About This Document

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Introduction

As a clinical software system, McKesson Practice Partner manages a variety of information including patient demographics, clinical details, and production analysis. For more information on Practice Partner EMR visit our website http://emr.healthpointmedicalgroup.com

Objectives and Summaries

This manual contains objectives which provide you with overall goals that you will achieve by the end of this training. This manual contains a summary for your review at the end of each lesson.

Special Symbols

Throughout this manual symbols will highlight areas that require additional attention.

- **NOTE** Indicates guidance information that expounds upon the provided information.

- **TIP** Indicates supplemental help to the supplied information.

- **STOP** Indicates important information that can include specific instructions that are required.

- **Meaningful Use** Indicates Meaningful Use required objective
# Meet the EMR Team

<table>
<thead>
<tr>
<th>EMR IS Team</th>
<th></th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMR Steering Committee</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Sherry Dorsey, Chair</td>
<td>Tim Thompson</td>
<td></td>
</tr>
<tr>
<td>Dr. Lee Kirkman</td>
<td>Chris Jenkins</td>
<td></td>
</tr>
<tr>
<td>Dr. John Fraker</td>
<td>Dr. Bruce Flareau</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Advisory Committee</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. John Fraker, Chair</td>
<td>Silvana Henley</td>
<td>Dr. Gilbert Pitisci</td>
</tr>
<tr>
<td>Dr. Lee Kirkman</td>
<td>Dr. Fred Taylor</td>
<td>Dr. Mark Borden</td>
</tr>
<tr>
<td>Sherry Dorsey</td>
<td>Dr. Stuart Helms</td>
<td>Dr. Satish Dholakia</td>
</tr>
<tr>
<td>Ivie Isaiah</td>
<td>Dr. Richard Hodges</td>
<td>Dr. Tung Wynn</td>
</tr>
<tr>
<td>Howard King</td>
<td>Dave Plattner</td>
<td></td>
</tr>
<tr>
<td>Dr. Michaela Mallon</td>
<td>Dr. Nancy Silva</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Clinical Workgroups</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Adult</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Stuart Helms, Chair</td>
<td>Dr. Nancy Silva, Chair</td>
<td>Dr. John Fraker</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Barrington Lynch</td>
<td>Dr. Mercy Baker</td>
<td>Nicole Gilman</td>
</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Dr. Mary Thomas</td>
<td>Dr. Carolyn Marasco</td>
<td>Pat Gatto</td>
</tr>
<tr>
<td>Dr. William Werden</td>
<td>Dr. Neil Surti</td>
<td></td>
</tr>
<tr>
<td>Dr. John Fraker</td>
<td>Dr. Brent Mook-Sang</td>
<td></td>
</tr>
<tr>
<td>Diane Williams</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Lesson One: Logging in/Out of Practice

Objectives:
By the completion of this chapter, you will be able to:
- Successfully log into Practice Partner
- Successfully log out of Practice Partner
Access Standards

HealthPoint Medical Group and all our members have a responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of employment or assignment you will come into contact with confidential patient information. The following access standards will be followed:

- Only authorized persons will be granted access. This access will be appropriate to the job role.
- Only authorized persons may enter and view data.
- Passwords and system IDs will **not** be shared. Practice Partner keeps an audit trail of all entries and can generate reports of a user's access and activity within the system.
- Physical security of the workstations and files will be maintained.
Logging in/out of Practice Partner

Accessing Practice Partner:
To access Practice Partner, you must first login into HealthPoint EMR Citrix Portal by clicking on the HealthPoint EMR icon or by typing http://hpemr.baycare.org on the internet page.

The Citrix screen will open to the HealthPoint access screen, click OK.
To Log in:

- Enter your User ID and Password. This is the same user ID and password you use to log into the computer.
- Once the login process is completed, the HealthPoint EMR icon will be available to select.

**NOTE**
If prompted, follow instructions to download the Citrix upgrade.

To access Practice Partner, click on the HealthPoint EMR icon. There are two icons to choose from. To access the Production click on the HealthPoint EMR icon, to access test click on the HealthPoint EMR Test icon.
Each icon used to access Practice Partner has its own separate database.

For example:

- HealthPoint EMR - Is where the production database resides. This is where all our live patients are stored.
- HealthPoint EMR test - Is where training and testing will take place.

**Practice Partner Login:**

Every Operator has an assigned user ID, password, and access level. This prevents unauthorized access to the system, protects critical patient information, and protects patient confidentiality.

The password must be alphanumeric 8 characters, contain at least one uppercase, and one number.

**NOTE**

If you forget your password, contact the help desk to have your password reset. The help desk telephone number is **(813) 636-2034**, This is also located on your computer monitor.

**Logging On:**

![Practice Partner Sign In](image-url)
To Login:
Enter your assigned EMR User ID and Password. The password displays as asterisks (*) so it can’t be seen.

You may use the tab key or the mouse to advance the cursor from field to field.

```
| NOTE | When logging in for the first time a temporary password will be given to you. Once you log in you will be prompted to change your password. This will occur at your initial login. |
```

```
| NOTE | You have 5 attempts to log into EMR, if you are not able to log in because either the user ID or password is incorrect; you will receive a pop up stating “The system could not log you on. Make sure your User ID is correct, then type your password again”. |
```

In the Provider ID field, select the appropriate provider by selecting the drop down arrow. If you know the providers code, you can type the code in the Provider ID field.

After selecting the drop down arrow a Provider Select screen will open. To search by name select the radio button Name, type the last name of provider and click the Search button, highlight the name and click the OK.

In the Practice ID field, select the drop down arrow then select the appropriate practice code.
After logging in, a disclaimer screen will appear in yellow. Please pay attention to the top of the screen where it states Practice Partner “LIVE” database. This is the only place in Practice Partner to notice if you are in the “LIVE” database or in the “TEST” database. It is very important to make sure you are logged into the correct database.

Click the OK button and it will take you to Practice Partner’s main screen.
Lesson Two: Navigating Practice Partner

Objectives:
By the completion of this chapter, you will be able to:

- Navigate within Practice Partner
As a clinical software system, Practice Partner manages a variety of information including patient demographics, clinical details, and production analysis.

Navigating Practice Partner:

- **Title Bar** - This bar displays the title Practice Partner and Patient Records.

- **Menu Bar** - This bar provides options to various areas of the application.

- **Toolbar** - Displays the Exit, Park, Dash, Chart, Sched, Patient, Msg, Chk In, Review, Letter, Prov, and Help buttons.
Menu Bar

The Menu bar consists of **File, View, Task, Maintenance, Reports, and Help**. These options provide access to various areas of the application.

- **File** – Will allow the user to open a chart, open a patient which will display patient demographics and allow the user to view the last 15 patients opened.
- **View** – Will allow the user to change the look of their screen.
- **Task** – Gives the user options to access various parts of the application.
- **Maintenance** - Is used for system build. Only individuals with administrator and security rights for HealthPoint will have access.
- **Reports** – Are used to pull out canned reports from Practice Partner.
- **Help** – Is a great tool to use when you need help on a particular screen.
<table>
<thead>
<tr>
<th>Icon</th>
<th>Tool Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit</td>
<td>Exit – To exit Practice Partner</td>
</tr>
<tr>
<td>Park</td>
<td>Park - This feature will not be used. It keeps the session open and does not release the license.</td>
</tr>
<tr>
<td>Dash</td>
<td>Dash - Opens Provider or Nurses Dashboard</td>
</tr>
<tr>
<td>Chart</td>
<td>Chart – Opens the search screen to locate a patient’s chart.</td>
</tr>
<tr>
<td>Sched</td>
<td>Sched – Opens the default provider schedule.</td>
</tr>
<tr>
<td>Patient</td>
<td>Patient – Opens the search screen to locate patients chart.</td>
</tr>
<tr>
<td>Msg</td>
<td>Msg – Opens the Practice Partner internal email messaging programs.</td>
</tr>
<tr>
<td>Chk In</td>
<td>Chk In – Opens the search to allow you to check in patients.</td>
</tr>
<tr>
<td>Review</td>
<td>Review – By holding down the left mouse button, you can view Progressive Notes and Documents or Lab Tables.</td>
</tr>
<tr>
<td>Letter</td>
<td>Letter – allows you to create a new letter for a patient.</td>
</tr>
<tr>
<td>Prov</td>
<td>Prov - Allows switching to a different provider.</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Help</td>
<td>Help – Opens the online help system.</td>
</tr>
</tbody>
</table>
Lesson Three: Dashboard

Objectives

By the completion of this chapter, you will be able to:

- Understand the Dashboard
- Create a Message
- Create a To Do
Dashboard

This table has the information available in each area of the **Dashboard**. The table also shows the differences between what providers and nurses see.

The Dashboard will be the first thing you see when logging into Practice Partner, this screen is set up to view your **Schedule**, receive **Messages**, create a **To Do** list, review and process orders through **Operator Processing**.

**To open the Dashboard:**

- Click **Dash** on the **Toolbar**. The **Dashboard** opens.

**To refresh information on the Dashboard:**

Do one of the following to update information the **Dashboard**.

System will automatically refresh after 120 seconds.

**NOTE**

To display overdue orders: On the **Dashboard**,

- Click **Overdue Orders**. A dialog opens with any overdue orders for the current provider.
- It will be “greyed out” if there are not pending orders:

**The Dashboard by Area:**

**Schedule**

Click on the schedule title bar to view full screen.

- Click once on the schedule title bar to access the full view of the scheduler.
After you have opened the full schedule screen you will see on the upper left hand side a gray bar that will display **Schedule for**: this will display the provider schedule you are viewing.

**The schedule will display:**

- **Time** - Appointment time
- **Name** - Patient name
- **Age** - Age of patient
- **Sex** – Patient’s gender
- **Check in Time** - Time patient was checked in
- **Len** - Length of visit
- **Stat** - Appointment status code, i.e. LA for late, NS for no show
- **TOV** - Type of office visit
- **Note** – Notes that have been assigned to the patient’s appointment
• **Note Status** – Status of the note
  - **Blank** (I.e., nothing displayed in field). A note has been created for the visit or a note was created and then deleted.
  - **O**- A note has been created and is in a “Shared Note” but has not been permanently saved. O stands for “Open”.
  - **C**- A note has been created and permanently saved but has not been signed by the provider. C stands for “Closed”.
  - **S**- A note has been saved and signed by a provider. S stands for “Signed”.
  - **?** – Patient records cannot definitively determine if there is a note because the patient has multiple appointments on the same day. ? stands for “Multiple appointments for the patient the same day”.

