Northwoods Virtual Epic Training –

Ambulatory Provider Lesson Plan

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## Introduction

### ****Welcome****

Hello and welcome to Aspirus Outpatient Provider Epic training. I am excited to walk with you through this information to give you a basic idea of how the system functions. Class layout will include instructor lead demos and individual exercises.

### ****Administrative Notes****

Before we get started, I would like to go over some administrative notes. Please silence cell phones for the entirety of the class. Feel free to stand and stretch during class if you need to. We will have routine breaks scatter throughout the session along with a lunch break at around the mid-mark of the class.

### ****Questions****

I welcome questions as we go through the material. If there are any questions that I am unable to answer they will be added to the parking lot. Feel free to shout them out as we go through the material. Or, since we will be reviewing each individual lesson plan upon completion, you can feel free to save them until that natural break in the action.

### ****Materials****

The binder contains exercises and a classroom information sheet that will be used throughout class to guide you through some hands-on practice. There is a training companion at the end of the binder that we will reference during class. At the end of class, we will show you where to find all these materials, as well as tip sheets on the intranet. The job aid is there for you to take notes and use in your clinic.

### ****Environment****

Class is trained in a training environment with fake patients and end users. Our class focuses on teaching you Epic functionality. We attempt to create scenarios with rich patient data that are as realistic as possible, but there are some instances where the environment we are using and the scenarios we are going through are not completely accurate/complete from a clinical standpoint. However, feel empowered to make these scenarios your own so that they are reflective of your clinical specialty.

### ****Meaningful Use****

Another thing we will discuss throughout this training as it relates to workflows in Epic is the term “Meaningful Use.” Meaningful Use is a government mandated program controlled by the Centers for Medicare and Medicaid which defines criteria for ‘Meaningfully using’ an Electronic Health Record or EHR. Aspirus must report on certain criteria to qualify for reimbursement. There are several training points we will make through the curriculum that relate to “Meaningful Use.”

### Pre-Requisites

* Epic - Overview of Hyperspace in an Outpatient Setting
* Epic - Office Visit Demonstration
* Epic - Ambulatory: Ordering in an Outpatient Context
* Epic – Ambulatory: Wrapping Up a Visit
* Epic - Overview of In Basket
* Epic - In Basket: Following Up on Result Messages
* Epic – Overview of My Chart
* Epic – Releasing Results to MyChart
* Epic – Querying for a Patient’s Outside Record
* Epic – Reconcile Outside Patient Information
* Epic - Prenatal E-Learning

### Classroom Materials = 480 minutes (8 Hours)

* Introduction PowerPoint (15 minutes)
* Explain Classroom Materials (Login Sheets and Lesson Plans)
* User Guides and Tip Sheets for Playground Login for post-class practice

### Departments and Patients Used for Training

* Department: Weston Clinic Family Practice
* Patients: Fred, Betty, Melissa, Nancy, Mason

## ****Logging In/Orientation to the Epic Workspace****

1. Log in using your **User ID** and **Password** on the provided Login Sheet.
	* User ID: trn####
	* Password: logins
2. Keep the **WESTON CLINIC FAMILY PRACTICE** department and click **Continue**.
	* If you need to log into a different department, you can change it here.
		+ Click the magnifying glass icon to change the Department if you are working in a different clinic, or in an inpatient department at the hospital.
	* Epic remembers the last place you logged into and will store it on the **Recent** tab.
		+ Otherwise, use the **Search** tab to locate your clinic.
3. Click **OK on the Message of the Day** and click **Remind Me Later** for the pop-up window that appears.
	* The system defaults to the **Schedule.**
	* The **Schedule** provides an overview of all the patients scheduled to your clinic as determined by your Login Department, arranged chronologically by appointment time.
	* The Schedule will always default to today’s date, but as you can see, users can navigate to different dates using the Calendar on the top left side of the activity to review different dates of service, moving both forward for to review future visits, or backward to review past visits.
4. Let’s quickly explore some of your other Home Workspaces in Epic.
	* Notice that there are several tabs just beneath the Epic Button in the top left portion of the screen. These are referred to as Home Workspaces.
5. Select the My Dashboards tab.
	* Sometimes called The Learning Home Dashboard, the My Dashboards tab will contain a host of information containing various reports, references, clinic metrics, as well as Tip Sheets which users can access to review both basic and advanced workflows.
	* My Dashboards will also be used to disseminate details about Epic upgrades, outlining cosmetic modifications to the user interface as well as workflow changes that may been made to the system.
	* Point out the Patient Lists workspace – Inpatient users will find all admitted and Emergency Dept-based patients within Patient Lists. If outpatient or Ambulatory users are keen to review information pertaining to any admitted patients that they also see in the clinic, they can go to Patient Lists, or they can simply go to **Chart Review** which we will discuss shortly.
6. Let’s return to the Schedule for further review of our primary workspace. Find the green calendar icon in the tab just below the Epic button and click on it.
	* Let’s review some additional landmarks and baseline utilities within Epic to ensure that we can effectively navigate, exploit basic functionality, and even customize our experience within the system.

### Hyperspace Title Bar

* + At the very top of our screen is the title bar.
		- This shows what time zone, environment, department, and who is logged in to the workstation, representing a great way to ensure we are not stepping on each other’s toes in shared workspaces.
			* If things ‘don’t look right’ in Epic, change the Title Bar to ensure you are in the correct department, and also that you are the one logged into the system.
		- **Note:** It is very important that you log into the correct time zone when you are using the live system.
			* If you log into the Central Time zone and are working in Eastern Time zone, you may not be able to document as it will be “Read only.”

### Main Hyperspace Toolbar

* + The Epic button is out Lighthouse, anchoring us in the system. It will always be visible.
		- Think of the Epic button like a “File” button in a Word document containing all the necessary tools that can be used within the software.
	+ On the same bar as the Epic button, you’ll see a series of frequently used tools or buttons on the main toolbar. These will be referenced throughout class.
	+ At the end of the Toolbar, we can see some very useful tools:
		- **The Wrench** icon – Allows users to edit the activities we can quickly access
		- **Log Out** button – Which users should click when they are leaving the system for an extended period of time, either for lunch or at the end of the day.
		- **The drop-down arrow next to Log Out** contains two additional items.
			* Secure: If you plan to shortly return to your workstation but are briefly leaving, Secure the workstation to save time when logging back in, protecting patient data as well as your own work.
			* Change Context: Allows users to switch Login Departments without needing to log out completely.

### Schedule Toolbar

* + Each Home Workspace will also contain a set of tools that are specific either to the patient population housed there, or the specific utility that is being offered.
		- The primary button we will user here is the **Review** function. Before we go into a patient’s chart, we will explore a few other tools available on the schedule.
			* Hover over the Review button to see Epic’s Hover to Discover functionality.
			* Notice that most of these items are greyed out and inaccessible. Before they are available, we will need to tell the system whose information we would like to review.
		- Let’s talk about that next.

## Finding Your Patients

**Scenario: We are coming into the clinic for a routine day of appointments and want to take a look at our schedule for the day.**

* + When you first log in to Epic, you may see a full list of patients that are coming in for the day to the clinic. While informative, we will not be caring for the entire department’s patient population, at least not today, so we want to narrow that down just to our own scheduled patients.
1. First, let’s configure our screen – Click the “carrot”, or drop-down arrow, next to the **Weston Clinic Family Practice Department (All Providers)** text just above the list of scheduled patients.
	* In the menu, you should be able to see your username, along with the name of the login department (Weston Clinic) once again.
	* Next to the **Dept:** field, you should see a small, sideways pin icon .
2. Click the pin icon.
	* You should now see a Calendar on the left side of your screen along with your username and login department listed just below it.
3. Click on your user’s folder just below **My Schedule**.
	* The Schedule gets a lot tidier as you now only see your patients for today’s date.
		+ Click the drop-down arrow next to the Weston Clinic Family Practice folder to see the full list of providers at your clinic.
	* You can always un-pin this section of the screen by once again clicking the pin icon, now vertical, next to the **Dept:** field.
	* Before reviewing our patient’s information, let’s review some additional components of our schedule screen.
4. Make sure your username’s Schedule is selected
	* Looking at the scheduled patients, you will notice that each row in the schedule represents an appointment. These appointments are scheduled chronologically
		+ Note the carrot or arrow at the top of the **Time** column
	* Review some of the other columns that are present on your Schedule:
		+ Status, (Patient) Name, Notes, Office Type, PCP, etc.
5. Find the **gears** icon just above your username on the left side of the screen and click on it.
	* Users can Add, Remove and Arrange these columns to their preferred order that displays the most essential information their patient.
	* Watch as your trainer demonstrates adding a new column and removes several others.
6. **Remove** (3): First Name, Age, Sex
7. **Add Column** (1): Patientcolumn that includes patient’s full name, age and sex.
8. Move the new column to the top of the **Selected Columns** using the arrows at the bottom of the screen.

