Eyefinity EHR iPad App User's Guide

August 2016

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Getting Started

In this chapter:

This guide will assist you in getting started with Eyefinity EHR.

Logging in and Logging Out

▶ **To open the Eyefinity EHR app**

1. Tap the **Eyefinity EHR** icon on the home screen.
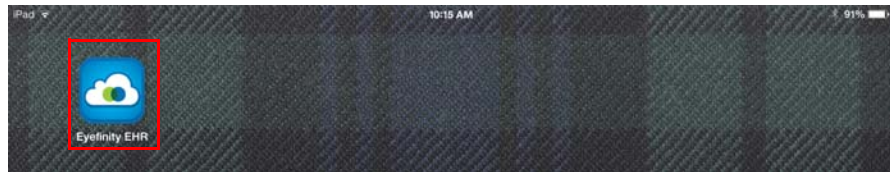
2. Type the **Company URL**.

NOTE	Your company URL is your practice's unique eyefinityehr.com address. Do not include "http://" or "https://".

3. Type the **Username** and **Password** that your administrator assigned to you.
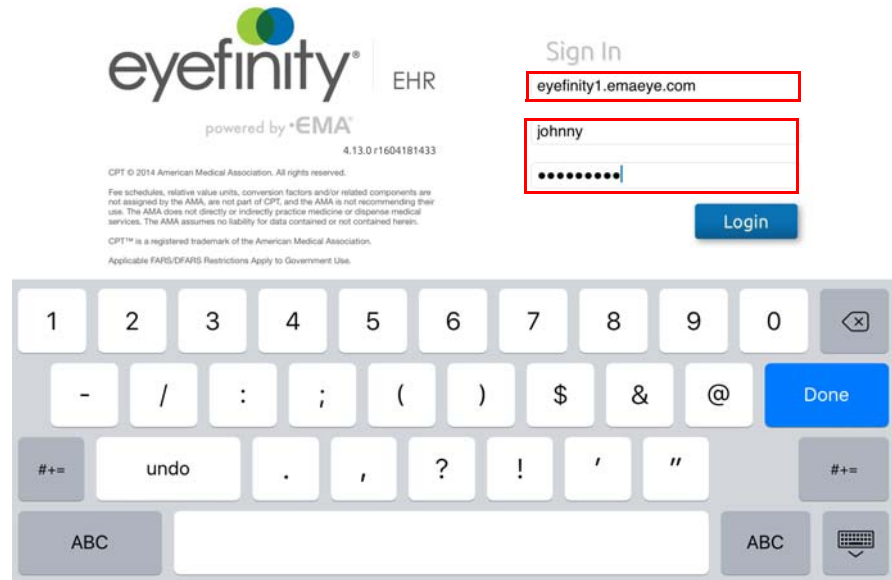
4. Tap **Login**.
5. If prompted, tap **I Agree** to accept the terms of service.

▶ **To log out**

1. If you are in a patient chart, tap **Home** to return to the home screen.
2. Tap **Logout**.

3. The message, "Are you sure you want to logout?" appears.
4. Tap **OK**.

Navigating the Home Screen

The Eyefinity EHR app uses a series of tabs and toolbars to help you easily find patients, take patient history, and create visit notes. The following section shows you how to navigate the Home screen.

Home

Patient Search. Type a few letters of the patient's last name, birth date, PMS ID, or MRN and autocomplete suggests the best matches.

Action Bar. Tap the icons on the Action Bar to perform a particular task.

Agenda. Tap a scheduled patient to create a new visit. Swipe from right to left to see tomorrow's agenda.
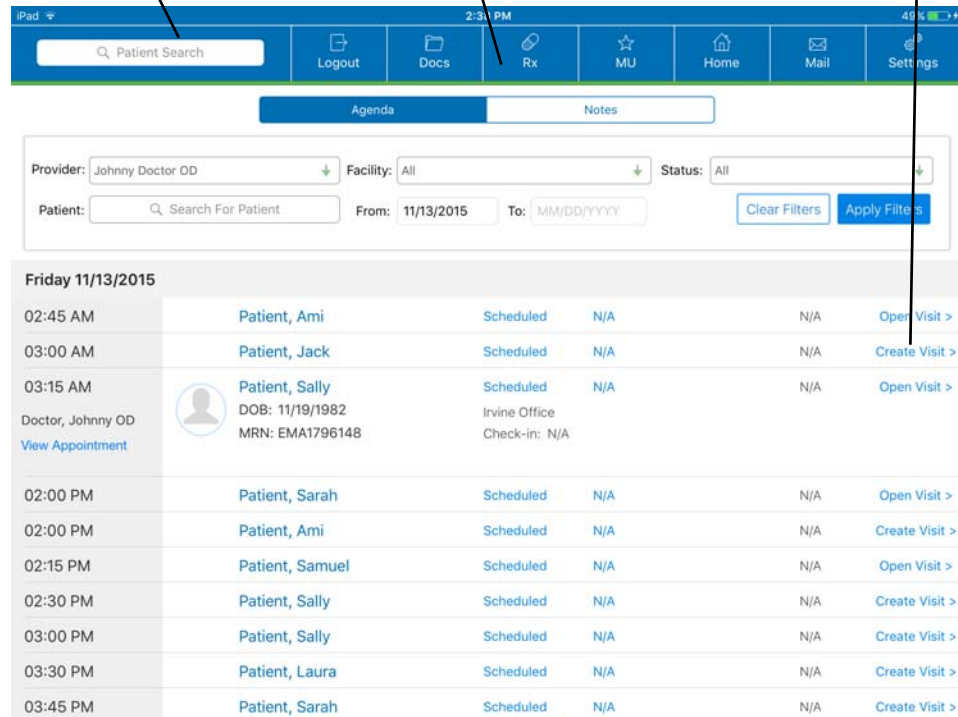
Figure 1-1: The Eyefinity EHR app opens to the Agenda screen, which is streamlined to give you quick access to the most essential tasks. To view a patient's chart, type a few letters of a patient's name, and autosearch begins displaying results. Tap the icons in the Action Bar to perform a particular task. You can tap hyperlinks, shown in blue, to navigate to different parts of the Eyefinity EHR app,

Navigating the Patient Chart

You can use the patient chart to perform actions regarding the patient, to take the patient's history, to view past visits, and to view additional information about a patient visit. This section gives you an overview of the patient chart.

Patient Chart

Patient Profile. The Patient Profile displays the patient name, date of birth, gender and photo. Tap the Bread Crumb to return to the Patient Chart.

Clipboard. Tap the arrow for the appropriate section to open the patient's Clipboard.

Tabs. Tap the tabs to jump from one area of the patient chart to another. The tabs displayed depend on your role in the practice.

Figure 1-2:   The Patient Chart in displays a preview of the patient history and past visits. Tap the tabs to navigate to different functions within the patient chart and tap the icons in the Action Bar to perform a particular task.

The Patient Chart Action Bar

The Action Bar allows you to perform specific actions within the patient chart. The following actions are available from the Action Bar in the patient chart:
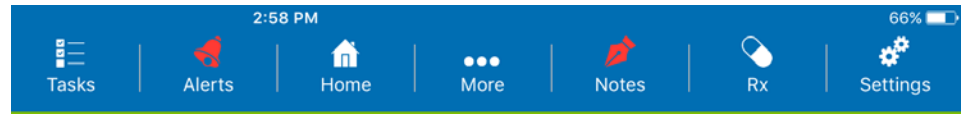
- **Tasks**. Assign tasks to the office staff. Tasks appear on the OfficeFlow tab on the web app.

- **Alerts**. When the Alerts icon is red, there are alerts regarding important information about the patient. Alerts are hidden from immediate view to prevent patients from seeing the alert if the iPad is left unattended.

- **Home**. Returns you to the Home screen.

- **More**. Displays many actions you can perform while reviewing the patient chart.

- **Notes**. Adds a note or a sticky note. When the Notes icon is red, there are sticky notes for the patient that should be reviewed. You can also create a note to create encounters for patients who didn't physically visit the practice, such as when they call on the phone. Sticky notes are hidden from immediate view to prevent patients from seeing the notes if the iPad is left unattended.

- **Rx**. View the patient's prescriptions, add a prescription for a patient, or submit a prescription for a patient.

- **Settings**. View and edit the system settings for Eyefinity EHR.

The Clipboard

The Clipboard is used for patient intake. You can record a patient's medical, social, and family history which can be used for meaningful use. You can also record the patient's medications and allergies. You can tap any arrow to open a specific section of the Clipboard for editing.

For established patients, the Clipboard shows a list of patient problems as well as the procedures and plans used for treatment. Providers may want to review this section before performing an exam.
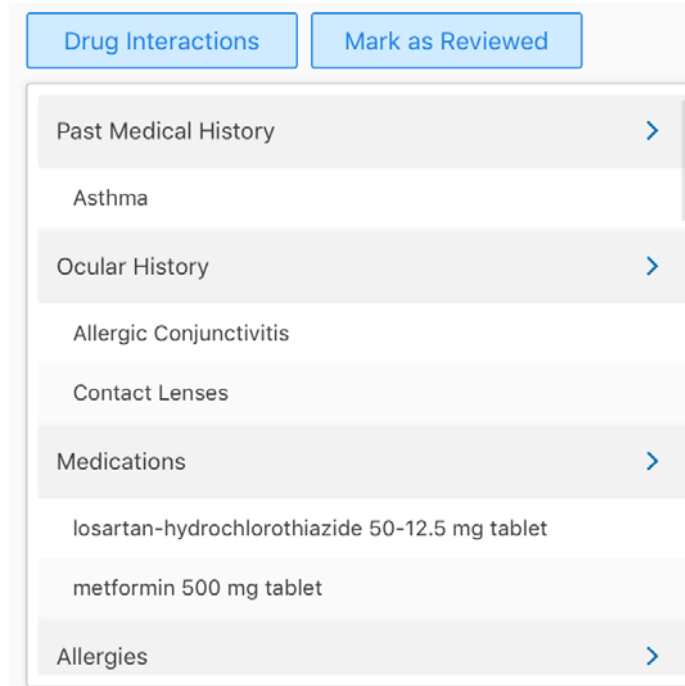
Past Visits
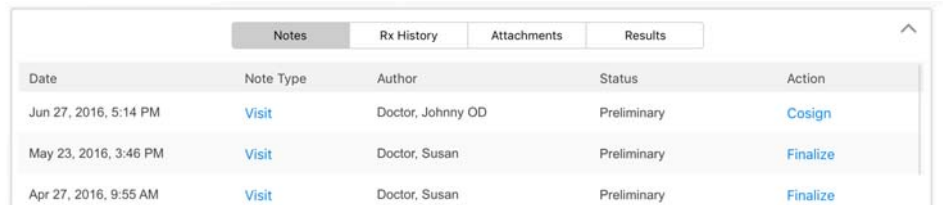
For established patients, Past Visits shows a list of the patient's previous visits. If the visit has been finalized, an F shows in the first column of the visit.

You can tap a visit to open it. Visits that have not been finalized open in the Visit Overview screen where you can view and edit the details of the visit. Visits that have been finalized open in PDF format on the visit note screen.

The Patient Chart Tabs

For established patients, the tabs allow you to view additional information that has been added to the patient's chart. The following information is available from the patient tabs:

	Notes	Rx History	Attachments	Results	
Date	Note Type	Author		Status	Action
Jun 27, 2016, 5:14 PM	Visit	Doctor, Johnny OD		Preliminary	Cosign
May 23, 2016, 3:46 PM	Visit	Doctor, Susan		Preliminary	Finalize
Apr 27, 2016, 9:55 AM	Visit	Doctor, Susan		Preliminary	Finalize

- **Notes**. Lists the past visit notes for the patient. For each note, you can tap the type of note to see additional details.

  For each note, you will see an action that can be taken. Preliminary notes can be cosigned or finalized. Finalized notes can be amended.

- **Rx History**. Lists any medications that have been prescribed for the patient during visits.

- **Attachments**. Shows a list of images and files attached to the patient's chart. You can tap the filename of the attachment to open it.

- **Results**. Shows the results of a procedure that was performed for the patient.

Navigating the Visit Overview

You can use the visit overview to navigate to any section of the visit, to perform the patient's ocular exam, to record your impressions, the morphologies, and treatment plans. To view the Visit Overview screen, you must open an existing visit or create a new visit.

This section gives you an overview of the visit overview.

Visit Overview

Action Bar. Tap the icons on the Action Bar to perform a task within the exam. The red Alerts button indicates that alerts are available for the patient.

Boxes. Tap the header on the box to jump from one area of the patient exam to another. The tabs display a summary of the information gathered for that area of the exam. Swipe left to view additional boxes.

Buttons. Tap the buttons to jump from one area of the patient exam to another. The buttons correspond to some of the icons on the Action Bar and to some of the boxes at the bottom of the screen.
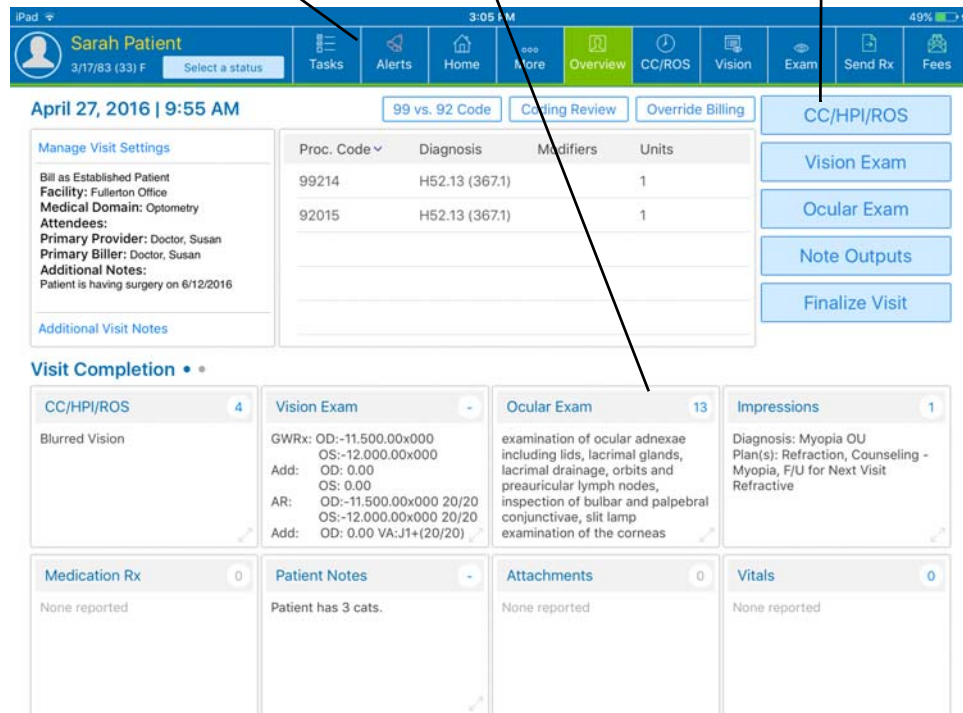
Figure 1-3: The Visit Overview in the Eyefinity EHR app displays an overview of the patient's exam. Tap the buttons or boxes to navigate to different areas in the exam and tap the icons in the Action Bar to perform a particular task.

The Visit Overview Action Bar

The Action Bar allows you to perform specific actions within the patient chart. The following actions are available from the Action Bar in the patient chart:
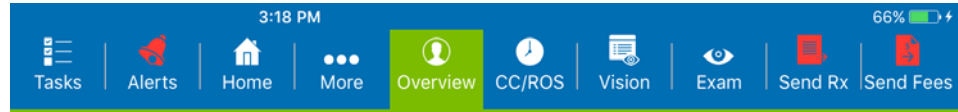
- **Tasks**. Assigns tasks to the office staff. Tasks appear on the OfficeFlow tab on the web app.

