

Charting FAQs

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How do I print survey after it has been completed?

Once a survey has been completed for a patient, the best way to print it is from the Event Chronology.

How do I create an Asthma Action Plan when in a note?

If you routinely do an Asthma Action Plan at your asthma maintenance visits, you can add it as a standing order to your template for the doctor to complete. To add a standing order to your templates, navigate to **Clinical tab > Encounter Templates**.

1. Select the template you would like to add the task for the asthma action plan.
2. Double click on the template or highlight and select **Edit**.
3. Click on the **Orders/Workflow** Tab.
4. Select the **Other Tasks** tab, and click "+" to create new Task.
5. In the Task Description field, enter a description. **Example:** Update Asthma Action Plan.
6. In Task Type field, select **Asthma Plan** from the drop-down.
7. Click the drop-down in the Department field, and select the **department** responsible for completing the Asthma Action Plan.
8. In the Usage field, click the drop-down and select **Standing**.

When the template is applied to the visit, the task for the Asthma Action Plan will be automatically created. Clicking on the task will open the Asthma Action Plan. This order will show in the Summary of your note, so it will be clear that it was completed during the visit.

Do nurses need to enter rendering provider on visit info tab for every visit?

Nurses/MA's do not need to choose a rendering provider for each visit. When the provider logs into the note that was started by the nurse for the first time, OP will automatically enter them as the rendering provider. If the provider who logs in is not the provider whose schedule the appointment has been made, they will get the pop up asking them to claim the appointment.

Why do I have two notes opened?

There could be two reasons as to why there are two notes opened.

Reason 1:

- A staff member already right clicked to open an encounter, and another staff member right clicked to open a well visit. The incorrect note will need to be deleted.

Reason 2:

- If a staff member was trying to add a sick encounter onto a well visit there are actually two notes that exist: one that is in relation to the well visit, and one that is in relation to the sick encounter.

How do I delete well note?

To delete a well visit note, follow the steps below:

1. Go to the patient chart and open the existing well visit note.
2. Click on the red minus sign at the top of the screen to delete the note.
3. Click Ok in the popup.
4. Type the reason you are deleting the note and click Ok.

How can I view the last sick visit while I am writing my well visit note?

You can utilize Medical Record to view a prior note while documenting a well visit. You can open Medical Records in the background, or select the **Personalize** tab and select **Use tabbed interface** to navigate between the windows.

How do I document on school form that patient has sports restrictions?

You can enter notes to appear on the school form in 2 places:

- Patient Chart > Overview Tab > Health Summary Recommendations field (lower right hand corner)
- Well Visit > School Exam > Exam Note Field

If a survey is done at 6 and 9 months and answers are unchanged, can I make a note in the patient's chart rather than re-administering the survey?

This is up to the practice. If you use a note it will not appear in the survey section. You can also indicate this using the Risk Assessment.

How can I create pick list of diagnoses associated with template, so I can choose appropriate diagnosis when applying template?

When you add diagnoses to a template you have a checkbox to indicate if it is primary diagnosis. If there is more than one diagnosis marked as primary, you will get a popup box when the template is applied asking you to choose the primary diagnosis for this visit. For example, if you chose to include left otitis media, right otitis media, and bilateral otitis media as primary, when you apply the template those 3 diagnoses will appear and you will select one. Any additional diagnoses such as URI that you added to the template, but did not mark as primary will be added to your note automatically.

How can I find patient's future appointments when I am in note?

You are able to have the Search Appt window open independently of the Calendar, so you can keep that open behind your windows if you like and then bring it up when you are trying to see future appointments for a patient.

When appt type is set as new well or new sick, does CPT code automatically code new patient visit?

No, OP does not change the code **based on the appointment type**.

