IntraHealth Profile EMR Introduction Instruction Sheets

EMR Introduction Instruction Sheets for new users.

Startup FAQs

i. How do I log on?
   1. In the office
   2. Remotely

ii. How do I access my schedule?

iii. How do I get to my patient's chart?

iv. How do I document a transaction:
   1. SOAP note,
   2. Order investigations,
   3. Labs,
   4. Forms
   5. Referral letters
   6. Prescriptions
   7. Billing/coding

v. How do I access my inbox (assigned transactions/tasks)?

vi. How do I access historical information?

Disclaimer: This is an independent quick reference guide on getting started with IntraHealth that has been created by physicians, for physicians, and was not authored by your EMR vendor or issued as part of their official documentation. Your EMR vendor support desk should be the first point of contact if you have questions or need additional workflow guidance with your EMR software, and can also provide you with any official training materials or help files for your system on request.

Should you have any feedback or suggestions for improvement on this quick reference guide, please send to RandRCommittee@doctorsofbc.ca.

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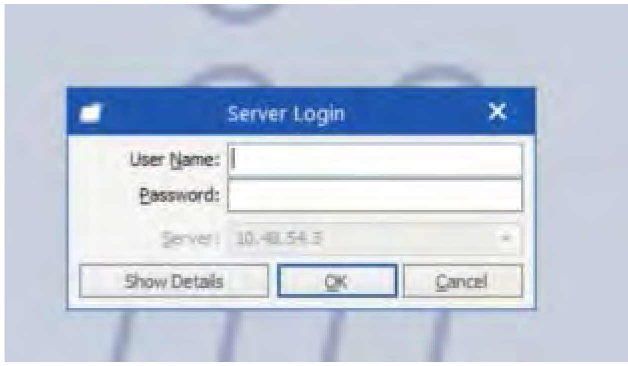
How do I log on?

1. In the office

i. Double on Profile icon on the desktop

ii. The EMR login window will open



iii. Type in the User Name and Password given to you by the office administrator. Login.

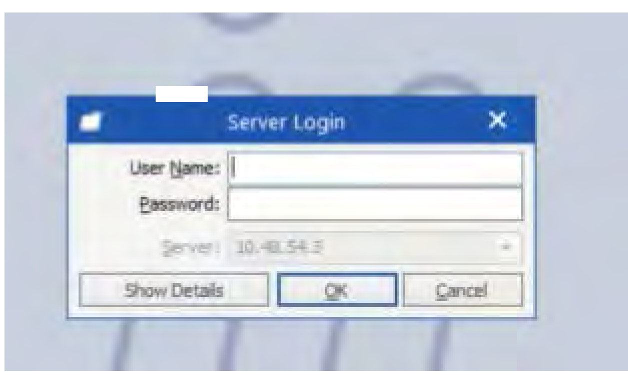
2. Remote Log in

i. If unsure of your personal computer's installed software for remote access, contact IntraHealth Help desk @ 1-800-708-6442 to check and ask for help to install the appropriate remote access software.

ii. The following is one possible method using Pulse Secure VPN software

iii. Go to menu bar (on mac) and click on 'Pulse Secure' icon, then on VPN link (vpn1ppn.bc.ca in this example) and click connect

iv. The EMR login window will open



v. Type in the User Name and Password given to you by the office administrator. Login.

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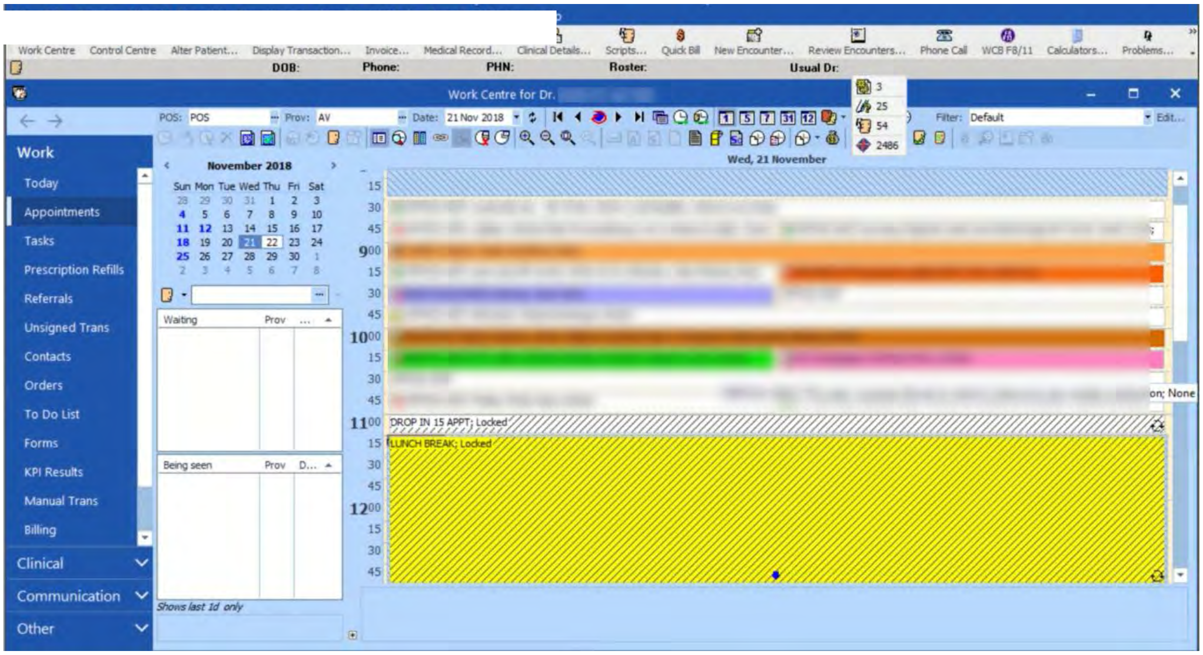
How do I access my schedule?

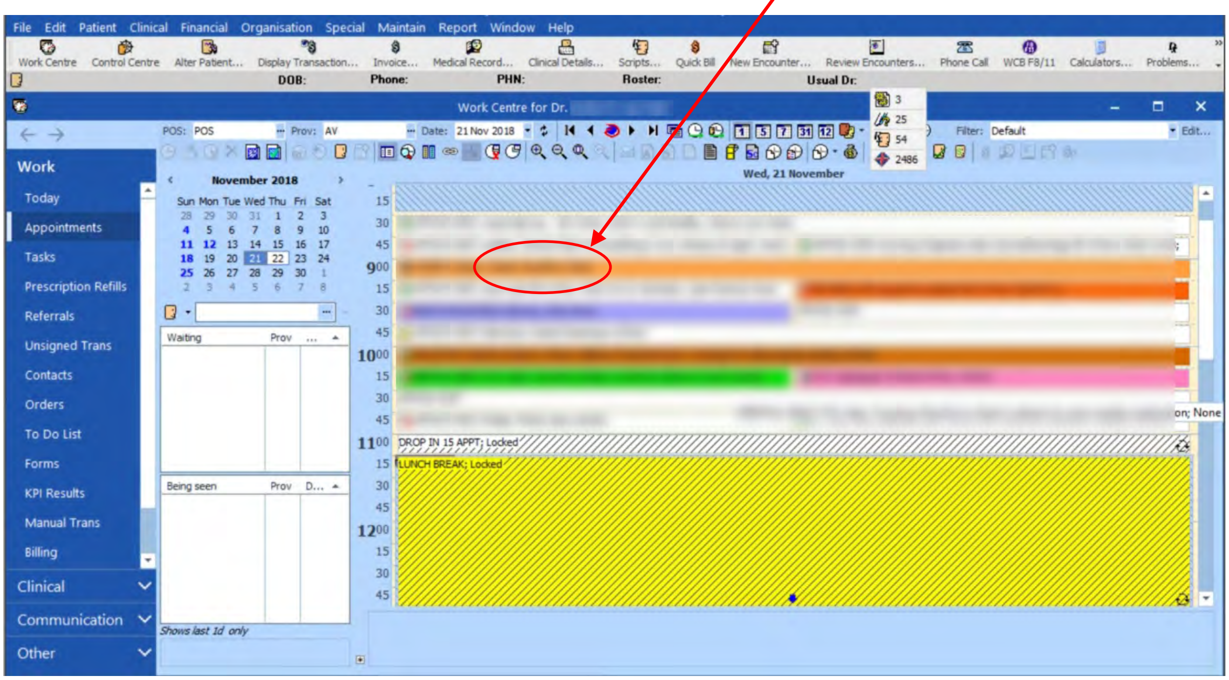
i. When you log in, you will go to an initial screen that will be set up differently in each clinic, but which will have a schedule in the window.

ii. Other information may be accessed in this window, including Tasks from the toolbar on the left. This window is user configurable to show various types of displays for different clinical or admin roles.



How do I get to my patient's chart?

i. From your schedule, double click on the patient name of the chart that you want to access.