• **Process** - Stages of the appointment

**To view the entire calendar:**

- On the provider schedule screen, click the **Calendar** button to display an entire month’s schedule for the current provider. Days for which the provider is scheduled are highlighted.
- To change the month, select a month from the drop-down list. To change the year, click the year list box.
- To view schedule detail for a day, double-click the appropriate date. The Schedule screen appears.
Group Management (GE) will be used to manage **ALL** patient appointments and demographics. There will be no scheduling, rescheduling, or canceling appointment in Practice Partner. All appointments are passed through an interface which will allow the providers and staff to view their daily schedule. It may take up to 120 seconds before appointments will display from Group Management; however you can also click on the **Refresh** button refreshes the display sooner.

When patient’s comes in for their appointment the Medical Receptionist will **arrive** the patient in Group Management. The **arrive** will display as **Check In** on the scheduler. Note: If the patient is a phone registration you will need to convert the patient first prior to arriving. If you arrive the patient as a phone registration the appointment will not display in Practice Partner.
Messages

You can view all incoming messages right from your dashboard. When viewing your message you will be able to see the message priority, the sender, patient name if attached, subject, and date received.

All unread messages will display in **BOLD**, to view the message you can either click on the title bar called **Messages**, or click on the message. You can also access the messages by clicking on the **Msg** button on the Toolbar.

<table>
<thead>
<tr>
<th>Message ID</th>
<th>Message Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>BERRPI ZZTEST, 18YOFI</td>
</tr>
<tr>
<td>3</td>
<td>BERRPI</td>
</tr>
</tbody>
</table>

**NOTE**

If the message is urgent the **Msg** button on the toolbar will display in **RED**, urgent will be a priority of 9. If there is at least one new message waiting the **Msg** button will display in **BLUE**.

It is possible to:

- When writing a message, select a message template that automatically inserts patient information and often-repeated text.
- Insert **QuickText**, **Dot codes**, and **Letter codes** into messages.
• Format the message text by changing the font style, size, or color. Text may be **bolded**, *italicized*, underlined, or indented. Bulleted lists may be created. Text alignment may be changed.

• Check messages for spelling.

• Turn on return receipt to receive notification that the recipients (the message's To field) opened your message.

• Use operator groups to send messages to a specified group of Practice Partner operators.

• Link to the chart section referenced by the message's type. For example, if the message type is HM, click **Link** to open the patient's health maintenance chart section.

• Record the message as a progress note in the patient's chart.

Messaging is *operator-based*. Any Practice Partner operator may use the messaging feature if they have an access level that allows it.

If you have used Microsoft® Office Outlook® or a similar e-mail program, **Messages** should look familiar. The left box displays the **Archived, Deleted, Inbox, Pending,** and **Sent** folders. The right box displays the messages in the selected folder.

In addition, you can use many common word processing shortcut keys to complete messaging tasks, such as CTRL+P to print a message.
Messages

Messages: Have three areas: Folders, Messages, and Buttons.

The Folder Area

This displays the default messaging folders. Clicking a folder displays any messages in that folder in the messages area. The currently-selected folder is highlighted in gray.

In the figure below, the Inbox folder has been selected. Any messages in the Inbox display in the Message Area.
<table>
<thead>
<tr>
<th>Folder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archived</td>
<td>The Message Area sorts Archived messages in the following order:</td>
</tr>
<tr>
<td></td>
<td>• Date received</td>
</tr>
<tr>
<td></td>
<td>• Priority</td>
</tr>
<tr>
<td>Deleted</td>
<td>The Message Area sorts Deleted messages in the following order:</td>
</tr>
<tr>
<td></td>
<td>• Date received</td>
</tr>
<tr>
<td></td>
<td>• Priority</td>
</tr>
<tr>
<td>Inbox</td>
<td>The Message Area sorts Inbox messages in the following order:</td>
</tr>
<tr>
<td></td>
<td>• Date received</td>
</tr>
<tr>
<td></td>
<td>• Priority</td>
</tr>
<tr>
<td>Pending</td>
<td>The Pending folder stores messages from the current operator that are waiting to be sent. A pending message may be edited before sending it. The messages will release once the date to activate has arrived. The Message Area sorts Pending messages in the following order:</td>
</tr>
<tr>
<td></td>
<td>• Date to activate</td>
</tr>
<tr>
<td></td>
<td>• Priority</td>
</tr>
<tr>
<td>Selected</td>
<td>The Message Area displays selected messages after users have selected what messages they would like to view from the Select Messages screen.</td>
</tr>
<tr>
<td>Sent</td>
<td>The Message Area sorts Sent messages in the following order:</td>
</tr>
<tr>
<td></td>
<td>• Date sent</td>
</tr>
<tr>
<td></td>
<td>• Priority</td>
</tr>
</tbody>
</table>
The Message Area

This displays any messages in the folder selected in the Folder Area.

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alt</td>
<td>The message's priority, from 0 being the lowest priority and to 9 being the highest.</td>
</tr>
<tr>
<td>Att</td>
<td>A paper clip symbol displays if a message has an attachment.</td>
</tr>
<tr>
<td>From</td>
<td>The Practice Partner user sending the message.</td>
</tr>
<tr>
<td>Patient</td>
<td>The patient referenced in the message.</td>
</tr>
<tr>
<td>Subject</td>
<td>A brief summary of the message.</td>
</tr>
<tr>
<td>Received</td>
<td>When the message was received.</td>
</tr>
<tr>
<td>Type</td>
<td>The message type. Many types correspond to a tab on the patient chart, such as HM or Lab.</td>
</tr>
</tbody>
</table>
Shortcut menu for the messaging system:

Without opening a message, right-click to use a shortcut menu to perform any of the following actions:

- Reply
- Reply to all
- Forward
- Delete
- Archive
- Print
- View

<table>
<thead>
<tr>
<th>Location of Messages</th>
<th>Method</th>
</tr>
</thead>
</table>
| Adjacent Messages    | 1. Select the first message.  
                      | 2. Hold down SHIFT and click the last message in the group.  
                      | 3. Right-click the selected messages.  
                      | 4. Select **Archive** or **Delete**. |
| Non-Adjacent Messages| 1. Select the first message.  
                      | 2. Hold down CTRL and click each message in the group.  
                      | 3. Right-click any of the selected messages.  
                      | 4. Select **Archive** or **Delete**. |
The Button Area

Click to do any of the following actions:

<table>
<thead>
<tr>
<th>Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close</td>
<td>Close the messaging system.</td>
</tr>
<tr>
<td>New</td>
<td>Create a new message.</td>
</tr>
<tr>
<td>Delete</td>
<td>Delete the selected message. Deleted messages move to the Deleted folder.</td>
</tr>
<tr>
<td>View</td>
<td>Open the selected message. In addition, a message may be opened by double-clicking it.</td>
</tr>
<tr>
<td>Link</td>
<td>Click to jump to the chart of the patient referenced in the selected message. If a chart section is specified in the <strong>Type</strong>, the chart opens to there.</td>
</tr>
<tr>
<td>Change Op</td>
<td>Click to change operators. The messaging system displays messages only for the current operator, so you can use this to view messages for another Practice Partner operator. If a person changes to another operator and sends a message, the message will be sent from the original operator. This prevents a user from sending messages using another user's name.</td>
</tr>
<tr>
<td>Print</td>
<td>Click to print the selected message.</td>
</tr>
<tr>
<td>Select</td>
<td>Click to select messages to view from the Select Messages screen. This screen allows you to select the messages displayed in the message area.</td>
</tr>
</tbody>
</table>
To open the messaging system:

- Click on the Msg button in the tool bar.
- From the Task menu, click Messages. The Messages screen appears.

From this screen, you can send a message (New button), view a message (View button), delete a message (Delete button), open the chart section referenced in the currently-selected message (Link button), change the operator who is currently accessing the messaging system (Change Op button), and print a message (Print button).

Creating a New Message

The process for creating and sending messages should be familiar to anyone who has used Microsoft Outlook or a similar messaging application. In a nutshell, you select to whom you want to send the message, type the message (or insert a message template), and select other options such as patient, message type, and priority. You can also attach files and request a return receipt.

From the Message screen click the New button. The New Message screen appears.
On the top portion of the screen it displays the following fields:

- **To** – Who the user will be sending the message to.
- **Cc** – The user can send a copy of the message to a separate operator.
- **Type** – The user can select a message type by clicking on the drop down arrow.
- **Priority** – Select a priority from the drop down arrow. This ranges from 0 being the lowest and 9 being the highest.
- **Date to activate** – You can select the day you would like the message to be sent. Once you have created a message with an active date, the message will display in Pending.
- **Patient** – If the message relates to a patient, type the patient information in the **Lookup** screen and it will attach the patient to this message.
- **Subject** – Type a brief summary of the message.
- **Text Box** – The user will type the message here.

HealthPoint has decided on standard naming conventions for messages:

**Sick call** - Patient age, CC, for x days (9 year old fever and cough, 4 days).
**Refills** – Refill and name of medication. (Refill: Amoxicillin)
**Referral Request** – Referral and type of referral. (Referral: ENT)
**Lab Results** – Lab Results Patient Name, date of lab results. (Lab results, John Doe, 10/23/10)

The bottom of the screen displays:

- **Send** – Will send the message. If date to activate is later than current date then the message will be stored under **Pending**.
- **Cancel** – This will clear the message and close the **New Message** screen.
- **Template** – Click this button to select templates to insert in the body of this message.
- **Quick Text** - Click this button to select quick texts to insert in the body of this message.
- **Spell Check** – Click this button to check spelling. If there are any errors with spelling, an error box will populate to give suggestions on correct spelling.
- **Attachments** – The user can attach text, images, or other files to the message. You can attach up to 50 items to one message.
- **Return Receipt** – Click this button if you want to receive notification that the recipient has read the message.
- **Record** – If this message pertains to a patient and you want to record this information into the patients chart, click **Record**. This will record the information in the Progress Note.