- **Alerts**. When the Alerts icon is red, there are alerts regarding important information about the patient.

- **Home**. Returns you to the Home screen.

- **More**. Displays many actions you can perform while reviewing the visit overview screen. The contents of the More menu changes to show the most helpful options, depending on which section of the app you are currently using.

- **Overview**. Returns you to the Visit Overview screen.

- **CC/ROS**. Opens the Chief Complaint tab where you can record the patient's chief complaint and review of systems.

- **Vision**. Opens the Vision Exam screen where you can record the patient's patient's pretest information as well as prescriptions.

- **Exam**. Opens the Ocular Exam Room where you can record the results of the patient's ocular exam, including your impressions, the morphologies, and plans.

- **Send Rx**. When the Send Rx button is red, a prescription is available to send to the practice management system. When the prescription has been sent, the Send Rx button turns green. After you have sent a prescription to your practice management system, you can change or add prescriptions and resend, if necessary.

- **Fees**. When the Fees button is red, fees are available to send to your practice management system. When the fees have been sent, the Fees button turns green. Once fees have been sent to your practice management system, they cannot be resent.

Manage Visit Settings

The Visit Settings include information that determine how the patient is billed, such as the providers and whether the patient is new or established. The provider may want to verify this information before beginning an exam.

The Additional Visit Notes allow you to enter information that will render at the bottom of the patient's chart. The Visit Settings are summarized on the Visit Overview screen along with any notes that were added.

Manage Visit Settings

Bill as Established Patient

Facility: Fullerton Office

Medical Domain: Optometry

Attendees:

Primary Provider: Doctor, Johnny

Additional Visit Notes

Visit Completion Boxes

The Visit Completion boxes allow you to see which sections of the visit that have been completed and to quickly jump from one section of the exam to another.

You can tap the box to open the corresponding portion of the exam. If that section of the exam has been completed, the dot shows the number of items recorded for that section of the exam. You can tap the double gray arrow in the lower right corner of the box to open up a summary of the information documented for that section of the exam.

NOTE	The Vision Exam will never show a number in the box.

The following Visit Completion boxes are available from the Visit Overview:

- **CC/HPI/ROS**. This box opens the Chief Complaint tab where you can record the patient's chief complaint, follow up visits, and review of systems.
- **Vision Exam**. This box opens the Vision Exam screen where you can record the patient's pretest information as well as prescriptions.
- **Ocular Exam**. This box opens the Ocular Exam Room where you can record the results of the patient's ocular exam, including your impressions, the morphologies, and your plan for treatment.
- **Impressions**. This box provides any impressions documented in the Ocular Exam Room.
- **Labs**. This box is not used.
- **Medication Rx**. This box lists the therapeutic prescriptions that were prescribed for the patient.
- **Sticky Note**. This box opens the Sticky Note window where you can view any Sticky Notes created for the patient.
- **Attachments**. This box opens the Attachments window where you can view any attachments created for the visit.
- **Vitals**. This box opens the Visit Vitals List where you can take the vital measurements for the patient.

Coding

The Coding area of the Visit Overview is automatically populated with the procedure code and diagnosis as you complete the exam.

| 99 vs. 92 Code | Coding Review | Override Billing |

Proc. Code ⌄	Diagnosis	Modifiers	Units
99214	H01.029 (373.00), H52.10 (367.1)		1
92015	H52.10 (367.1)		1

Buttons

The buttons allow you to quickly jump from one portion of the exam to another. They are arranged from top to bottom in the way you would typically perform the exam. The following buttons are available in the Visit Overview:

CC/HPI/ROS
Vision Exam
Ocular Exam
Note Outputs
Finalize Visit
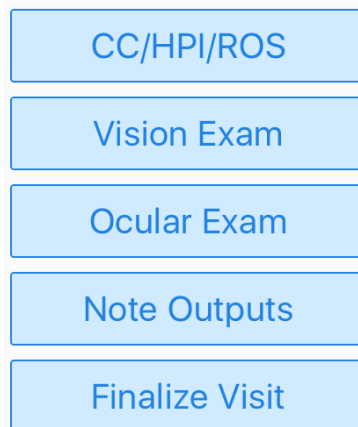
- **CC/HPI/ROS**. This button opens the Chief Complaint tab where you can record the patient's chief complaint and review of systems.
- **Vision Exam**. This button opens the Vision Exam screen where you can record the patient's pretest information as well as any prescriptions.
- **Ocular Exam**. This button opens the Ocular Exam Room where you can record the results of the patient's ocular exam, including your impressions, the morphologies, and your plans.
- **Note Outputs**. This button opens the Visit Note screen where you can view a PDF of your visit note. You can also view and print patient handouts.
- **Finalize Visit**. This button opens up the Finalize screen where you can mark the visit note as finalized. Only doctors should finalize Visit Notes. Once a

visit is finalized, no changes can be made; however, an addendum may be added.

Using Toggle Switches and Check Marks

Several of the screens within Eyefinity EHR have toggle switches and check marks. This section describes how to use them.

Check Marks. The check marks on the Review of Systems indicate whether an item has been reviewed.

Toggle Switches. The toggle switches default to No or to the last review of systems. Tap a toggle to indicate a positive finding. tap it again to change it back to No.

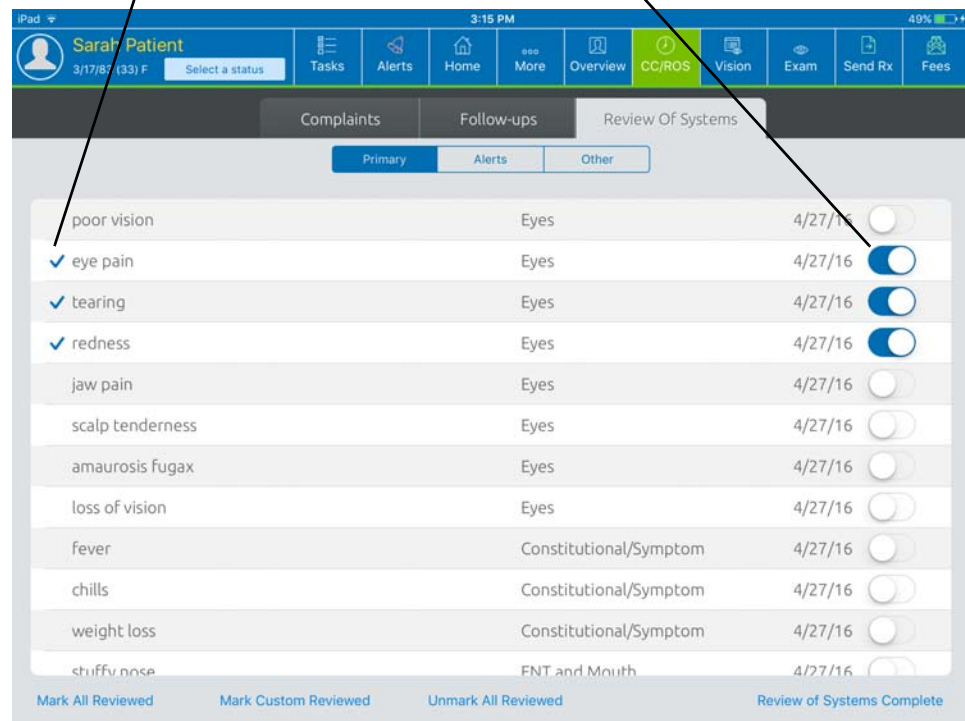Figure 1-4: The toggle Switches allow you to indicate positive findings in the review of systems.

Sticky Fields

Any field with a green S next to it is a sticky field. Any information documented in the field will be saved as the default value for the user currently logged in.

Finding Patients

Eyefinity EHR enables you to locate your patients' records quickly and easily. This section tells you how:

▶ **To find today's patients**

The Home screen displays a list of patients who have scheduled appointments for today. To view tomorrow's patient's, swipe from right to left.

1. Use the filters to limit your view based on provider, office location, patient status, patient name, and date range.

2. Locate the patient you want to see and perform one of the following tasks:

   – Tap the patient name displayed as a blue hyperlink to open the Patient Chart.

   – Tap **Open Chart** to open the Patient Chart.

   – Tap **Create Visit** to create a new visit note.

   – Tap **Open Visit** to open the patient's preliminary or final visit note.
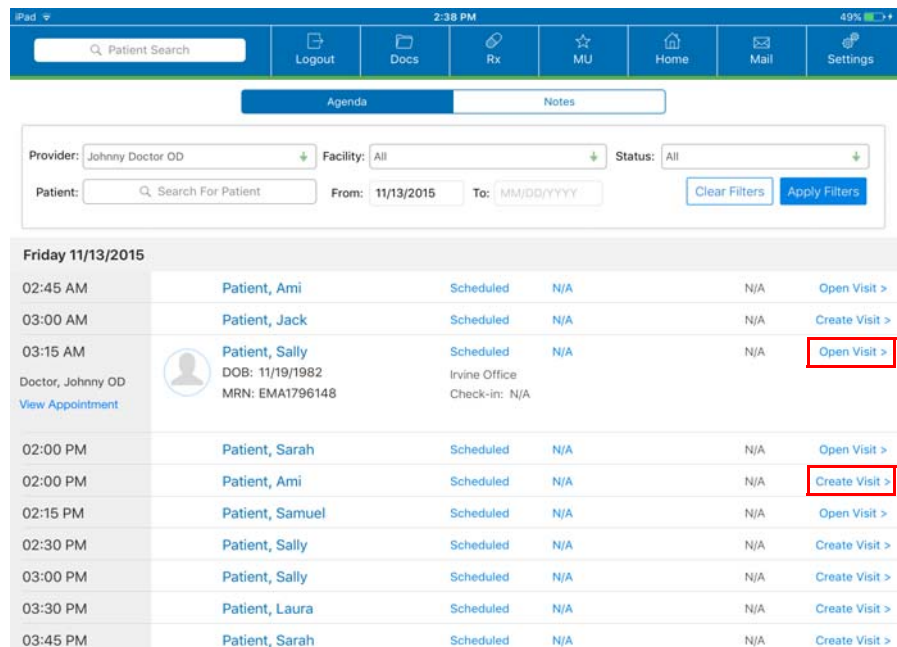
▶ **To find patients on the Home screen**

The Home screen enables you to search for patients based on name, date of birth, record number, and more.

1. Tap the **Patient Search** text box.

2. Type a few letters of the search criteria (e.g., name, ID, email address).

3. Tap a patient in the results list to open their chart.

Taking the Patient History

2

In this chapter:

You can use the Clipboard on the patient's chart to review and edit the patient's history, check for drug interactions, and indicate that the patient's history has been reviewed.

Accessing the Clipboard

You can access the Clipboard from within the patient chart or by using the More icon from the Action Bar.

▶ **To open the Clipboard from the patient's chart**

1. Open the patient's chart.

2. Tap the arrow next to the section you want to edit.
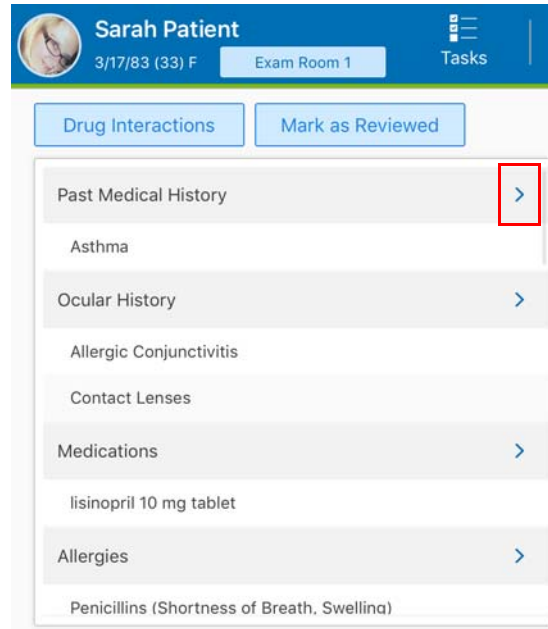
3. The Clipboard opens and displays the section you selected.
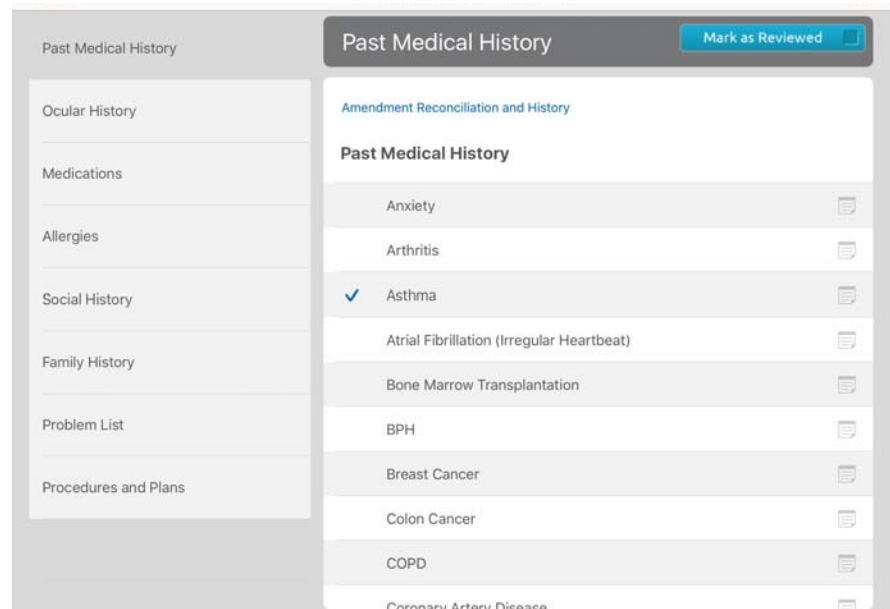
▶ **To open the Clipboard from the Action Bar**

1. Open the patient's chart

2. Tap the **More** icon on the Action Bar.

3. Tap **Clipboard** from the menu.

   The patient's summary Clipboard appears.

4. Tap **Edit**.

   The patient's Clipboard appears.

Marking a Patient's History as Reviewed

This section explains how to quickly mark a patient's entire history as reviewed. Typically you will mark the history as reviewed, unmark any systems you have not reviewed, and make any changes since the patient's last visit.

1. Open the patient's chart.

2. Tap **Mark as Reviewed**.

   Each section of the patient's history is updated with the date the history was reviewed.

Editing a Patient's Medical History

This section explains how to record the details of the patient's past medical history and how to mark the patient's medical history as reviewed.

- To edit a patient's past medical history, 19

▶ To edit a patient's past medical history

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Medical History** button.

   A list of medical conditions and surgeries appears.

3. If this is an established patient and if you have reviewed the patient's medical history, tap **Mark as Reviewed** or, if this is a new patient, tap the medical conditions and surgeries that apply to the patient.