It is the responsibility of the provider to confirm that a patient really is a new patient based on CPT rules, which are not necessarily the same rules your practice might use to classify a patient as new vs. established. For example:

Appointment Type	CPT Rules
Your receptionist creates a new patient appointment because the patient moved away two years ago to Wisconsin, was seen by a Wisconsin doctor, and now has moved back to your community. The new patient appointment prompts your staff to get a new health history form and a release for interval records.	This is an established patient because three years have not elapsed since you saw them last.
Your receptionist creates a new patient appointment for a newborn weight check because the baby has never before been seen in your office.	This is an established patient if your practice provided newborn nursery services.
Your receptionist creates an established patient appointment for a child's first visit face-to-face with a provider. A few months ago, you provided a flu shot (90471 admin) by your office nurse. Your receptionist sees that the child had this prior appointment in the past 3 years.	This is a new patient because your office has not yet provided provider-level services to a patient.
Your receptionist creates an established patient appointment for a child on 5/1/23. The child was last seen on 3/15/20 in your office. Your receptionist interprets the difference between 2020 and 2023 as "three years".	This is a new patient because the patient was seen after 3/15/23 (which would be three years by CPT rules.)
A new physician in the community joins your practice. Many of her patients from the old practice want to see her at your office. Your receptionist books one such appointment as a new patient appointment because your office has no records on them and you've never seen them before.	This is an established patient visit because the patient is considered established with your new physician.

How do I remove school exam from showing in summary and exit note?

The school exam of the well visit is used to populate school forms that are printed out of OP. This gives you the control over what is included in the school form, which may not include all of what you documented in your exam. You do not need to have this show up in the summary of your note, as it will still generate the school forms. Just remember to complete the school exam

tab so that your forms are accurate.

To change this, go to the summary tab of a well visit (you can also do this under Utilities).

1. Click on Edit Criteria.
2. Select Encounter Sections tab.
3. Uncheck include School Exam findings (well visits).

How do I add more information for visit after note finalized?

If you have already finalized the note for a visit and would like to add more information, you can create an addendum [Click here](#) to see the instructions for how to do this.

How do I document chaperone present during exam?

While creating either a Well or Encounter Visit, there is a field on the **Visit Info** tab for **Staff Chaperone**. If a chaperone is selected from the drop down, it will appear in the **Summary** of both types of notes, provided that the **Providers** checkbox is checked in [Report Criteria/Encounter Sections](#).

How can I see patient's insurance within chart?

The primary and secondary insurance can be seen at the top of the Overview tab within the patient's chart.

How do I create Well Visit Template?

How do I document in-office procedures?

OP's best practice is to create Procedure Templates for all procedures that are performed in office. Some examples are: Nebulizer Treatment, Circumcision, Ear Lavage, Rocephin Injection, etc. If one of the procedure templates is needed during a visit, then the Nurse/MA or Provider would layer the template into the Encounter. The template would already have the specifics related to the procedure, such as tasks, medications, follow-up protocols, etc.

[Click here](#) to learn how to create procedure templates.

How do charges get to the superbill?

Why do I see gibberish in the summary note?

If the note is unfinalized or in Edit mode:

1. Go to the patient's chart and open the note.
2. Search all sections where free text was entered (including ROS and Exam comments) for an open '{'.
3. Edit the text, so the beginning and ending brackets are the same. By using '[' brackets, the text within the brackets will

appear bold on the summary sheet.

4. Rebuild the summary.

If the note has been finalized, contact OP Support at 800-218-9916, option 2.

How do I change the visibility of finalized note?

To change the visibility of a finalized note, follow the steps below:

1. Open the Patient's Chart.
2. Select Encounters or Well Visits.
3. Select the note to change the visibility level and click **Open Note**.
4. Select the appropriate visibility from the **Visibility** drop-down located at the bottom of the note.
5. Click the **Save** button.

How do I view limited visibility sections in Encounter Notes?

To view a finalized note:

1. Click the **Chart** button on the main menu.
2. Click the **Encounters** tab.
3. Select the encounter note and click the **Open Note** button.
4. Click the **Summary** tab.
5. Select the checkbox for Include Records/sections with limited visibility (EFR) in the Summary Report Criteria field group.
6. Click the Alternate Notes tab.
7. Click the **Rebuild Summary** button.
8. The section that was set for higher visibility will populate under the Alternate Notes tab.