**Tip Sheet Available!** - *How to Create and Modify Your Schedule*

1. Click **Accept**.
	* Back on the Schedule screen, note the changes and continue reviewing other aspects of the workspace.

### Status

* + Notice the **Status** column on the schedule. Most of your patients will have a status of Scheduled and perhaps have a comment about their Check-in Time beneath it.
		- Note: Until a patient is checked in for their appointment, users cannot begin documenting patient care.
			* When a user attempts to access the chart, a **Pre-Charting** option will appear.
	+ Review the list of additional Schedule Statuses in the table below:

|  |  |
| --- | --- |
| **Scheduled** | Patient has not arrived at the clinic yet |
| **Arrived** | When the patient is checked in for their appointment by Front Desk staff |
| **Rooming in Progress** | Nursing staff is logged in and started documenting |
| **Waiting** | The time between nursing staff and provider logging in |
| **Visit in Progress** | Provider is logged in and started documenting |
| **Checked Out** | When the patient checks out of the clinic |
| **Signed** | Required documentation has been completed and the encounter is Signed. |

### Type

* + Informs us as to the nature of the visit.
		- i.e. Worker’s Comp., Office Visit, Wellness Exam, OB Visit, etc.

### Notes

* + Allows us to see the free text reason for visit that the scheduler recorded when making the appointment.

### Calendar

* + When looking at the calendar, today’s date is automatically selected and displays the patients who are scheduled for today.
		- You have the capability of navigating to a future, or past date, by clicking on the desired day on the calendar.
			* Not the **Today** button just above the calendar which will always bring you back to the present day.
	+ Epic has a functionality called **Date Conventions** which are essentially shortcuts to documenting dates and times in the system
		- For example, to see a month into the future, type in “M+1” and press “Enter” or “W-1” to go to back one week.
			* T = Today
			* W = Week
			* M = Month
			* Y = Year
		- And elsewhere in the system, Time can be documented in the same manner:
			* N = now
			* H = hour

**What questions do you have about Finding Your Patients?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## Reviewing Patient Information

**Scenario: Prior to our first patient’s (Fred) arrival, we are hoping to gather information about their historical as well as their most recent care, whether it was received at our clinic, or at a different facility.**

1. Click once on Fred’s appointment.
	* Clicking twice open the patient’s encounter so that charting can begin.
		+ If you did this, use the “X” on the patient’s tab to close their chart.
	* On the Schedule workspace, in addition to our list of patients for the day, we should also see a report on our selected patient either in the bottom, or right half of our screen.
2. Find the **Preview** box in the top right corner of our screen, just above the Schedule.
	* Ensure the Preview box is checked off.
3. Click the carrot, or black arrow beside Preview and select either *Auto-position*, or *Right/Bottom* depending on where you want your patient report located on the screen.
	* Wherever you place the report, you should be able to see that you are able to review basic patient data including Demographics, Current Meds, Allergies, among other key health indicators.
		+ Can anyone tell me the name of this report?
			- *SnapShot*
	* Notice the Search box to the right of the report button.
		+ Users can search for other reports using the magnifying glass icon and even *wrench in* those reports, creating new buttons for quick access using the available Wrench icon.
4. To gather more data about your patient we can use Chart Review. Ensure you are reviewing details relating to your Fred patient and click the **Review** button on the Schedule toolbar.

### Chart Review

* + A “Welcome” screen may appear highlighting Epic’s new **Storyboard** functionality. Click “Let’s Go” to bypass it.
		- We will discuss this in more detail in a moment.
	+ **Chart Review** is a gateway to your patients’ complete medical history.
		- Imagine an old paper chart that would contain a myriad of notes, lab results, x-ray images, prescriptions, signed consents, surgical details, etc.
			* Chart Review organized this method of patient data storage.
		- Chart Review is broken down into tabs containing details pertaining to specific medical categories.
			* Take a moment to orient yourself to the screen.



* + First note the list of tabs at the very top of the screen. There are known as Activity tabs, a common theme within Epic.
		- Notice that the Chart Review tab is lighter in color than the rest. That tells us where we are in the system. We are in **Chart Review**.
	+ Within Chart Review, there are additional tabs such as Labs, Meds, Notes/Trans, etc.
		- Notice the Encounters tip has a pink box around it. That tells us where we are within Chart Review, on the **Encounters** tab.

### Encounters tab

* + Epic is an Encounters-based system. Every time patient care is delivered in some instance, an encounter will be or must be created.
		- Different types of encounters include an Inpatient admission, an office visit, a telephone call at the clinic, a procedure (e.g. a Colonoscopy), or a visit to the Emergency Dept.
			* Note: Users do have the ability to Edit or Addend encounters from this screen by right-clicking on the desired encounter.
		- Single-clicking on an Encounter will allow users to review the high-level details of that encounter, including the Provider’s note, orders that were placed

### Lab

* + Click the Labs tab.
	+ This tab displays current, standing, future, and final lab/pathology orders along with the associated results, if available. Single-click any Lab to view the associated results.
	+ Filters are a good way to narrow down the available information within Chart Review, isolating the most pertinent details regarding your patient’s care.
		- Click the Filters button on the left side of the screen just beneath the Encounters tab.
			* We recall from the Schedule report that Fred has a history of High Cholesterol. We want to focus on those labs.
		- In the list of Orders, check off *LDL* and *Lipid Panel*, and click **Save as New Filters**
		- Type “Cholesterol Labs” in the Capton space and click **Accept**.
			* You should see a Cholesterol Labs check box at the top of the Labs tab which will now be available for all of your patients in Chart Review.

### Imaging

* + This tab displays information related to XR, CT, MRI (MR), DEXA, VAS, and US images and studies.
	+ Single Click an imaging study to view results report.

### Cardiology

* + Contains results and reports related to EKG, Echos, Stress Test, Holters, and Cath Reports.

### Procedures

* + Displays information related to Sleep studies, PFTs, and Biopsies

### Other

* + Displays information related to Discharge instructions, diet orders, DME orders, and consult orders.

### Meds

* + Contains a list of the patient’s current and historical medications.
		- Current Meds Only filter is always checked by default
			* So if you want to locate the origins of a prescribed medication, this check box will need to un-checked.

### Letters

* + If any letters were written on behalf of the patient to another provider, employers, school, or any other institution, those will be stored here.

### Notes/Trans

* + Contains all dictated, transcribed, or typed notes and instructions.
		- Make note of the “Me” filter at the top of the tab.
			* Note that only notes that have been Signed will appear in this tab. Notes that are in a Draft status will exist only within the Encounter until signed.
	+ Find the patient’s visit with Dr. Lahren from 6 months ago. This is the encounter when the patient was first diagnosed with COPD.
	+ On the far left side of the encounter row, you should see a Bookmark icon. Click on it.

### Blood

* + Past blood administrations

### Media

* + Displays information related to Aspirus based scanned documents and annotated images (for example: scanned consent or HIPAA forms).
		- Handwritten notes, pictures drawn by a child, or other pertinent paper-based documents may be stored here upon scanning into Epic.

### Episodes

* + Pregnancies, Worker’s Comp visits, Psychiatric Care often user Episodes of Care to track ongoing care across a period of time.

### Misc Reports

* + External med lists, Code Status, coverage-related info, and Immunization Summary

### Hx/Off Premise Rec

* + This tab displays information related to medical records from outside organizations that are not on Epic. Users bring these details into Epic using **Care Everywhere**.

### Referrals

* + This tab displays information related to both external and internal referrals.

### LDAs

* + Lines, Drains & Airways (LDAs).
		- Additional information includes wounds, pressure ulcers, burns, incisions, etc.

### Consents

* + Any consents that have been completed and signed within Epic.
		- Blood transfusion consents, Informed consent forms, Release of Information (ROI), etc.
1. When you have completed reviewing the patient’s chart, exit out of the workspace by clicking on the ‘x’ beside their name on the tab in the upper left corner of the screen, below the Epic button.
2. Back on the Schedule, once we are Live, look for the “green dot” associated to your patient’s appointment.
	* This will indicate that your Nurse or MA has completed rooming your patient and you can proceed to the exam room.