4. Tap the paper icon if you need to enter additional information about the medical condition or surgery.

5. Tap **Save**.
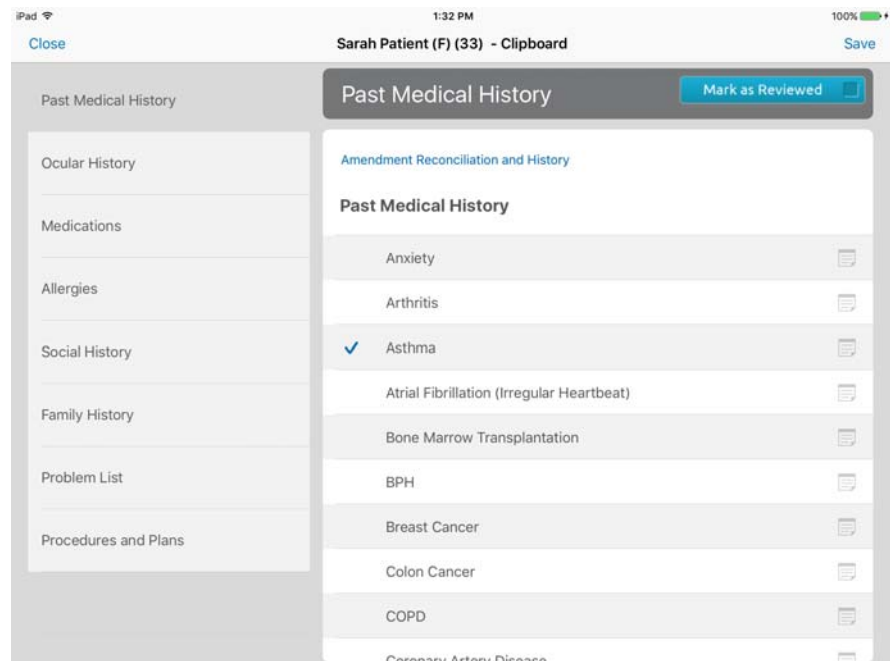
Editing a Patient's Ocular History

This section explains how to record the details of the patient's ocular conditions and surgeries and how to mark the patient's ocular history as reviewed.

- To edit a patient's ocular history, 20

▶ **To edit a patient's ocular history**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Ocular History** button.

   A list of ocular conditions and surgeries appears.
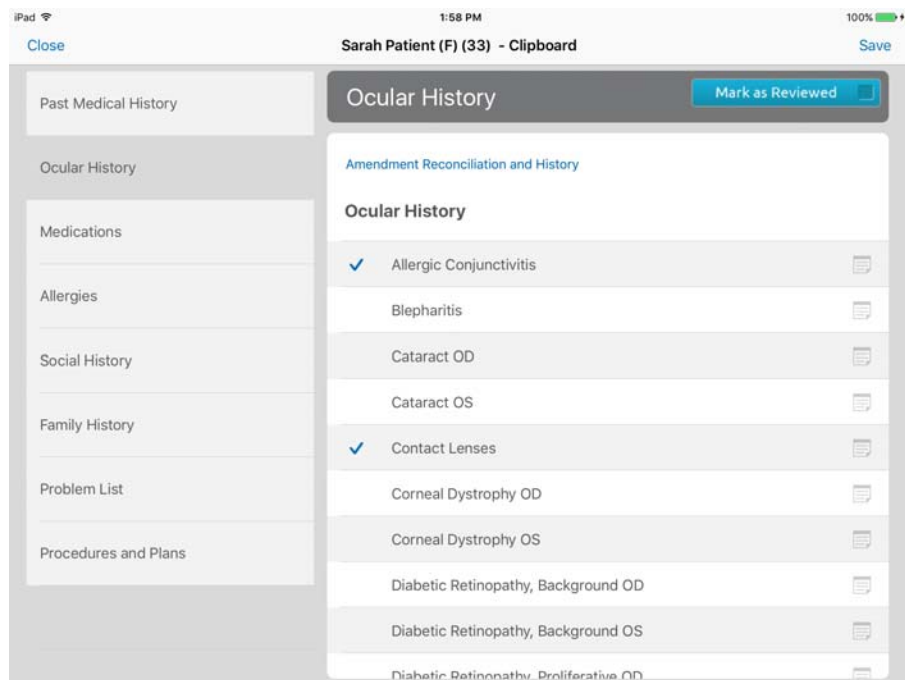
3. If this is an established patient, tap **Mark as Reviewed**. If this is a new patient, tap the conditions and surgeries that apply to the patient or tap **None** if the patient has no ocular conditions or surgeries.

4. Tap the paper icon if you need to enter additional information about the ocular condition or surgery.

5. Use the filters to limit your view based on provider, office location, patient status, patient name, and date range.

6. Tap **Save**.

Editing Medications and Drug Interactions

This section explains how to record the medications the patient takes and how to review drug interactions for the medications.

- To add a medication, 21
- To mark as no medications, 23
- To review drug interactions from the patient's chart, 24
- To review drug interactions from the Clipboard, 25
- To mark a medication as active or inactive, 26

▶ **To add a medication**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Medications** button.

   The Medications screen opens.

3. Tap **Add Medication**.

   A Search window opens.

4. Type the first few letters of the medication name to search.

5. Tap the name of the medication.

The Select Dispensable window opens.

6. Tap the dosage for the medication or tap **Add with unspecified dispensable** to add the medication without specifying a dosage.

The medication is added to the patient's Clipboard.

7. Tap **Save**.

▶ **To mark as no medications**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to .

2. Tap the **Medications** button.

   The Medications screen opens.
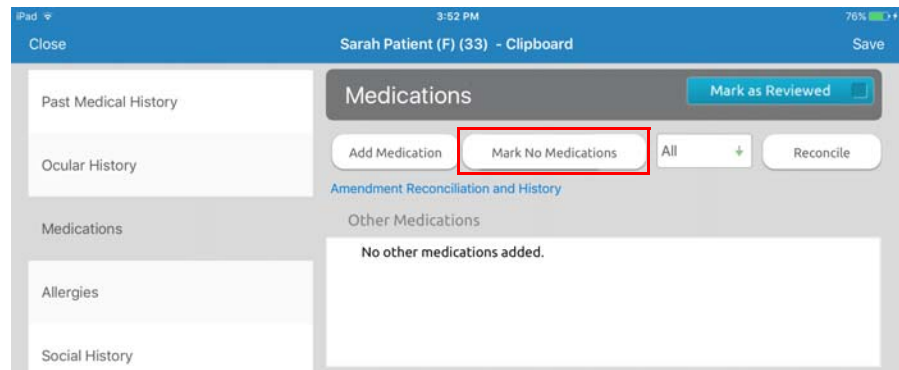
3. Tap **Mark No Medications**.

4. Tap **Save**.

▶ **To review drug interactions from the patient's chart**

1. Open the patient's chart.
2. Tap **Drug Interactions**.

The Drug Interactions window opens and displays a list of drug interactions for the patient.
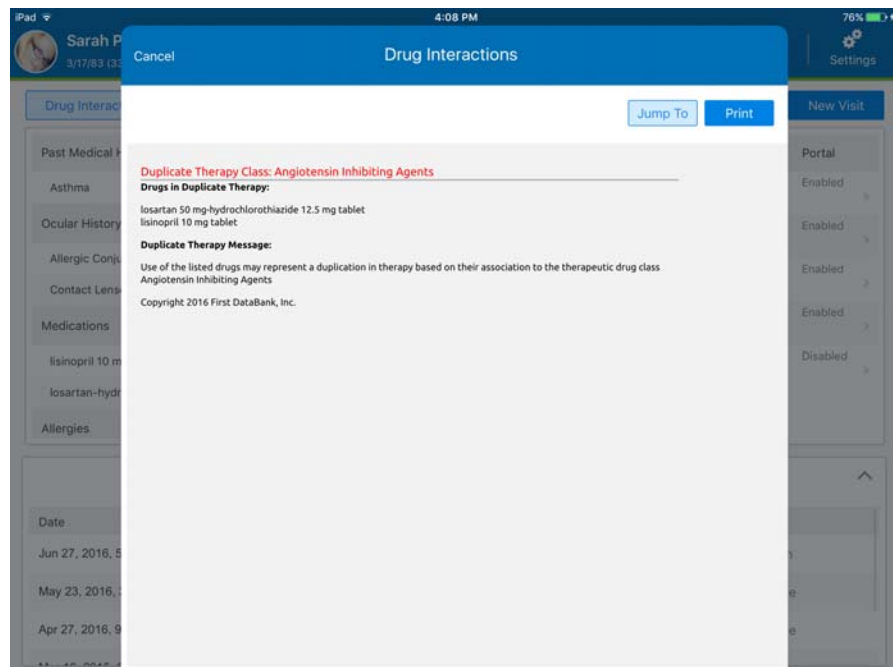
3. Review the drug interactions.
4. Tap **Cancel** to close the Drug Interactions window.
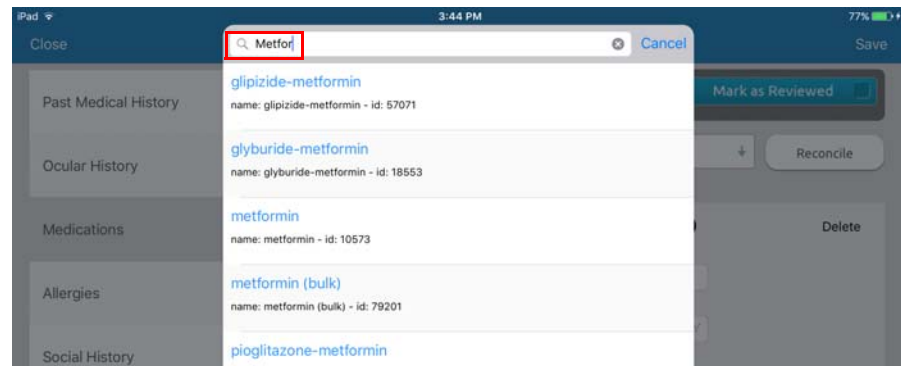
▶ **To review drug interactions from the Clipboard**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

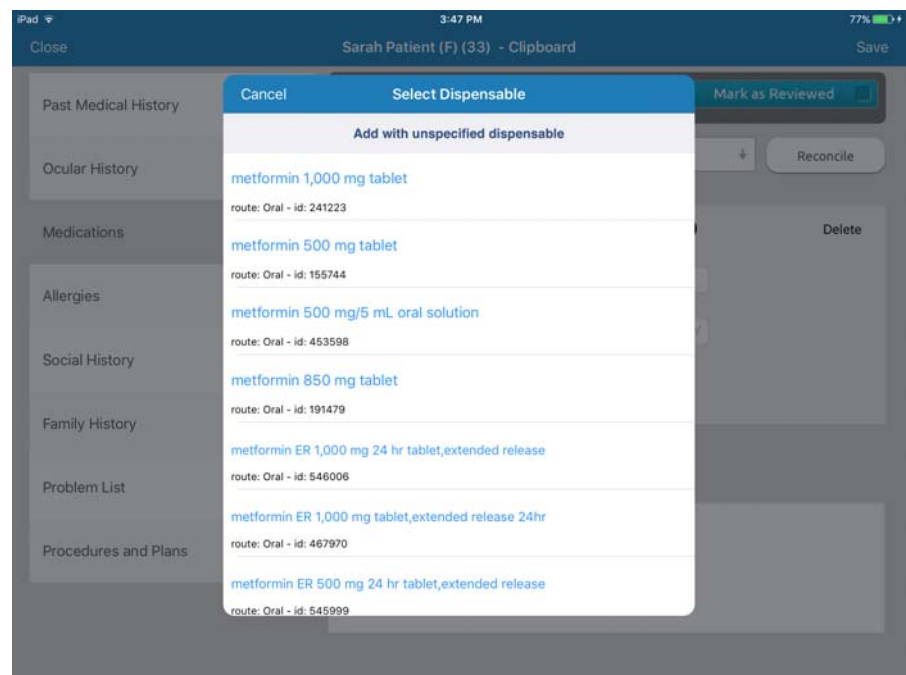2. Tap the **Medications** button.

   Tap **Drug Interactions**.
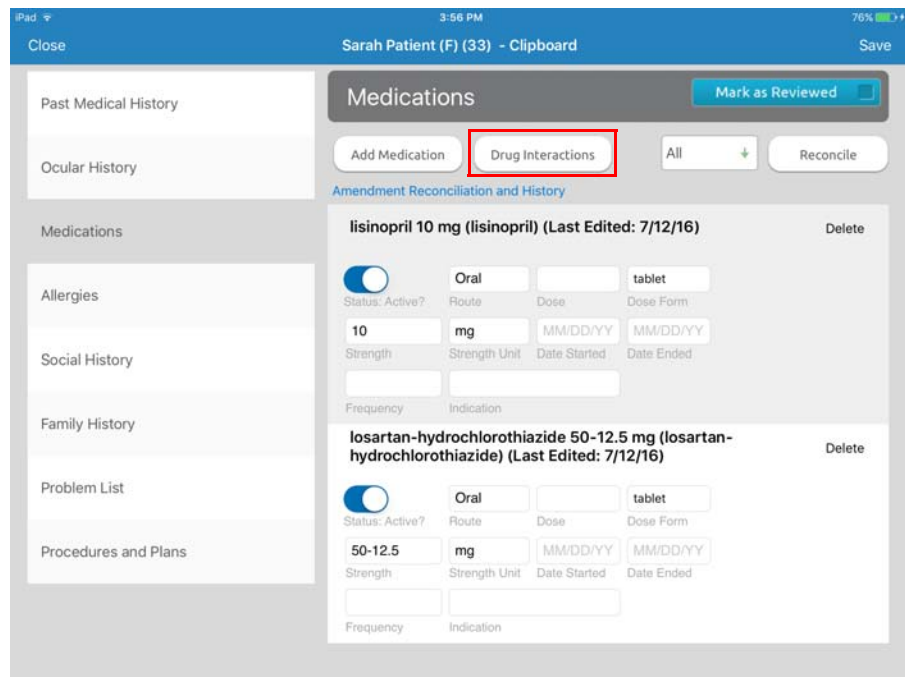
| NOTE | The Drug Interactions button only appears if one or more medications have been added for the patient. |

3. The Drug Interactions window opens and displays a list of drug interactions for the patient.
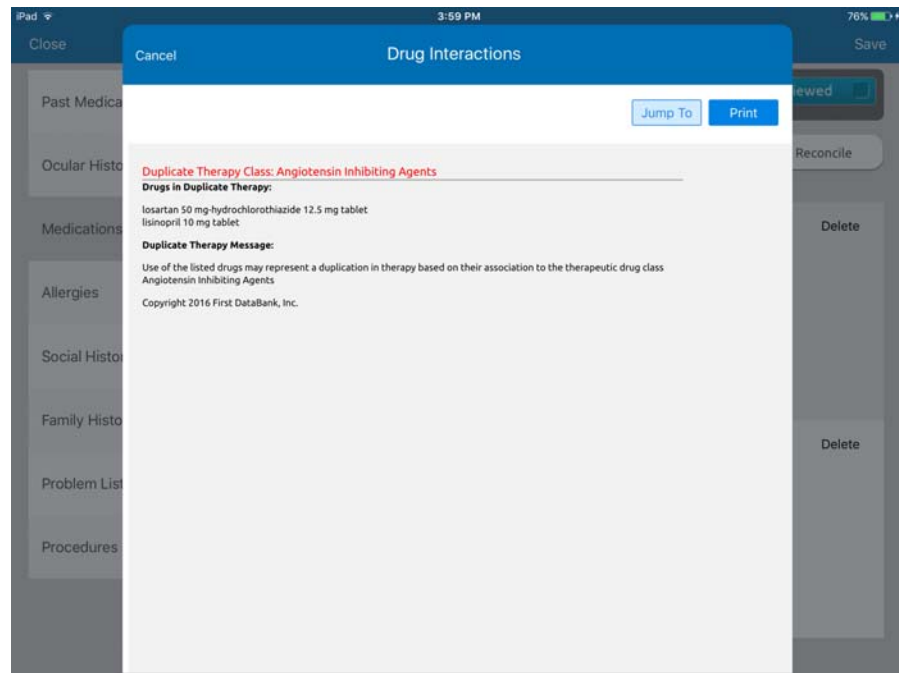
4. Review the drug interactions.

5. Tap **Cancel** to close the Drug Interactions window.

▶ **To mark a medication as active or inactive**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Medications** button.

3. Tap the toggle button to activate or inactivate a medication.

4. Tap **Save**.

Editing Allergies

This section explains how to record the details of the patient's allergies and allergic reactions.