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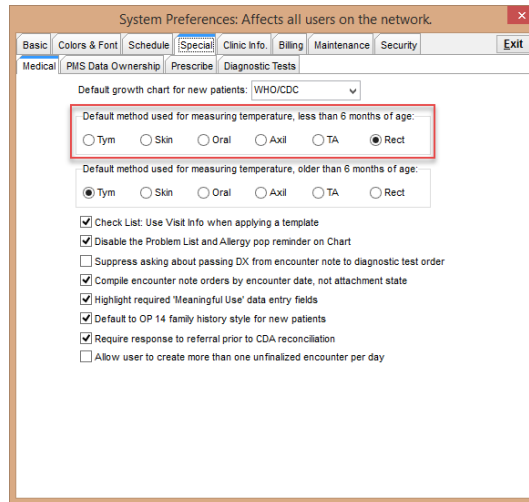
How do I set the default method of measuring the temperature of patients less than 180 days old?

Versions previous to OP 14.8.30 defaulted to Rectal as the temperature-measurement method for patients younger than 180 days. Providers had to change the measurement method manually for each patient. OP 14.8.30 allows you to set a default method of measuring temperature for patients younger than 180 days old (in addition to patients older than 180 days old).

To set a default method of taking the temperature of patients less than 180 days old:

1. Log on to OP 14 with a logon account that has Administrator permissions.
2. Click **Utilities / System Admin / System Preferences**
3. Click on the **Special** tab.
4. Click on the **Medical** tab. The Default Method Used for Measuring Temperature now has two rows of default settings. The top set of radio buttons is for patients less than 180 days old (Rectal is still the default setting). The bottom set of radio buttons is for patients older than 180 days old.

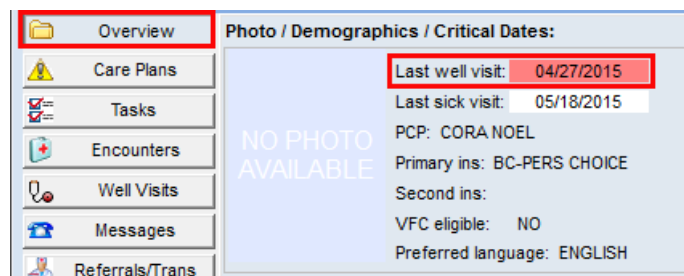
- In the top row of radio buttons, select the method for measuring temperature that you want to set as the default for all patients less than 180 days old.



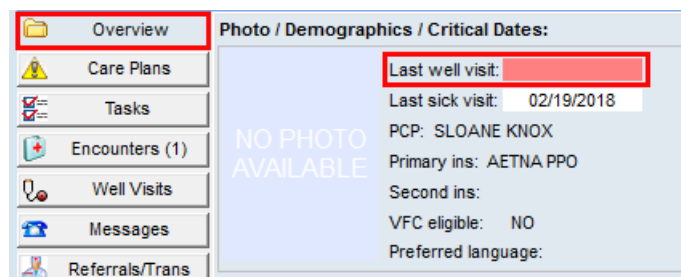
- Click the **Exit** button to save your changes and exit the System Preferences window.

Does OP flag charts that are due for well visits?

When patients are due or overdue for their well visit, their **Last well visit** field will be indicated in red in the Overview tab of their Chart. Additionally, the date of the last well visit will appear.



Patients who have not had a well visit will also have a **Last well visit** field red indicator in the Overview tab of their Chart. However, the **Last well visit** field will not contain a date.



What diagnosis codes are included in the 'patient recent' search?

While searching for a diagnosis code, you have the option of searching by 'Patient recent'. This option will display diagnosis codes that have been saved in an encounter or well visit note or are listed in an active problem in the patient's problem list.

Note: For problems in the problem list to be displayed in the patient recent search, a diagnosis code must be entered for the problem.

Are ICD-10 codes automatically updated in OP?

Yes, the ICD-10 code set is maintained by Office Practicum via Health Language (HL) updates.

- HL content is updated on a monthly basis, and content is released on an intermittent basis (determined by the vendor).
 - HL only returns codes that are appropriate for billing purposes.
 - Any codes that have been retired from HL will no longer be available in OP for selection.
- Once it is determined that an ICD-10 code has been excluded from Health Language content, users should review their templates to update codes as necessary.
- Client Server and Cloud clients both use the same endpoint for communication, so there is no difference in updating one versus the other.