* + - A red dot indicates that rooming is in progress

**What questions do you have about Chart Review?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Exam Room****

**Scenario:** Fred is here for an Annual Physical. However, he is also reporting some fairly severe back pain which we will need to take a closer look at. He has been roomed by the Nurse/MA who has recorded the patient’s vitals along with some other details. Let’s spend some time reviewing that documentation with the patient**.**

1. Double click your **Fred** patient’s appointment on the schedule.
	* Upon accessing a patient’s appointment, you will be brought directly to the **Plan** activity
		+ Notice the tabs at the top of the patient’s chart. The Plan activity tab is a lighter shade than the rest which orients users to where they are in the system, orienting us to where we are physically located in Fred’s chart.

### Storyboard

* + On the left side of the screen, you should see a sidebar containing an assortment of patient information. This is called the patient’s Storyboard.
		- Hovering over the data in Storyboard will reveal additional data about that specific aspect of the patient’s condition.
			* Hover over the patient’s Demographics. What happens?
		- Clicking on a segment of data will allow a user to edit that aspect of the patient’s condition.
			* Click on Allergies. What happens?
	+ Storyboard contains additional items such as the patient’s Problem List (patient diagnosis list), MyAspirus status, Covid-19 status, PCP, upcoming or overdue screenings/immunizations (Health Maintenance), the FYI Flag, as well as the clinical Sticky Note.

### Rooming Activity

1. Navigate to the **Rooming** activity tab.
	* In the Rooming Activity, make note of the of the links at the top of activity. These links allow you to quickly access points of documentation and information:



1. Click the **Visit Info** link.
	* Here, your nurse or MA will have documented the patient’s Chief Complaint(s) during their initial discussion.
		+ This is a good place to begin your conversation with the patient about their condition
			- **Chief Complaint**: Physical and Back Pain
2. Click the **Vital Signs** link:
	* Note that the nurse has already documented vitals earlier in the day
		+ How would you go about documenting additional vitals for your patient?
3. Click the New tab just below the Vital Signs headers:
	* Fred’s blood pressure has come down from the initial check, so let’s document that:
	* BP: 139/80
	* Pulse: 71
	* Temp: 97.9
	* Source: Oral (you can just type ‘O’ and select “Oral” when it appears)
		+ Skip Weight and Height
	* Resp: 20
	* Sp02: 97
	* Pain Score: 5
4. Continue scrolling through the Rooming tab to review the patient’s Allergies and Medication List.
	* Look up at the tabs on the screen and note the smaller **History** tab just beside the Rooming activity.
5. Click the **History** tab
	* The History tab allows users to document the patient’s Medical, Surgical, Familial history, as well as any pertinent social history such as substance and alcohol use, sexual activity and other socioeconomic indicators.
	* We recall from the Schedule report that this patient has gout, but we do not see it in the Medical History section.
6. In the Add medical history field, type ‘gout’ and hit Enter, or click **Add**.
7. Fred’s gout impacts his left knee, and it is chronic.
8. Click **Accept.**
	* Notice that a diagnosis code is being calculated as you modify the specifics of the issue.
	* A window appears allowing users to add a diagnosis date
	* We recall from our perusal through **Chart Review**, that Fred was diagnosed with gout about a year ago
9. In the Date field, type ‘y-1’ and hit Enter
	* Epic allows users to enter date/time shortcuts in this manner.
	* Note that users can also document pertinent negatives by clicking the **Move to Pertinent Negative** button.
10. Click **Accept** once again.
11. Click **Mark as Reviewed**.
	* Marking information as reviewed is a requirement for office visits that documents that essential data was communicated or reviewed with the patient during the encounter.
		+ Whoever is reviewing the data should click the Mark as Reviewed button.
12. In the upper left corner of the History activity, find the **Surgical** option.
	* Again, we recall from Chart Review that our patient had a Pulmonary Function Test last November, but we do not see it in the Surgical section. Let’s add it.
13. In the **Add surgical history** field, enter ‘PFT’ and click **Add** (or hit your Enter key).
14. In the Lookup, select the **PFT Spirometry** option and click **Accept**.
15. In the Date field on the next screen, type ‘m-10’ and hit Enter.
	* We should see a date reflecting 10 months ago.
16. Click **Accept.**
17. Mark the Surgical section as reviewed.
18. Click into the **Family history** section.
	* Note that Fred’s mother and father are both deceased and suffered from Hyperlipidemia and Heart Disease, respectfully.
	* Note that Fred’s brother has Diabetes
		+ Use the pencil icon beside the family members’ name to add an Age of Onset for any of the documented problems.
		+ Pertinent Negatives are available here, also.
	* Notice the **Pedigree** link in the top right corner of the Family section
19. Click **Pedigree**.
	* As users update the Family History section, the Pedigree tree will update accordingly.
	* We are no longer in the History activity.
		+ Which activity are we in? Look at the tabs at the top of the chart.
20. Click back into the **History** tab and take a few minutes to review the remaining sections pertaining to the patient’s **Substance & Sexual Activity**.
	* Feel free to review the **Social Determinants of Health** section, also.

### Screening Activity

1. Click the **Screening tab**
	* Here providers can review screenings, questionnaires or assessments that may have been conducted by the nurse or MA or submitted by the patient through the MyAspirus gateway in advance of their appointment.
	* If you would like to document your own screening, simply click on the link at the top of the activity to access the desired form or flowsheet.



* + Note: There is an Aspirus policy regarding Depression Screening, Learning Assessment, and Safety and Abuse.
		- The Gender Identity/Sexuality section is only addressed when applicable
	+ Make note of the additional screenings available including the ADL, Fall Risk, Gender Identity/Sexuality, as well as the Add’l Screenings section which will open up the Nursing Flowsheets activity where users can access other screenings.
1. Click on MyAspirus Signup (MyChart) which gives patients web access to some of the information in their Epic chart.
	* We can see if a patient is currently signed up for MyAspirus by checking the top portion of Storyboard.

### Other Pertinent Items in the Rooming/History/Screening Activities

***Trainer Note****: These sections can be quickly reviewed without extensive data entry.*

* + **Verify Rx Benefits** (Rooming) -A nightly process checks and displays any coverages and prescription benefits. If there are multiple coverages, check with the patient regarding which coverage is active. If the patient was an add-on appointment you must run the query manually. In this instance you will click “Check Again” in the Verify Pharmacy Benefits section.
		- When the providers are ordering medications, they will be prompted to select medications that are on the patient’s formulary.
	+ **Goals** (Rooming) -The PCMH (Patient Centered Medical Home) coordinator and physician use this area to add or update patient goals.
	+ **Care Everywhere –** Allows clinicians to ping non-Aspirus organizations that also use Epic, who may contain recent records of care for the patient we are seeing in the clinic.
		- For example if a patient visited St. Luke’s in Milwaukee, we could theoretically pull in the record for that visit or admission.

**Scenario:** We’re checking on Fred’s **status regarding several topics we are seeing in their Health Maintenance report. We ask about a colon screening, and he reports that he recently had this done a few months ago at a different clinic.**

### Health Maintenance

* + On the Storyboard, scroll down to the **Health Maintenance** section and hover over it.
		- Health Maintenance informs users about upcoming or overdue vaccinations, screenings and other periodic health checks that might be needed for our patients.
		- Let’s document the details that Fred provided to us:
	+ Click on Health Maintenance on the Storyboard.
		- Note the tab that you are now in.
	+ Select **Colon Health** and click **Address Topic**.
		- The Address Topic window appears:
			* Click **Add Completion**.
			* Completion Reason: **Patient reported already completed outside of Aspirus**.
			* Completion Date: **m-3**.
			* Enter the procedure location in the Comment section: **GI Associates**.
			* Click **Accept**.
	+ Note: This information would likely be presented to users in a red box called “Reconcile Outside Information” which can then be confirmed with the patient upon viewing.
	+ We will talk more about completing Health Maintenance-related items in the next lesson.

**What questions do you have about the Rooming Activity?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Planning Treatment****

**Scenario:** Now that we’ve properly examined Fred, reviewing his vital signs and recorded symptoms, we must update our own documentation and consider what prescriptions will require reordering or modification.

### The Plan Activity

1. Still in Fred’s chart, navigate to the **Plan** tab.
	* The Plan tab is where providers will perform most of their work, updating the patient’s Problem List, confirming the patient’s Visit Diagnoses and potentially, using a SmartSet to complete documentation such as billing requirements, follow-ups and placing orders for the patient’s visit.
	* At the top of this section you see a best practice advisory showing in yellow.
		+ This is the BMI Age 18 Years and Older
	* BPAs present information based on patient criteria such as orders, diagnoses, age, and/or history. Advisories can recommend specific treatments and suggest follow-up actions, such as orders, which you can either accept or dismiss.
2. Address the BPA, by click on the double arrows (or chevron) to expand it.
	* This BPA is recommending a SmartSet which you can open right from the BPA.
3. Select **Not appropriate for this visit** and click **Accept**.