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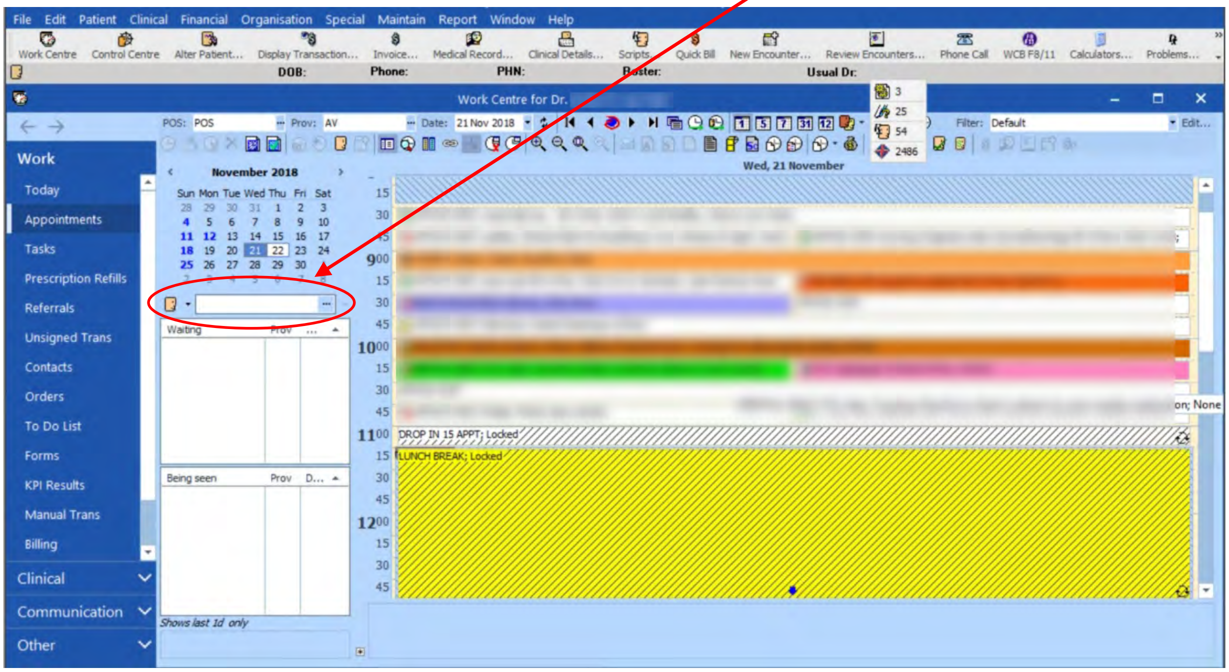
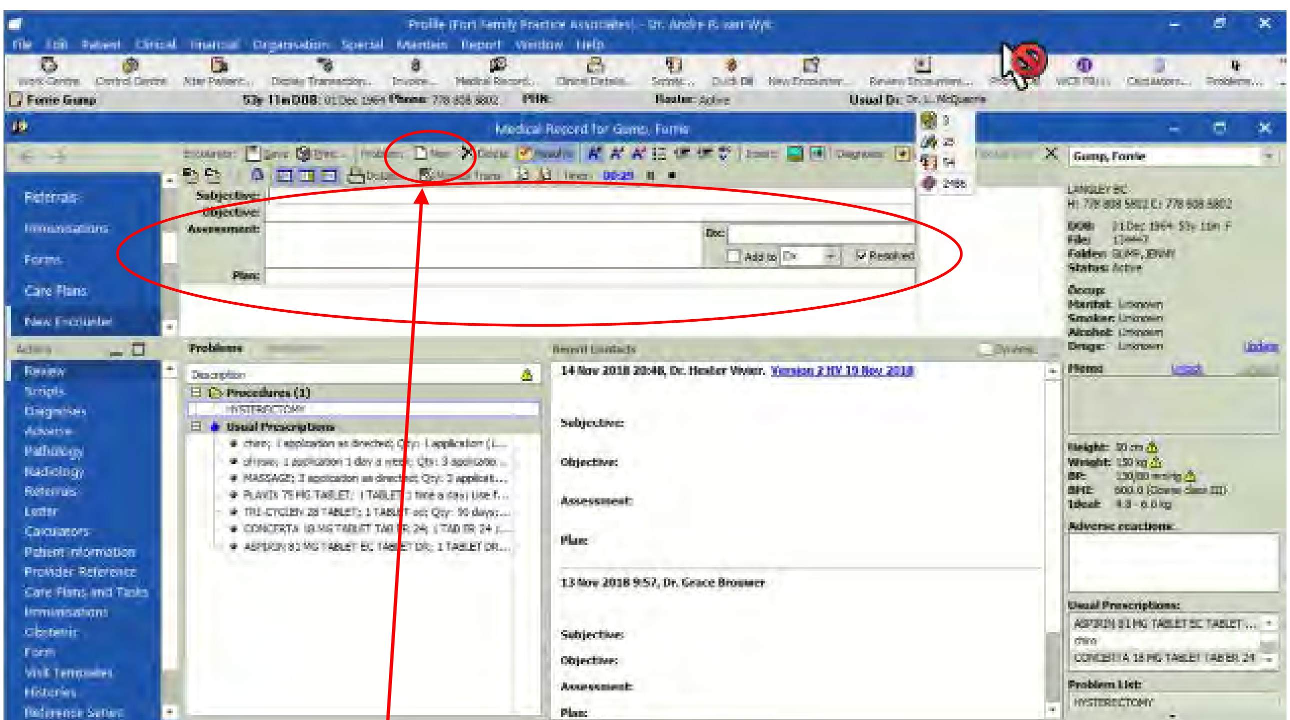
ii. To access a file not in schedule, type name into small box just under calendar on right then click medical record and patient file will open



iii. Once the chart is opened, the default view is the default visit template window (which may be a SOAP note or another template). This can be personalized depending on your preferences, ask the clinic administrator.



iv. Clicking "New" opens up a new problem field with new diagnosis box

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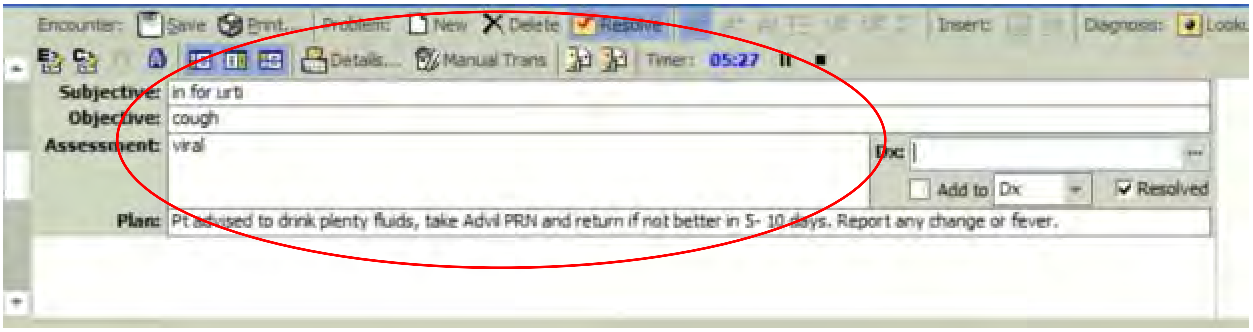
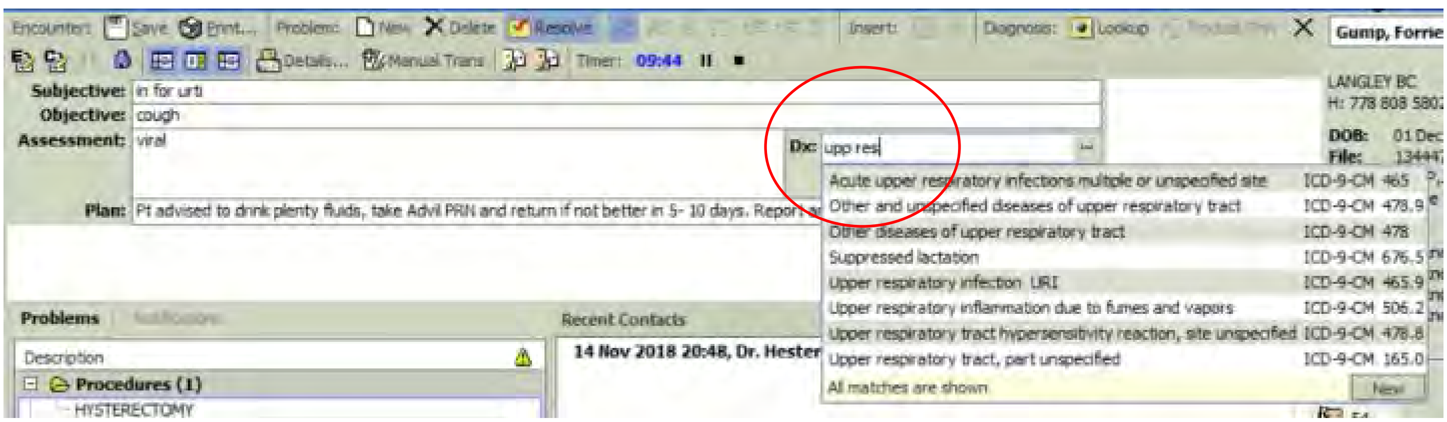
How do I document a transaction:

i. SOAP note

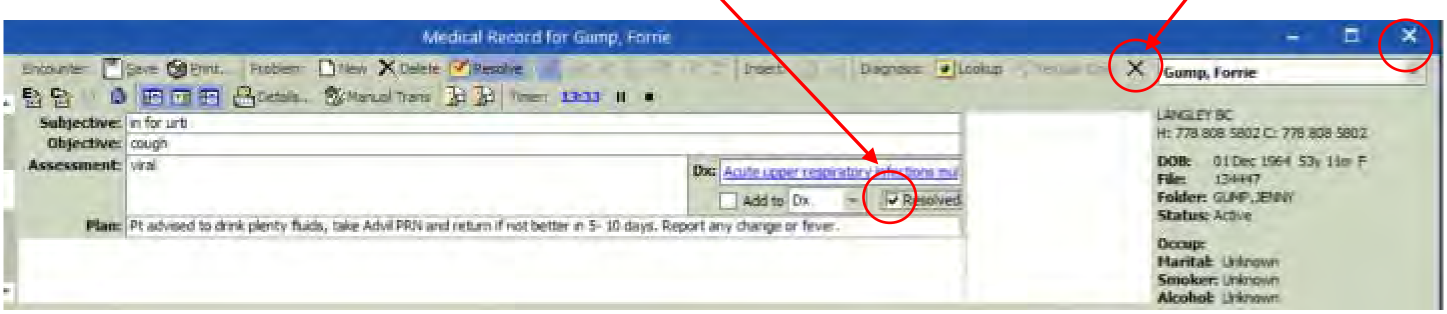
i. Start dictating or typing in the SOAP note box.



ii. In the ‘Dx’ field, enter either the diagnosis partial or complete text or ICD9 code. This will populate the appropriate diagnosis in the billing to MSP.



iii. Once the notes are typed in, complete and close the visit by clicking on the ‘X’ to either close encounter or close record in the upper left corner of the window. The visit will be complete if the ‘resolved’ field is checked. It is incomplete and available to edit if this box is left unchecked.