Can Visit Stages be set up to change automatically?

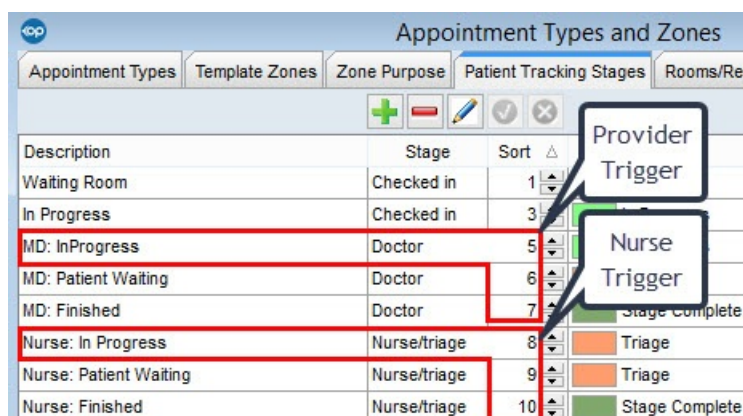
In the Schedule tab within the System Preference window there is a preference to "Automatically reset visit stage when encounter notes are opened." This setting only applies to the lowest sort number for the following OP stages:

- **Nurse/triage**
- **Doctor**

Once a staff member with a Clinical level of the "Clinical Staff" or higher (which is set in the Staff Directory) opens the Encounter note, the Visit Stage in Tracking will automatically change to the lowest sort number for that stage (see example below).

- Once the Clinical staff member opens the encounter, the Visit Stage in Tracking will automatically change to the lowest sorted stage for Nurse/triage (we suggest **Nurse: In Progress**).
- Once the Provider opens the encounter, the Visit Stage in Tracking will automatically change to the lowest sorted stage for Doctor (we suggest **MD: In Progress**).

Review the image below. In order for the **Nurse: In Progress** and **MD: In Progress** to be the automated stages, the Patient Tracking Stages setup should appear as follows.



Description	Stage	Sort	Provider Trigger	Nurse Trigger
Waiting Room	Checked in	1		
In Progress	Checked in	3		
MD: InProgress	Doctor	5		
MD: Patient Waiting	Doctor	6		
MD: Finished	Doctor	7		
Nurse: In Progress	Nurse/triage	8		
Nurse: Patient Waiting	Nurse/triage	9		
Nurse: Finished	Nurse/triage	10		



Note: This will also alter the color of the patient's appointment in the schedule (assuming the stages are not set to the same color).



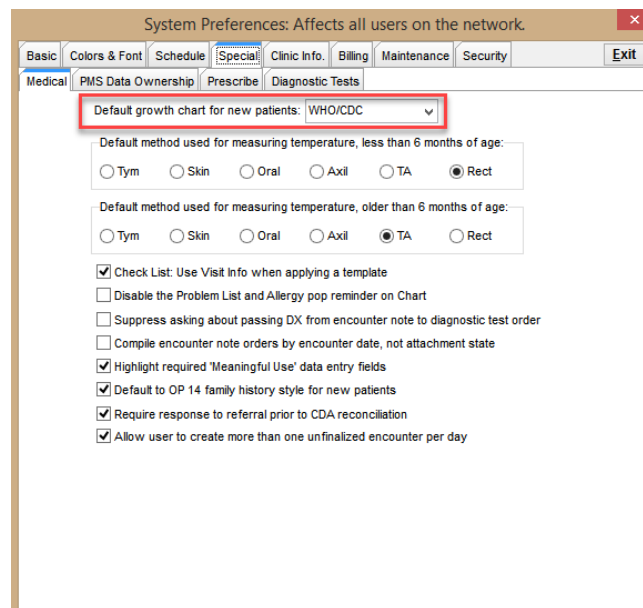
Note: If you have previously edited your [Patient Tracking Stages](#), you will need to review your Stages. After making edits to the Patient Tracking Stages, you will need to log out of OP completely, exit the program, and relaunch to see the changes.

What growth chart should I use?

It is the recommendation of the CDC that the CDC growth reference charts should be used when a child reaches 24 months. This requires a switch from the WHO growth standards charts.