### Problem List

* + Upon examining Fred, we want to update the patient’s active problems, or diagnoses, to reflect the medical condition of our patient.
	+ When a patient is no longer being treated for a problem, the **Resolve** button is used to remove that item from the Problem List.
		- For patients with no problems you would add an entry of **No known problems**.
	+ **Note:** the Problem List must **Marked as Reviewed** before the encounter or visit can be successfully signed off on.
1. To add a new medical problem to the Problem List start typing in the **Search for a new problem** field.
2. Type ‘back’ and press Enter.
	* **Back Pain** should be selected on the next screen.
3. In the **Select additional details** section on the bottom half of the screen, select:
	* low back pain
	* acute
	* midline
4. Click **Accept**.
	* A **New Problem** window appears where we can continue to modify the details of the Problem.
	* If the issue were chronic, the check box can be selected.
		+ Note that some of the other diagnoses on the Problem List have push pins associated. The push pin icon indicates a chronic issue.
5. You would like this to appear on the patient’s medical history, so click **Add to Hx** button toward the bottom of the window.
6. Click **Accept**.
7. Click **Mark as Reviewed**.

### Visit Diagnoses

* + Note the **Visit Diagnoses** section of the Plan activity just below the Problem List.
		- This section helps us associate essential billing details when placing orders or signing off on encounter documentation, which we will come to better understand shortly.
	+ Users can manually update the Visit Diagnoses section, or they can use a shortcut.
	+ Low Back Pain is going to be a visit diagnosis for today’s encounter, so let’s add it as one:
1. Still in the Problem List, find the **green plus sign** associated to our *Acute midline low back pain* diagnosis and click on it.
	* A calculator tab may pop up requesting that we modify the diagnosis which you can do, or you can simply click Accept to bypass.
2. Make your clinical decision and click **Accept**.
	* Note that there is now an entry in the Visit Diagnoses section
		+ However, back pain is not the only diagnosis for today’s visit, so let’s add another.
3. In the **Search for New Diagnosis** field, enter ‘annual’ and press Enter.
4. Select **Annual physical exam [Z00.00]** from the lookup and click **Accept**.
	* **Note:** if you enter this diagnosis often and want it included as a “speed button”, right-click on the diagnosis and select “add to commons diagnosis button list”.
5. Annual Physical Exam is our **primary diagnosis** for today’s visit, so move your mouse just to the left of that diagnosis and click once.
	* While hovering, a tooltip will appear that says, “Set as primary diagnosis”.
	* A **blue diamond** now appears next to the Annual physical exam diagnosis indicating that it is now our Primary diagnosis for the visit.

### SmartSets (aka Encounter Plans)

* + This tool provides a singular location to address multiple points of documentation, all in one screen.
		- Note templates, Diagnoses, Orders, Billing, Follow-ups
1. In the Plan activity, find the SmartSets section.
	* Note the suggested SmartSets which appear based on reason for visit, sex, visit type, and department.
	* For SmartSets you may commonly use, right click the name of the SmartSet and select Add to Favorites.
		+ Users can also search for SmartSets if a preferred option is not suggested.
2. Select the **ACI – Annual Exam (Male or Female)** SmartSet.
3. Click the **Open SmartSets** button.
	* A series of sections and options appears allowing you to:
		+ Generate a note template (**Documentation**)
		+ Order Imaging (**Orders**)
		+ Order Labs (**Labs**)
		+ Add a diagnosis (**Diagnosis**)
		+ Detail follow-ups and order referrals (**Disposition**)
		+ Complete billing for the visit (**LOS**)
		+ Place additional orders (**Ad-hoc Orders**)
	* In theory, providers can complete the bulk of their required documentation via the SmartSet.
		+ However, this is entirely up to your preference.
4. Hover over the **ACI Annual Exam Male** template in the Documentation section.
	* Notice that a blue **Add Now** hyperlink appears.
5. Click Add Now.
	* In the sidebar on the right side of the screen, a note template appears
		+ These templates are known as **SmartTexts** in Epic.
	* Templates will pull in a myriad of details from the patient’s chart into your note, saving providers time.
		+ There will also be additional required fields (Called **SmartLists** and **Wild Cards**) in the note template that providers must address before having the ability to sign the note.
	* The notes placement in the sidebar allows users to continue to document or review patient details elsewhere in the chart all while the note stays accessible and available at all times.
6. Spend a couple minutes reviewing the remainder of the SmartSet, expanding the different sections and exploring the available options.
	* Note: users can modify available SmartSets, creating their own version(s) of the SmartSet, storing their preferred selections for quick access during future visits.
7. In the top right corner of the screen, click the magnifying glass beneath the **Log Out** button and type ‘smart’ (do not press Enter).
	* We are using Epic’s **Chart Search** function which providers can use to search the patient’s chart for utilities or activities, specific patient details or even specific SmartSets.
	* Notice that an option for **User SmartSets** appears.
		+ This is where users can go to locate both system and User SmartSets and edit/save their own versions of existing SmartSets.
8. Back in the Plan activity, scroll to the bottom of the SmartSet, just below Ad-hoc Orders and click the **Remove** button.
9. Select **Yes** to the pop-up window.
10. Click **Discard** in reference to the Note we opened.
	* We will discuss notes in depth later in class.
		+ Notice that there were also **Pend** and **Sign** buttons at the bottom of the SmartSet which is where you could save your work, or sign off on your Orders, LOS, Diagnoses, etc. adding them to the patient’s chart.

### Medications & Orders

* + We can also see the patient’s active medications list in the Plan activity.
	+ This is a great place to Discontinue  or Reorder patient prescriptions based on your examination, as well as the patient’s personal need for refills.
	+ Users can also modify prescriptions from this location. 
	+ Clicking on the Prescription will allow users to view the details of the order.
1. Reorder Fred’s Lipitor using the icon.
	* The renewal appears in the bottom right corner of the screen in our **Unsigned Orders** window.
2. Modify Fred’s Norvasc order by clicking the  icon.
	* The Order Composer opens allowing us to modify the contents of the prescription.
3. Change the **Dose** to 10mg.
	* Notice the Supply-related warning in the Order Composer.
		+ Do we need to modify the **Dispense** details?
4. Change the **Quantity** field to 60 tablets.
	* At the bottom of the Order Composer, make note of the **Class** field which is set to *Transmit*.
		+ This indicates the order will be eprescribed to Fred’s preferred pharmacy.
5. Click **Accept.**
	* Where can you see Fred’s preferred pharmacy?
		+ In the Unsigned Orders window
		+ Also, at the bottom of the Medications and Orders section of the Plan activity.
			- Note: You can change the preferred pharmacy by clicking on it in either location and searching for a different pharmacy.
6. We are going to write a different pain relief/anti-inflammatory script for Fred, so let’s Discontinue the Naproxen by clicking the  icon.
7. In the Discontinue window, provide a reason for the DC order.
8. Select **Alternate Therapy** and click **Accept.**
9. Click to Reorder Fred’s Lipitor
	* Before we sign these orders, we also want to place a few additional orders in the system.
10. You should see button in the bottom right corner of the screen that says 2 Unsigned Orders. Click on it.
	* The Unsigned Orders window reappears.
11. You should now also see a **Pend** button beneath the Unsigned Orders window. Click on it.
	* The orders will remain there until we activate or delete them.
		+ Note: If the workflow at your clinic is to have Nurses and MA’s simply “queue up” orders for Providers to sign, this is what you will see upon accessing the patient’s chart.

**What questions do you have about the Plan Activity?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Placing Orders****

**Scenario:** We would like to order some additional labs to keep an eye on Fred’s various issues as well as a medication for Fred’s back pain. Additionally, based on a review of Fred’s Health Maintenance report, we also want to order a tDap jab.

### The Visit Taskbar

* + Recall that we have two Unsigned Orders based on the updates we made to our patient’s medication list. Let’s add some more.
	+ On the bottom left side of your screen, just to the right of the Storyboard, you should see a series of buttons.
	+ Presented are two different methods for locating and placing orders in the system.
1. Click **Add Order**.
	* A box appears displaying the test “Search for new orders”
		+ Here, users can type out the name of an order and search for it.