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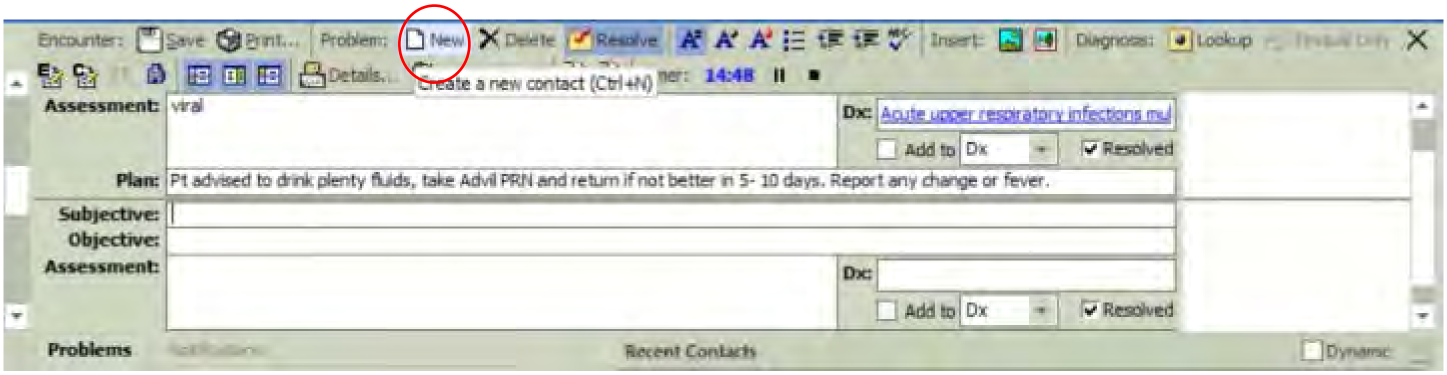
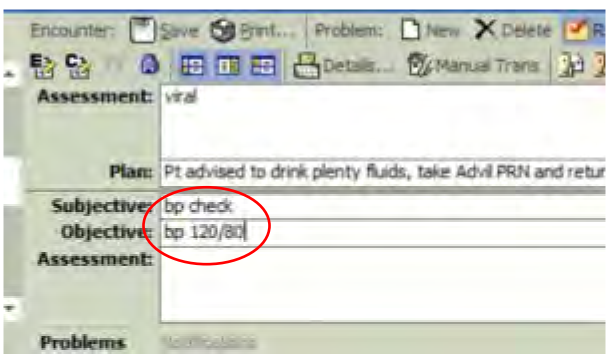
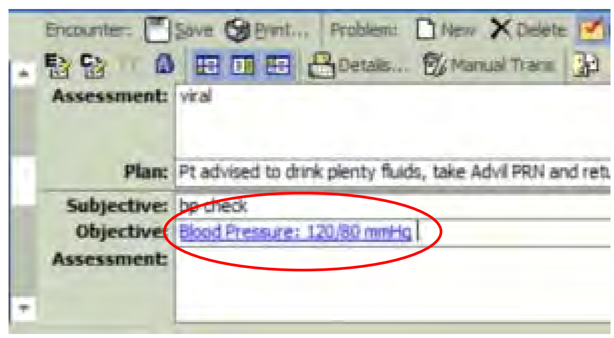
iv. If you want to capture a second problem, click on the ‘New’ button above the SOAP note and a new set of SOAP fields opens below the original SOAP note

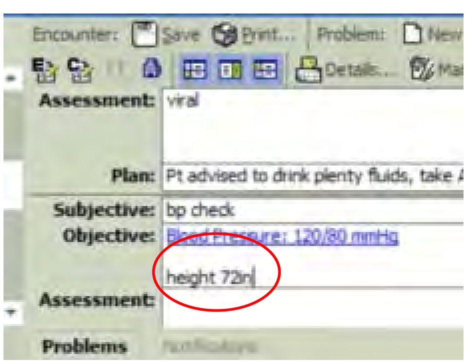


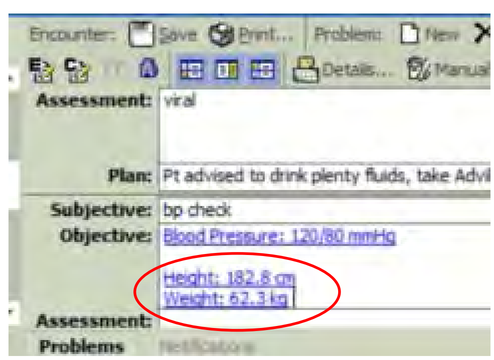
v. If you want to capture discrete information, e.g. BP, type in ‘bp 120/80’ and push space bar





vi. If you want to convert from inches to cm when recording height (same if wanting to convert pounds to kg, except type in ‘wt’). Type in ‘ht space 72in’ and push the space bar





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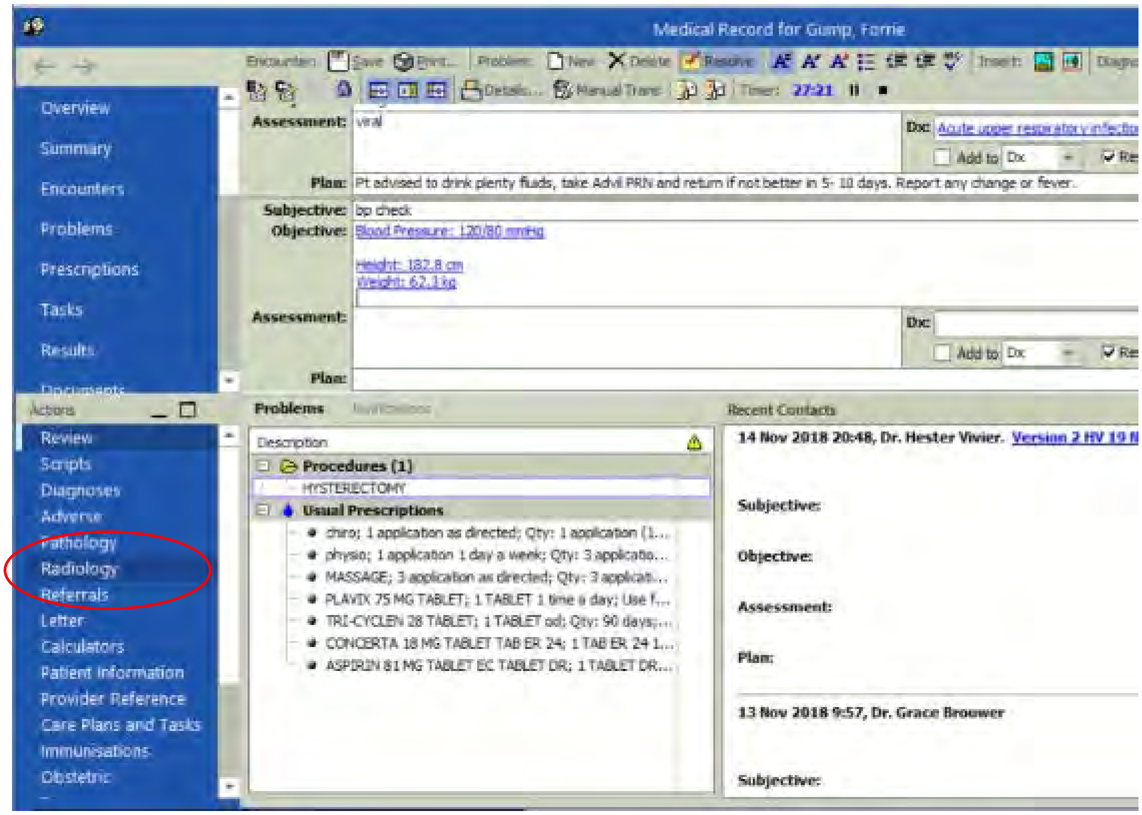
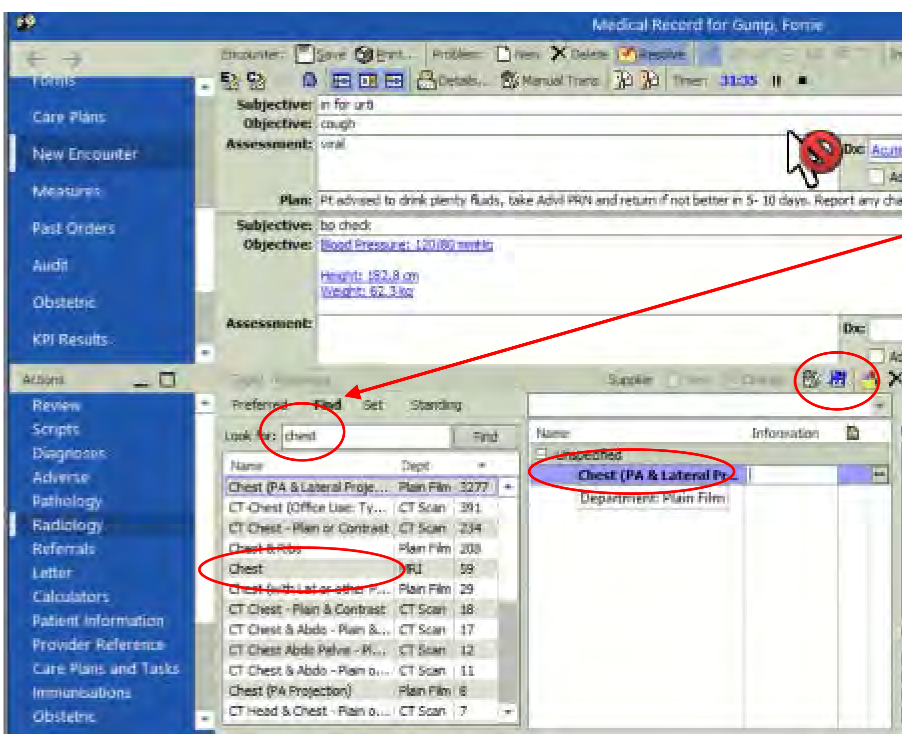
ii. Order Diagnostic Imaging

i. When ordering Imaging during a patient visit, click on the ‘Radiology’ label in the ‘action’ column to the left and below the SOAP note window.



ii. This will open the available imaging.



In the ‘Look for:’ field, type in the type of requisition and body area you want and select from the list that appears beneath the window.

Not all types of imaging requisitions or body areas are in the list. Ad hoc items (like ‘x-ray left 5th finger) can be added by clicking on the blue icon on the same line as the ‘Supplier’ tab.