▶ **To add an allergy**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Allergies** button.

   The Allergies screen opens.
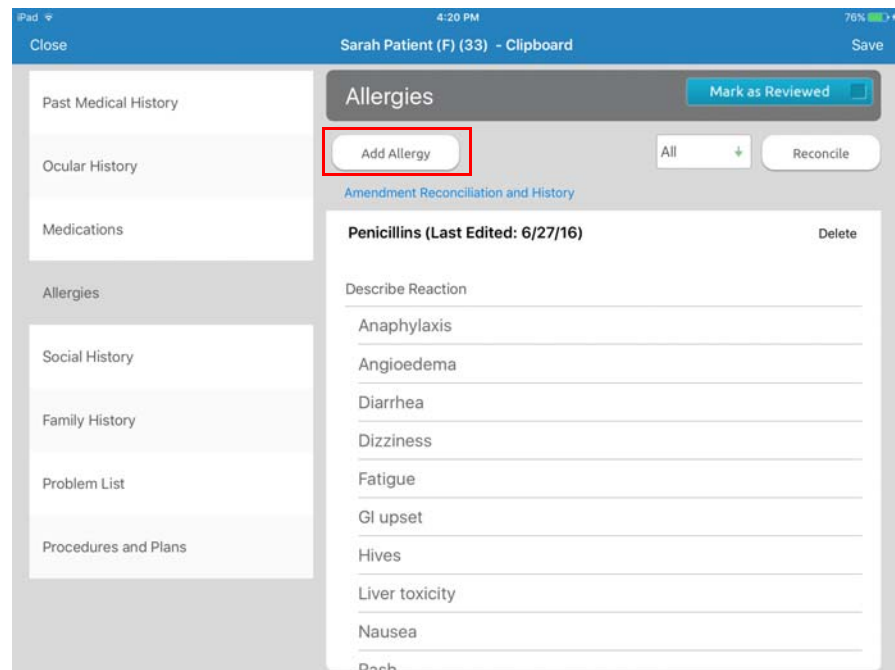
3. Tap **Add Allergy**.

   A Search window opens.

4. Type the first few letters of the allergy name to search.
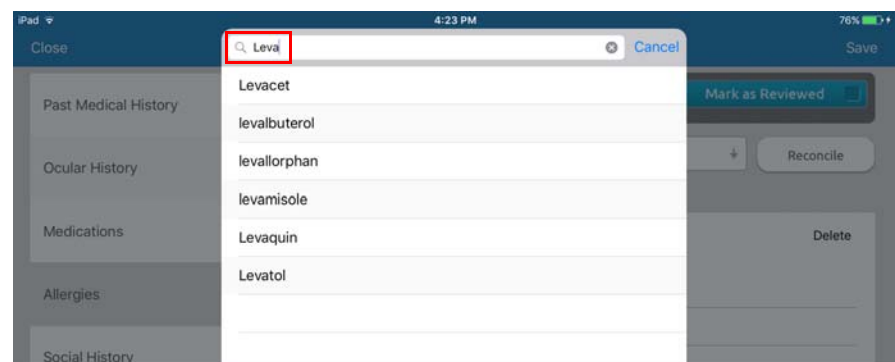
5. Tap the name of the allergy.

The allergy is added to the patient's Clipboard and a list of reactions appears.

6. Tap one or more reactions.

7. Answer the allergy questions at the bottom of the screen.
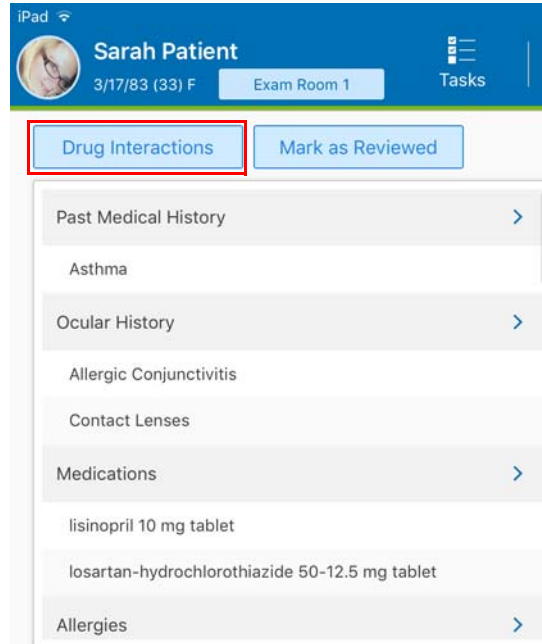
8. Tap **Save**.

▶ **To mark as no known drug allergies**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Allergies** button.
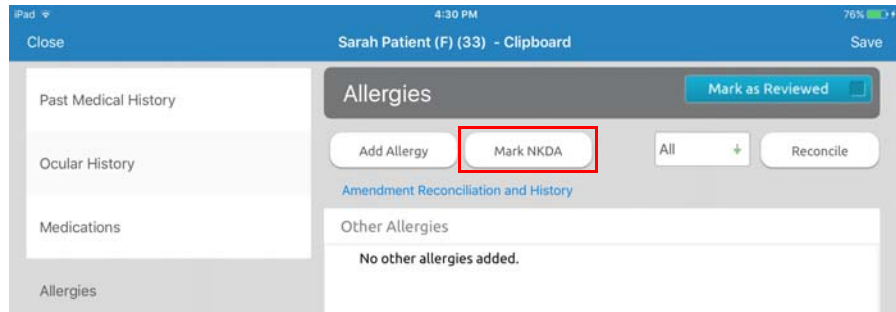
3. Tap **Mark NKDA**.

4. Tap **Save**.

Editing a Patient's Social History

This section explains how to record the details of the patient's social history and how to mark the patient's social history as reviewed.

- To edit a patient's social history, 29

▶ **To edit a patient's social history**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Social History** button.

   A list of questions appears.

3. Answer the social history questions.

NOTE	The patient's Smoking Status must be something other than "unspecified" for Meaningful Use.

4. Tap **Save**.

Editing a Patient's Family History

This section explains how to record the details of the patient's family history and how to mark the patient's family history as reviewed.

NOTE	You must add family history. If there is no family history, search by "No Family History" to add history.

- To add a patient's family history, 30

▶ **To add a patient's family history**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Family History** button.

3. Tap **Add Family History**.

   A Search window opens.

4. Type the first few letters of the medical condition name to search.

5. Tap the name of the medical condition.

6. The medical condition is added to the Clipboard and a list of family members appears.
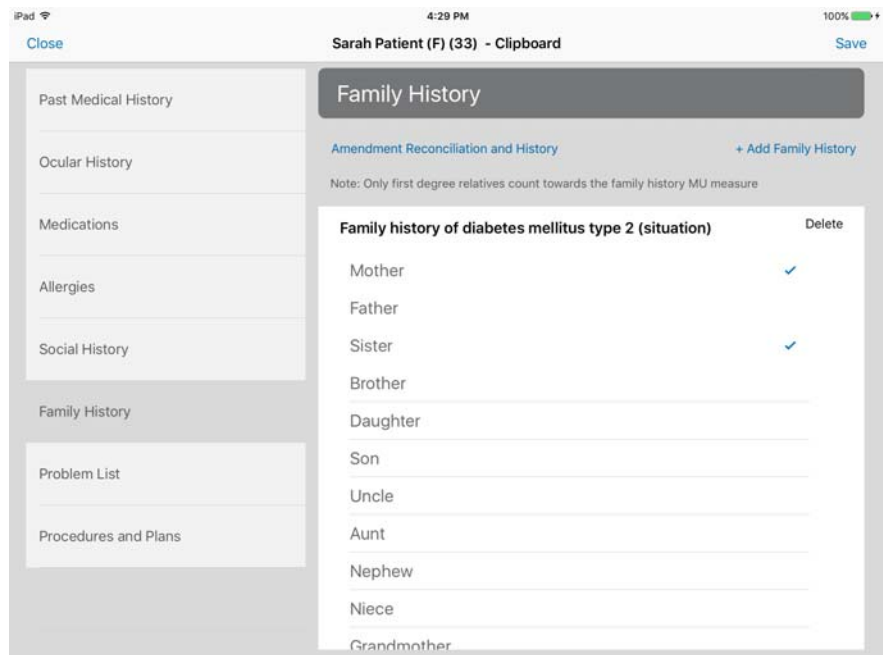
7. Select the family members who have/had the medical condition.

8. Tap **Save**.

Marking as No Known Problems

The problem list is automatically populated as you begin to treat the patient and record the chief complaints. This section explains how to mark a patient as having no known problems.

NOTE	You can add a problem from the Problem List screen but it is not recommended by Eyefinity.

- To mark as no known problems, 31

▶ **To mark as no known problems**
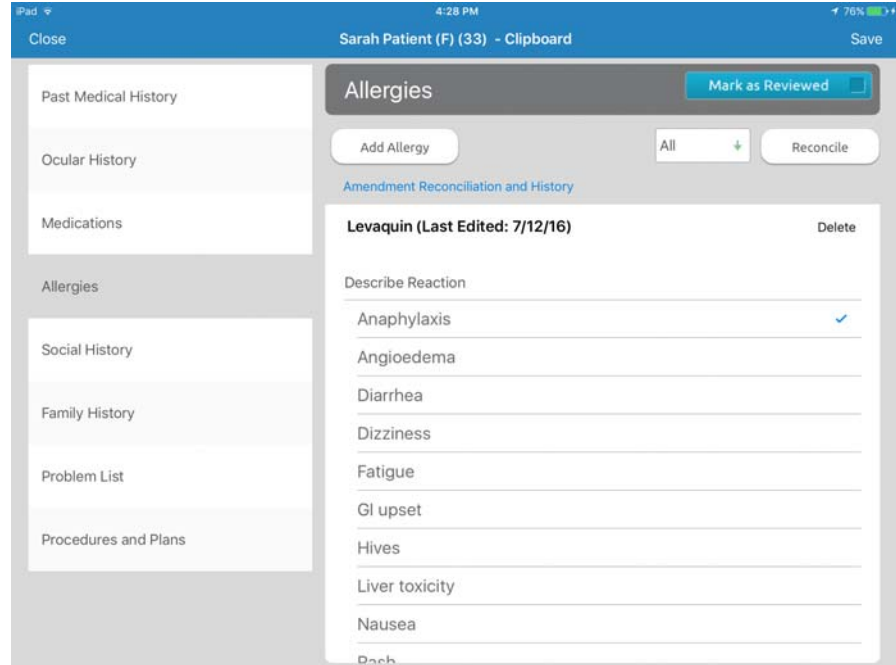
1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Problem List** button.

3. Tap **Mark No Problems**.

4. Tap **Save**.

Viewing the Procedures and Plans

The Procedures and Plans window is automatically populated as you begin to treat the patient and add procedures and plans to the patient's visit note.

NOTE	You can add a procedure from the Procedures and Plans screen but it is not recommended by Eyefinity.

Reconciling Changes Made in the Patient Portal

In the Patient Portal, a patient can add or edit their past medical history, ocular history, medications, allergies, social history, and family history. As you review the patient's history, you can choose whether to accept the changes and add them to the patient's chart, or deny the changes.

You can see changes that were made, when they were made, by whom they were made by, and the current status of the changes.

- To reconcile changes made in the Patient Portal, 31

▶ **To reconcile changes made in the Patient Portal**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the item you want to reconcile, such as Medications, Allergies, etc.

3. Tap **Amendment Reconciliation and History**.

   The Reconcile Differences window appears.
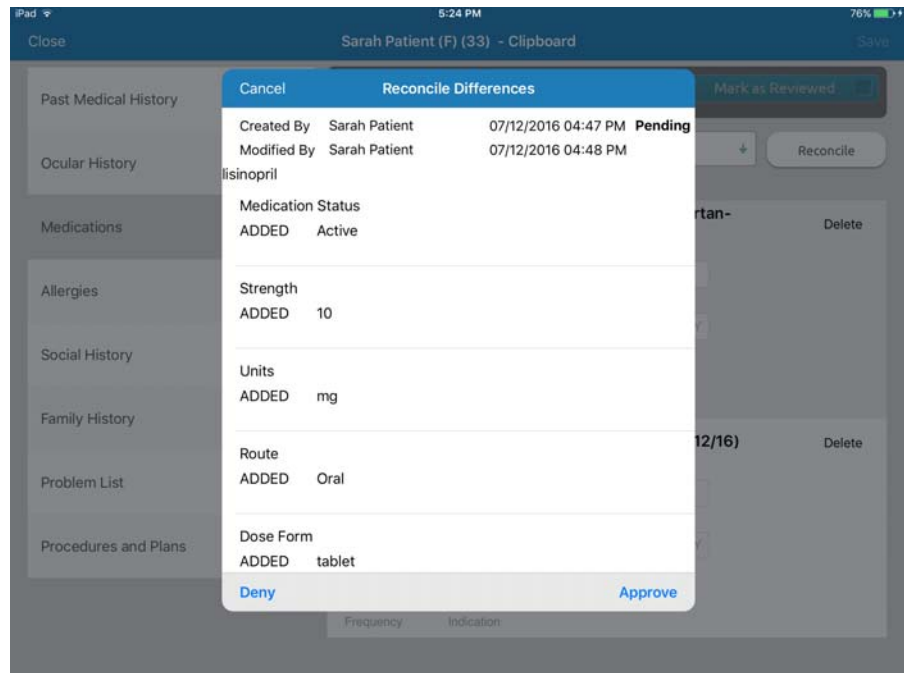
4. Tap **Approve** to add the changes to the patient's chart or tap **Deny** to cancel the changes.

Viewing Attachments from the Medication or Allergy List

When you view attachments in the clipboard, you can view a medication list or allergy list and add them at the same time.

▶ **To view attachments from the Medications or Allergy List**

1. Open the patient's Clipboard. For more information on opening the Clipboard, go to "To open the Clipboard from the patient's chart" on page 18.

2. Tap the **Medications** tab or **Allergy** tab.

3. Tap **Reconcile**.

4. From the drop-down menu, select **Attachments**.

5. Tap the green drop-down arrow to choose an attachment.

6. From the drop-down list of attachments, select the attachment you want to view.

7. Tap **Add Medications** or **Add Allergies** while viewing your attachment.

8. When you finish comparing medications or allergies, tap **Hide Comparison**.

Editing the Patient's Personal Information

Editing is only available in the standalone version of Eyefinity EHR. If you're using a practice management system, edit the patient demographics there.

- To edit the patient's personal information, 33

▶ **To edit the patient's personal information**

1. Access the patient overview screen.
2. Tap **More**.
3. Tap **Edit Patient**.

   The Patient Basics tab of the Patient Data window appears.

4. Edit the Contact Info, Pharmacy, and Practice Data, as necessary.
5. Tap **Take Photo** to take a photo of the patient and add it to the patient's chart.
6. Tap **Done**.

Signing the Consent

From the patient's chart or from within the patient visit, you can view your available consent forms, edit a consent form, and have a patient sign a consent.

- To sign the patient consent, 33

▶ **To sign the patient consent**

1. Access the patient chart or the patient overview screen.
2. Tap **More**.

3. Tap **Consents**.

    The Select Consent(s) window shows the available provider-specific and practice-wide consents.

4. Select the consent(s) you want the patient to sign.

5. Tap **Sign Consent(s)**.

    The Consents to Sign window shows the text of the selected consent(s).

NOTES	• If you have the ability to print from an AirPrint printer, tap **Print** to print the consent(s).
	• To add text to the consent, tap **Add Text**. A text box appears where you can type text. Use the slider to increase or decrease the font size. Use the color palette to choose the color of the text.