### Lab Orders

1. Type Lipid and press your Enter key.
	* The **Search Order** window appears displaying the matching orders based on your search parameters.
		+ Notice how we did not have to enter the full order for results to appear.
		+ Epic allows for a myriad of methods when searching for order including completion matching, partial word, and synonym searches.
	* Make note of the 3-4 tabs in the top right corner of the screen:
	* We will discuss the **Browse** tab momentarily, but notice that we begin on the Preference List tab.
		+ The **Preference List** is constructed based on the most commonly placed orders by the user that is logged into the system (based on their role), as well as the most commonly placed and available orders in the Login Department.
			- The Preference List will also contain your personalized **Favorite** orders.
		+ If you do not find the orders on your Preference List, check the **Facility List**, which will allow for a wider search of less commonly placed orders at your clinic.
		+ The **Database List** searches the Aspirus enterprise for additional orders.
			- Note: Use of the Database tab is discouraged because the orders you find there may not be available at your clinic to be administered, drawn, or acted upon.
2. Based on what the Preference List has returned, we see the order that we want; select the top **Lipid Panel (Px Code 330275)** order and then click **Select And Stay** in the bottom right corner of the window.
	* Clicking Select And Stay allows us to continue searching for additional orders.
		+ If you only needed the one order, or found the order(s) you need, you would click Accept.
3. In the top left portion of the Order Search window, type CBC and hit Enter.
	* Note that the first CBC is highlighted in purple, meaning that it is selected.
4. Click **Select and Stay** once more.
	* Notice that you now have two additional orders in the sidebar, or shopping cart of the Order Search window.
5. Click **Accept**.
	* Notice in the bottom corner of the screen on the Visit Taskbar, we now see a button indicating how many orders we have queued up.
		+ The window will initially display all of the orders.
	* However, we want to place a few more orders.

### Medication and Immunization Orders

1. On the Visit Taskbar, click the Preference List icon  beside the **Add Order** button.
	* The Search Order window opens once again.
		+ Which tab are we in?
	* The **Browse** tab display our Preference List in a different manner, allowing us to review our most commonly placed orders using individual order categories (on the left) in conjunction with a check box functionality for selecting orders (on the right).
	* Again, Fred came to the office complaining of pretty severe back pain, so we are going to provide him with an NSAID.
2. Expand the Medication category on the left side of the window and select the “Others” sub-category.
	* A list of medications presents itself on the screen.
3. Scroll through the list and check off the ibuprofen (MOTRIN) order.
	* **Note:** When ordering medications there is a column that can provide formulary information.
		+ This will help to order medications most likely covered through the patient’s drug coverage.
			- Epic runs a nightly process to verify pharmacy benefits for patients with scheduled appointments
4. Click **Accept**.
	* If the Order Composer pops up. Just click cancel.
	* We noticed earlier while examining Fred’s **Health Maintenance** that he is due for a Tetanus shot. So let’s order one for him.
5. Go back to the **Plan** tab and navigate to the **SmartSets** section.
	* SmartSets are also known as Encounter Plans.
		+ Providers generally use these SmartSets to generate documentation, write orders, add billing information, add diagnoses to the visit and even include follow-up details for the patient that will appear on their After Visit Summary (AVS).
	* We will also need to use SmartSets to locate our clinic-administered medications.
	* The provider wants us to administer a pain medication for Fred in the clinic.
6. In the **Search for New SmartSet** field, type ‘Family’ and press Enter
7. Select the **ADS Family Practice MAR** options and click **Accept**.
8. Make sure the SmartSet is checked off on the next screen and click **Open SmartSets**.
9. Expand the **Injections** section and select the **ketorolac (Toradol) 60 mg injection** order.
10. Scroll down to the bottom of the SmartSet and click **Pend**.
	* Note that we now have an **Unsigned Order** in the bottom right corner of the screen.
		+ We will sign it shortly.
11. In the top portion of the SmartSets section, notice there are suggested SmartSets.
	* These will contain suggestions based on patient diagnoses, age, sex, etc.
	* They will also contain a list of favorites and user SmartSets.
		+ Users have the ability to modify certain SmartSets and save them as their own version.
12. There should be an **ACI-Immunizations** option. Select it.
13. Click **Open SmartSets**.
14. Expand the **ACI Adult Immunizations** section.
15. Select the Boostrix option at the top.
16. Scroll down to the bottom of the SmartSet and click **Pend** once again.
	* Point out the bed icon that is associated with both the Toradol and Boostrix orders.
		+ This indicates that these are going to administered in the clinic.

### Signing Orders

* + Often times, before we can sign off on our orders, the orders themselves will require additional information.
		- For example, the Motrin order should be presenting itself to you on the screen, seeking additional information as designated by the Stop Sign icons.
			* Stop Signs indicate required fields which cannot be ignored
			* Yield signs indicate recommended fields which can be bypassed.
		- This window is called the **Order Composer**.
	+ Let’s take a closer look at the Motrin order to ensure that the order will be prescribed as desired.
	+ **Dose:** 600 mg looks correct. If we wanted to change it, we could simply modify it using free text.
	+ **Route:** Oral. We did order tablets, so this is correct.
	+ **Frequency:** The order defaults to “q6h prn”, however we only want Fred taking this medication every 8 hours, as needed.
		- Click “q8h prn”.
			* Note that users can also use the magnifying glass icon if the Frequency of their choice is not presented in button form.
		- Note the available PRN reasons.
	+ **Duration:** While not a required field, is available. You can select Doses or Days.
	+ **Dispense:** Can take the place of Duration by limiting the patient to only taking a certain amount of the medication.
	+ Enter:
		- Quantity: 90
		- Refill: 1
	+ **Patient Sig:** Directions for administration will often be contained in the order already, but users can update the Sig within the free text box.
	+ **Class:** How the order will be submitted to the Pharmacy.
		- **Transmit –** the medication will be ePrescribed to the patient’s pharmacy
		- **Print –** the prescription will be printed, and the patient will take it to the pharmacy to be filled.
1. Click **Accept** in the bottom right corner of the Order Composer.
	* We should not see any additional Stop Signs, or required fields, however we do want to make some additional edits to our orders.
2. Click the CBC order.
	* We can see that the order it ready to be drawn today. However, we want our patient to have the lab drawn while on an empty stomach sometime in the next 3 months.
3. Change the order **Status** to Future.
4. For the Expected Date, click the “3 Months” button.
	* Check of the Approx. box, also.
5. Click **Accept**.
6. Next, click the Lipid Panel.
	* The patient has high cholesterol, and we want this lab drawn quarterly to keep a close eye on it.
7. Change the order **Status** to “Standing”.
	* An **Interval** field appears.
8. Click the magnifying glass and in the lookup, select “Every 12 Weeks”.
9. In the **Count** field, enter “4”.
	* Over the next year, Fred will have a Lipid Panel performed about every 3 months.
10. Click **Accept**.

### Creating Favorites

* + Recall that we had to do some work to create our standing Lipid Panel order.
	+ To reduce the time it takes in the future, we are going to save that order as a **Favorite**.
1. Hover over the Lipid Panel order.
	* You should see a Star, along with an “x” icon.
2. Click the Star icon.
	* An “Add to Preference List” window appears which will allow us to specify the contents of our order, along with ‘where’ on the Preference List we would like the order stored.
3. In the right corner of the window, click the **New** button, next to “Section”.
	* Here we can create a brand new subcategory for our order.
		+ We want to create a Standing Labs subcategory.
4. Within the New Section screen, enter Standing Labs into the **Display Name** field.
5. Click **Accept**.
	* Back on the Add to Preference List screen, notice that we can also modify the **Display Name** of the order itself.
		+ Here you can change the order to be simpler to understand or easier to quickly identify later on when searching for your order.

**TIP:** *For your favorite lab orders, change the Display Name to something like, “Standing CBC” or “Quarterly Lipids” or even “Monthly A1C” for easy identification.*

1. Change the **Display Name** to “Lipid Panel – Quarterly”.
2. Click **Accept** to close the window and create your new Favorite order.
	* A “Replace Order” window appears.
3. Click “No” to close the window.
	* + Here you can change the order to be simpler to understand or easier to quickly identify later on when searching for your order.