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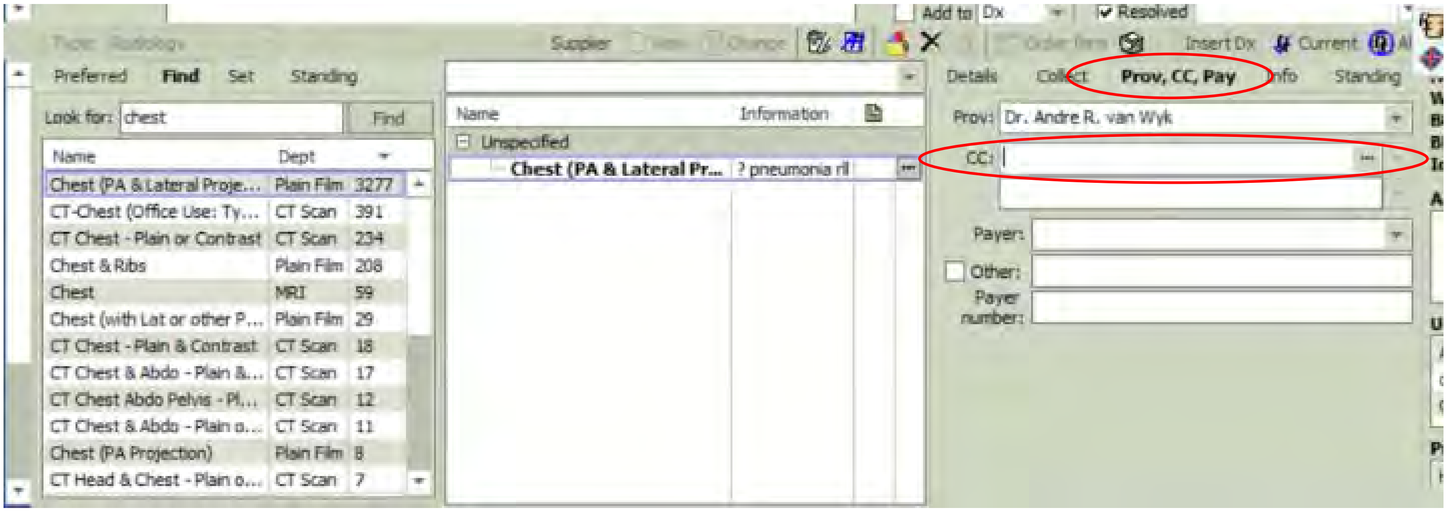
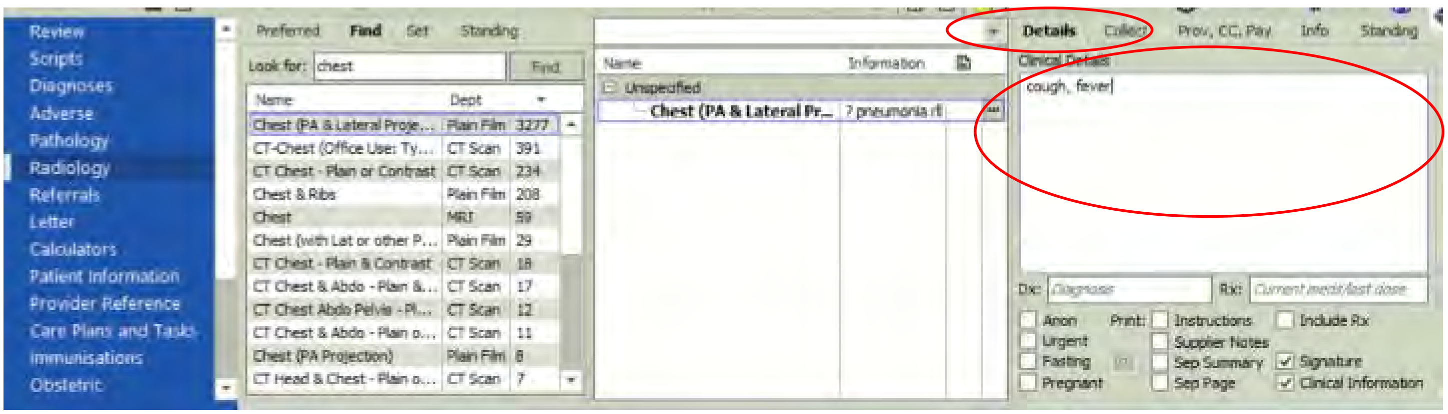
iii. To add a 'cc' to another physician, click on Prov, CC, pay tab and type name and search in the 'cc:' field

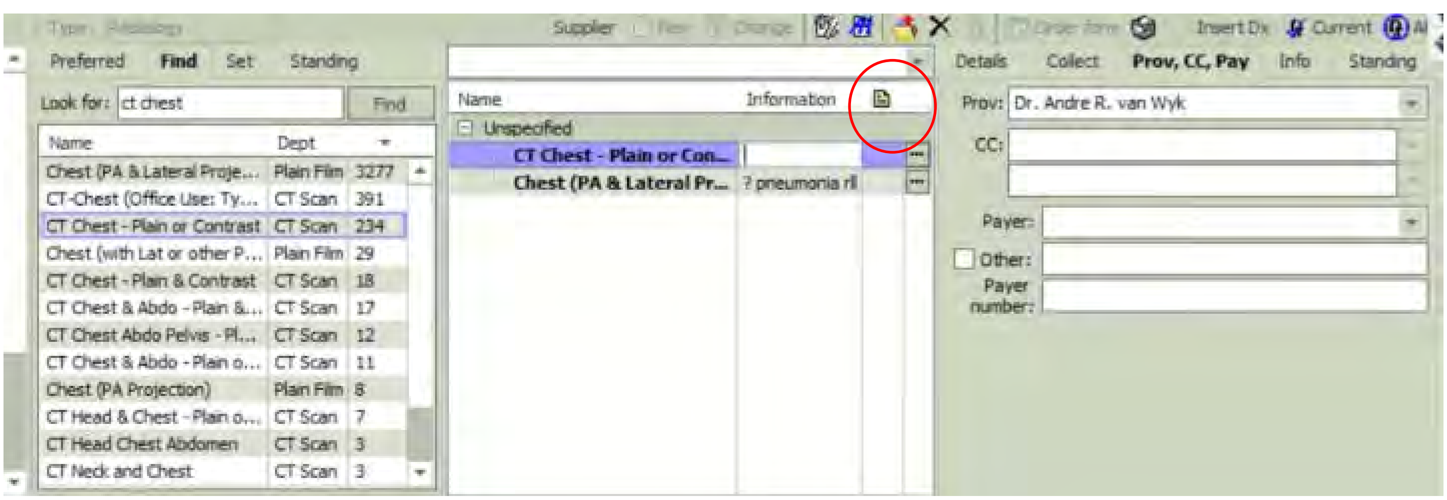


iv. To add in clinical information, click on 'Details' tab and type or cut and paste from clinical notes



v. You can either print the requisition by clicking on the print icon, or when you close the patient's chart you will be prompted to print any outstanding unprinted documents.

vi. If two items are to be printed, click on the small page icon to separate the requisitions into two pages.



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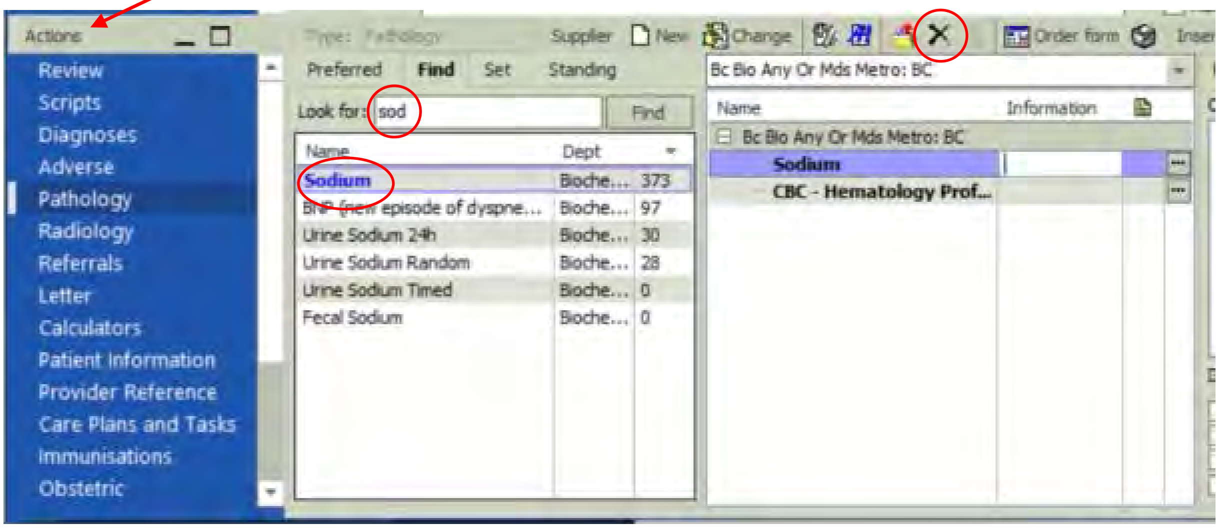
iii. Labs

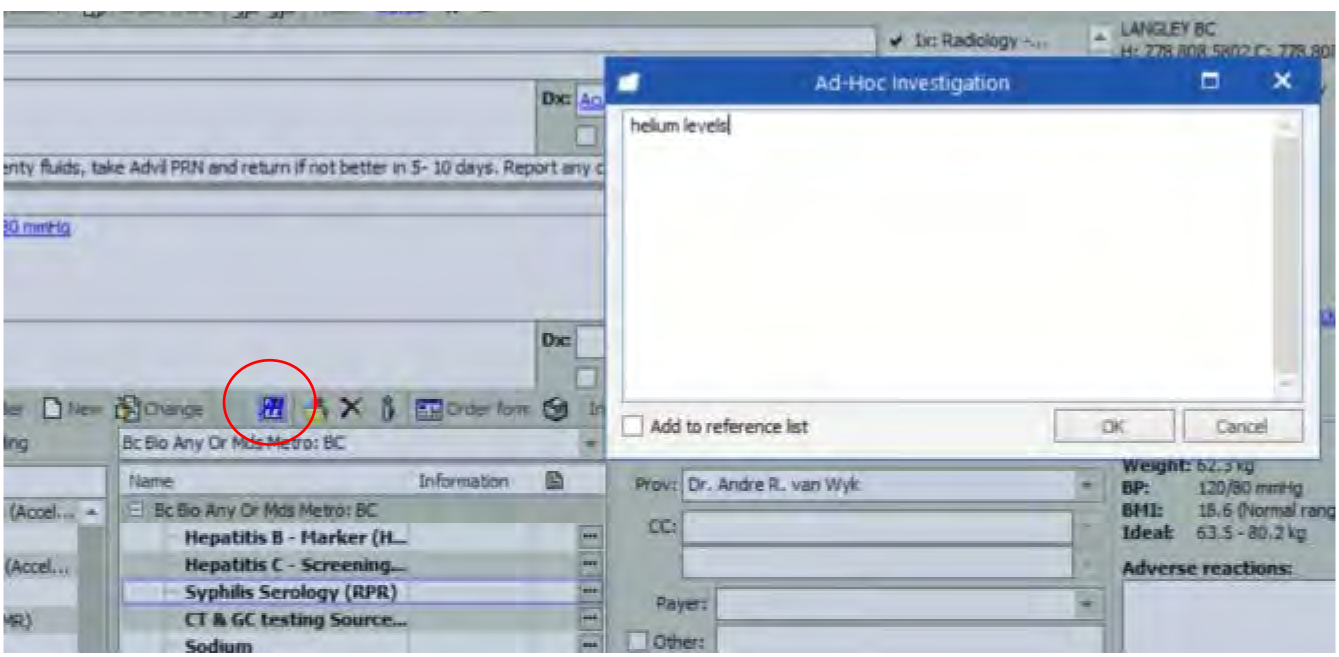
i. When ordering labs during a patient visit, click on the 'Pathology' label to the left and below the SOAP note in the 'Actions' area.

ii. Use the 'Look for:' field to type in the individual labs (e.g. CBC) that you want and double click on the item in the list to have it populate the field to the right. You can add other items (e.g. sodium) and double click or drag it into the order field.