6. Tap **Sign Form**.

7. Have the patient sign the consent(s).

8. Have the witness sign the consent. A witness can be a family member or staff member.

NOTE	Use the slider to increase or decrease the line size. Use the color palette to choose the color of the line.

9. Tap **Done** when the patient and witness have finished signing.

10. Tap **Save** to save the signed consent(s).

Recording the Chief Complaint, HPI and ROS

3

In this chapter:

You can use the Visit Overview screen to manage visit settings, add notes, record the patient's chief complaint, perform a review of systems, and set up alerts for important information about the patient.

Creating or Opening a Visit

You can create a new visit from the Home page or from the patient's chart. This section tells you how:

▶ **To create a new visit from the Home page**

1. Locate the patient for which you want to open a new visit.

2. Tap **Create Visit**.

   The Visit Overview screen appears and a visit is created for today.

▶ **To create a new visit from the patient's chart**

1. Open the patient's chart.

2. Tap the **New Visit** button.

   The Visit Overview screen appears and a visit is created for today.

▶ **To open a visit from the patient's chart**

1. Open the patient's chart.

2. Tap the visit you want to open.

   The Visit Overview screen shows the details for the visit.

Managing Visit Settings and Adding Notes

The Visit Settings consist of provider and billing information about the visit. The provider information is sent to the practice management system. The Visit Settings are summarized on the Visit Overview screen.

Notes are any type of information you want to record about the visit. Notes are summarized on the Visit Overview screen and will render in the visit note. This section tells you how:

- To manage visit settings, 39
- To archive a visit created in error, 40
- To add additional notes, 40

▶ **To manage visit settings**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **Manage Visit Settings** button.

   The Manage Visit Settings window opens.

3. Select the provider for the visit.

NOTE	The **Provider** and **Visit Biller** must be the same in order to properly send charges to your practice management system.

4. In **Preferred Attendees**, tap the name(s) of the people in attendance for the visit. The staff member will already be marked as in attendance.

5. In **Scribe(s)**, select the name of the scribe in attendance, if any. If the staff member is recording the chief complaint or documenting for the provider in the Ocular Exam Room, they must select themselves as the Scribe.

6. If the patient is a new patient referred from another provider, slide the **Is Transition of Care** toggle to on. You must reconcile medications for the patient in the Clipboard. This allows you to get credit for medication reconciliation.

7. Select the **Facility** where treatment was provided.

8. Adjust the **Visit Date** and **Time Zone**, if necessary.

> NOTE   Do not change the **PMS Visit ID**, **PMS Visit Type**, and **FIN Visit ID**. These fields are filled in by your practice management system.

9. Tap **Save**.

▶ **To archive a visit created in error**

1. Open a patient visit. For more information on opening a patient visit, go to .

2. Tap the **Manage Visit Settings** button.

   The Manage Visit Settings window opens.

3. Tap **Archive**.

   A confirmation window appears.

4. Tap **Yes, Confirm Archive**.

   The visit is archived.

▶ **To add additional notes**

> NOTE   Notes added using this method will be rendered in the visit note.

1. Open a patient visit. For more information on opening a patient visit, go to .

2. Tap the **Additional Visit Notes** button.

   The Additional Visit Notes window opens.

3. Type the note.

4. Tap **Save**.

   The note is added to the visit note.

Managing Patient Location and Tasks

OffliceFlow is a way to keep track of the patient's location in the office. It's also a way to see what tasks have been ordered. Choosing the patient's location and assigning tasks can be done on the iPad; however, in order to review these statuses, you must view the OfficeFlow tab on the web application. This section tells you how:

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▶ **To manage the patient location settings**

> | NOTE | In order to select a patient location, locations must first be set up in the administration section of the web app. |
> | --- | --- |

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **Select a Status** button.

   A list of locations opens.
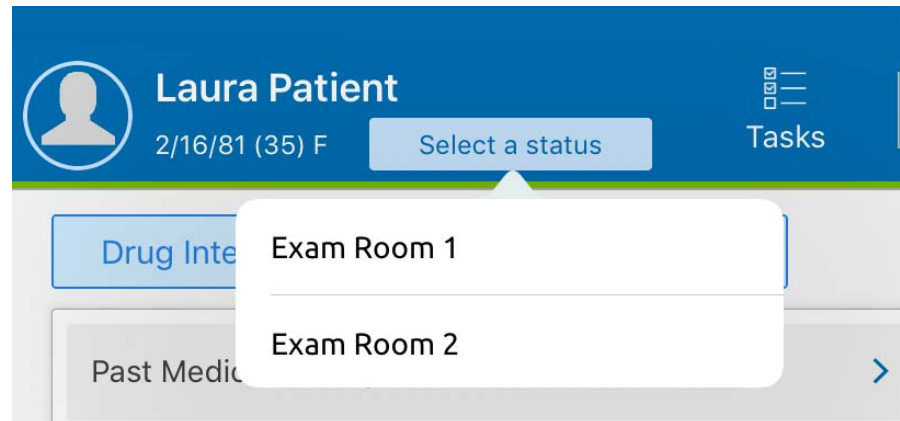
3. Select the location of the patient.

▶ **To manage tasks**

> | NOTE | In order to assign tasks, tasks must first be set up in the administration section of the web app. |
> | --- | --- |

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **Tasks** button.

   A list of tasks opens.

3. Select the task you want to assign.

   The task will appear on the OfficeFlow tab of the web app.
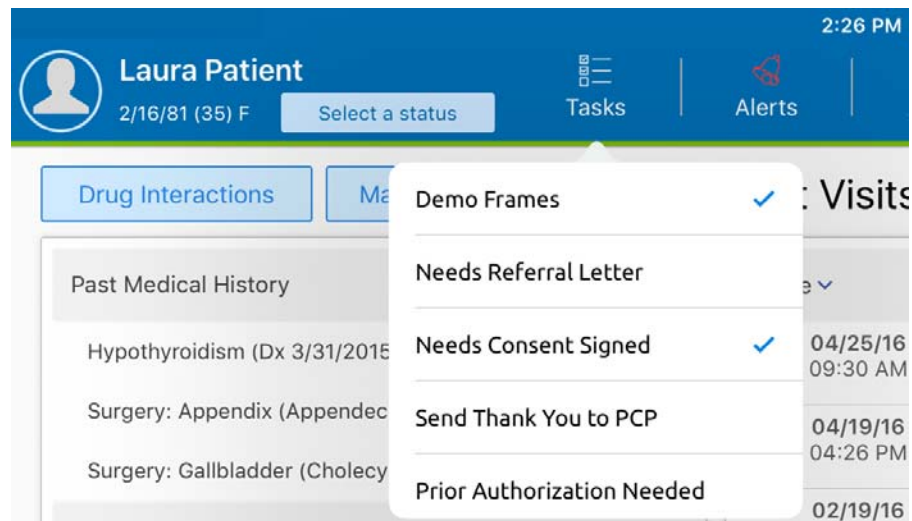
Adding and Editing Patient Complaints

This section explains how to record a patient's chief complaint and any secondary complaints as well as how to edit the CC/HPI statement.

▶ **To add a new chief complaint**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

   The Complaints tab opens.

3. Tap **Add a New Chief Complaint**.

   A Search window opens. The most common complaints are displayed at the top of the search list.

4. Select the patient's chief complaint.

   The External diagram appears.
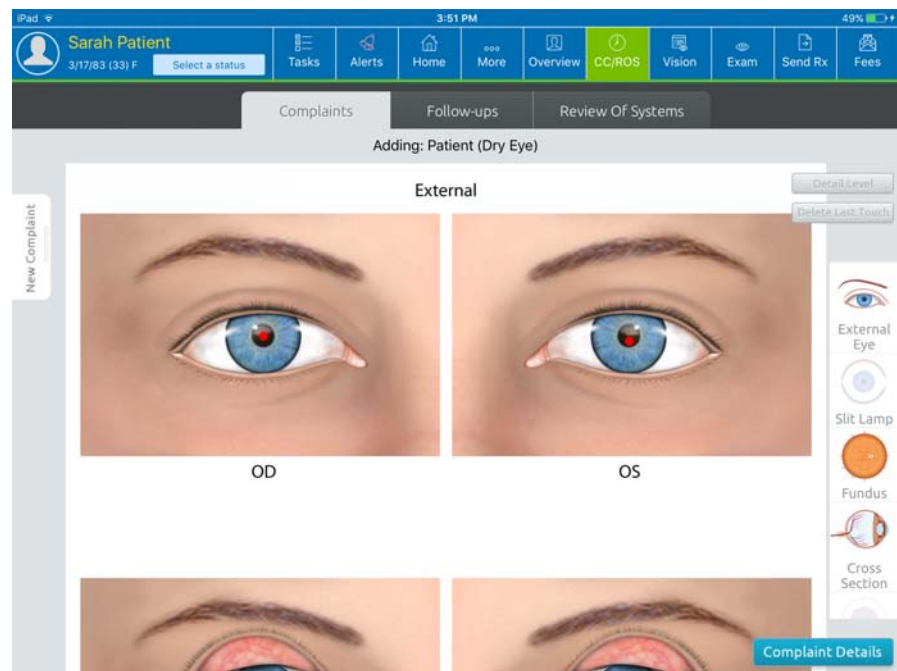
5. On the right side of the screen, tap the Eye diagram view you want to use to record the location of the chief complaint.

6. Tap the Eye diagram to indicate the location of the problem.

> **NOTE** If you make a mistake, you can tap **Delete Last Touch** in the upper right corner of the Eye diagram to remove the dot you last entered.

7. Tap **Complaint Details**.

The Complaint Details screen appears.
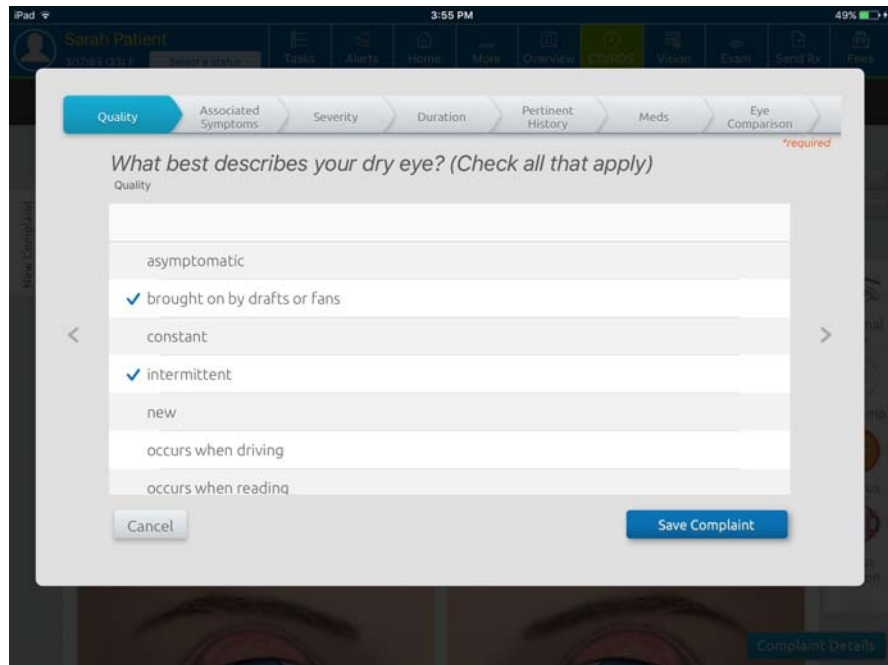
The tabs along the top of the screen allow you to access windows where you can describe the qualities, severity, and duration of the chief complaint.

> **NOTE** Swipe left or right to see additional tabs.

8. Tap the tabs for which you want to enter details and answer the questions.

9. Tap the **HPI Title** tab.

10. Select whether this is a new presentation or a follow-up to the complaint.

11. Tap **Save Complaint**.

▶ **To add a new secondary complaint**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

The Complaints tab opens.

3. Tap **Add a New Secondary Complaint**.

    The Complaint Details screen appears.

    The tabs along the top of the screen allow you to access windows where you can describe the condition, qualities, severity, and duration of the chief complaint.

4. Tap the tabs for which you want to enter details and answer the questions.

5. Tap **Save Complaint**.

▶ **To edit the CC/HPI statement**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

    The Complaints tab opens.

3. Tap the paragraph of the chief complaint.

    The Edit CC/HPI window opens.

4. Type your changes.

5. In HPI Components:

    – Select the items you want to appear in the chief complaint.

    – De-select the items you do not want to appear in the chief complaint.

NOTE	Ensure that the paragraph of the chief complaint correlates to the selected HPI components

6. Tap **Save**.

▶ **To edit the chief complaint**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

    The Complaints tab opens.

3. Tap **Modify** for the chief complaint you want to edit.

    The Eye diagrams appear.

4. Tap **Complaint Details**.

    The Complaint Details screen appears.

5. Tap the tabs for which you want to edit details and answer the questions.

6. Tap **Save Complaint**.

▶ To delete the chief complaint

1. Open a patient visit. For more information on opening a patient visit, go to .

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

   The Complaints tab opens.

3. Tap the the chief complaint you want to delete.

   The Edit CC/HPI window appears.

4. Tap **Delete**.

   A verification message appears.

5. Tap **OK**.

6. The Complaints tab opens.

Adding Follow-ups to a Visit

This section explains how to create a follow-up visit for an established patient.

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▶ To add follow-ups to a visit

1. Open a patient visit. For more information on opening a patient visit, go to .

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

   The Complaints tab opens.

3. Tap the **Follow-ups** tab.

4. Tap **>** for the condition for which you are performing a follow-up exam or tap **Add All** to follow-up on all of the conditions listed.

5. Enter the details for the follow-up.

6. Tap **Save**.

   The details for the follow-up are added to the chief complaint.

Performing a Review of Systems

This section explains how to record the review of systems and how to set alerts for the patient.

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▶ **To perform a review of systems**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

   The Complaints tab opens.

3. Tap the **Review of Systems** tab.

4. The Review of Systems tab opens.
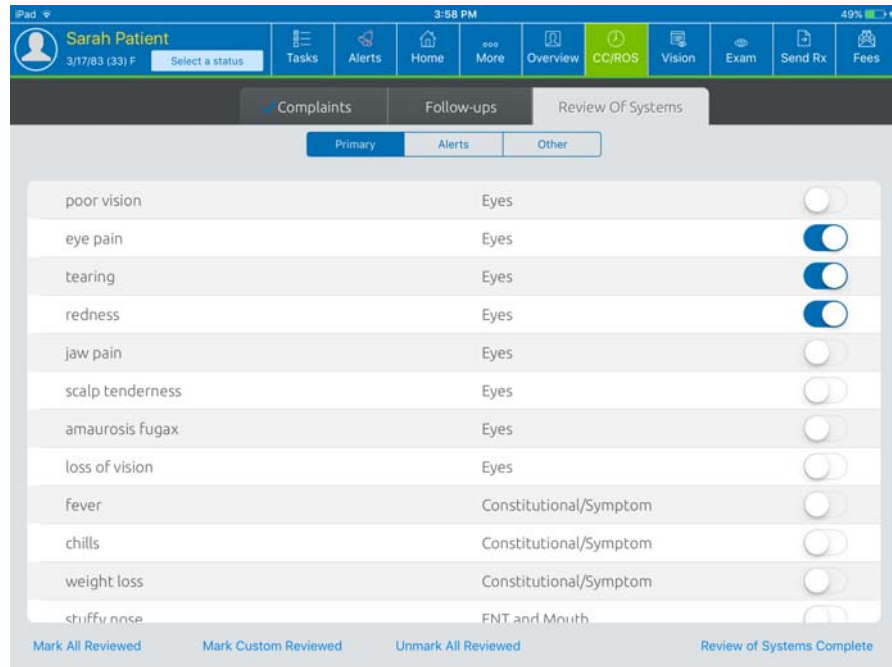
5. For a new patient, tap **Mark All Reviewed.** For an existing patient, tap **Mark Custom Reviewed**. You should only toggle a result on if the patient is presenting with the problem on the day of the visit.