### Selecting an Operator

![Image of Select Destination screen]

- Click on the To button on the **New Message** screen, a new screen will open called **Select Destination**.
- Click in the Operator radio button.
- To select the operator the message will be sent to, you can either type in the name(s), ID(s), in the Operator box and click **Search** or use the up and down arrows to scroll to search the operator’s name.
• Make sure the operators name is highlighted then select the To ->> to pull the operators name into the yellow box. You can do the same for Cc and Bc, then click OK. If you pulled the wrong name in error, you can select the <<- to remove the operators name. The name will display in the To field in New message.

Type/Priority

To select a message Type or a Priority click on the drop down arrow list, select the type or priority and it will automatically default to the white box.

About messaging types:

When you create a message, you can add a message Type to reference a related section of the patient chart. For example, if your message is about Richard Stein's health maintenance items, you can select "HM" as the message type.

Message types are used with the Link button on the Messages screen (the main screen in the messaging system). When message recipients click the Link button, the appropriate patient chart opens to the location associated with the message type.
Messaging types and their chart locations:

Many of the message types are self-evident. The table below lists the message type and its corresponding location in the patient chart.

<table>
<thead>
<tr>
<th>Message type</th>
<th>Chart location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrived</td>
<td>Chart summary</td>
</tr>
<tr>
<td>Chart</td>
<td>Patient chart</td>
</tr>
<tr>
<td>Chart summary</td>
<td>Chart summary</td>
</tr>
<tr>
<td>Email</td>
<td>Patient chart</td>
</tr>
<tr>
<td>Flow charts</td>
<td>Flow charts</td>
</tr>
<tr>
<td>HM</td>
<td>Health maintenance</td>
</tr>
<tr>
<td>In</td>
<td>Chart summary</td>
</tr>
<tr>
<td>Lab</td>
<td>Laboratory data</td>
</tr>
<tr>
<td>Lab micro</td>
<td>Laboratory data - microbiology</td>
</tr>
<tr>
<td>Lab misc</td>
<td>Laboratory data - miscellaneous</td>
</tr>
<tr>
<td><strong>Lab most recent</strong></td>
<td>Laboratory data - most recent lab data</td>
</tr>
<tr>
<td>Letters</td>
<td>Letters</td>
</tr>
<tr>
<td>Problem list</td>
<td>Problem list</td>
</tr>
<tr>
<td>Progress notes</td>
<td>Progress note - most recent</td>
</tr>
<tr>
<td>Reminder</td>
<td>Chart summary</td>
</tr>
<tr>
<td>Rx</td>
<td>Rx/medications</td>
</tr>
<tr>
<td>Schedule</td>
<td>Provider schedule</td>
</tr>
<tr>
<td>Tel -chart</td>
<td>Patient chart</td>
</tr>
<tr>
<td>Tel -progress note</td>
<td>Progress notes (most recent)</td>
</tr>
<tr>
<td>Tel -chart summary</td>
<td>Chart summary</td>
</tr>
<tr>
<td>Vitals</td>
<td>Vital signs</td>
</tr>
</tbody>
</table>

Date to activate

If you want to delay sending the message, select (or type) the activation date. When an activation date later than the current date is selected, the message is stored in the Pending folder until the activation date. The people to whom the message is addressed (in the To, Cc, and Bcc fields) will not receive the message until the activation date.
Inserting a Template:

To open a template, click on the Template button at the bottom of the screen, the Template Lookup screen will display.

The Template button holds several templates that can be entered into the body of the message. These templates are Telephone Message, Vitals Checks, Cholesterol Results, Lab Results, Rx Refill.

The Provider and Practice box will not be used. HealthPoint has made the decision not to have specific templates made for providers and practices.

The user can search by Template Name if they know the name of the template or they can highlight the template and click OK. This will insert the template right into the body of the message.
Understanding the Template

The template is designed to help reduce free texting by allowing you to click on areas to complete within your note. Practice Partner has the capability of utilizing templates in **Letters, Progress Notes**, and **Messaging**.

There are a few things you should know about templates:

- **DEL** – Means if no information is added to the right of the marker the information will be deleted.
- **Asterisk** – Means there's a space to add additional information.
- Anything Displayed as **REQ** is a required field.

Once you have completed the template in the message screen, click **Send** to send the message off to the operator.
Quick Text

You can use **Quick Text** to add commonly-used words, phrases, comments, sentences, and even paragraphs of up to 1000 characters of previously defined text. You assign each text fragment an easy-to-remember sequence of keystrokes. Quick text can be used in messages, letters, and progress notes.

To insert quick text, click on the **Quick Text** button. This will open a new screen called **Insert Quick Text**. You can select through the radio button Regular **Quick Text**, **DOT codes**, and **Letter Codes**.

**NOTE**

**DOT** codes are codes used to tell the patient records what type of information you are entering. Properly coded text is automatically transferred into the appropriate chart section, like the problem list, vital signs, laboratory, allergy, clinical elements, and health maintenance. All DOT codes need to be entered directly to the left of the text page. If you do not enter the DOT code on the left of the text page, you will receive errors when the note is signed.
**Letter codes** work similar to **DOT codes**. You can embed letter codes so that when you write a letter, patient specific information appears whenever you have inserted a letter code.

**Quick Text Names** allows the users to search for a particular quick text by name. You can also use the scroll bar to move up and down the **Quick Text** list.

Once you have picked the quick text desired, click on the **Insert** button to add to the body of the message.

| NOTE | Where you cursor is placed is where the quick text will be inserted. |

**Attachments**

The user can attach text, images, or other files to the message. You can attach up to 50 items to the message.
To attach a file to the message:

- Click on the Attachment button on the bottom of the message screen. A new screen called Attachments will open.
- Click on the New button. A screen called Select Attachment will open. Here you will be able to locate the file you are looking to attach.

- Highlight the file you want to attach and click Open. The file will display in the Attachments box. You can view the image by clicking View, if not click Close.
- On the bottom of the message screen in the Attachments screen it will display how many attachments are listed.
After go-live date if a message is taken on a patient in the EMR once the message is complete the staff needs to place this message in the Paper chart as well.

**To Do**

The **To Do** is used for notes for the provider. Think of it as a “sticky note”. The **To Do** displays notes that have been added for the patient and that have been assigned a function of “**Patient**”. This will display when opening a patients chart like a “pop up”. A **To Do** is patient specific, unlike messages where you do not need to assign a patient.

**To create a new To Do:**

- Click on the title bar within the Dashboard called To Do.

  ![Dashboard To Do](image)

- A screen called **To Do Note Select** will appear. This screen will display the **Activate Date**, **Patient ID**, **Name**, **Category**, **Priority**, **Assigned To**, and **Subject** columns on the top. The bottom displays **Close**, **New**, **Edit**, **Delete**, **Archive**, **Print**, and **Filter** buttons.

  ![To Do Note Select](image)
• Click on the **New** button and the patient **Lookup** screen will appear.

• Click **Close** to close the **To Do Note Selected** screen.

• To edit a “**to do**”, highlight the note and click the **Edit** button.

• To delete same rule applies, highlight the note and click **Delete** button.

• If you chose to archive the note, highlight the note and click the **Archive** button. Click **Yes** to verify the note is to be archived.

• The **Filter** button will open a **To Do Filter** screen. This area is used to set the criteria.

• You can assign an operator in the **Assigned To** box.

• **Demog Type** will automatically display **Patient**.

• Other options you have a chose to select:
  o **Current/Archived**
  o **Function**
  o **Category**
  o **Priority**

• Under **Date Selection**, you can choose an **Active Date** by adding dates in the **From** and **To** box.

• When finished, click **Ok** and your notes will display on the **To Do List**.

![To Do Filter](image)

• Once you have located the patient from the **Lookup** screen, the **Patient Note <New>** screen will appear.
Patient Note <New>

This screen has several fields that include:

- **Function** - Where the note should display
- **Active Date** - The date the note is active. The active date is the day the note becomes "functional".
- **Expire Date** - The note’s expiration date. The expiration date is the day the note will be archived.
- **Cycle** - Has not been implemented through Practice Partner.
- **Practice** - Indicated the practice that created the note.
- **To Do** - If this note is a To Do check off the box.
- **Completed** - If the note is a To Do and has been completed, click completed.
- **Priority** - This is used to prioritize the “to do” note.
- **Category** - This is used to sort the “to do” note.
- **Assigned To** - This is where the operator will be assigned to the note.
- **Subject** - Used to type in a brief description of the “to do” note.

After you have filled out the necessary fields, type the note in the text box, and then click **OK**.
Lesson Four: Patient Lookup

The purpose of this chapter is to give you an overview on how to look up a patient record.

Objective

By the completion of this chapter, you will:

- Have a complete understanding of the Lookup screen
- Have the ability to look up a patient using patient name, and patient ID
Patient Lookup

In order to access a patient, you must go through the Patient Lookup Screen.

You can locate patient lookup screen by doing the following:

- **File/Open Chart** on the Menu Bar, the Chart button on the tool bar, or the Patient button on the toolbar.
- You can locate a patient by selecting the radio button Patient Name, Patient ID, and Phone Number.
- When you have selected your search criteria, fill in the areas under Search for or Patient Name Search Filters.
- Click the Lookup button, locate your patient and click OK. This will bring you to the Patient Chart. Repeat the step if you are not able to locate the patient.
Lesson Five: Chart Overview

The purpose of the chapter is to give an overview of the patient chart.

Objectives

By the completion of this chapter, you will be able to:

❖ Navigate around the patient chart
The Patient Records is organized in much the same way as most paper-based medical record systems. The patient chart is used to store a wide variety of patient information, including progress notes, medications, and patient histories.