iii. Items in the order field can be removed by highlighting and clicking on the 'x' icon.



iv. To add 'ad hoc' items that may not be listed, click the blue 'ad hoc' icon and type in the item you want to order



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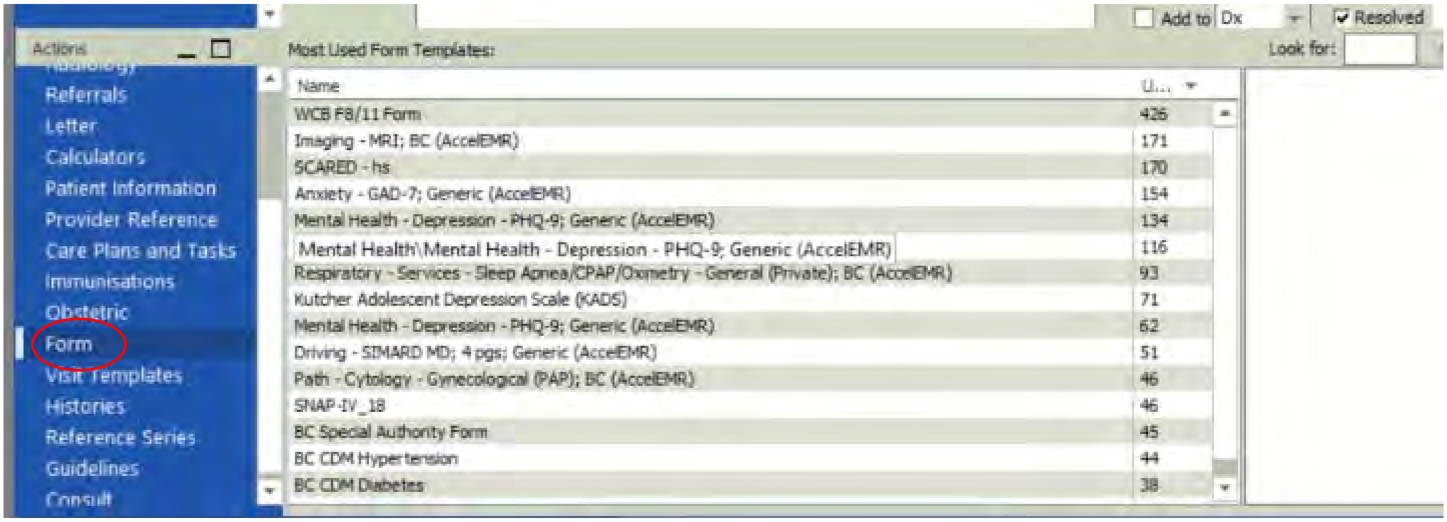
iv. Forms

i. When ordering labs during a patient visit, click on the 'Form' label to the left and below the SOAP note in the 'Actions' area.



ii. Different clinics and users have different forms available from the dropdown list. These forms that display are previous forms used for that patient only. Click on the 'New' icon to get a list of forms available for the clinic.

v. Referral letters

i. When writing a consult request during a patient visit, click on the 'Referrals' label in the Actions box column, scroll and find the common specialists that have been frequently used and double click on the name or click 'New Referral' (make sure that the 'Outward' button is selected.

ii. Some EMRs may be configured such that when you click on the 'Referral' label, it opens the default consult template.

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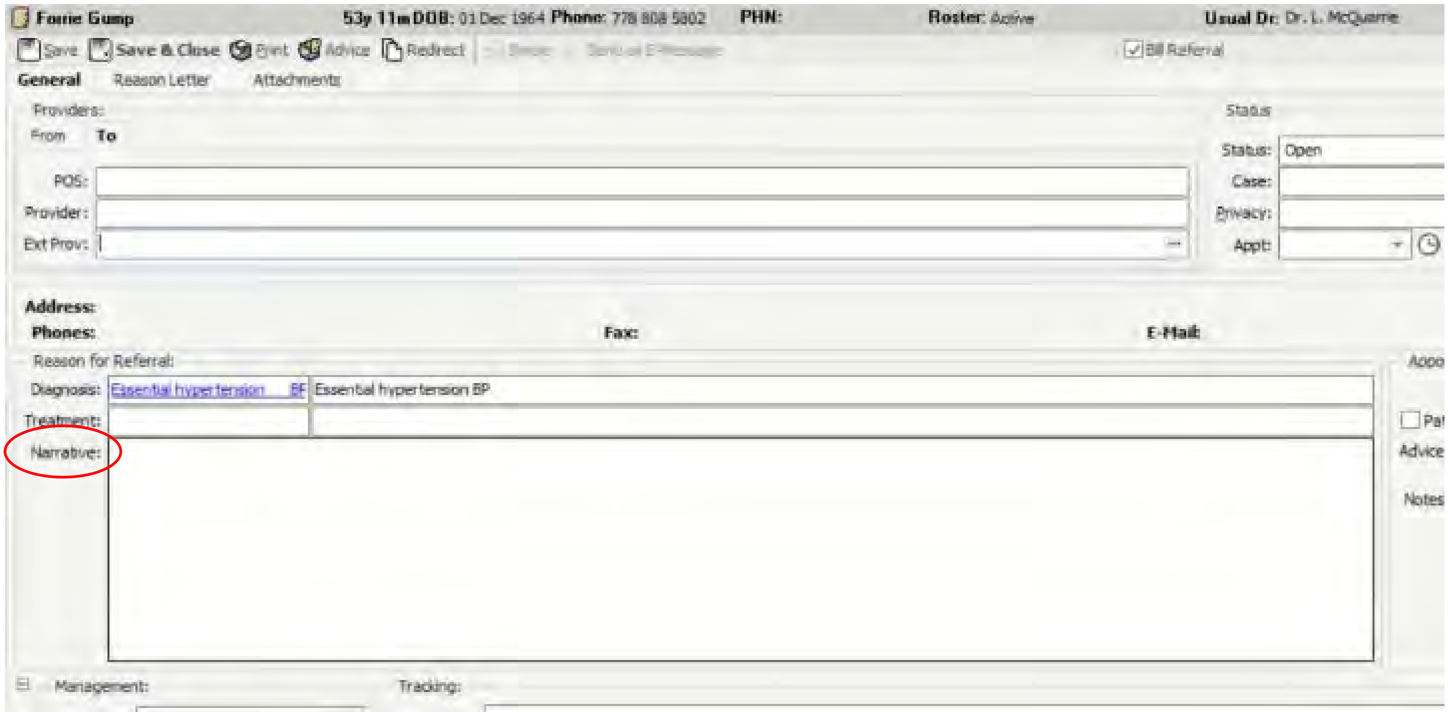
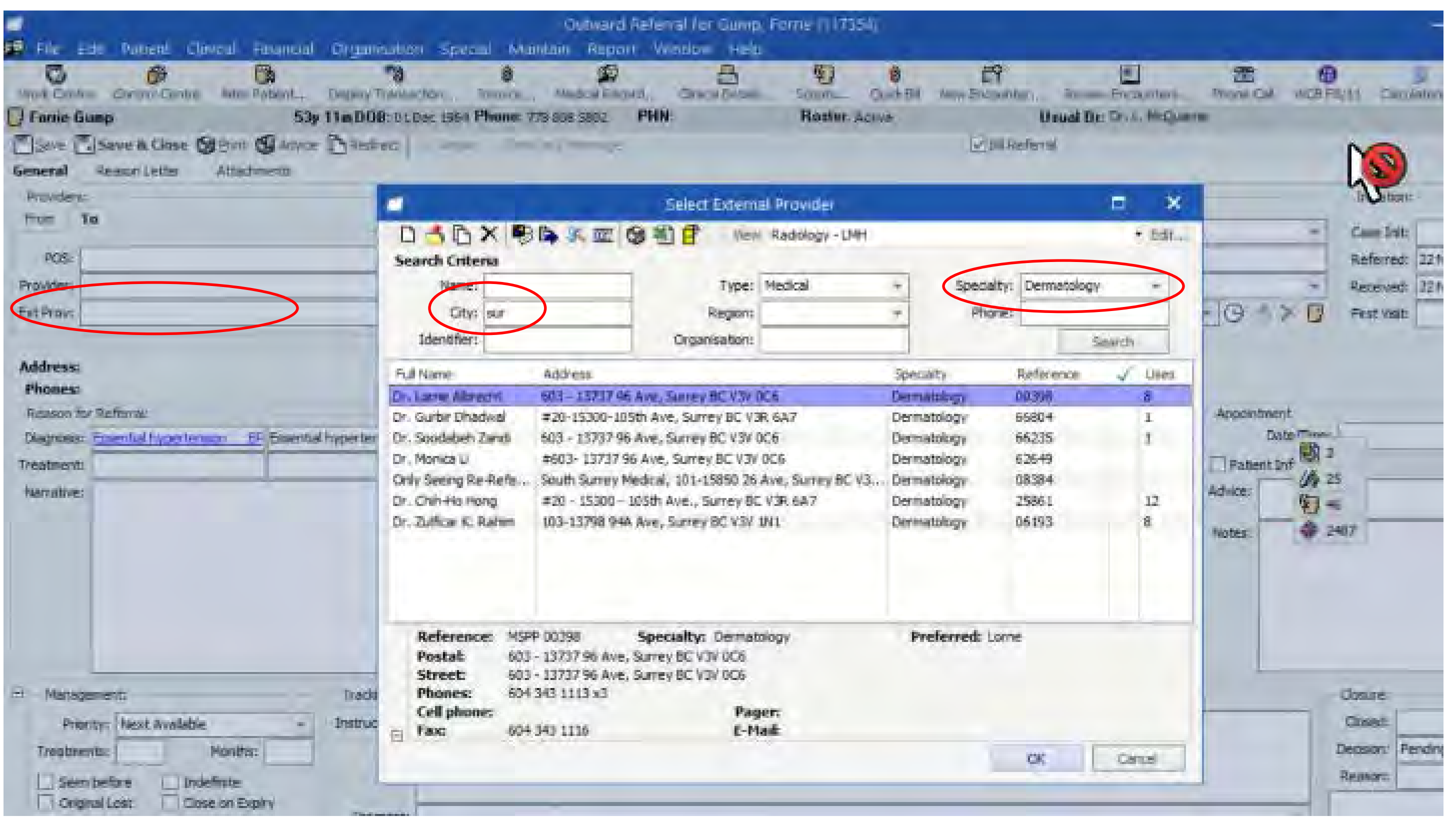
iii. This will open the default consult template. The body of the letter can be typed or dictated in the 'Narrative' text box field. Office notes, lab reports, and x-ray results can be added into this field from the menu line above the text of the letter.