NOTE	• To maximize your billing, you must indicate that you have reviewed more than one system.
	• You can customize the Review of Systems list in the administration section of the web app.

6. Tap **Review of Systems Complete**.

▶ **To set an alert for the patient**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

   The Complaints tab opens.

3. Tap the **Review of Systems** tab.

4. Tap the **Alerts** button.

   The Alerts tab opens.
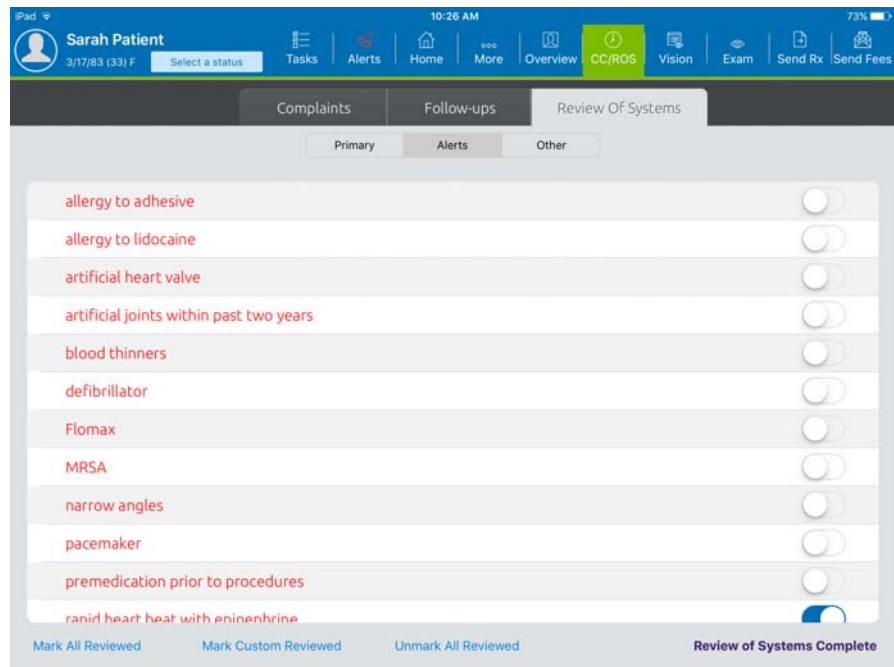
5. For each of the alerts, tap the toggle switches for the appropriate conditions to turn on alerts.

   When you set an alert for the patient, the Alert icon on the action bar turns red.

NOTE	You can customize the Alerts list in the administration section of the web app.

6. Tap **Review of Systems Complete**.

▶ **To add other symptoms for the patient**

1. Open a patient visit. For more information on opening a patient visit, go to "To open a visit from the patient's chart" on page 38.

2. Tap the **CC/ROS** button on the Action Bar, tap the **CC/HPI/ROS** button or tap the **CC/HPI/ROS** box.

   The Complaints tab opens.

3. Tap the **Review of Systems** tab.

4. Tap the **Other** button.

   The Other tab opens.
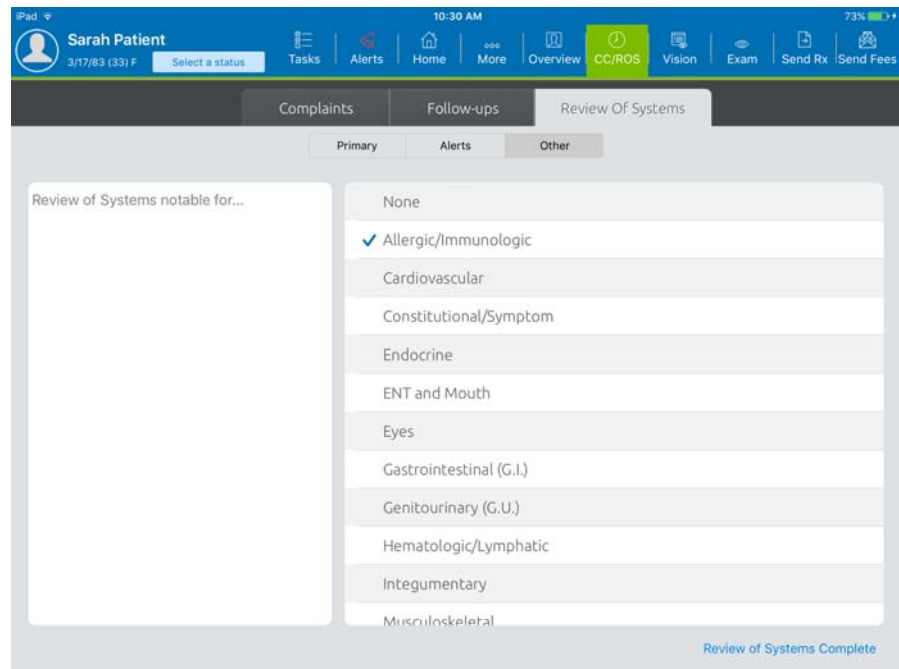
5. Select the system.
6. Type the symptom.
7. Tap **Review of Systems Complete**.

Recording the Vision Exam

4

In this chapter:

You can use the Visit Exam screen to document pretest data as well as refractions and generating eyeglass and contact lens prescriptions.

Opening the Vision Exam Screen

▶ **To open the Vision Exam screen**

1. Open a patient visit.

2. Tap the **Vision** button on the Action Bar, tap the **Vision Exam** button or tap the **Vision Exam** box.

   The Vision Exam screen appears.
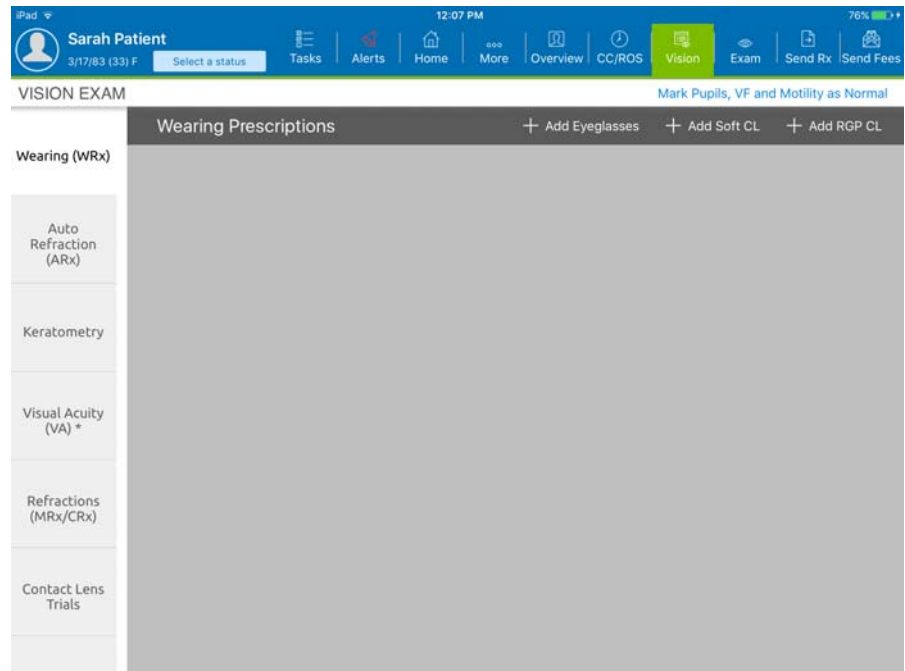
Performing a Routine Vision Exam

You can use the Visit Exam screen to document pretest data as well as refractions for a routine visit exam. The five areas that count toward billing are:

- visual acuity
- pupils
- motility
- visual fields
- IOP

These required areas are marked with an asterisk. This section tells you how:

▶ To document the wearing RX for a patient's eyeglasses

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Add Eyeglasses**.

   The Refractions tab opens.

3. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's eyeglasses.

   – **Refractions** Select the **Eyeglass Type** and **Usage** from the drop-down menus. Tap the appropriate **Eyeglass Options**. Select the values for the **Eyeglass Prescription** from the drop-down menus.

   > **NOTE** You can tap **Copy OD to OS** to copy the prescription for the right eye to the left eye.

   – **Visual Acuities** Select the patient's **Distance Vision** and **Near Vision** from the drop-down menus. You can tap the 20/20 OU link to populate the Visual Acuities. You can tap the down arrow to select the **HPrism Base** and **VPrisim Base**.

4. Tap **Save**.

▶ **To view and edit auto refractor readings**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to .

2. Tap **Auto Refraction**.

   The Auto Refractions tab opens.

   > **NOTE** When using the Equipment Integration, the Auto Refractions tab may be automatically populated with readings from the auto refractor entered in the Eyefinity EHR web application.

3. If you need to add refraction readings manually, tap **Add Refraction**.

   The Refractions tab appears.

4. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's refraction.

   – **Refractions** Select the values for the **Refraction** from the drop-down menus. Select the values for the **Additional Refraction Fields**.

   > NOTE   You can tap **Copy OD to OS** to copy the refraction readings for the right eye to the left eye.

   – **Visual Acuities** Select the patient's **Distance Vision** and **Near Vision** from the drop-down menus. You can tap the 20/20 OU link to populate the Visual Acuities. You can tap the down arrow to select the **Glare**, **BAT**, **PAM**, and **RAM**.

5. Tap **Save**.

▶ To enter visual acuity findings for an adult

> NOTE   If the Visual Acuities are documented correctly in the Wearing Rx tab, you do not need to document them again in the Visual Acuity tab.

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Visual Acuity (VA)**.

   The Visual Acuity tab opens.

3. Select the **Distance Test Type**, **Distance Correction Type**, **Near Test Type**, and **Near Correction Type**.

4. Tap **Save**.

▶ **To enter visual acuity findings for an infant**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Visual Acuity (VA)**.

   The Visual Acuity tab opens.

3. Tap the **Infant Vision** tab.

4. Select the values for the **CSM Method** from the drop-down menus.

5. Tap **Save**.

▶ **To enter refraction readings**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Refractions**.

3. Select the type of refraction you want to add from the drop-down menu.

   The Refractions tab appears.

4. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's refraction.

   – **Refractions** Select the values for the Refraction from the drop-down menus. Select the values for the **Additional Refraction Fields**.

NOTE	You can tap **Copy OD to OS** to copy the prescription for the right eye to the left eye.

   – **Visual Acuities** Select the patient's **Distance Vision** and **Near Vision** from the drop-down menus. You can tap the 20/20 OU link to populate the Visual Acuities. You can tap the down arrow to select the **Glare**, **BAT**, **PAM**, and **RAM**.

5. Tap **Save**.

▶ **To create the final prescription for glasses**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Refractions**.

   The Refractions tab appears with a summary of the patient's refraction information.

3. Tap **+Final Rx**.

   The Rx Details tab of the New Glasses Rx screen appears.

   – **RxDetails** Select the values for the **Prescription** from the drop-down menus. Type the prescription **Start Date** and **Expiration Date**. Select the **Visual Acuity** for Distance and Near. Select the **Usage**.

NOTE	• You must select a **Usage** or you will not be able to save the prescription.

   – **Lens Details** These options are not used in Eyefinity EHR.

   – **Frame Details** These options are not used in Eyefinity EHR.

   – **Special Instructions** Type any special instructions.

4. Tap **Save**.

▶ **To enter pupil findings**

> **NOTE**   You can tap the **Mark Pupils, VF and Motility as Normal** to mark each of the three sections of the vision exam as Normal.

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Pupils**.

   The Pupils tab opens.

3. Tap **Mark as Normal** or select the pupil **Measurements** and **Reactions**.

4. Tap **Save**.

▶ **To enter motility findings**

NOTE	You can tap the **Mark Pupils, VF and Motility as Normal** to mark each of the three sections of the vision exam as Normal.

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Motility**.

   The Motility tab opens.

3. Select the **Motility** from the drop-down menu.

4. Tap **Mark as Normal** or select the test performed. You can also select "Attempted but not achieved."

   – **Ductions and Versions** Select the values for the right and left eye on the drawing.

   – **Cover-Uncover** Select the Near and Distance values.

   – **Alternate cover** Select the Top, Middle and Bottom values.

   – **Reflex** Select the Hirschberg and Krimsky values.

5. Tap **Save**.

▶ **To enter visual field readings**

NOTE	You can tap the **Mark Pupils, VF and Motility as Normal** to mark each of the three sections of the vision exam as Normal.

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Visual Fields**.

   The Visual Fields tab opens.
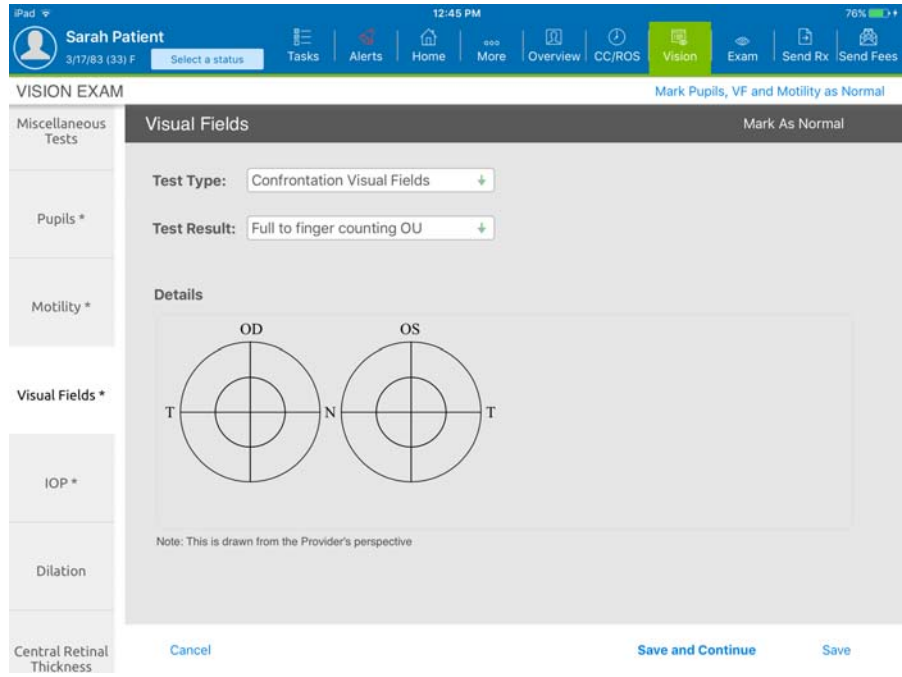
NOTE	The Visual Fields defaults to Confrontation Visual Fields. This is a sticky field. If you change it, your change will be retained for the logged in user.

3. Tap **Mark as Normal** or select the test type and test results. You can also select "Attempted but not achieved."

4. Mark any problem areas on the **Visual Field** drawing.

5. Tap **Save**.

▶ **To enter IOP readings**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **IOP**.

   The IOP tab opens

3. Enter the **IOP** readings. You can also select "Attempted but not achieved."

NOTE	This is a sticky field. If you change it, your change will be retained for the logged in user.

4. Tap **Save**.

▶ **To enter dilation readings**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Dilation**.

   The Dilation tab opens.

3. Select the dilation solution used for the right eye.

NOTE	This is a sticky field. If you change it, your change will be retained for the logged in user.

4. In **Counsel**, indicate whether you have counseled the patient.

NOTE	You can tap **Copy OD to OS** to copy the dilation information from the right eye to the left eye.

5. Tap **Save**.

▶ **To show refraction history**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

NOTE	Refraction history is available on any tab where a refraction is documented, such as Wearing Rx, Auto-Refraction, Contact Lens, RGP/Hybrid, and Refraction.