Many of the chart sections (or tabs) are note-based. That is, they contain mainly non-numeric data.
As you open the patient’s chart new buttons appear on the toolbar:

- **Close** – Allows you to close the chart.
- **Timing** - Is a way to track the patient progress during an appointment.
- **Note** - Allows the users to create a new progress note.
- **Patient Education** - Provides materials that can be used as handouts for your patients.
- **Patient Information** - Is a quick snap shot of patient’s demographics Insurance, over due **Health Maintenance**, and **Allergies**.
- **Rx** – Provides a short cut way to enter new medications.
- **Orders** – Provides a short cut to processing a new order.

You can view, add, or update the information that appears on the user-defined chart sections in the same way you would information in any of the text-based section of the patient chart.

| NOTE | Each tab that displays a BLUE marking informs the user there is information in that tab. If it displays WHITE, no information is currently in that tab. |

**Accessing and closing patient charts:**

You can access the patient chart in several ways: from the menu bar **File/Open Chart from**, from the toolbar click **Chart** button, or by double clicking on the patients name on the **Scheduler**.

| Tip | From the menu bar go to File/Recently Reviewed, this will display up to 15 patients whose charts were recently opened by the operator. |
To open a patient chart:

- Select **File/Open chart**, or click the **Chart** button on the tool bar. The **Lookup** screen appears. Enter the **Patient Name** or **Patient ID**, click **Lookup** or press enter.
- Select the patient and click **OK** or press enter.

To close a patient chart:

- Click the **Close** button on the tool bar, or click the **Close** icon in the upper-right corner of the patient chart screen. The current patient chart and any related screens for the patient will close. If a progress note is open, you will be prompted to save it.

When the patient has an appointment for the current day, you can use the **Timing** button (available in the tool bar only when a chart is open) to track process information for patient visits. You can record the exact time a patient checks in, is put in the exam room, sees the provider, is finished with the provider, and leaves. This feature helps you to determine the average amount of time patients spend waiting and with providers.

To use the timing feature:

- When a chart is open, click the **Timing** button in the tool bar, or select **Task/Timing** from the menu bar. The Timing screen appears.
- Check the radio button for each process (check-in, check out, in exam room, in treatment, in lab, in x-ray, provider finish, ready, with nurse, and with provider) that you want to track.
- Under Room, select the location where the patient is.
- Type a time in the field; or mark the check box to use the current system time.
- When you finish, click the OK button.

**Workflow Process:**

As the MR you will arrive the patient in GM then go to Practice Partner locate your patient and click the Timing button check the box **Check-In**, and then go to **Process** and click the drop down arrow and choose **WTG**. This will update the process in the schedule and inform the MA the patient is ready to be seen.

When the patient is ready to be checked out you will go back into the patients chart click on the Timing button and click **Check-Out**. This end the timing process.
Lesson Six: Patient Information

The purpose of the chapter is to give an overview of the patient information screen.

Objectives

By the completion of this chapter, you will:

- Understand what displays in the Patient Information screen.
Patient Information

The Patient Information screen provides quick access to a patient’s data. The information displayed is pulled from the Patient screen and includes, if available the patient’s name, ID, address, home address, telephone numbers, account type, head of household, insurance carriers, usual provider, and referral sources. Keep in mind that this information displays only if it has been entered via Group Management and sent across the interface. For example, if a Usual provider is not indicated on the Patient Information screen in Group Management, the Usual provider field on the Patient Information screen will be blank in Practice Partner.
To access the Patient Information screen:

- When a patient chart is open, select **Show/Patient Info** from the menu bar, or click the **Pt Info** button on the toolbar. The **Patient Information** screen for the current patient appears.

The screen includes several buttons that will allow you to quickly jump to additional patient information.

**You can click the:**

- **HM** button to view the patient’s overdue health maintenance.
- **Allergies** button to view the patient’s allergies.
- **Co-pay** button, no information will display here.
- **Guarantor** will display guarantor information.
Lesson Seven: Patient Screen

The purpose of the chapter is to give an overview of the patient screen and all tabs associated with the Patient section.

Objectives

By the completion of this chapter, you will be able to:

- Upload a photo and attachment
- View insurance information
- Add a provider
- View all present and past appointments
- View progress notes
- Configure a pharmacy
Patient Screen

To access the Patient screen, click on the **Patient** button from the toolbar, or **File/Open Patient** from the menu bar. The **Patient** screen is set up with several different tabs.

The **General** tab will display demographics that have been sent from Group Management. This area is **NOT** to be modified in Practice Partner. If any changes need to be made to the patient’s demographics these changes **MUST** be made in Group Management. The information will come through the interface within 120 seconds and will automatically update Practice Partner.

Within the **General** tab, the only areas the user will need to access is **Photo** and **Attach** button.
About patient photographs:

You can add an image file (.bmp, .gif, or .jpg format) of the patient through the Photo button. The photo displays on the Patient screen's General tab.

To add or change a patient photograph:

1. The receptionist will take the photo via a digital camera or webcam.
2. The photo will be saved, by the receptionist, to the following location as the patient’s name:
   - T:\ppart\Patient Photos\%dr.'s name\Mickey Mouse
   - Example: t:\ppart\Patient Photos\Wray\Mickey Mouse
3. The receptionist will attach the patient’s photo to their chart by opening their chart.
4. Click on Patient icon located on the toolbar.

5. Click Photo. The Load Patient Photo screen will appear.
6. Click **Browse**.

![Image of Browse window]

8. Navigate to the location where you saved the photo T:\Ppart\Patient Photos. Choose your sites folder and click **Open**.

![Image of Select Patient Photo Directory]

9. You should be able to see the list of photos available. Select the correct picture and click OK. Check the box labeled “Delete Original File After Load?” after you make sure you are loading the correct photo for the patient.

![Image of Patient Photo Selection](image)

10. Once you click OK, you will be able to see the photo on the patient information screen. Click OK to close.

To delete a patient photograph:

- From the General tab click the Photo button. The Patient Photo screen appears.
- Click the Delete button. A message asks you to confirm the deletion.
- Click the Yes button.
Billing tab

The **Billing** tab will display the Primary and Secondary insurance only. This information comes from Group Management through the interface. This area is **NOT** to be modified in Practice Partner. If any changes need to be made to the patient’s demographics these changes **MUST** be made in Group Management. The information will come through the interface within 120 seconds and will automatically update Practice Partner.
Other Data tab

This displays the language field that is brought over through the interface from GM.

Providers tab

This screen will allow the user to add the primary provider and referring sources.

To add a provider:

- Click on the drop down arrow under Primary Provider. A screen will display called Provider Select. You have to select the Name button and click OK or use the scroll bar to move up and down the screen.
- Select whether the provider is an Internal provider or External provider.
- Select Date Active.
To add a referring source:

- In the **Referring Sources** area, click **New Src**.
- Under **General Information** select who the referring source is **From** by clicking on the drop down arrow. A screen called **Referring Source Select** will display, highlight the name and click **OK**.
- To add the **To Provider**, click the drop down arrow and select the provider from the **Provider Select** screen.
- Add a **Description** and **Auth#** if necessary.
- Fill in all necessary dates.

To change a referring source:

- In the **Referring Source** area, select the referring source to be changed. Click **Edit Src**. Make the changes. When finished, click **OK**.

To delete a referring source:

- In the **Referring Sources** area, select the referring source to be deleted. Click **Delete Src**. A message asks to **confirm the deletion**. Click **OK**.
**Dates tab**

The **Dates** tab will display all previous and pending appointments. The most recent appointment will display on top. Under **Appointments** it will display the **Providers** code, **Date** of appointment, **Time** of the appointment, **TOV** – the office visit, and **Status**.

You can also access any overdue Health Maintenance by clicking on the **RED HM** button. The overdue Health maintenance screen will display called **Overdue Health Maintenance** with a list of all the patients overdue **HM**.
Notes tab

The notes section will display all patient notes that have been created in the patient record.

Configuration tab
From the **Configuration** tab you can associate pharmacies with the patient.

- From the **Configuration** tab, click the **New** button to the right of the **Patient Pharmacies** section.
- In the **Pharmacy ID** box, click the drop down arrow to select pharmacy. A screen called **Pharmacy Select** will appear.

- Locate the desired pharmacy; you can search by **Pharmacy Name**, **Pharmacy ID**, or **Nickname**.

- If this is a preferred pharmacy, click on the **Preferred** check box.
- Enter a **Note** if applicable.
- Click **Ok** when finished.
Lesson Eight: Patient Education

The purpose of the chapter is to give an overview of the patient education.

Objectives

By the completion of this chapter, you will:

- Understand Patient Education
- Know how to search for handouts
- Know how to Modify handouts
- Know how to Print handouts
Patient Education

The Patient Education feature of Patient Records provides education materials that can be used as handouts for your patients. You can even create customized notes to add to your handouts prior to printing. The Patient Education feature will automatically select the appropriate education handout based on the age and sex of your patient, and diagnosis.

Some of the Patient Education materials are available in English and Spanish. An asterisk next to the index entry will indicate there is a Spanish version of the handout.

To access Patient Education:

- Click on the Patient Ed button from the patients chart on the toolbar. A screen will open called PMSI – Patient Education or you can go through the Task/Patient Education from the menu bar.

Required Core Objective:

Use certified EMR technology to identify patient-specific education resources to patient if appropriate.
The buttons on the menu bar are:

- **File** – Will allow you to **Print** handouts. If you have added a progress note for a patient and if the patient is currently selected on Patient Profile, a notation will be added to the progress note that lists the handouts that you print for the patients.

- **Task** – Will allow you to search the patient education database, Index, Notated, look at Patient Profile, and select Mode. These same actions can be accessed by the buttons below the menu bar.

- **Bookmarks** – Add and Edit your bookmarks.

- **Maintenance** – Not being used.

- You can click on the **Search** button, the **Search** screen will display. This section will allow a search by **Title**, or you can scroll up and down to locate a folders name.

- **Index** button, is currently not available.

- To notate on the actual handout, click on the **Notate** button. The handout will appear in word format. Add additional notes and click **Print**.

- **E-Mail** - is currently not available.

- **Profile** - this opens the Patient Profile and the patient’s name, age and sex display. The diagnostic coding system used and the diagnostic code, if available, also display.

- **Help** - is currently unavailable.
Lesson Nine: Knowledge Base

The purpose of the chapter is to give an understanding of the Knowledge base.