iv. To see a list of physicians, from which you can select the physician you want to send the consult to. Click the mouse in the 'Ext Prov:' text box and click the space bar. There are many ways to find a specialist, either by typing the first few letters of a name, or selecting the specialty type from the 'Specialty:' field and type the first few letters of the city in the 'City:' field



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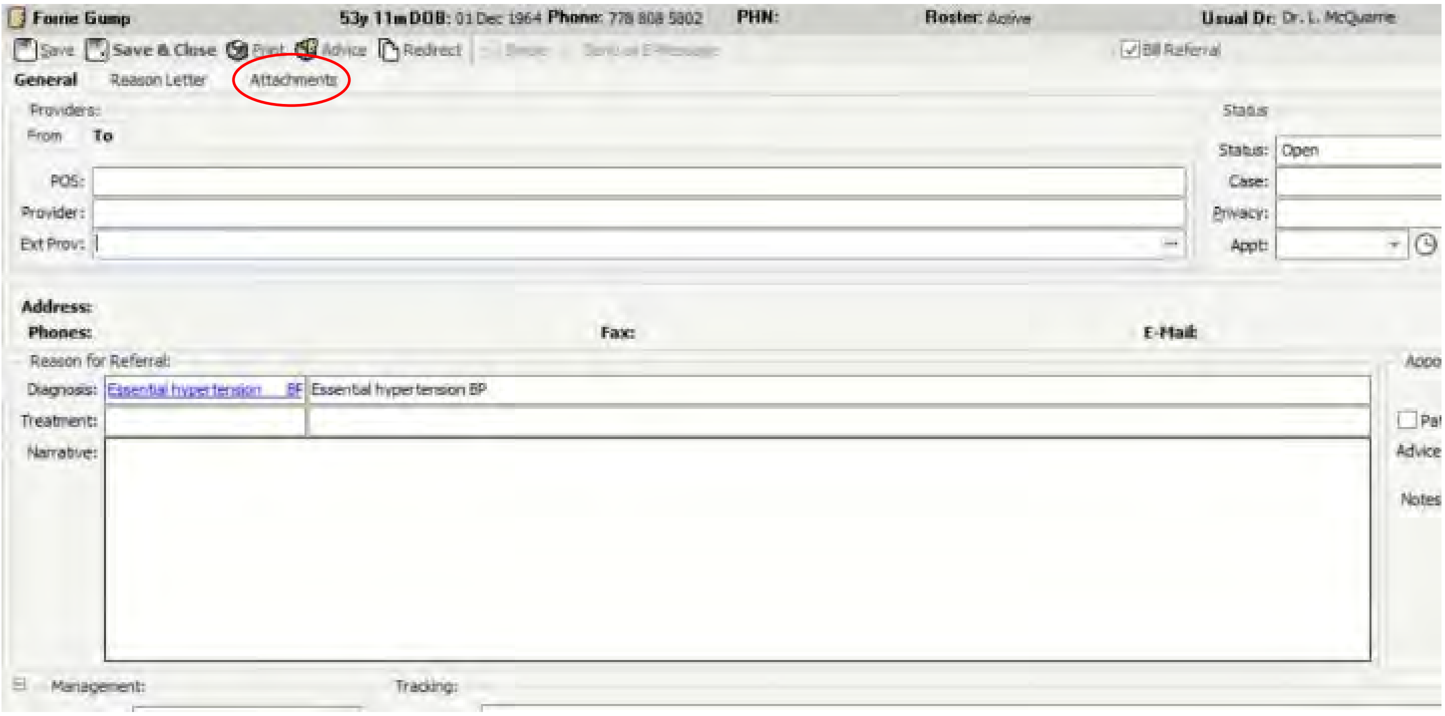
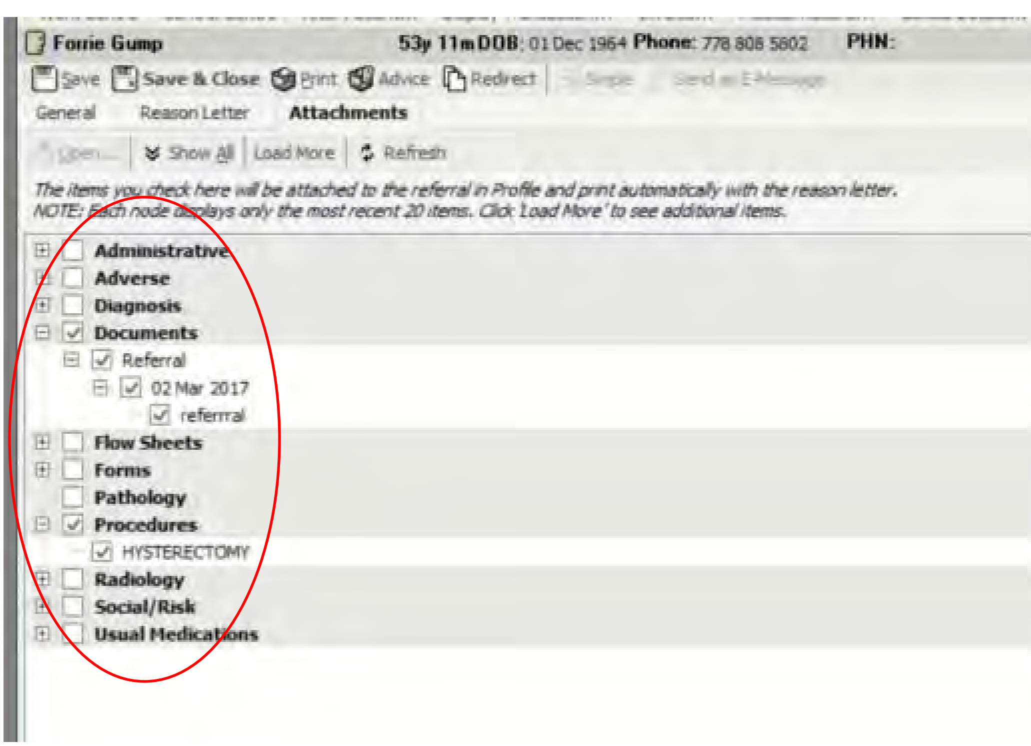
v. To add attachments to the consult referral letter, click on the ‘Attachments’ tab



vi. Check the attachments you want included in the consult letter. The small + boxes expand the different attachment categories so that specific items from that category can be added



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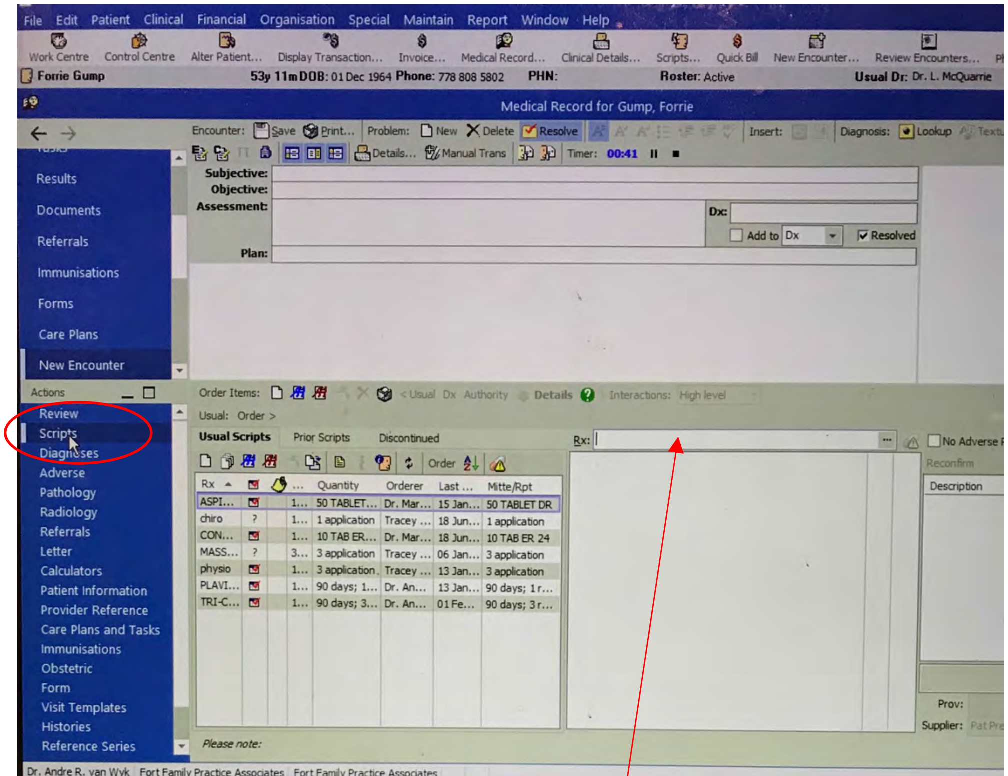
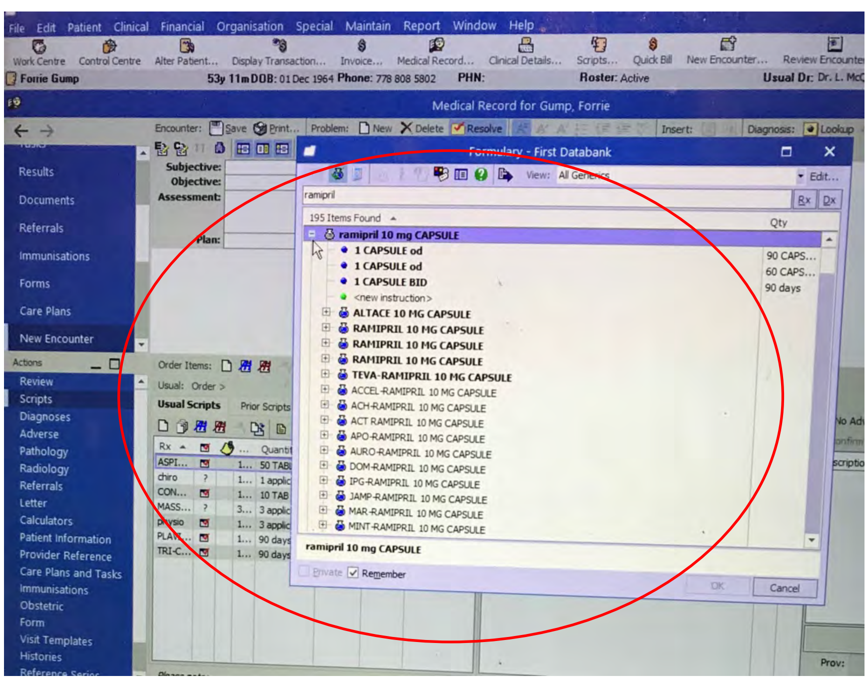
vi. Prescriptions

i. When writing a prescription during a patient visit, click "Scripts"



ii. This will open the prescription writing window.

iii. Type in the first few characters of the medication name and click enter to show a list of medications to choose from.



