changes that have been made to the Problem, Allergy, and Medication List, and other clinical list.

**Note:** Signing clinical list changes is an important habit to get into when placing your document on HOLD. Any unsigned clinical list changes from this visit will prevent other users across the entire HealthTeam from making clinical list changes in their EMR documents until you sign your clinical list changes or until you sign the document.

- In this example, we will click the **Sign Document** button.
- The **Sign Document** pops up: You can check the box **Don’t show me this message again** and click **OK**.
- Notice that the system has returned you to the patient’s Chart Summary.
  - On the Documents screen, the text translation is now black (not green and blue). This is a visual indication that the note has been signed and is no longer editable.
  - To add additional information to a signed document use the Append button on the Documents toolbar.
- Click the Log Out button or navigate to the EMR Desktop.