Objectives

By the completion of this chapter, you will be able to:

- Understand how to access the Knowledge Base
- Understand how to search for HMG forms
Knowledge Base

Patient Records provides access to local and Internet-based knowledge bases through its built-in browser. The Knowledge Base contains links to clinical reference tools, practice guidelines, medical information databases as well as online journals.

To access the knowledge base:

Select Task from the menu bar then select the Knowledge Base from the pulled down list. The Knowledge Base start page appears.

- Click the links to bring up selected HTML documents that may in turn be linked to other documents.
- To see material you previously viewed in this session, click the Back or Forward toolbar buttons.
To access HMG Forms Clinical - Non Clinical, click that link which will take you to the listing of the current approved forms. By clicking on a form, you will be taken to that form enabling you to print out a copy.

To close the knowledge base:

- Select **File** on the menu bar then **Exit** from the pull down list.

You can use the built-in browser to access the World Wide Web. By default, the McKesson web page appears.

**To access the Internet browser:**

- Select **Task** from the menu bar then **World Wide Web** from the pull down list. The McKesson Web Home Page appears.
- To search the World Wide Web, click the **Search** button and Yahoo.com will come up.
- Click the **Back** or **Forward** toolbar buttons to view previous internet searches.

**To close the browser:**

- Select **File** from the menu bar then **Exit** from the pull down list.
Lesson Ten: Chart Summary

The purpose of the chapter is to give an overview of the chart summary in a patient's chart.

Objectives

By the completion of this chapter, you will be able to:

❖ Display the Chart Summary
❖ Access values from the each section of the Chart Summary
Chart Summary

The Chart Summary section of the patient chart displays the most recent information about the patient in a concise, easy-to-read format. You can use the Chart Summary screen to get a quick overview of a patient’s chart.

The chart summary is solely for viewing existing patient information. You cannot delete or change information directly on the Chart Summary screen. If you need to change any information displayed here, you must change it in the appropriate section of the patient chart.
The default chart summary display shows the patient’s

- Visits
- Vitals Signs
- Allergy
- Health Maintenance needed
- Most Recent Labs
- Procedures
- Medication
- Major Problems

Other than Procedures, you can click any chart summary item to go directly to that section of the chart. If you click on the Procedures title bar it will not display anything. For example, you can click a Problem to go to all visits for that problem. Click Health Maintenance to display the Health Maintenance section.

You can use the arrows to scroll through the information in each section of the chart summary screen.

**To access the chart summary:**

- Select Show from the menu bar the Chart Summary from the drop down list, or click the Chart Summary tab on the patient chart. You can also click the Summary button on the go to bar.
Lesson Eleven: Progress Note

The purpose of the chapter is to give an overview of the Progress Note.

Objectives

By the completion of this chapter, you will be able to:

- View the Progress Note
- Process the Electronic Encounter Form for charges
Progress notes

Progress notes are records of the patient visits. You can add or update notes on any of the progress notes screen, as well as move from one progress notes screen to another.

Accessing the progress note:

- To access progress note, click on the **Note** button on the toolbar, or click on the **Progress Note** tab from the patient record. The **Progress Note** screen will appear.
- When selecting the **Progress Notes** tab, a dialog box will appear called **Progress Note Selection**.
- You will have the option to select by:
  - **Most Recent** - Displays in chronological order with the most recent note first.
  - **By Problem** - Displays listing in alphabetical order by problem. This option only displays unique problems. It does not represent the actual number of progress notes in the chart.
Choose From List - Displays in order of notes by date of progress note.

By Special Criteria - Allows the user to select special criteria to view progress notes. Criteria included: By Provider, By Practice, By Date, By Problem, By Text Pattern.

Add/Edit Shared Note - If there is a shared note (a note that has not been permanently saved) it will display on the list. If there is no shared note, a new blank progress note will open.
Practice Partner allows you to view particular parts of the progress note by clicking the **Past Medical History** tab, **Social History** tab, and **Family History** tab.

The top blue banner area of the progress will display patient name, ID, Age, and Date of Birth. This information comes through the interface from Group Management.

The progress note will automatically time stamp the date and time on the upper left corner.

The right of the **Progress Note** screen displays:

- **Cancel**
- **QT Auto** which works like the TAB and F10 keys. When you click on the **QT Auto button**, the cursor jumps to the next label. If the current label marker has an embedded QuickText item name, the item name is replaced with the associated QuickText.
• **Print**
• **Fax**
• **Image** can create and display in the patient’s chart.
• **Spelling** will check for spelling error.
• **Insert Tables**
• **EM Codes** will allow the user to add E & M coding labels to the note for each service provided to the patient.
Electronic Encounter Form (EEF)

The Electronic Encounter Select screen lists all existing electronic encounters. It is also the main screen for starting new encounter forms, entering encounter data, and reviewing existing forms. Providers can check off the appropriate procedure codes and diagnosis codes through the progress note or by the EEF. Then the Medical Receptionist staff can review the completed forms and post the resulting charges to the Group Management for processing.

- To access the EEF screen go to Task/Electronic Counter Forms through the menu bar.
- A screen called Electronic Encounter Select will display. This displays all encounters forms that are pending and completed.

Encounters on this screen display by date and time the encounter was created. You can filter the electronic encounter forms that display on this screen by using the fields at the top of the screen:
- **Practice:** Select a practice to display electronic encounters for that practice only, or leave the field blank to display electronic encounters for all practices.

- **Provider:** Select a provider to display electronic encounters for that provider only, or leave the field blank to display electronic encounters for all providers.

- **Appointment From and To:** Select from and to dates to display the electronic encounter forms with an **Appointment Date** between the specified dates. You can click the down arrow button to select the date from a calendar. You can also leave the fields blank to display electronic encounter forms for all dates or you can leave the **From** field blank to display all electronic encounter forms with an Appointment Date before the To date.

- **Complete:** To display electronic encounters marked complete, select Yes. To display electronic encounters that are not marked complete, select No.

- **Status:** Select an option to display either current or archived electronic encounter forms.

- **Patient ID/Patient Name:** Select a patient to display electronic encounters for that patient only, or leave the field blank to display electronic encounters for all patients. Use the Lookup button to locate the appropriate patient, then click the Search button to filter the data in the encounter list.

**NOTE**
If the **From** date is not specified, and the selected status is "Archived", the **From** date will default to the current date.
Also to view encounters for all patients again, click the **Clear** button to clear the Patient ID and Patient Name fields, and then click the **Search** button.

- To display electronic encounter forms in ascending date/time order, you must select a practice and/or provider. If both filters are blank, electronic encounter forms display in the order they were created.

- When you change one or more filters, click the **Search** button. This refreshes the list of electronic encounters, using the new filter criteria.
• If a patient is currently selected in Patient Records, encounters for that patient only display in the list.
• Practice Partner automatically assigns a control number to the electronic encounter form. This number prints on the Encounter Form Tracking report, available in Medical Billing for Windows. You cannot edit the control number.

To open the Electronic Encounter Select screen:

• Select Task/Electronic Encounter Forms from the menu bar. The Electronic Encounter Select screen appears.

To Edit an electronic encounter form:

When the provider has completed the progress notes and signs the note, any procedure codes and diagnoses codes will display through the EEF. All charges will be generated through Practice Partner then pushed over via interface to Group Management.

The Medical receptionist will review the EEF for each patient in Practice Partner and process the EEF for it to be transmitted to Group Management for billing.

• On the Electronic Encounter Select screen, highlight the electronic encounter form that you want to change. Click the Edit button. Make the appropriate changes. When you finish, click the OK button.
The Electronic Encounter <Edit> screen appears.

Verify the EEF has correct provider, practice name, and template.

Click on the Template drop down arrow to choose the correct template. A template must be chosen, if a template is not selected the Procedure and Diagnosis tab will be empty. For example if the provider is an internal medicine provider, then the Internal Medicine template must be selected.

The Template Name screen appears, select template and click OK.

The EEF creates a control number this number is not to be edited at any time.

*NOTE* The EEF will display the last practice, provider and template you view. Verify the information is correct before moving forward. Also note the EEF will display the practice name you are assigned to.
The procedure code and diagnoses code will display from the progress note. Verify the information is correct. The diagnosis code must be attached to the procedure code. You can highlight the diagnosis code in the **Diagnosis Summary** box and drag it to the procedure in the **Procedure Selection** box.

You can also move the procedures up or down depending on how you want to the order to display highlight the procedure and drag it up or down to the desired location.

Or click on the **Assign Dx** button and the **Assign Dx** screen will appear. Select the category that best applies and click **OK**. The diagnosis codes will display in the Procedure Selection box.

To add a modifier right click on the procedure code and the **Edit** screen will appear. Under modifier add the recommend modifier.

Click **OK** when finished.
If the patient is a self paying patient add the modifier SD. The same modifiers that are used in IDX for discounts will be the same modifiers used in Practice Partner. VF modifiers will be used for the Medicaid patients.

- When all information has been updated check the Complete box and click OK, this will generate the charges to be pushed over to Group Management.

Medical Receptionist will verify the EEF and check the complete box.

When IDX is open and Practice Partner on the same patient it will duplicate charges in IDX, print a receipt at the end of the appointment to verify charges are correct. Also when correcting charges in Practice Partner, it will duplicate old charges and place the new charges in. The MR must remove duplicate charges in IDX.
To add an additional procedure code on the Electronic Encounter Form:

If a procedure such as a flu shots, X-rays, or procedures that are done the same day which require the same code to be charge out that day, you will need to add the additional code in the electronic encounter form.

- Go to **Task** on the **Menu** bar, and then down to **Electronic Encounter Forms**.
- Highlight the patient’s name and click on the **Edit** button.

- Highlight the procedure code that needs to be entered in a second time and right click.
A new screen will appear called <Edit>. Click on the Add New button on the bottom on the <Edit> screen.

A new screen called <New> will appear. Add the procedure code in the Procedure Code box. Add the additional modifier in the Modifier box. For example if a patient came in and had two flu shots A and B. You would add the code 87804 in the Procedure Code box, and the modifier 59 in the Modifier box.