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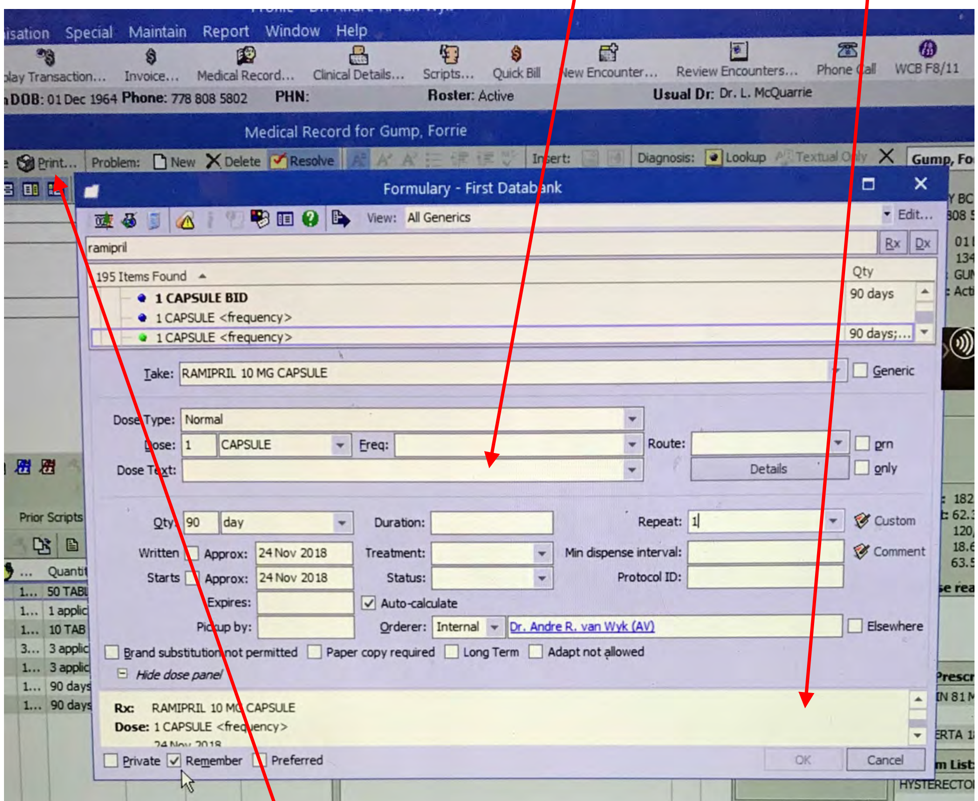
iv. Select the medication that you want and then fill in the rest of the prescription template with the appropriate instructions. Note, the “OK” button will be grey unless all the conditions for a legal script are met. (Drug, Dose, Instructions, Duration etc.)



v. To print, click on “Print” icon. The EMR should also prompt for printing when you close an encounter.

vi. Note the prescription warning window should appear when prescribing interacting or allergic medications. The prescriber may manually over-ride the warning in order to print the prescription.

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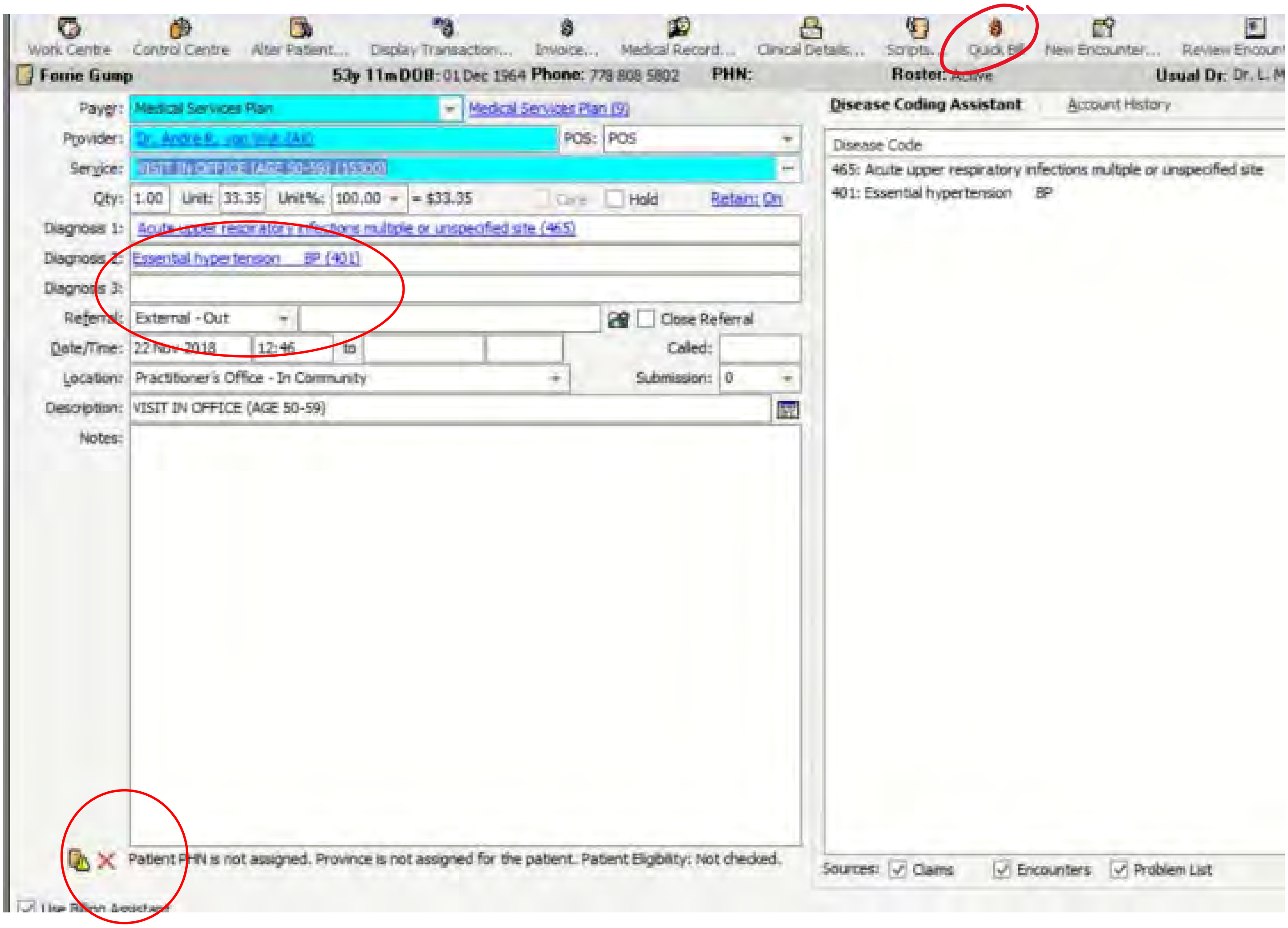
vii. Billing/coding

i. Any one office may do its billing differently. Discuss the office's billing process with the office staff. The following method uses the "Quick Bill" method by the physician.

ii. Entering a billing and diagnostic code can be done from within patient visit by clicking on the "Quick Bill" icon below.



iii. Enter the service provided and the relevant diagnosis. The EMR should auto-populate these fields if your encounter was completed.

iv. In the bottom of the billing window, a billing integrity review is displayed. A green check indicates no issues found.

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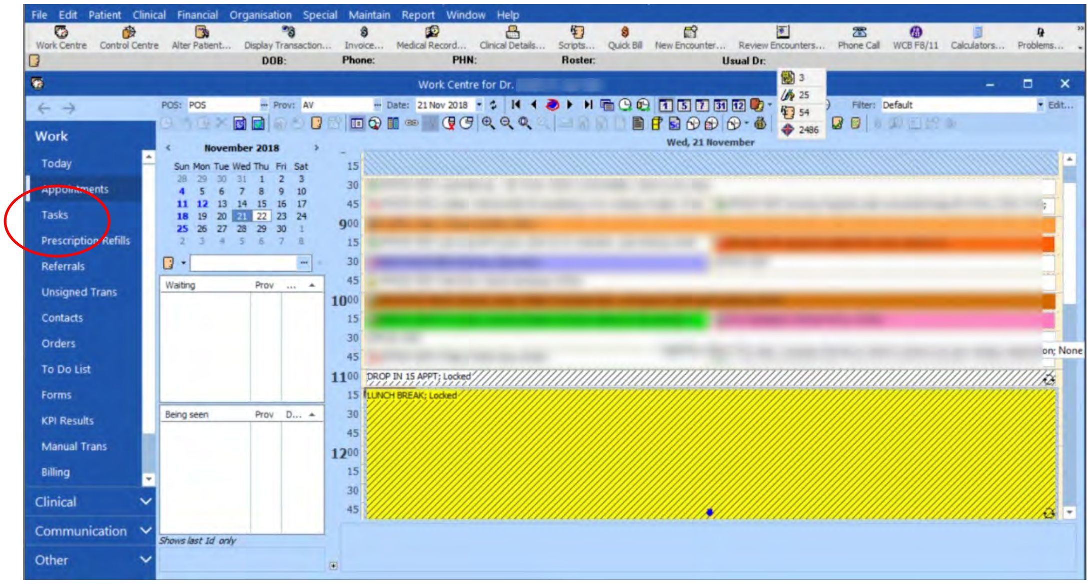
How do I access my inbox (assigned transactions/tasks)?

A. To show all tasks for all your patients or for generic messages

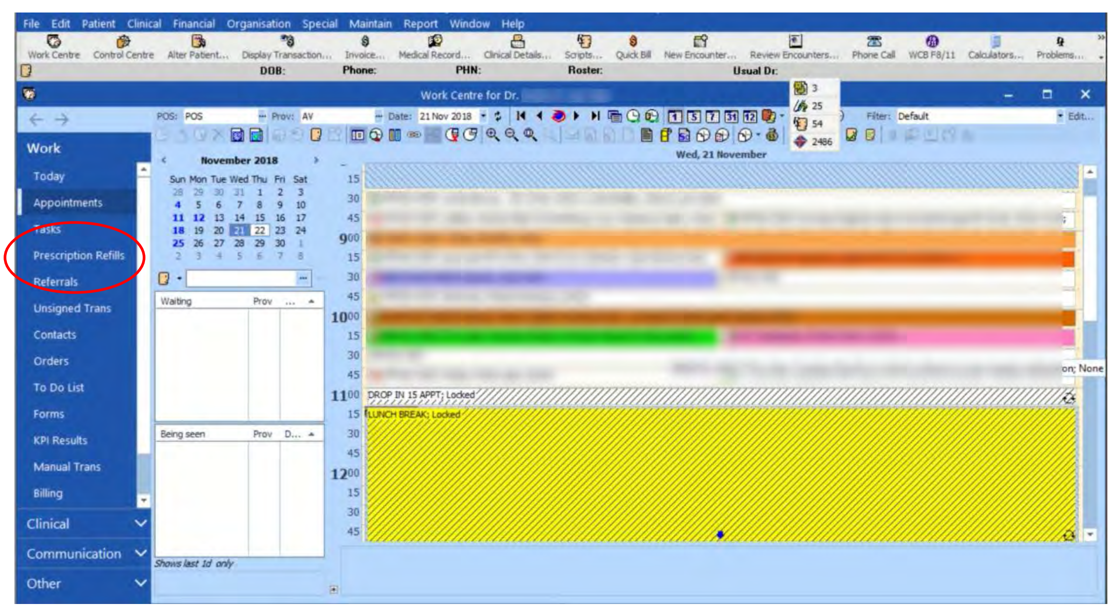
i. Access tasks from the opening screen after log on by clicking on 'Tasks' label in the left column.