2. Access the **Refraction** tab.

3. Tap **Show Refractions History**.

4. A history of the patient's refractions appears.

5. Tap anywhere outside of the Refractions History to return to the **Refractions** tab.

Performing Additional Testing for Contact Lenses

In addition to recording the results for a routine vision exam, the Vision Exam allows you to record test results for patients using contact lenses. This section shows how:

▶ **To document the Wearing Rx for the patient's current soft contact lenses**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Add Soft CL.**

   The **Refractions** tab opens.

3. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's contact lenses.

– **Refractions** Select the **Contact Usage** from the drop-down menus. Select the **Product Manufacturer** and **Series**. Select the values for the **Contacts Prescription** from the drop-down menus.

> NOTE You can tap **Copy OD to OS** to copy the prescription for the right eye to the left eye.

– **Visual Acuities** Select the patient's **Distance Vision** and **Near Vision** from the drop-down menus. You can tap the 20/20 OU link to populate the Visual Acuities. You can tap the arrow to select the Glare, BAT, PAM, and RAM.

– **Assessment** If the test result was normal, tap **Mark as Normal.** Select the patient's Torics Rotated Right and Left, the Movement, Centration, Vision, Comfort and Torics Right.

– **Over Refraction** Select the patient's Sphere, Cylinder, Axis, Distance Visual Acuity and Near Visual Acuity.

– **CL Regimen** Select the Wearing Schedule, Replenishment, and Disinfecting information. Type any Special Instructions.

4. Tap **Save**.

▶ **To document the Wearing Rx for the patient's current RGP contact lenses**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Add RGP CL.**

   The Lens Fitting tab opens.


3. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's contact lenses.

   – **Lens Fitting** Select the **Manufacturer, Product,** and **RGP Type** from the drop-down menus. Select the values for the **Visual Acuity** from the drop-down menus. Type the values for the prescription.

NOTE	You can tap **Copy OD to OS** to copy the prescription for the right eye to the left eye.

   – **Special Instructions** Select the **Usage**, **Wear Schedule**, **Disinfecting**, and **DOT** from the drop-down menus.

4. Tap **Save**.

▶ **To view and add keratometer readings**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Keratometry**.

   The Keratometry tab opens.

   The Keratometry tab may be automatically populated with readings from the keratometer entered in the Eyefinity EHR web application.

3. If you need to add keratometry readings manually, type the **Keratometry** readings for the right eye

4. Type the **Keratometry** readings for the left eye or tap the arrow to copy the reading for the right eye to the left eye fields.

5. Leave **Manual Entry** set to on.

6. Tap **Save**.

▶ **To setup a soft contact lens trial**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Contact Lens Trials**.

3. Select **Soft CL Trials**.

4. Tap **Add Trial**.

   The Refractions tab appears.

   > **NOTE**   You can tap **Show Refractions History** to view a history of the patient's refractions.

5. Select the **Manufactuer** and the **Series**.

6. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's contact lenses.

   – **Refractions** Select the Contact Usage from the drop-down menus. Select the values for the Contacts Prescription from the drop-down menus.

   > **NOTE**   You can tap **Copy OD to OS** to copy the prescription for the right eye to the left eye.

   – **Visual Acuities** Select the patient's Distance vision, Near Vision and PH Value from the drop-down menus. You can tap the 20/20 OU link to populate the Visual Acuities. You can tap the arrow to select the Glare, BAT, PAM, and RAM.

   – **Assessment** Select the patient's **Torics Rotated** Right and Left, the **Movement**, **Centration**, **Vision**, **Comfort** and **Torics Right**.

   – **Over Refraction** Select the patient's **Sphere**, **Cylinder**, **Axis**, **Distance Visual Acuity** and **Near Visual Acuity**.

   – **CL Regimen** Select the **Wearing Schedule**, **Replenishment**, and **Disinfecting** information. Type any **Special Instructions**.

7. Tap **Save**.

▶ **To setup a RGP contact lens trial**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Contact Lens Trials**.

3. Select **RGP/Hybrid CL Trials**.

4. Tap **Add Trial**.

   The Lens Fitting tab appears.

5. Tap **Import Previous Refraction** and select the refraction you want to import, or enter the details for the patient's contact lenses.

   – **Lens Fitting** Select the **Manufacturer, Product,** and **RGP Type** from the drop-down menus. Select the values for the **Visual Acuity** from the drop-down menus. Type the values for the prescription.

NOTE	You can tap **Copy OD to OS** to copy the prescription for the right eye to the left eye.

   – **Special Instructions** Select the **Usage**, **Wear Schedule**, **Disinfecting**, and **DOT** from the drop-down menus.

6. Tap **Save**.

Performing Testing for Specific Eye Conditions

The Vision Exam screen allows you to record test results for other types of conditions such as glaucoma, macular degeneration, and color blindness.

- To enter binocular test results, 65
- To enter accommodative facility and MEM retinoscopy test results, 66
- To enter the central retinal thickness, 66
- To enter the RNFL thickness, 66
- To enter pachymetry test results, 67
- To enter endothelial cell counts, 67
- To enter test results on the Amsler Grid, 68
- To enter color vision test results, 68

▶ **To enter binocular test results**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Binocular Tests**.

   The Binocular Tests screen opens.

3. You can use the **Jump to Section** dropdown to jump to a specific section.

4. Select the **Near Point Convergence** and **Near Point Accommodation**.

5. Select **Phorias for Distance** and **Phorias for Near.**

6. Select **Vergence**, **Cross-Cylinder**, **Relative Accommodation**, **AC/A Ratio**, and **Fusion/Stereopsis.**

7. Select **Worth Four Dot** test results, **Titmus Stereo** test results, and **Dominance**.

8. Tap **Save**.

▶ **To enter accommodative facility and MEM retinoscopy test results**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Miscellaneous Tests**.

    The Miscellaneous Tests screen opens.

3. Select values for **Accommodative Facility**.

4. Select values for **MEM Retinoscopy**.

5. Tap **Save**.

▶ **To enter the central retinal thickness**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Central Retinal Thickness**.

    The Central Retinal Thickness screen opens.

3. Type the **Central Retinal Thickness** in micrometers for the right and left eye.

4. Tap **Save**.

▶ **To enter the RNFL thickness**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **RNFL Thickness**.

    The RNFL Thickness screen opens.

3. Type the **RNFL thickness** in micrometers for the right and left eye.

4. Tap **Save**.

▶ To enter pachymetry test results

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Pachymetry**.

   The Corneal Pachymetry Thickness screen opens.

3. Select the **Corneal Pachymetry Thickness** measurements for the right and left eye.

4. Tap **Save**.

▶ To enter endothelial cell counts

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Endothelial Counts**.

   The Endothelial Counts screen opens.

3. Type the **Endothelial Counts** for the right and left eye.

4. Tap **Save**.

▶ **To enter test results on the Amsler Grid**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Amsler Grid**.

    The Amsler Grid screen opens.
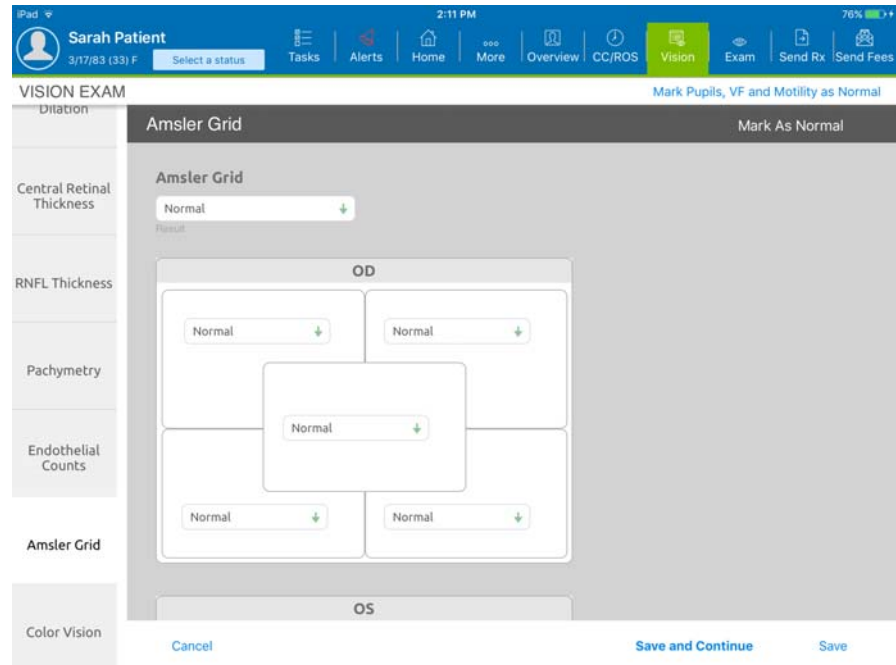
3. If the test result was normal, tap **Mark as Normal.** If the test result was abnormal, select **Abnormal** in the drop-down menu and select the abnormal result in the right and left eye grids.

4. Tap **Save**.

▶ **To enter color vision test results**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **Color Vision**.

    The Color Vision screen opens.

3. If the test result was normal, tap **Mark as Normal**. If the test result was abnormal, select **Abnormal** in the drop-down menu.

4. Select the **Test Type** in the drop-down menu.

5. Type the results for the right and left eye.

6. In **Details**, tap any plates the patient missed.

7. Tap **Save**.

Viewing the Final Prescription

▶ **To view the final prescriptions**

1. Open the Vision Exam screen. For more information on opening the Vision Exam screen, go to "To open the Vision Exam screen" on page 50.

2. Tap **More** on the Action Bar.

3. Tap **G&C**.

   The Glasses tab displays the final glasses prescription for this visit, if any.

NOTES	• From the Glasses tab, you can tap **+** to add a new prescription.
	• From the Glasses tab, you can tap **Send Rx** to send the prescription to the practice management system.
	• If you have the ability to print from your iPad to an AirPrint printer, you can tap **Print** to print the prescription.
	• From the Glasses tab you can **Edit**, **Copy**, or **Delete** a prescription.

4. Tap the Contacts tab.

   The Contacts tab displays the final contact lens prescription for this visit, if any.
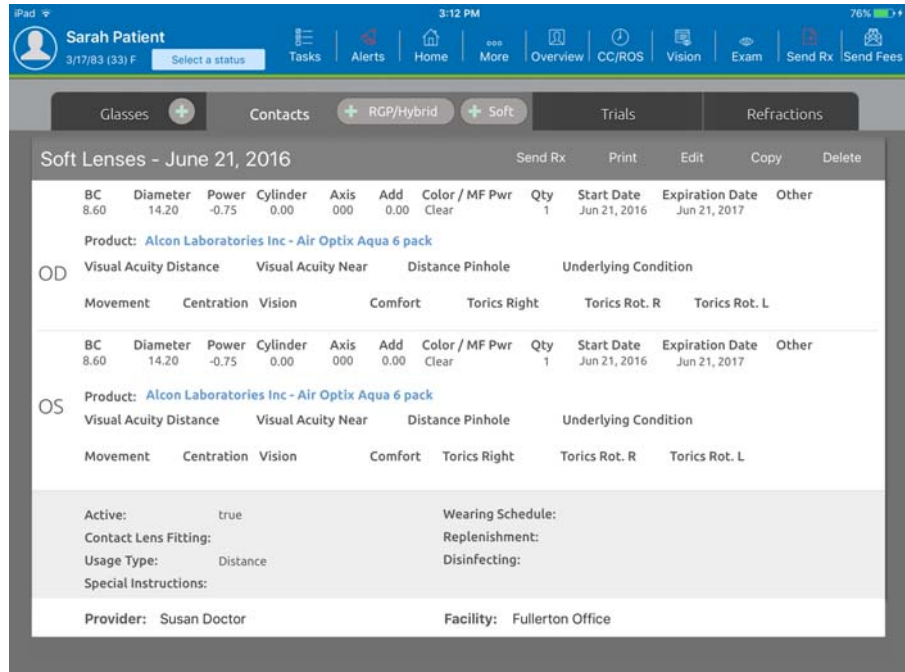
NOTES	• From the Contacts tab, you can tap **+RGB/Hybrid** or **+Soft** to add a new prescription.
	• From the Contacts tab, you can tap **Send Rx** to send the prescription to the practice management system.
	• If you have the ability to print from your iPad to an AirPrint printer, you can tap **Print** to print the prescription.
	• From the Contacts tab you can **Edit**, **Copy**, or **Delete** a prescription.

5. Tap the Trials tab.

   The Trials tab displays the trials for this visit, if any.
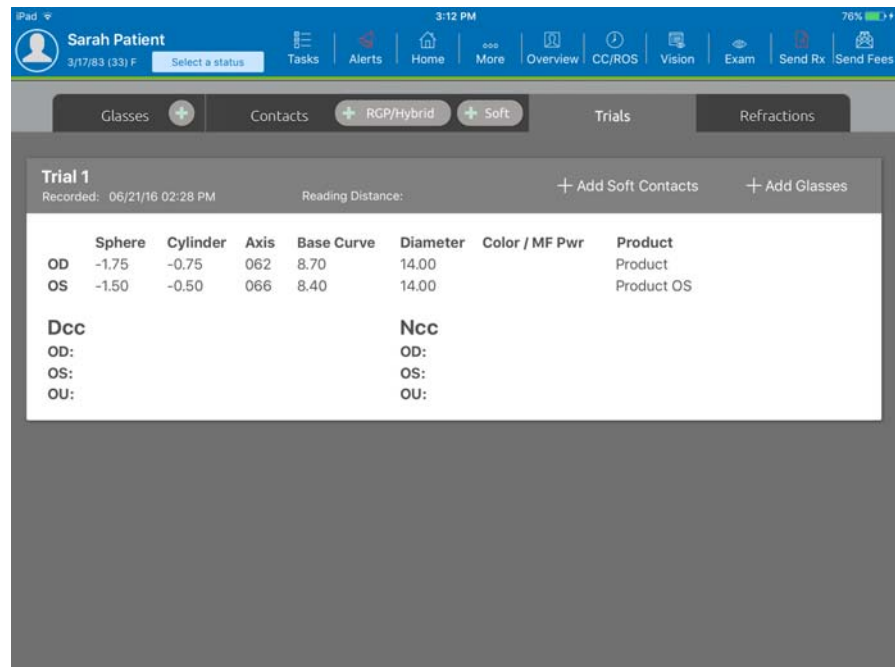
NOTE	From the Trials tab you can tap **+Add Soft Contacts** or **+Add Glasses** to add a prescription based on the trial.

6. Tap the Refractions tab.

The Refractions tab displays the refractions for this visit, if any.
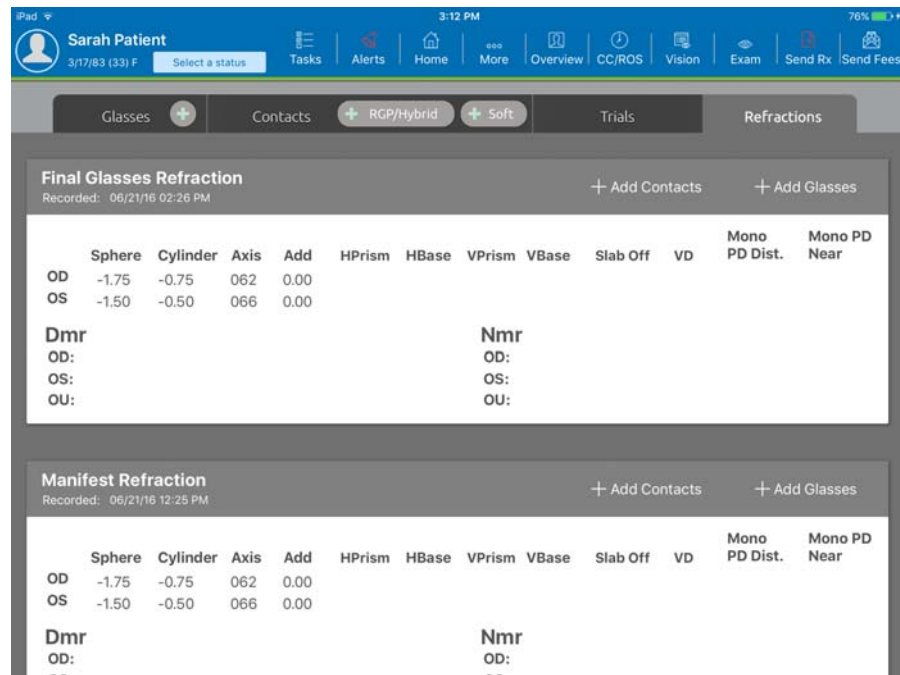
NOTE	From the Refractions tab you can tap **+Add Contacts** or **+Add Glasses** to add a prescription based on the refraction.