Click OK when finished.
- The additional code will appear on the **Electronic Encounter**. Add the diagnosis codes to the appropriate procedure codes and check of the **Complete** box.
- Click the **OK** button when finished.
Procedure codes **MUST** have a diagnose code attached prior to marking complete.

- The diagnosis code must be attached to the procedure code. You can highlight the diagnosis code in the **Diagnosis Summary** box and drag it to the procedure in the **Procedure Selection** box.
- Or click on the **Assign Dx** button and the **Assign Dx** screen will appear. Select the category that best applies and click **OK**. The diagnosis codes will display in the Procedure Selection box.

- To move a procedure code either up or down highlight the procedure code and drag it upward or downward until you place it in the desire location.
- When all information has been updated check the **Complete** box and click **OK**, this will generate the charges to be pushed over to Group Management.
Lesson Twelve: Past Medical/Social and Family History

The purpose of the chapter is to provide an overview of the Past Medical/Social and Family History.

Objectives

By the completion of this chapter, you will be able to:

- Review the histories tab
Past Medical/ Social and Family history

The patient chart provides three patient history sections:

- **Past Medical History** – Records all the chronic illnesses, hospitalizations, and other health information for the patient.

- **Social History** – Records medically relevant information about the patient’s life, such as marital status, habits, work, etc.

- **Family History** – Records medically relevant information about the patient’s family, including major diseases and chronic conditions.
Lesson Thirteen: Hospital Records, Records Request, and Correspondence.

The purpose of the chapter is to provide an overview of the Hospital Records, Records Request, and Correspondence tab.

Objectives

By the completion of this chapter, you will be able to:

- Review all scanned documents in the Hospital Records, Records Request, and Correspondence tab.
Hospital Records

The Hospital Records section contains all patient hospitalizations records; this information will be scanned into the patients chart for viewing.

- Click on the Hospital Records tab.
- To view records, you can click on the Newer or Older button to locate the scanned document and click Ok when finished.

Correspondence

Works the same as Hospital Records. Information such as letters will be scanned into the patient’s chart.

- Click on the Correspondence tab and select the scanned correspondence desired.
- To view records, you can click on the Newer or Older button to locate the scanned document and click Ok when finished.
Records Request

Works the same as Hospital Records. Request will be scanned into the patient’s chart for viewing.

- Click on the Records Request tab and select the scanned correspondence desired.
- To view records, you can click on the Newer or Older button to locate the scanned document and click Ok when finished.
Lesson Fourteen: Letters

The purpose of the chapter is to provide an overview on the use of the letters.

Objectives

By the completion of this chapter, you will be able to:

- Create letters from a template
About letters

The Letters section of the patient chart is designed to allow providers to write letters about their patients. For example, you can write letters to a patient about a lab test or physical, etc., refer a patient to another provider, send back a consultation report, respond to an insurance company request, or just write a general letter. Letters written in Patient Records are stored in the **Correspondence tab** where they can be reviewed or edited at a later time.

Letters are a modified version of the progress notes feature, and are part of the other text-based section of the patient chart. Many of the functions available for the notes feature work with letters, such as entering and editing text, inserting Dot codes and images, and using QuickText.

Letter templates can also contain conditional logic that determines which phrases appear, and can contain page templates that specify how the letter should be printed. You can control the margins, font, and font sizes to be used. Headers and footers can also be included.

**To create a letter:**

- Click on the **Letter** button on the toolbar.
- Select the desired template and click **Insert**, this will display the letter in the patients chart.
• The letter displays the date, time, title which is the letter template name patient name, and address.
• You can modify any part of this letter. Click Print when finished then click OK. The note will be saved into the patients chart.

To change a letter:

• In the patient chart, select Correspondence tab.
• Use the Newer and Older buttons to find the letter that you want to change.
• Click the Edit button. Make the appropriate changes.
• When you finish, click the OK button.
• If prompted, type your signature.
• Click the Print button to print out the letter.

To print a letter:

• Click the Print button.
EMR MR Manual

To Print.
Lesson Fifteen: Orders

The purpose of the chapter is to provide an overview on using Orders.

Objectives

By the completion of this chapter, you will be able to:

- Navigate the order processing screen
Orders

Orders allow you to create, process, and review laboratory, pathology, diagnostic test, procedures and referrals. Orders can be issued from the progress note using the Orders button, or from the Orders tab on the patient chart.

The Orders screen has three different tabs:

- **Pending** - Will display orders that have not been processed.
- **In Progress** - The order has been processed and pending for completion or result to be entered.
- **Completed** - The results or order has been received and/or completed.
**Request for electronic copy of health information:**
(Meaningful Use required objective)

When a patient requests a copy of their record electronically you must create and order for this request.

- Click on the **Order** button the **Orders** screen will display.
- For **Facility** click on HMGFAC.
- Add a diagnosis code and a processor.
- Under order tree click on **Request for E-Copy** and add it to the Queue pane.
- Click **OK** when finished.
- When the patient has received the electronic copy of health information the order must be completed.

<table>
<thead>
<tr>
<th>Required Core Objective:</th>
</tr>
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<tbody>
<tr>
<td>Provide patients with electronic copy of health information upon request within 3 business days.</td>
</tr>
</tbody>
</table>
Lesson Sixteen: Clinical Messaging

The purpose of the chapter is to provide an overview of the Clinical Messaging.

Objectives

By the completion of this chapter, you will be able to:

- Understand Clinical Messaging
Clinical Messaging

The Clinical Messaging tab stores the patient clinical messages that were created in Messages from the dashboard. When the provider receives a message from the dashboard and wants to record this message for the patient it will display as a note in the Clinical Messaging tab.

- To access the note click on the Clinical Messaging tab.
- The note will display, you can view older messages by clicking on the Older button.
- When finished click Ok.
Lesson Seventeen: Flow Chart

The purpose of the chapter is to provide an overview of the Flow Chart.

Objectives

By the completion of this chapter, you will be able to:

❖ Navigate the Flow Chart
❖ Select different flow chart templates
Flow Chart

Flow charts help you analyze and compare patient data. You can view patient flow chart in numeric and textual data, including vital signs and health maintenance.

- To access the Flow Chart, click on the Flow Chart tab. A screen called Flow Chart Selection will display. You can select a flow chart based on the Template Name.
- Click on the drop down arrow, select the template name, and click OK when template has been selected.

![Flow Chart Selection](image)

- The flow chart you chose will display.

![Flow Chart for HYPERTENSION](image)
The Flow Chart contains clinical data elements that originate from several possible areas:

- Interfaces such as the lab interface.
- Chart updates containing form components that are programmed to record to specific health maintenance.
- Manual updates to the flow chart during documentation of a progress note.

The Flow Chart’s label goes vertically down the page. The values lie within the grid and correspond to the values and the date the values were observed.
Lesson Eighteen: Clinical Elements

The purpose of the chapter is to provide an overview of Clinical Elements

Objectives

By the completion of this chapter, you will be able to:

- Navigate the Clinical Elements screen
- Select different clinical element templates
Clinical Elements

Historically, Practice Partner users had to create custom Laboratory Names as a workaround for recording custom discrete and non-discrete data. The Clinical Elements feature provides a way for you to do this without using Laboratory Names, and with greater power and versatility. For example, you can enter physiological parameters that don’t constitute vital signs, such as left ventricular ejection fraction, standardized symptom scores, intraocular pressure, etc. A clinical element provides a convenient and flexible way for you to enter and display this data. You can display and enter clinical elements using flow charts, you can insert them into notes and letters using Insert Codes, and you can record them from notes using Dot codes. 

To select a template click the drop down arrow.
To access the Clinical Elements screen:

- In the patient chart, click the Clinical Elements tab. The clinical elements screen will display.

Viewing older and newer clinical elements data:

- To view previous clinical elements data, click the Older button. To view more recent data, click the Newer button.
- To display clinical element details (such as clinical element name, the time the clinical element data was entered and the data entered):
- Select the Details check box located on the bottom right of the screen.
Lesson Nineteen: Preventive Health, Outside Records, and care Plan

The purpose of the chapter is to provide an overview of Outside Records and Preventive Health.

Objectives

By the completion of this chapter, you will be able to:

- View scanned Outside Records
- View scanned Preventive Health records
- View scanned Care Plans
Preventive Health

The Preventive Health tab will display scanned documents, this section works the same as the Hospital Records tab.

To access the Preventive Health Records:

- Click on the Preventive Health tab, click on the Newer or Older button to locate the scanned document and click Ok when finished.

Outside Records

The Outside Records tab works the same as Hospital Records.

To access this section:

- Click on the drop down arrow and select Outside Records.
- To view records you can click on the Newer or Older button to locate the scanned document and click Ok when finished.
Care Plan

The Care Plan tab will display scanned documents. Care Plan tab will contain scanned information in regards to long term care, home health care and orders.

To access the Care Plan:

- Click on the drop down arrow on the Outside Records tab.
- Select the Care Plan
- To view records you can click on the Newer or Older button to locate the scanned document and click Ok when finished
Lesson Twenty: Problem List

The purpose of the chapter is to provide an overview of Problem Lists.

Objectives

By the completion of this chapter, you will be able to:

- Navigate the Problem List screen
Problem list

The Problem List section of the patient chart constitutes a longitudinal record of the problems for which the patient has sought or received care. Problems are organized into the following six categories, each displayed under a separate Tab:

- **Major Problems** – The patient’s major medical problems. This is the "chronic" problem list for the patient.
- **Other Problems** – This category is intended as a list of problems of secondary importance, and/or chief complaints for individual patient visits as represented, for instance, by the "Title" section of Progress Notes.
- **Procedures** – Significant procedures which the patient has undergone.
- **Diagnoses** – This category represents the diagnoses from specific patient visits.
- **Risks** - The conditions that put patients at risk for diseased states and other adverse health events.
- **Hospitalizations** - The problems for which the patient has been hospitalized.
Lesson Twenty One: Health Maintenance

The purpose of the chapter is to give an overview of Health Maintenance.