1. From this task screen can also create new tasks for your self or for others—is a new task button on menu bar.



ii. Unsigned Transactions to review (suggest you add this as not in current cheat sheet)

1. On the initial screen after login there is a list of available boxes listed on left hand of screen
2. "Unsigned Transactions" will display a list of all the labs, X-rays, reports, etc. for all patients that have not been reviewed and signed off.
3. Can review these and sign them off (by clicking "Sign" button then they disappear from this box to patient chart
4. If you want to action something based on the result press "Annotate" button to create a task that will be associated with this result. Can direct task to yourself or MOA (like call patient back to discuss result). Need to put name of person task is directed to in task box.



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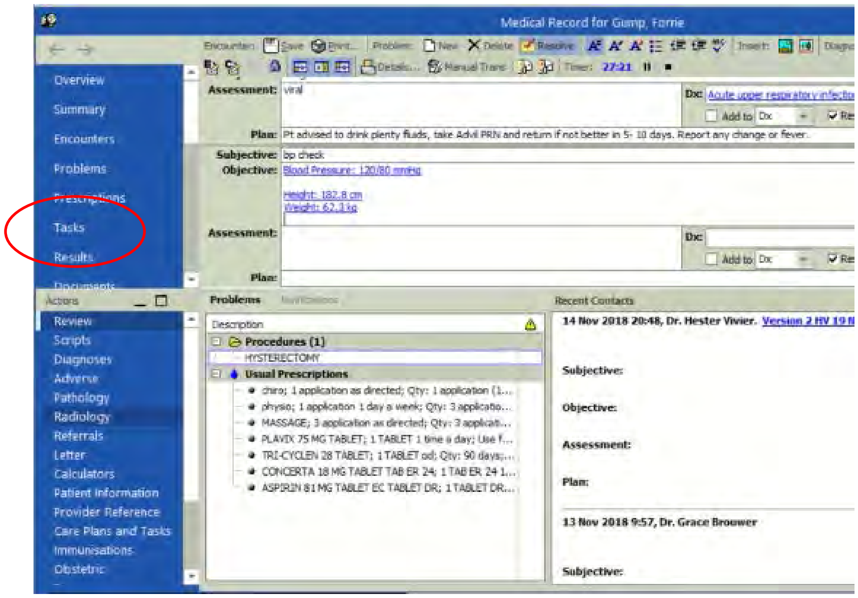
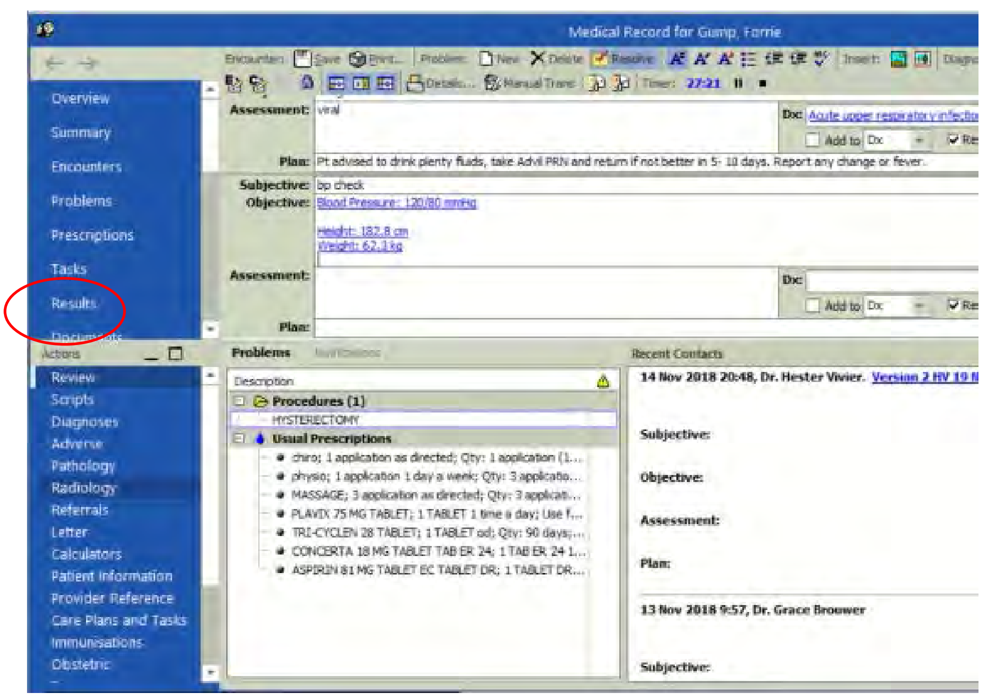
B. To show tasks for an individual patient from within the chart:

i. From the schedule window, click on the “Tasks” area on the left upper pane.



ii. The new window that opens has a list of all unfinished tasks and tasks from MOAs (e.g. phone messages, etc.) This are can include task assigned to you by any team member including yourself.

iii. Click on any description to open the task on that line. The task can be completed from the within the window that opens.



iv. For unsigned results click on “Results “

v. The new window that opens has a list of all unsigned labs, electronic documents (e.g. referral consult responses, etc.), scanned results attached to a message task (e.g. investigation results)

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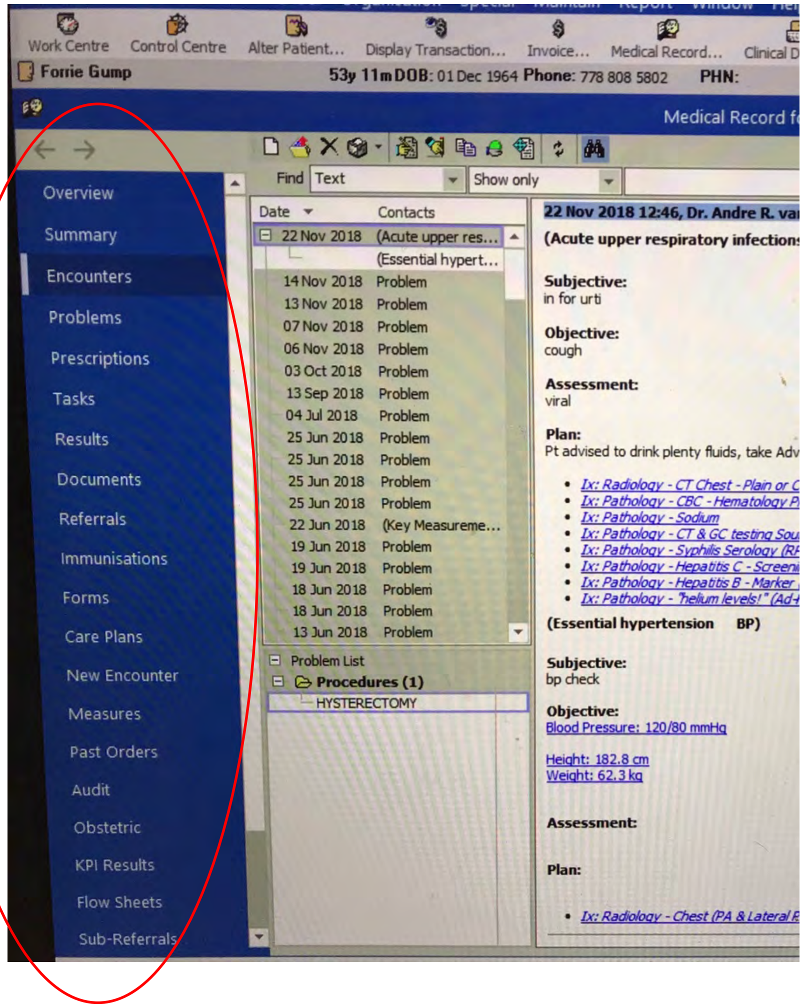
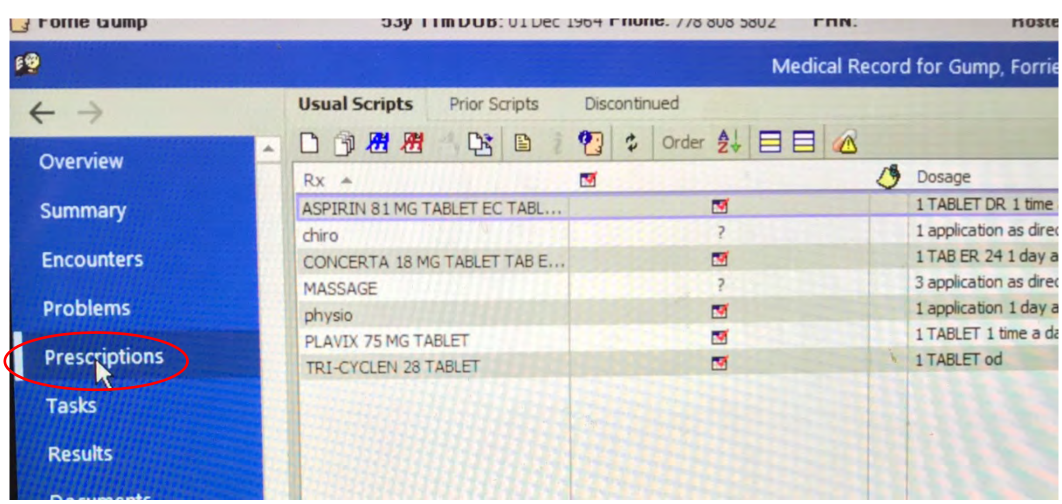
How do I access historical information?



To access historical items from the patient's chart, click on the appropriate tab e.g. Encounters (visits), Tasks, Billing, Prescription (Meds), Pathology (Labs), Referrals (Consults) Immunizations, .



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vi. This opens the historical items in this category. Any one-line item can be opened by double clicking on the observation or using the edit button.