### Diagnosis Association

* + When signing orders in an outpatient setting, Epic will always force users to associate a diagnosis to certain orders.
		- Primarily labs, referrals, procedures, but rarely medications.
	+ Users can anticipate this requirement by associating diagnoses before clicking “Sign”.
	+ In the bottom right side of the screen, your unsigned orders should be visible.
		- If not, click the Unsigned Orders button to make them visible.
1. Click the **Dx Association** button on the top left portion of the window.
	* A window will appear containing all the orders that will require a diagnosis to be associated prior to signing.
	* Within the window, note that users have access to a **Problem List** drop-down.
		+ In the window, Hyperlipidemia, Back Pain and the Annual Physical diagnoses should already be present.
2. Associate the Lipid Panel and the CBC to the Hyperlipidemia diagnosis.
3. Associate the Motrin, Toradol and Boostrix vaccine to the Low back pain diagnosis.
	* Note – Immunizations will likely be associated to an “Annual Visit” or “Physical” diagnosis, but we can bypass it for now.
4. Click the **Problems** drop-down, locate Hypertension and click on to pull it into the window.
5. Bypass the additional diagnosis screen by clicking **Accept**.
6. Associate the Norvasc to the Hypertension dx.
	* Once all orders have a pair of colorful linked rings  associated we are good to go.
7. Click **Accept**.
8. In the bottom right corner of the screen, locate the **Sign Orders (#)** button and click on it.
	* The system will perform background checks against known allergies and other prescriptions to ensure patient safety.
	* Next to the **Sign Visit** button in the bottom right corner of the screen, you should now see a clipboard icon which will display a report showing the orders you placed.
	* Your Nurse, MA and Lab Techs will use the Schedule screen to stay informed about whether the patient has medications or immunizations requiring administration, or if a point of care test needs to be performed.

**What questions do you have about Placing Orders?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## ****Completing Visit Documentation****

**Scenario: While our clinical support staff addresses Fred’s Toradol and tDap administrations, we want to make sure we document some appropriate follow-up information and provide any necessary documentation they might need prior to leaving the clinic today. We will also complete a visit note.**

### Wrapping Up the Visit

1. Navigate to the **Wrap-Up** tab.
	* This is a shared activity where both providers and clinical support staff can draw up patient instructions, write letters on behalf of the patient, enter billing details for the visit, provide follow-up instructions for the patient, as well as Preview and Print the patient’s discharge instructions (known as the After Visit Summary (or, AVS) in Epic).
2. In the **Patient Instructions** section, click the “Go to Clinical References” link in the top right corner.
	* Clinical References will recommend additional clinical guidance to patients based on the Problems and Diagnoses documented during the visit.
		+ Users can select from the suggested topics, or they can search for additional documents to share with the patient.
3. From the **Relevant Documents** tab, select the Adult Advisor: High Cholesterol
	* A preview of the document appears on the right side of the screen.
4. Find the **Add to Patient Instructions** button and click on it.
5. Click the **Additional Search** tab and type “Back exercises” in the search bar. Press Enter.
	* A list of selections appears.
6. Select “Low Back Pain Exercises” and click the **Add to Patient Instructions** button.
	* Note: these instructions can be translated to a number of different languages.
		+ Observe the multiple Language drop-down boxes.
7. Click back on the **Wrap-Up.**
	* If you scroll through the note box within Patient Instructions section, you should see the documents that we intend to share with the patient.
8. Click the **Communication Management** link at the top of the Wrap-Up activity.
	* This section allows us to generate letters and other communications on behalf of the patient.
		+ We could be sending correspondence to the patient’s PCP, their school or work, or to some other organization that requires documentation of a test, condition, or other medical detail.
	* Users will first select the recipient
		+ PCP, other provider, patient him/herself.
	* Then, they will select the type of correspondence.
		+ Referral, work/school excuse, waiver, etc.
			- A template will then generate where the user can modify existing documentation, or free text the necessary details.
	* Letters and other communications generated in this activity will be stored in **Chart Review** on the **Letters** tab.

**Tip Sheet Available!** – ***Send a Letter to a Patient or Another Clinician***

1. Click the **Review** section
	* In case you forgot to mark that the Problem List, or any other portion of the patient’s chart has been reviewed, the Review section provides the opportunity to do so.
		+ Again, users are required to review the Problem List before they can Complete/Sign the visit.
2. Click the **Follow-up** link at the top of the Wrap-Up activity.
	* Here we can document when the provider wants to see or hear from the patient.
		+ Users can either use the available speed buttons or document their own timeline manually.
3. **Return in**:
	* Enter “2” and then click the Weeks button.
		+ The **Return on:** field should now display a date that is 2 weeks from now.
4. Check off the **PRN** box.
	* You can leave the defaulted text or replace it with more specific information.
5. **For**
	* Check off the **In-Person Visit** box indicating that the patient should set up an appointment should things not improve.
6. Click the **Preview** button in the **After Visit Summary** section.
	* Spend a few minutes reviewing the contents of the AVS noting all the details included and recalling where we documented or entered that information in the chart.
	* This is a good place to ensure that the directions about how the patient should take their new or modified medications are clearly stated.
	* If you added any clinical documentation in the Patient Instructions section of the Wrap-Up activity, they should be visible in the AVS.
		+ The AVS can be printed by the nurse, provider, or reception and will be provided to the patient prior to their departure which emphasized that it’s important to get documentation, follow-up details included in the AVS as quickly as possible.
	* Note the **Print AVS** button on the Visit Taskbar.
7. Click the **LOS** section.
	* Here users can choose from a selection of speed buttons which provide access to the most commonly billed CPT Codes.
		+ Note that users do have the ability to modify which buttons/codes are available by using the wrench icon on the right side of the section.
	* Users can also seek assistance from the **Calculate LOS based on time** section where they can choose if the patient is a *New* or *Established* patient along with the total time spent with them.
		+ Make note of the **Estimated time:** which can help providers select the most accurate time frame.
8. Click **Established**, followed by **20** minutes.
	* Note that a speed button is now shaded in blue at the top of the section.

### Completing a Note

* + Recall from the Plan activity lesson how we were able to generate a note template from a SmartSet.
		- This is one way to generate a note template to facilitate the required visit documentation.
	+ Another way is to pull in a note template using SmartText templates.
1. In the sidebar on the right side of the screen, click Create Note.
	* Quick Note: If you are currently dictating your notes, you will still be able to do that within Epic.
		+ But let’s see what the manual process looks like
	* Find the **Insert SmartText** field in the upper middle portion of the sidebar.
2. In the Insert SmartText field type **ACI SOAP** and press Enter.
	* ACI = Aspirus Clinics Incorporated
	* A SmartText Lookup window appears which allows us to see a Preview of the template we’ve selected.
		+ If this is a SmartText you will use frequently, click the **Star icon** beside the entry.
			- To use favorites in the future, check the Favorites Only box on the bottom right side of the window.
3. Click **Accept**.
	* Our template appears in the sidebar.
	* Take a moment to scroll through the note template, making note of the information that is automatically pulled into the note directly from the chart:
		+ Patient demographics, diagnoses, allergies, medical history, medications, vitals, etc.
		+ The defaulted information that appears in blue are called SmartLinks
			- These fields are editable by right-clicking and selecting “Make Selected Text Editable.”
	* Earlier we talked about many Epic templates have required fields
		+ These are points in the documentation where a provider is given space to either highlight pertinent systems, add information that might not be reflected elsewhere in the chart, or to document a specific free text plan for the patient.
	* **Note:** If you want to document the note in a full screen, press the F3 button on your keyboard.
4. Scroll back to the top of the note and click beside the **Aspirus Clinics** header.
	* Address required fields by clicking the F2 button on your keyboard, or by using the *Yellow Arrows* on the Note toolbar.
5. Use the forward button or, click F2 to address the first required field.
	* The first required field contains three (3) asterisks next to the **HPI:** section.
		+ The asterisks are called **Wild Cards** and require free text (or deletion).
6. With the asterisks highlighted, document that “The patient has been experiencing consistent lower back pain for the last 2 weeks. The injury is not work-related.”
	* Just start typing and the asterisks will be replaced with the text above.
7. Again, click F2 or click the yellow forward arrow
	* We are sent to a **Review of Systems** where we have to either where we can select a Male or Female ROS or select another Wild Card if we’d prefer to free text these details.
8. Fred is a male, so left-click on the **Male** option and press **Enter**.
	* A list of systems appear that we can choose to pull into our note and document upon.
		+ Note: this is called a **SmartList**.
			- SmartLists with blue backgrounds allow us to select multiple choices, left-clicking on each choice.
			- SmartLists with yellow backgrounds will only allow for one selection.
9. Left-click **Constitutional**, **Musculoskeletal** and **All other review of systems are negative**.
10. Press **Enter**.
	* Note: you can also right-click to bring these selections into the note, but you must keep your mouse within the selection box. Clicking outside of it will cause the list to close without any selections being saved.
11. For **Constitutional**, select **Energy level is fair** and press **Enter**.
12. For **Musculoskeletal**, select the **Positive for** option and press **Enter**.
13. In the next list, select **low back pain** and **muscle weakness** and press **Enter**.
	* Note that the system immediately transports us to the next required field which is a single-select **Physical Exam** SmartList.
14. Select **Physical Exam Complete Male** and press **Enter**.
15. Observe the available systems but only select the **Wild Card** (\*\*\*) at the bottom of the list and press **Enter**.
16. Address the Wild Card by typing “Patient’s range of motion is limited to a fair degree. Walking is laborious and relief is achieved only by lying flat on the back.”
	* Feel free to document anything more appropriate/pertinent.
17. Press F2 or use the Yellow Forward Arrow once again.
18. Enter a free text **Impression** just below the Visit Diagnoses.