Objectives

By the completion of this chapter, you will be able to:

- Navigate the Health Maintenance screen
Health Maintenance

The health maintenance feature helps you track a patient’s periodic preventive and follow up care treatments. You can use this feature to schedule patients for periodic examinations and tests based on age/sex criteria, medications, problems, diagnoses, protocols, or individual patient needs. You can track a wide variety of items including the entire USPHS guidelines, cholesterol, immunizations, pap smears, mammograms, chemistry panels, creatinine, HgBA1C, and so forth.

Health Maintenance:
If a patient has an overdue Health Maintenance a pop up called **REMINDER – the following are overdue for:** will occur when opening the patients chart. Click **Close** after reviewing the reminder.

![REMINDER pop up](image)

**To print health maintenance data:**

- On the **Health Maintenance Summary** screen, click the **Print** button. If the **Windows Print** screen appears, select the printer and click the OK button.
Lesson Twenty Two: Rx/Medications

The purpose of the chapter is to give an overview of Rx/Medications tab.

Objectives

By the completion of this chapter, you will be able to:

- Navigate around Rx/Medications
Rx/Medications

**Patient Records** offers a comprehensive way to record a patient’s current, historical, and ineffective medications on the **Patient Chart** by using **Rx/Medications**.

**Rx/Medication** screen serves many purposes. It allows the user to add, modify, and delete **Allergies and Intolerances**. It also allows the users to add a New medication, **Renew** a medication, **Renew All** medication, and **Discontinue** medications. You can also view the detail on the medication by clicking on the **Detail** button. The **Action** button will allow you to **Print**, **Edit**, **Renewal History**, view **Drug History**, **Interactions**, **Delete** and **View** a prescription. **Other** button will allow you to put a **Flag**, add **Note**, **Print All Rx**, and **Print Med List**.

**The Tabs on Rx/Medications**

- **Current tab** - Displays the patient’s current medication, including dosage and frequency.
- **Ineffective tab** - Displays discontinued medications that were ineffective.
- **Historical tab** - Displays discontinued medications that were effective.
- **Rx Fill History tab** - Displays pharmacy prescription fill events that are downloaded to your system from the patient’s Pharmacy Benefit Manager.
- **Eligibility tab** - Displays pharmacy benefits eligibility data.
Under each tab there is a **Status** column this column allows you to view the status of electronic prescription messages that have been sent or attempted to be sent to pharmacies affiliated with the SureScripts or RxHub network. The list of the possible status values includes:

- **Pending** – this status is displayed if the prescriber has created a prescription and clicked the **Transmit** button but the prescription has not yet been transmitted to SureScripts.

- **Transmitted** – this status is displayed if the transcription has been sent to SureScripts but no positive verification has been sent back to the receiver.

- **Delivered** – this status is displayed if the prescription has been sent to SureScripts, and a confirmation message has been received from the pharmacy.

- **Error** - this status is displayed if the prescription has been sent to SureScripts and the verification message has been returned with an error code. An error message will usually be sent to the operator who is set to receive messages for the sending provider.
Lesson Twenty Three: Allergies and Intolerances

The purpose of the chapter is to give an overview of Allergies and Intolerances.

Objectives

By the completion of this chapter, you will be able to:

- View the Allergies
**Allergies and Intolerances**

To add a patient’s allergies and intolerances, click the **Allergy** button from the **Rx/Medications** tab. This feature allows you to add, modify, and delete allergies and intolerances for medications. You can enter an unlimited number of allergies and intolerances for a patient. When an allergy or intolerance is added, it will be displayed in the **Allergies or Intolerances** list at the top of the **Rx/Medications** screen. Scroll down or up to see all allergies and intolerances.

Using drug interaction, Patient Records will validate the medication or allergy name entered. First, the drug name is checked using the drug interaction database. If the entry is not found there, then the drug name cross-reference file is checked. If the entry is not found in either, a list displays from which to pick a medication.
Lesson Twenty Four: Vital Signs

The purpose of the chapter is to give an overview of Vital Signs

Objectives

By the completion of this chapter, you will be able to:

❖ View Vitals Signs
Vital signs

The Vital Signs section of the patient chart lets you record vital signs data, and pre-configured data including: height, weight, temperature, pulse, systolic blood pressure, diastolic blood pressure, OFC, and one other category of vital signs data. Vital signs data can be viewed in either tabular or graphic form.

This Vital Signs section of the patient chart also allows you to record postural Blood Pressure and Pulse data in recumbent, sitting, and standing positions. You may enter up to 3 sets of postural data from the Posturals screen.
Lesson Twenty Five: Laboratory Data

The purpose of the chapter is to give an overview of Laboratory Data.

Objectives

By the completion of this chapter, you will be able to:

❖ Navigate the Lab Data screen
Laboratory data

The Laboratory Data section of the patient chart is used to record numeric and textual laboratory data for the patient. To help you interpret this data, you can display selected numeric and textual laboratory data items on a patient flow chart or on a laboratory data table.

There are several ways to enter laboratory data. An interface exists that can handle file formats provided by most outside labs.
You can view four different types of laboratory data on the Laboratory Data screen:

- **Most Recent Lab Data** – Provides a convenient display of the most recent information for each category of laboratory data in the Lab Data Tables. You may graph the most recent laboratory data but you may not add or edit laboratory data in this screen.

- **Lab Data Tables** – Lets you add, view, edit, or graph numeric laboratory data for any laboratory data category.

- **Microbiology** – Lets you view and edit text information about microbiology data. This will also display Allergies and AFP.

- **Miscellaneous** – Lets you view and edit text information about miscellaneous laboratory data. Example: Allergy Panels and AFPs

The Microbiology and Miscellaneous categories are for text information and work like all text-based sections of the patient chart.
Lesson Twenty Six: Lab Table Review

The purpose of the chapter is to give an overview of Laboratory Table review.

Objectives

By the completion of this chapter, you will be able to:

- Navigate the Lab Table
- View progress notes from the Lab Table Review
Lab Table Review

The Lab Table Review feature enables you to review laboratory test results for one or more patients. You can sign the lab test results and forward them to other providers so that they can review and sign the test results, as well.

You can see a list of all patients whose lab needs reviewing. You can also change the sequence in which you view lab data. While you are viewing lab data, you can also view any progress notes linked to that lab data or look at the patient chart.

You can add a progress note related to lab results by clicking the Note button in the tool bar.

| NOTE | If no provider code is assigned to the loaded laboratory data an error is written to the error log and the laboratory data will not be sent for review. |
To access Lab Table Review:

- Select **Task/Review Data /Lab Tables** or hold down your left mouse button while clicking the **Review** button on the toolbar and select **Lab Tables**. The **Lab Table Review** screen appears. From the **Dashboard**, click on **Lab Review**, click the area titled **Lab Table Review**.
- When there are multiple lab tables for a patient, this screen displays "First for Patient" on the first lab table and "Last for Patient" on the final lab table.

**NOTE**
The **Recently Reviewed** submenu located under the **File** menu will show up to 99 patients whose lab results, progress notes, or documents were most recently reviewed by the operator.

To view the laboratory data table:

- Double-click the laboratory test result or select the test result and press **ENTER**. The **Laboratory Data Table** appears.

Double click on the lab results to view more information about the lab results.
To view the list of all lab tests to review:

- Click the List button. The List for Labs to Review screen appears.
- From the table, select the patient whose lab tests you want to review.
- Each row displays the date and time of the lab tests, as well as the patient name and ID. Use the scroll arrows to scroll up or down the list.

**NOTE** The list for Labs to Review screen displays critical tests in red. Critical tests are defined as those with abnormal values.

- Click the OK button or double-click the lab. The Lab Table Review screen displays the lab template that you selected.
Lesson Twenty Seven: Images

The purpose of the chapter is to give an overview of the Image tab.

Objectives

By the completion of this chapter, you will be able to:

❖ Navigate the Image tab
Images

The image section is used to create and modify graphic images and graphic image
templates. Images can be added from the progress note or scanned from Zoom.

- From the patient’s chart click on the Image tab. To view an image, highlight
  the image and click OK.
Lesson Twenty Eight: Radiology, EKG, and Pathology.

The purpose of the chapter is to give an overview of the Radiology tab, EKG tab, and Pathology tab.

Objectives

By the completion of this chapter, you will be able to:

- Navigate the tabs
- View scanned reports
- Understand what type of reports display in each tab
Radiology

The Radiology section will be used to view all scanned radiology documents like MRI, CT scan, and Stress Test.

To view Radiology reports:

- Click on the **Radiology** tab.
- You can view Radiology documents **by Problem** and **Choose From List**.
- Select the link.
- You can also click on **Newer** or **Older** button to move from each Radiology report.

**NOTE**
The Most Recent option will not display.
EKG

The EKG section will be used to view all scanned EKG reports.

To view EKG reports:

- Click on the EKG tab.
- You can view EKG reports by Most Recent, By Problem, and Choose From List.
- Select the link.
- You can also click on Newer or Older button to move from each EKG report.
Pathology

The Pathology section contains pathology reports such as all cytology and pap smears, whether they are scanned in or electronic resulted in through the interface.

The Pathology section consists of a single note that displays the date you first entered pathology information for the patient.

To view Pathology:

- Click on the Pathology tab.
- You can view Pathology reports by Most Recent, By Problem, and Choose From List.
- Select the link.
- You can also click on Newer or Older button to move from each Pathology report.
Lesson Twenty Nine: Special Studies, Consults, Advance Directives, and Level II.

The purpose of the chapter is to give an overview of Special Studies, Consults, and Level II tabs.

Objectives

By the completion of this chapter, you will be able to:

- Navigate the tabs
- View scanned reports
- Understand what type of reports display in each tab
Special Studies
The Special Studies section of the patient chart contains reports from any other type of test or study. For Example: Sleep Studies will display here.

To view Special Studies:

- Click on the Special Studies tab.
- You can view Pathology reports by Most Recent, By Problem, and Choose From List.
- Select the link.
- You can also click on Newer or Older button to move from each Pathology report.

Consults
The Consults section of the patient chart contains scanned consult reports from other providers.

To view consults:

- Click on the Consult tab.
- You can view scanned consults reports by Most Recent, By Problem, and Choose From List.
- Select the link.
- You can also click on Newer or Older button to move from each Consult report.
**Advance Directives**

The Advance Directives section of the patient chart contains scanned Advance Directives.

