Access Home Screen to View Ambulatory Organizer/Selecting Provider to be Displayed

1. Click the Home button
2. From the Day View, click the dropdown next to Patients For:
   Patients for: No Resource Selected
3. Select Add Other
4. Search for and select the name of the resource
5. Click on the name to select that resource and click OK

Opening a Patient Chart
1. Click on the patient’s name from the organizer
2. Or search for the patient’s name using the search bar and clicking the magnifying glass
3. The patient search dialogue box opens
4. Search for the patient by last name
5. Identify the correct encounter from the list
6. Select the encounter
7. Click OK

Navigating the Cardiology Amb Workflow
1. Chief Complaint
   a. Type or dictate the patient’s chief complaint or reason for visit
2. Home Medications
   a. ✓ Mods History indicates that Home Medications were reviewed for this encounter. Review documented home medications.
   b. Add a new one by clicking the add button
3. Documents
   a. Click on the document once to open the preview pane
   b. Tag information from the previewed document
   c. Click open document to open the document in a separate screen
   d. Use filters to group
   e. Click the dropdown next to Display to change the types of documents that display

f. Check the box next to “Group by Encounter” to organize documents by the encounter under which it was created.

4. Diagnostics
   a. Click on the blue report link to view the report
   b. Tag information you wish to include in your note by highlighting the text and clicking Tag
   c. Click the diagnostics heading to see the Documents folder hierarchy
   d. Click the back arrow to return to the workflow

5. Labs
   a. Review the latest labs and filter (will include CCHS and non-CCHS lab results)
   b. Click on the row of a result to see a graph for trending
   c. Click on a single result to see a preview
   d. Tag and multi tag lab results to include in note
   e. Click the labs header to see the Flowsheet
   f. Click the back arrow to return to the workflow

6. Histories
   a. View the tabs: Procedure, Family, Social
   b. Add procedure by typing in the Add field
   c. Click on a documented procedure for a preview
   d. Click Histories heading.
   e. Click the Procedure Tab to review. Click Mark as Reviewed button.
   f. Click Family History tab to review, add or change family history. Then click Mark as Reviewed button.
   g. Click Social History tab to review, add or change social history. Then click Mark as Reviewed button.
   h. Click the back arrow to return to the workflow.

7. Allergies
   a. Add an allergy by typing the allergy name in the search field. Choose from the list of results. Select the category. Optionally you
can select the severity and reaction. Click Save.

b. Mark as Reviewed by clicking the Allergies heading and clicking the Mark as Reviewed button.

c. Click the back arrow to return to the workflow.

8. Subjective/History of Present Illness
   a. Dictate, type, or use auto text to add the HPI

9. Review of Systems
   a. Dictate, type, or use auto text to add the review of systems
   b. Use auto-text “ros_subj” to pull in Subjective items documented during intake.

10. Vital Signs
    a. Review the most recent vitals
    b. Click on the row of a result to see a graph for trending
    c. Use filters to see more or less results
    d. Click the blue dropdown arrow to access form to add additional vitals Vital Signs

11. Objective/Physical Exam
    a. Dictate, type, or use auto text to add the PE

12. Warfarin Management Trending
    a. View INR goals, values and trends

13. Consolidated Problems
    a. If appropriate, convert chronic problems to this visit by clicking “This Visit” button

This Visit
    b. Add new problems by typing in the quick search field
    c. Ensure the This Visit problem (diagnosis) is specified (this icon displays in the preview after clicking once on the problem name). If a problem is unspecified, click the icon to further specify the diagnosis.
    d. Assign priority by clicking on the dropdown next to the problem and selecting the correct number.

14. Assessment and Plan
   a. Dictate, type, or use auto text assessment and plan under each individual “This Visit” problem (diagnosis)

15. Patient Education
   a. Based on the diagnosis, a list of suggested patient education will default.
   b. To add the education, click on the name once. It will be added to the “Added Education” field.
   c. You can also save education as Favorites. Click on the star next to the title and select Personal Favorites. The, you can click the Favorites button to see the list of those you have saved.

16. Scales and Assessment
    a. Results from assessment documentation displays.
    b. To add new results for ICD Office Documentation, Implanted Loop Office Documentation, or Pacer Documentation, click the blue dropdown and complete the form.

17. Reminders/Notes
    a. Reminders added by office staff will display.
    b. Add a new reminder by clicking the blue plus sign.
    c. Complete a reminder by clicking on it and selecting Complete.

18. Health Maintenance
    Displays the Pending Health requirements for this patient.
    a. Single click on the measure to see the preview.
    b. Click the Actions button to select the appropriate document.
    c. After documenting the measure, click the green check mark to sign.

Quick Orders
1. Click on the QO-Cardiology tab.
2. Click on the items you want to order.
3. Click on the Orders for Signature icon

4. Associate the diagnosis with the order by clicking in the boxes

5. On the Orders for Signature screen, click on any order that has a blue circle with a white X which indicates it is missing required details. Complete any missing details.

6. Click Sign.
7. Repeat steps for any additional orders added.

Medication Reconciliation
1. Return to Cardiology Amb Workflow and click the Home Medications component.
2. Click Outpatient.
3. On the Order Reconciliation: Outpatient window, the left side shows any home meds and meds administered during the visit. The right side will display any meds you add to be taken after discharge.
4. If you want the patient to stop taking a medication, click the circle under the column with the red square, next to the medication.
5. If you want to refill a medication, click the circle under the column with the pill bottle, next to the medication.
6. If you want to prescribe a new medication, click the Add button. Select from the list or search for the medication.
7. After adding it, associate the correct diagnosis.
8. Select the Routing for the prescription by clicking the dropdown next to Send To:. The patient’s preferred pharmacy should be listed. You could also select to print the prescription.
9. Click the Acknowledge Remaining Home Meds button.
10. Click Reconcile and Sign to finish.