In OP, the switch to the proper growth chart can be accomplished by a setting in **System Preferences**. Verify your practice's growth chart setting:

1. Select **Admin > Global Preferences**
2. Click the **Special** tab
3. Confirm the **Default growth chart for new patients** is set to WHO/CDC.
4. If the WHO/CDC chart is not selected, click the drop-down and select **WHO/CDC**.
5. Click **Exit** to save.



All patients that were not using the WHO/CDC growth chart selection will need to be changed manually. Once changed the new growth chart selection is remembered. To manually change the growth chart settings for a patient:

1. Select **Patient Chart** and search for and select a patient.
2. Change the default growth chart using one of the below methods.
 - Click the **Vitals/Growth** tab.
 - Charting an Encounter or Well Visit note:
 - a. Click the **Encounter** or **Well Visit** tab.
 - b. Open a previous note or start a new note.
 - c. Click **Vitals/Growth**.

- Click the drop-down arrow on the Growth Measurement section and select **WHO/CDC**.

Why am I not seeing all finalized notes on the Schedule and Practice Workflow window?

From the Schedule and Practice Workflow window, if a user selects the **All** radio button for the Date Range field, the **Include Finalized** button will not render finalized notes for the Encounter and Well Visit tabs. This is intended functionality due to the amount of notes that would display on each of these tabs.

What references are used for Vital Signs?

The references OP use for vital signs are:

- BP: NHLBI guidelines
- All Other Vitals = Harriet Lane

How can I view a premie growth curve?

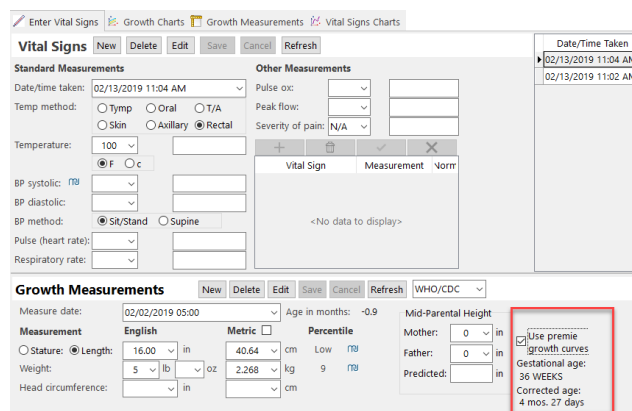
To use the premie growth curve, for growth measurements and growth charts, the following information must be entered.

- Navigate to the patient chart from **Clinical, Practice Management** or **Billing** tab.
- Click the **Patient Chart** button and search for the patient.
- Click **History**.
- Select the **Birth Info** tab.
- Click the drop-down arrow for **Gestational Age** and select from the list.



Note: The premie growth curve calculates on 36 weeks or less.

- Enter measurements in **Birth Measurements** section.
- Click Vitals/Growth and select the **Use premie growth curves** checkbox.

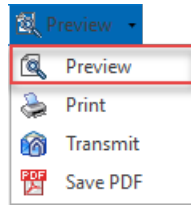


The screenshot shows the 'Vital Signs' and 'Growth Measurements' sections of the software interface. The 'Growth Measurements' section is highlighted with a red box, showing the 'Use premie growth curves' checkbox checked. The 'Growth Measurements' section includes fields for 'Measure date', 'Age in months', 'Mid-Parental Height', 'Mother', 'Father', and 'Predicted'. The 'Use premie growth curves' checkbox is checked, and the 'Gestational age' is set to 36 WEEKS and 'Corrected age' is 4 mos. 27 days.

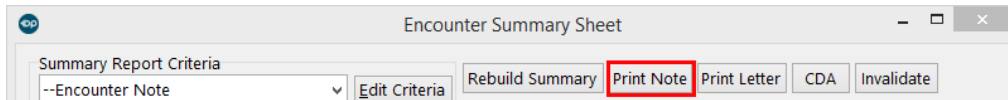
How do I save a PDF of a visit note?