### Create SmartPhrases

* + Often, we document routine pieces of information within our notes. Rather than having to continuously manually type out that information, Epic allows us to save blocks of text that can be deployed through shortcuts on future notes.
		- These are called SmartPhrases
1. Once again, press F2/use the Yellow Forward Arrow to continue to the **Plan** section where we encounter another Wild Card.
	* Toward the top of the note, you will see a green plus icon, right beside the Insert SmartText field.
2. Hover over the green plus icon to reveal the Create SmartPhrase tooltip.
3. Click the green plus icon.
	* A pop-up screen may appear asking if you want to include the select text from the note (which is a Wild Card)
4. Click **Create Without Highlighted Text**.
	* The SmartPhrase Editor opens
		+ This screen allows us to create our own templates which will contain canned pieces of text that we can quickly recall and deploy in our documentation when necessary.
	* Let’s develop a plan for patients experiencing lower back pain.
5. On the left side of the screen, type “Prescribed medication to alleviate pain and reduce any swelling. Patient provided with exercises to help stretch out problem area around lower back. We expect pain to alleviate and flexibility to return. Patient encouraged to follow-up in 2 weeks if conditions worsens or does not improve.”
	* On the right side of the screen, in the **Settings** section, notice we have a required field
		+ Stop signs indicate required fieds in Epic.
6. Click into the box and give your SmartPhrase a memorable name.
	* Note: We strongly recommend developing a naming convention that will allow users to easily recall their personal SmartPhrases. Using your personal initials to start each entry, or using your clinic’s initials is good practice.
		+ There are hundreds of additonal system-based SmartPhrases which users can leverage to pull in all kinds of documentation in their notes and we want to avoid confusing our personal SmartPhrases with them.
			- In other words, if your initials are “L.A.B.” then you might want to just go with “LB” as your naming convention as there are lots of Lab-specific SmartPhrases in the system.
		+ To review available SmartPhrases, use the Epic Search functionality beneath the Log Out button in the top right corner of the screen, by searching for ‘SmartPhrase’.
		+ **My SmartPhrases** will give you access not just to your own library of SmartPhrases, but also the full slate of system SmartPhrases.
7. **Name** your SmartPhrase “[INITIALS]PLANBACKPAIN”
	* The name will be on word and fully capitalized.
	* Observe that you can share these SmartPhrases with colleagues down in the Sharing section of the editor.
		+ Otherwise, only you will be able to access and edit the SmartPhrase.
8. Click **Accept** on the bottom right side of the window.
9. Click just above the **PLAN:** section header and press F2 or use the Yellow Forward Arrow to access the Wild Card.
10. Type a period (or dot) followed by the name of your recently created SmartPhrase.
	* e.g. AAAPLANBACKPAIN
	* As you type a window will pop up suggesting various SmartPhrases.
11. Click on your SmartPhrase and press **Enter** to insert it into your note:
	* If you have addressed all required fields, then the note is complete.
12. To be sure, scroll back to the top of your note, click next to **Aspirus Clinics** and either press F2 or use the yellow forward arrow.
	* If nothing happens, then we are good to go.
	* **A note** for providers whose clinical support staff may “queue up” notes on their behalf:
	* Upon entering the chart, you will see the note in the sidebar. It will have your nurse or MA’s name associated to it.
		+ Clicking the **Edit** button will open the note. However, the provider must click the  icon at the top of the note to “take over” as author.
		+ Neglecting to do so will prevent users from successfully **Signing the Visit** once their documentation has been completed.
13. Click **Accept** on the bottom right side of the sidebar.
	* Note: If we had failed to address all required fields, the system would inform us to go back into the note to address them.
	* Again, just go back in, click into the top of the note and press F2 or use the yellow forward button.

### Signing the Visit

* + We have completed our documentation for Fred’s visit.
1. Locate the **Sign Visit** button on the Visit Taskbar and click on it.
	* If the chart had any deficiencies (e.g. Problem List not Marked as Reviewed, unadministered meds or immunizations, incomplete notes, missing Level of Service, etc.) the system would inform us in the right sidebar, allowing us to address it there and then.
	* If we are good, then the system automatically closes the patient’s chart and sends us back to the Schedule workspace.
	* Note that Fred’s **Status** on the Schedule is now **Signed**.
2. Forget something? Double-click Fred’s appointment once again.
	* The system will give you the option to Added the visit, if necessary.



1. Click **Cancel**.
	* Any of Fred’s lab results that will be completed in the future will be routed to your In Basket for review.

**What questions do you have about Completing Visit Documentation?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson

## In Basket

**Scenario: We have wrapped up our appointments for the day and have some downtime to clean up our In Basket by responding to messages from colleagues, viewing correspondence with patients, as well as reviewing lab results, refill requests or other chart-related deficiencies.**

* + **In Basket** is Epic’s internal messaging system that not only allows us to communicate interpersonally with our colleagues, but also provides enhanced security and supportive functionality that allow us to track the progress of our patients who will require additional care and communication outside the confines of the routine appointment-centered workflow.
		- Let’s review some of the functionality and benefits it provides.
1. On your Schedule screen, use any of the are several ways that exist to access In Basket.
	* You can:
		+ Use the Epic Search utility to find In Basket.
		+ Click one of the “Cards” on the far right side of the Schedule workspace which displays individual messages from In Basket.
		+ Click the In Basket button from your Hyperspace Toolbar.
2. “I will select the In Basket button from my Toolbar”
	* Notice that a new Workspace tab appears displaying a yellow/golden envelope.
	* When you first open In Basket, you will see a list of folders on the left side of your screen.
		+ Think of these like the folders in Outlook or Gmail that store different types of messages.
		+ A folder only appears if there is a message within it.
			- Bold folders = New message(s) are present
			- Un-bolded = Previously read messages are still present in the folder.
	* There is also toolbar that appears across the top, from which we can edit various settings, while also allowing us to send messages to colleagues, as well as patients.

### Sharing Your In Basket

1. Let’s begin with a fun exercise – Everyone click the **Attach** button on your In Basket toolbar.
	* Ask your neighbor for their Login ID.
2. Click the **Grant Access** tab in the “Attach Other In Baskets” window.
3. Enter your neighbor’s Login ID at the bottom of the screen and then click the **Grant** button.
	* Wait a few moments for everyone to catch up.
4. Now, click the **Attach** tab at the top of the “Attach Other In Baskets” window.
5. At the bottom of that window, once again add your neighbor’s Login ID and click the **Add** button.
	* This is how you can share In Baskets with colleagues, or your provider
		+ First your neighbor needed to grant you access to their In Basket (and vice versa).
		+ Once they did, you were able to attach their In Basket to yours in case one of you went out on leave, vacation, etc. or, if the event that you simply share a workload.
	* Look on the left side of your In Basket. At the bottom of the screen you should see a folder called “Attached In Baskets”
6. Click on it to view your neighbor’s In Basket messages.

### Staff and Patient Messages

* + As stated in the introduction, In Basket helps facilitate conversations between colleagues and staff at the clinic (and beyond), as well as with patients who come to the clinic.
	+ On the In Basket toolbar, notice that just to the right of the In Basket banner are buttons for a **New Msg** and **New Patient Msg**.
1. Click New Msg.
	* This is where users can send a message to other users or colleagues either at your own clinic, or to another Epic shop.
		+ Users can either send a message directly to a single user such as a Provider, Nurse, Medical Assistant, Front Desk user, or they can send a message to a Pool.
			- Pools are essentially distribution lists that contain like users.
				* There may be several pools at your clinic for nurses alone, broken down by specialty or coverage area.
				* You can see which pools you are assigned and/or checked in to by clicking **Edit Pools.**
		+ Note that the messages can be patient-specific, or they can simply be logistical communications between users/ at the clinic.
			- Staff messages typically are not part of a patient’s permanent medical record. However, staff messages can be copied into Telephone Calls which will make them part of the patient’s medical record
	* Messages sent from the New Msg activity will appear in the Staff Message folder of the Recipient(s).
2. Send a message to your neighbor in class using their Login ID in the **To:** field, then adding a **Subject** and a quick message in the body of the note.
3. Click **Send**.
	* Note: every message you send, whether it be to a patient or colleague, will be stored in the **Sent Messages** folder at the bottom of your In Basket.
4. Click the **Refresh** button and go down to your **Staff Message** folder to see if you can find the message.
	* Note: Staff Messages referencing patients are not a part of the patient’s chart.
5. Click **New Patient Msg**.
	* Because we are not within a patient’s chart, or selecting a patient’s appointment on the Schedule, the system does not know who we are trying to communicate with.
		+ Users can search for patients using their MRN (Medical Record Number), or by searching for their name.
			- Note: It’s good practice to include additional demographic details about your patient when searching for them by name to avoid selecting the wrong patient.
	* You will only be able to send messages to patients who have been signed up for the MyAspirus patient portal (aka MyChart).
		+ Responses or direct messages from patients will appear in the **Pt Advice Request** folder.
	* Users can create templates called **QuickActions** that they can use as shortcuts when communicating with patients through In Basket.