To view Advance Directives:

- Click on the **Advance Directives** tab.
- You can view scanned consults reports by **Most Recent**.
- Select the link.
- You can also click on **Newer** or **Older** button to move from each **Advance Directives**.

**Level II**

The Level II section of the patient chart contains scanned reports which included Psychiatric and HIV reports.

To view Level II:

- Click on the **Level II** tab.
- You can view scanned consults reports by **Most Recent**, **By Problem**, and **Choose From List**.
- Select the link.
- You can also click on **Newer** or **Older** button to move from each **Level II** report.
Lesson Thirty: Prenatal Flow Chart

The purpose of the chapter is to understand how to navigate around the Prenatal tab.

Objectives

By the completion of this chapter, you will be able to:

❖ Understand how to navigate the prenatal tab
Prenatal Flow Chart

The first time the Prenatal tab is accessed for a patient, the Pregnancy <New> screen is displayed. This screen allows you to enter an identifying title for the pregnancy (e.g., “First Pregnancy”) and the LMP (last menstrual period). The remaining fields on this screen pertain to the ultimate outcome of the pregnancy and can be completed at a later time (unless you are documenting a past pregnancy).
The **Prenatal Visit Flow Chart** screen is displayed. For the remainder of the pregnancy, when you open the **Prenatal** section of the chart for the patient, the Prenatal Visit Flow Chart screen will be displayed.

**NOTE**

The Prenatal Visit Flow Chart will display only data from the prenatal flow chart template with the exact title **“Prenatal Visit”**. This screen will display current **Allergies**, **Medications** and pregnancy related **Problems**. The columns display information based off the prenatal visit template.
Lesson Thirty One: Patient Message

The purpose of the chapter is to view Patient Messages.

Objectives

By the completion of this chapter, you will be able to:

- Understand Patient Messages
Patient Messages

The **Patient Msg** tab of the patient chart opens the **Patient Messages** screen. This screen displays the messages for the patient from the current operator or all operators based on configuration.

The **Patient Msg** tab will allow the user to view messages regarding the patient that have not been saved as a clinical messaging.
Lesson Thirty Two: Reports

The purpose of the chapter is to understand how to print the various reports in Practice Partner.

Objectives

By the completion of this chapter, you will be able to:

❖ Understand how to print various types of reports.
Print Clinical Summary Report

(Meaningful Use required field)

You can use the Patient Clinical Summary report to provide clinical summaries to your patients' for their office visits. The report includes a summary of the patient's chart information. This report is required through Meaningful Use.

Before generating the Patient Clinical Summary report the system will see if a matching clinical encounter has been created for the patient. If a matching clinical encounter is found (i.e., the patient is the same, the clinical encounter date is the current date, or the encounter is for an "Office Visit") the encounter will be marked as "Printed Clinical Summary Provided". If no matching encounter is found, you will be given the option to create one before printing the report. The clinical encounter will be created for the selected patient with the type "Office Visit".

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<thead>
<tr>
<th>Required Core Objective:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide clinical summaries for patients for each office visit within 3 business days.</td>
</tr>
</tbody>
</table>

To Print Clinical Summary Report:

- From the patient’s chart go to Reports on the Menu bar
- Locate the Patient Records section and then click Print Clinical Summary Report.
- A screen called Patient Clinical Summary Report will open
• This screen will display the patient’s name on the top gray bar next to **Patient:**
• The date range **From** and **To** will default to the present day if nothing is chosen
• Under **Patient data to include in the report** will allow you to check off the information you chose to print for this report.
• You must choose a provider by clicking the drop-down arrow and selecting the providers’ code.
• Lab data, Lab-Microbiology, and Lab Miscellaneous allows you to select the dates you would like to go back to have the information print on the report.
• You have an option to check off each box individually or click on the **Check All** or **Uncheck All**.
• Click **Ok** when finished.

**NOTE**
If a clinical encounter is not found, a screen will display called **Clinical Encounter Not Found.**
This screen will allow you to create the clinical encounter for the patient. Click **Yes** on the radio button and it will generate the clinical encounter.

- Click **OK** and the print box will display to print the report.

**Print Chart Summary**

**To Print Chart Summary Report:**

- Go to **Reports** on the Menu bar.
- Locate the **Patient Records** section and then click on **Print Chart Summary Report**.
- The **Print Chart Summary** screen will appear.

- Select the **Single Patient** radio button and click **OK**, or
• **Scheduled Patients:** The Chart Selection screen appears. Enter the criteria, including scheduled provider and scheduled dates. When you finish entering your criteria, click the OK button.

• **Patients Last Seen on Specified Dates:** The Chart Selection screen appears. Enter the criteria, including scheduled provider and scheduled dates. When you finish entering your criteria, click the OK button.

• **All Patients Belonging to a Usual Provider:** The Chart Selection screen appears. Enter the scheduled provider, then click the OK button.

• All Patients

• **Patients in Patient Inquiry List:** The Patient Inquiry File screen appears. Enter (or browse to) the appropriate Patient Inquiry file, with an .inq extension. Then click the OK button.

• The Patient Lookup screen. Locate the patient you want to print the report.

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**NOTE**

If a clinical encounter is not found a screen will display called **Clinical Encounter Not Found.**

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• This screen will allow you to create the clinical encounter for the patient. Click Yes on the radio button and it will generate the clinical encounter.

• A screen will display asking to “Print any images associated with notes” if there is images click Yes if there is no images click No.
• Click OK and the print box will display to print the report.

Print Partial Chart

To Print Partial Chart:

• Go to Reports on the Menu bar.
• Locate the Patient Records section and then click Print Partial Chart.
• The Print Partial Chart screen will appear.

• Select the Single Patient radio button and click OK or,
• Scheduled Patients: The Chart Selection screen appears. Enter the criteria, including scheduled provider and scheduled dates. When you finish entering your criteria, click the OK button. The Select Partial Chart screen appears.
• Patients Last Seen on Specified Dates: The Chart Selection screen appears. Enter the criteria, including scheduled provider and scheduled dates. When you
finish entering your criteria, click the OK button. The **Select Partial Chart** screen appears.

- **All Patients Belonging to a Usual Provider:** The Chart Selection screen appears. Enter the scheduled provider, then click the OK button. The **Select Partial Chart** screen appears.

- **All Patients:** The **Select Partial Chart** screen appears.

- **Patients in Patient Inquiry List:** The Patient Inquiry File screen appears. Enter (or browse to) the appropriate Patient Inquiry file, with an .inq extension. Then click the OK button. The **Select Partial Chart** screen appears.

- The **Patient Lookup** screen. Locate the patient you want to print the report.

- A **Select Partial Chart** screen will display. This allows you to select the specific areas of the chart you would like to print.

- On the **Select Partial Chart** screen, use the **Add** button to move the appropriate chart sections from the **Selection Criteria** box to the **Print Order** box. Use the up and down arrows to arrange the items in the **Print Order** box into the order that you want the sections to print.

- When you finish, click the **OK** button.

- A screen will display asking to “Print any images associated with notes” if there is images click **Yes** if there is no images click **No**.
- Click **OK** and the print box will display to print the report.
Lesson Thirty Three: Meaningful Use

The purpose of the chapter is to understand the objective required for Meaningful Use

Objectives

By the completion of this chapter, you will be able to:

- Understand the requirements for Meaningful Use
What is "Meaningful Use"?

The American Recovery and Reinvestment Act of 2009 specify three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

Simply put, "meaningful use" means providers need to show they’re using certified EHR technology in ways that can be measured significantly in quality and in quantity.

**Required core Objectives:**

<table>
<thead>
<tr>
<th>Core Set Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use CPOE for medication orders directly entered by any licensed healthcare</td>
<td>&gt;30% of patients seen with at least one medication in their medication list has at least one medication order entered using CPOE</td>
</tr>
<tr>
<td>professional who can enter orders into the medical record per state, local,</td>
<td></td>
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<tr>
<td>professional guidelines.</td>
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<tr>
<td>2. Implement drug-drug and drug-allergy interaction checks.</td>
<td>Functionality has been enabled for the entire reporting period</td>
</tr>
<tr>
<td>3. Generate and transmit permissible prescriptions electronically (eRx).</td>
<td>&gt;40% of all permissible prescriptions are transmitted electronically</td>
</tr>
<tr>
<td>4. Record all of the following demographics: preferred language, gender, race,</td>
<td>&gt;50% of patients seen have demographics recorded as structured data</td>
</tr>
<tr>
<td>ethnicity, DOB.</td>
<td></td>
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<tr>
<td>5. Maintain an up-to-date problem list of current and active diagnoses.</td>
<td>&gt;80% of patients seen have at least one entry or indication that no problems are known</td>
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<tr>
<td>6.</td>
<td>Maintain <strong>active medication list</strong>.</td>
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<tr>
<td>7.</td>
<td>Maintain <strong>active allergy list</strong>.</td>
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<tr>
<td>8.</td>
<td>Record and chart <strong>changes in vital signs</strong>: Height/weight/BP; Calculate and display BMI for ages &gt;2 years; Plot and display growth charts for children 2-20 years, including BMI.</td>
</tr>
<tr>
<td>9.</td>
<td>Record <strong>smoking status</strong> for patients 13 years and older.</td>
</tr>
<tr>
<td>10.</td>
<td>Implement one clinical decision support rule relevant to specialty/high clinical priority with ability to track compliance.</td>
</tr>
<tr>
<td>11.</td>
<td>Report ambulatory quality measures to CMS or the States</td>
</tr>
<tr>
<td>12.</td>
<td>Provide patients with <strong>electronic copy of health information</strong> upon request.</td>
</tr>
<tr>
<td>13.</td>
<td>Provide <strong>clinical summaries</strong> for patients for each office visit.</td>
</tr>
<tr>
<td>14.</td>
<td>Capability to <strong>exchange key clinical information</strong> among care providers/patient authorized entities electronically.</td>
</tr>
<tr>
<td>15.</td>
<td><strong>Protect electronic health information</strong> created/maintained by EMR via appropriate technical capabilities.</td>
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