To save a PDF of an Encounter or Well Visit Note:

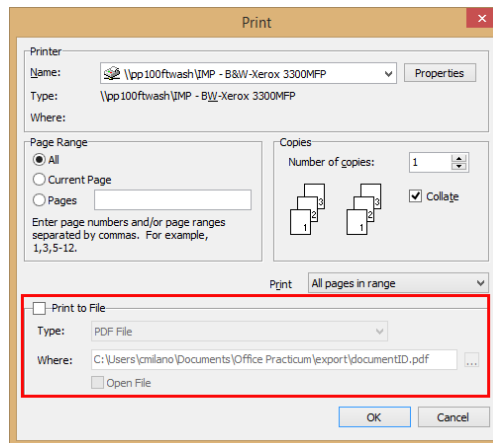
- Change the output selection located in the upper right-hand corner of OP to **Preview**.



2. Navigate to and open the note that will be saved as a PDF.
3. Click the **Print Note** button. The **Print Preview** window is displayed.



4. Click the **Printer** icon in the Print Preview window.
5. Select the **Print to File** checkbox and complete the Print to File fields:
 - **Type:** PDF File
 - **Where:** Use the browse button  to select where you want to save the PDF.

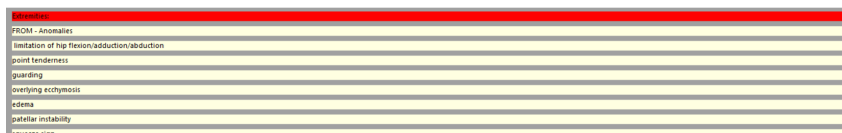


6. Click **OK**. The note is saved as a PDF in the specified location.
7. Complete the **Medical Record Disclosure** window.

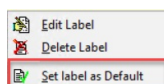
How can I change the default phrase for a narrative exam?

To change the default phrase used in a Narrative exam when the **Def** button is selected:

1. From the Narrative Exam, click the **Set All** button.
2. Click the **Set** button for an exam group. The current default phrase is displayed in red.



3. Click to select the phrase that is the new default, right-click and select **Set label as Default**



4. Click the **Done** button.
5. Repeat the above steps to change additional defaults.



Note: When changing the default phrase on a narrative exam you are changing the default globally for the exam group.

How can I have handouts display when selecting a diagnosis code?

Handouts will display when you highlight a diagnosis code and right-click. Handouts will only be available if the diagnosis code has been associated in the AAP Local Content Library. For additional information on adding diagnosis codes to handouts, click [here](#).

Why is my phrase constructor taking so long to load?

The load speed of phrase construction directly correlates to the number of pages and labels (phrases). Please discard any phrases that aren't used frequently in order to optimize speed. See [this article](#) for more information.

How do I see all of a patient's Visit Notes?

Use the **Dates** radio buttons located at the top of the Encounters and Well Visits sections of the Patient Chart to display:

- Past 5 years
- Past 10 years
- All

The radio buttons apply only to the section from which they are being accessed. For example, to show the past 10 years of a patient's Well Visits, go to the Well Visits section of the chart and select the Past 10 Years radio button. To see the past 10 years of a patient's Encounters, go to the Encounters section of the chart and select the Past 10 Years radio button.

What are the sections of a Visit Note?

A Well Visit note in Office Practicum is divided into sections which include conducting an interval history, a developmental screening, an exam, anticipatory guidance/counseling, screening tests, etc. Each practice determine how much of the note is completed by the Clinical Staff.

An Encounter note in Office Practicum is divided into sections similar to the SOAP (Subjective, Objective, Assessment, Plan) note. The subjective part of the exam includes sections such as Chief Complaint, History of Present Illness, and Review Of System. Each practice determines how much of the subjective portion of the visit is entered by the Clinical Staff. The Objective part of the exam includes sections such as vitals and the exam itself.

How can I make sure the correct template is applied to a Well Visit Note?

Questions in the Well Visit templates vary depending on the age of the patient. Additionally, starting at age 9, templates are also differentiated by gender (Male or Female). When the Front Desk staff schedules the appointment, they will select the reason for

the visit based on the age of the patient. For patients 9 years old and above, they will also distinguish between Male or Female.

When applying the template to a Well Visit note, if the appointment reason does not match the Office Practicum will alert the user if the appointment reason (template) does not match the patient, a Warning message is displayed.