**Tip Sheet Available!** – *Send Messages from In Basket Using QuickActions*

1. Click **Cancel** to close the Search pop-up.
	* Let’s explore some additional functionality and messages within In Basket.

### Refill Requests

* + Often times the Front Desk or a Nurse will receive a phone call from a patient requesting a refill of a prescription.
		- When the nurse routes it to your attention as the provider, a series of protocols will be run to determine whether it’s safe or appropriate to refill the script.
			* Ultimately, the decision is yours.
	+ **Note:** An encounter is created for refill requests which will need to be closed once the request is either approved or denied.
1. Click the **Rx Request** folder.
	* When you select a message, a few things happen:
		+ The original message is no longer bold
		+ The Status changes from New to Read.
		+ The message itself appears for us on the right side of the screen
2. Select your **Betty** patient’s message.
	* Note that the message appears on the right side of the screen.
		+ Here you can review who sent you the message, which medication is being requested and whether the request past or failed the protocols.
			- We can see information about the Statins protocol.
			- The system automatically checks to see if there is a protocol for that medication class.
			- There are specific protocols for different types of classes.
			- Nurses can use the protocol information to assist in filling medications and identifying care gaps.
	* We can see that the patient would like a refill of their Lipitor prescription.
	* We can take the following actions:
		+ **Approve All**: All requested medications will be signed, and a response sent to support staff.
		+ **Approve and Route**: Requested medication(s) will be signed, and a note will need to be written instructing indicated support staff about future care requirements. The note will be stored in the patient’s chart.
		+ **Edit Rx:** User will either choose to approve or refuse the request while having the option to modify the order details. If necessary, you can add a note to the patient's chart, send a response to staff, and close the original refill request encounter.
		+ **Refuse All**: Refuse requested medication(s) and automatically send a response to support staff.
		+ **Refuse and Route**: Refuse requested medication(s) and send a response to support staff. If necessary, you can add a note to the patient's chart, send a response to support staff, and close the encounter.
		+ **Encounter**: This will path will likely occur after a phone call or other communication is conducted with patient where the refill request encounter opens to order/modify the prescription(s), and document correspondence with the patient.
	* As we noticed, the request is failing a statins protocol. However, we can have the patient work to address that care gap while we provide a temporary refill for Betty.
3. Based on the message from our nurse, we see that a refill is queued up for an additional 30 day supply. We determine this is appropriate and click **Approve All**.
	* If a Diagnosis Association window appears, associate an appropriate option from the Problem list and click **Accept**.
		+ The Rx Request message for Betty now has a Status of **Done.**
4. **Refresh** your In Basket to witness the message disappear.
	* The message will be moved to your **Completed Work** folder, visible on the bottom left side of your In Basket.
	* **Note:** Approving the refill request completes the encounter, so no additional work is required.

### Results Report

* + If you place any lab orders (or your Nurse/MA place them on your behalf), then the results will be routed to your In Basket upon resulting.
		- The **Result Report** folder shows the final results of labs and procedures.
1. Click the **Result Report** folder and select your Melissa patient’s message.
	* We can see several abnormal results along with several normal results in the message on the right side of the screen.
		+ Abnormal results will be listed in red and generally have a red exclamation mark associated.
	* Available actions for Result Reports include:
		+ **Result Note**: File a note to the encounter or selected order. You can also route the note to a Nurse/Pool if any follow-up is necessary.
		+ **Web Release**: Allows results to be released electronically to a patient’s MyAspirus account
		+ **Reflex**: Create a reflex order from the currently selected order message. You have the ability to place reflex orders based on results.
		+ **Chart Review**: Review the patient’s chart if you need further information
		+ **Telephone Call**: Use if you speak to the patient directly regarding a result
		+ **Letter**: Notify patient of result via letter
2. Let’s write a Result Note – Click **Result Note** on the message toolbar.
	* **Results Review** opens
	* In the right sidebar, we can an available note window along with the listed results.
		+ Note the speed buttons available in the top right corner of the window.
3. Select the Abnormal button.
	* The two abnormal results are now checked off.
	* Note that the **Route** check box is selected automatically.
		+ If you are not sending this message to a colleague or nurse for follow-up with the patient, then you can un-click the Route box.
	* We are going to route this to a nursing pool for follow-up.
4. In the **To:** field, type ‘p awc nur’ and press Enter.
5. Select the **AWC Nursing Pool B** entry.
6. In the text box write, “Results indicate abnormal results that require follow-up labs. Please contact patient and have them schedule an appointment.”
7. Click **Accept** at the bottom of the screen.
	* Because someone else will be following up with the patient, we no longer require the Result Report message.
8. Back in Result Report for our Melissa patient, click **Done**.

### Cosign – Clinic Orders

* + If your clinic requires that mid-levels, or perhaps Nurses or MA’s route orders for cosignature to a Provider’s attention, then those orders will appear in the Cosign – Clinic Orders folder.
		- Note: Orders are active as soon as they are signed and are not waiting on a cosignature for release to be acted upon.
1. Click the **Cosign - Clinic Orders** folder.
2. Locate and click on your Nancy patient’s message.
	* A red message indicates that it is overdue
	* The message informs us that our nurse signed a Urine Macro order for Nancy.
	* We have four options:
		+ **Sign**: cosigns the order and marks message as Done
		+ **Decline**: declines the order with a reason for declination
		+ **Encounter**: opens the encounter that the order was placed in
			- Note: May require an Addendum be created unless you simply want to go to Chart Review.
		+ **Reassign**: reassigns cosign responsibility to another provider
3. Click **Sign**.

### Patient Calls

* + The **Patient Calls** folder is where **Telephone Call encounters** will be routed either directly to your attention, or to a Pool.
1. Click the **Patient Calls** folder and find the message for your Mason patient listed on your Login Sheet.
	* In the message we see that the Simvastatin order that we prescribed has triggered an allergic reaction.
2. Click the Meds/Problems report button above the message.
	* We confirm the prescription and decide that we want to discontinue the order.
3. Click the **Encounter** button on the message toolbar.
	* The phone call encounter opens, and we see that we are on the Take Action tab.
		+ How do we confirm this?
			- The activity tab is a lighter color than the rest.
4. Navigate to the Medications & Orders section and click **Load Meds**.
5. Discontinue the simvastatin prescription by clicking the **X**.
6. Discontinue reason: Allergic response.
7. Click Accept.
	* Because we also called Mason to tell them about our actions, we will want to document that conversation.
8. Click into the **Contacts** section and click **Outgoing Call**.
9. Document:
	* Relationship: **Self**.
	* Phone: **Home**.
10. Click **Accept**.
	* We also need to add the newly identified allergy to the patient’s chart.
11. Navigate to the **Call Intake** tab.
12. Click **Allergies**.
13. In the **Add a new agent:** field, type ‘Statins’ and press **Enter**.
14. Reactions: **Itch & Rash**.
15. Severity: **Medium**.
16. **Reaction Type: Allergy.**
17. **Click Accept.**
18. **Click Mark as Reviewed.**
	* Note that **Storyboard** is updated with the new allergy immediately.
19. Click **Create Note** in the right sidebar and document the changes you have made.
20. Click **Accept**.
	* We have completed this encounter.
21. Click **Sign Encounter** in the bottom right corner of the screen.

### Other In Basket Folders

* + **CC’d Results**
		- Contains FYIs regarding routed Result Notes
	+ **Open Charts**
		- All open encounters which have not been signed.
			* Can be signed directly from your In Basket.
			* If the encounter is complete and ready to sign, it will display what documentation elements are missing so you can take action on it.
	+ **Patient Advice Requests**
		- If a patient reaches out to you through the MyAspirus patient portal, they will appear in this folder.
	+ **Transcriptions**
		- If you are dictating notes and submitting them to a service for transcription, they will be sent back to your In Basket via this folder where they can be Accept/Re-Submitted.

**What questions do you have about In Basket?**

Trainer: Return to the PowerPoint to review the Questions and Key Takeaways for the lesson