Sending the Final Prescription

▶ **To send prescriptions to the practice management system**

1. Access the Visit Overview screen.

When there are prescriptions available to send, the Send Rx button is red.

2. Tap **Send Rx** on the Action Bar.

The message, "Sending data to PMS," appears and the Send Rx button turns green.

e-Prescribing a Medical Prescription

▶ **To e-prescribe from the Visit Overview screen**

1. Access the Visit Overview screen.

2. Tap **More**.

3. Tap **Rx**.

NOTE	You can also e-prescribe from the Home screen or patient chart by tapping **Rx** in the Action Bar.

4. The Rx screen shows a list of prescriptions previously written for the patient.
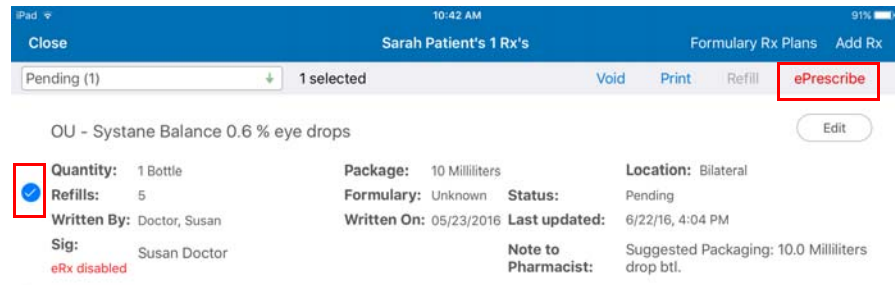
5. Select the prescriptions you want to send by tapping the circle to the left of the prescription.

6. Tap **ePrescribe** at the top of the screen.

<table>
<tr><td>NOTES</td><td>

- You can only send prescriptions for an individual patient. You cannot send prescriptions for multiple patients.
- If you add/change a pharmacy for the patient, the pharmacy will save to the patient's chart.
- If you want to write and send a new prescription, tap **Add Rx** and search for the medication. The medication is added to the queue.
- If you have the ability to print from your iPad to an AirPrint printer, you can tap **Print** to print the prescription.
</td></tr>
</table>

The preferred pharmacies for the selected patient appears.

7. Select the appropriate pharmacy.

8. Scroll to the bottom of the screen and tap **Send Prescriptions**.

Recording Exam Set Findings

5

In this chapter:

From the Ocular Exam Room you can select the exam set you want to use to record your findings for the patient's ocular exam. You can use filters to customize the exam set and view only the sections of the exam you perform.

When you initially open the exam, all of the sections of the exam are set to normal. You only have to record any abnormal findings.

Selecting the Exam Set

You can access an exam set and record your findings from the Ocular Exam Room. This section tells you how:

▶ **To select the exam set**

1. Open a patient visit.

2. Tap the **Exam** button on the Action Bar, tap the **Ocular Exam** button or tap
    the **Ocular Exam** box.

    The Ocular Exam Room opens.
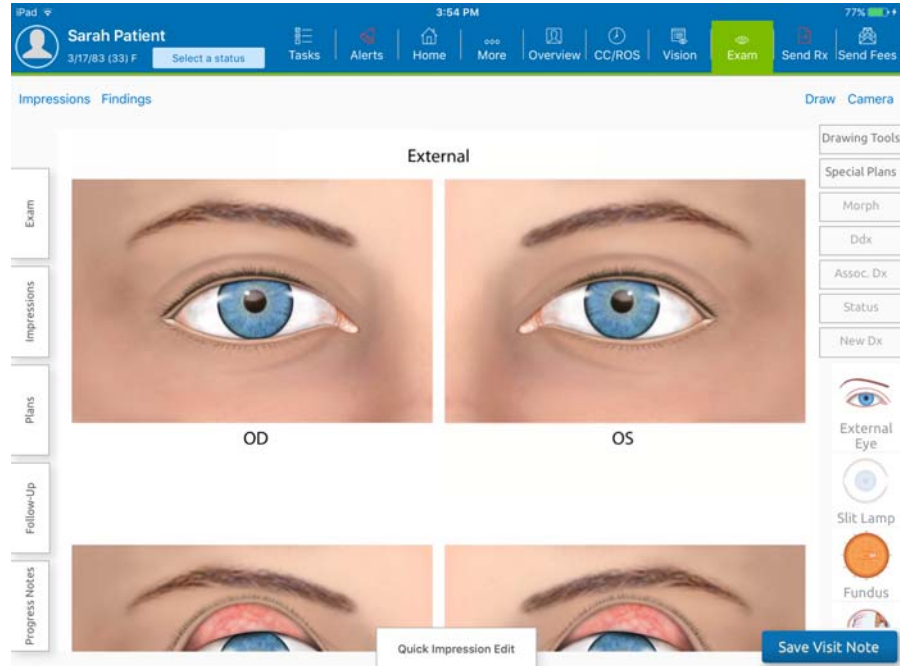
3. Tap the Exam tab.

    The Exam tab opens.

4. Tap **Perform Exam**.

    The Exam Set Selection screen opens.

    The buttons across the top of the screen show various types of exam sets.
    Each button opens a list of predefined exams.

5. Select one of the exam sets. To perform a routine exam, tap **Exam**.

6. A list of predefined exams opens.
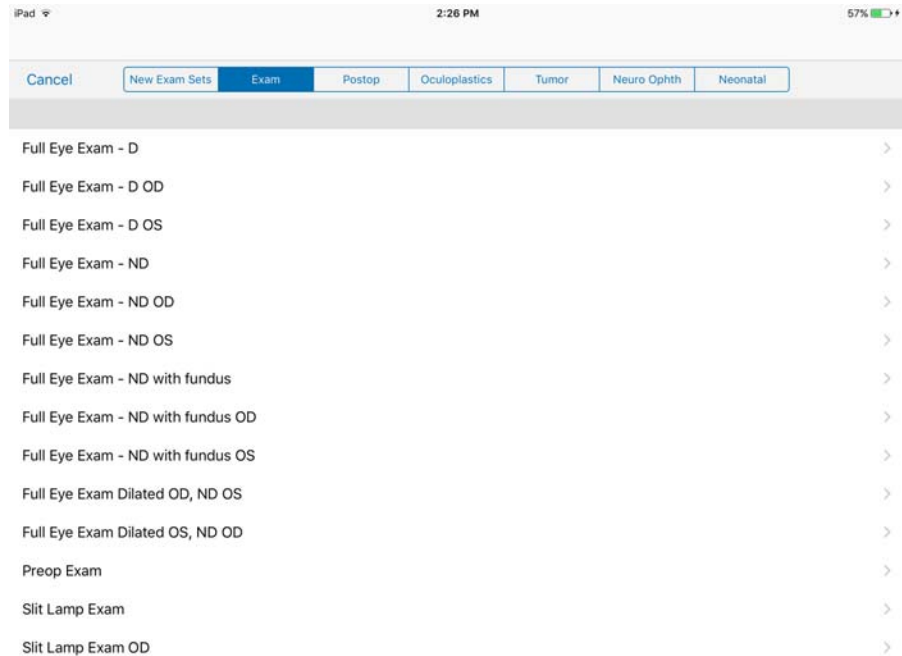
7. Select the exam you want to perform.

The Eye Exam Details screen opens.
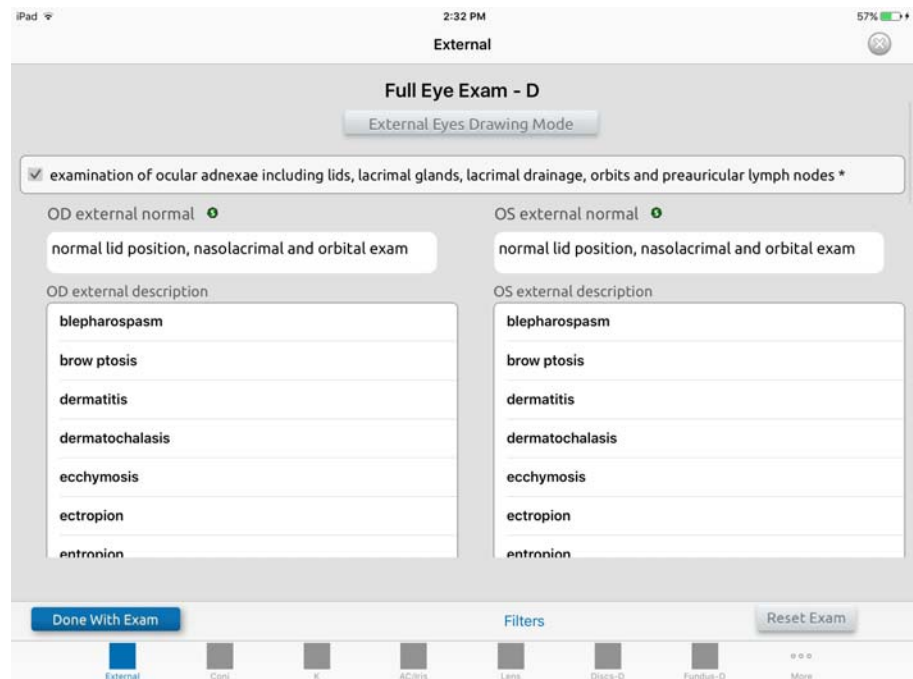
Marking a Patient's Data as Reviewed

If you have reviewed the data from the patient's chart, you can mark the patient's data as reviewed.

- To mark a patient's data as reviewed, 78

▶ **To mark a patient's data as reviewed**

1. Open a patient visit.

2. Tap the **Exam** button on the Action Bar, tap the **Ocular Exam** button or tap the **Ocular Exam** box.

   The Ocular Exam Room opens

3. Tap the Exam tab.

   A drawer opens.

4. Tap **Data Reviewed**.

   The Select Data Reviewed window opens.

5. Tap the items that you have reviewed.

6. Tap **Done Selecting Reviewed Data** to return to the Ocular Exam Room.

Copying Previous Findings

If you have an established patient you can quickly copy the findings from a previous visit to the current visit.

- To copy a patient's previous findings, 78

▶ **To copy a patient's previous findings**

1. Open a patient visit.

2. Tap the **Exam** button on the Action Bar, tap the **Ocular Exam** button or tap the **Ocular Exam** box.

   The Ocular Exam Room opens

3. Tap the Exam tab.

   A drawer opens.

4. Tap **Previous Findings**.

   The Previous Findings window lists the patient's previous visits.

5. Tap the visit to expand it.

   A list displays the type of exam performed and the diagnoses.

6. Tap the checkbox for the items you want to copy to the current visit.

7. Tap **Draw Selected Findings** to copy the findings.

8. The Ocular Exam Room appears.

Using Filters

You can use Filters to turn on and off the various sections of the eye exam. This allows you to include the sections of the exam you will be performing and exclude the sections of the exam you will not be performing. If you are performing a complete eye exam, you do not need to use filters.

- To use filters to customize the eye exam, 79

▶ **To use filters to customize the eye exam**

1. Access the Eye Exam Details screen.

2. Tap **Filters**.

   The Filters window opens.
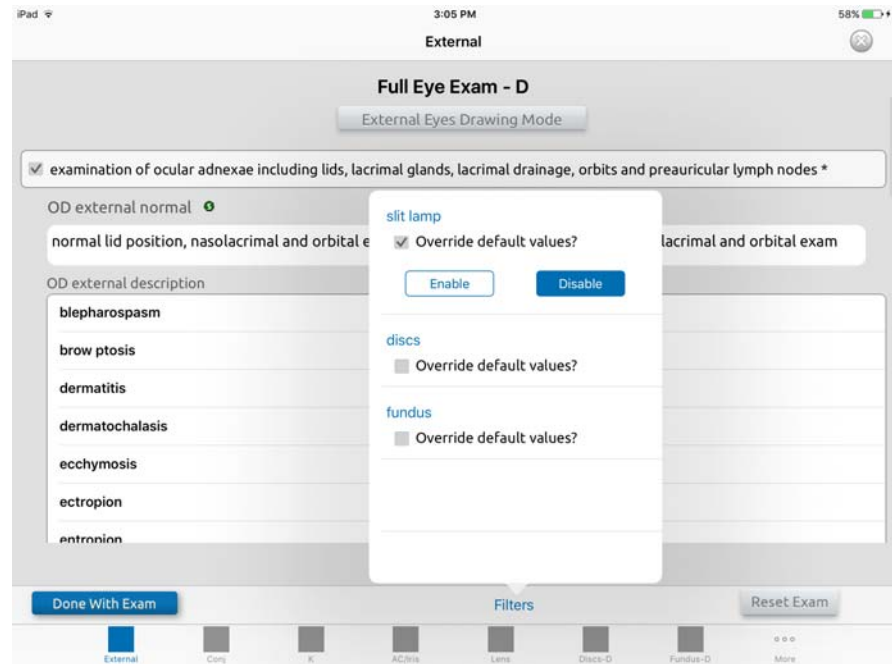
3. Select **Override default values** for the exams you are not performing and then tap **Disable**.

4. Tap anywhere outside the Filter window to close it.

Recording Findings

Buttons are displayed along the bottom of the Eye Exam Details screen showing the various sections of the eye exam. The default exam set includes findings for external eyes, conjunctiva, cornea, iris, lens, discs, and fundus. When you initially access the eye exam, all sections of the default exam set are set to normal. This saves you time because you only have to record abnormal findings.

This section explains how to record eye exam findings.

- To record eye exam findings, 79
- To record cup to disc ratio, 80

▶ **To record eye exam findings**

1. Access the Eye Exam Details screen.

2. At the bottom of the screen, tap the section of the exam for which you want to record your findings.

   The Eye Exam Details screen for that section opens.

3. If you are performing this section of the exam, select the check box for the exam description. If you are not performing this section of the exam, clear the check box for the exam description.

4. The description for the right and left eye is pre-populated with a description of normal findings. You can accept the default value or edit this field with your findings.

5. In the **OD description** and **OS description**, tap abnormal findings, if any.

6. If you have additional findings to record, tap the section of the exam for which you want to record findings. When you have finished recording findings, tap **Done with Exam**.

NOTES	If you want to view additional sections of the exam, tap **More** at the bottom of the screen. This opens the IOP, Gonio, Misc, Skin, and Exam Notes section of the exam.
	If you have made an error in recording your findings and want to start over with a blank exam set, tap **Reset Exam**.

▶ **To record cup to disc ratio**

1. Access the Eye Exam screen.

2. Tap the **Discs** section of the exam.

3. The Eye Exam - Discs screen opens.

4. In **OD CD Ratio** and **OS CD Ratio**, select the cup to disc ratio from the drop-down menu.

> NOTE You can tap **Copy to OS** to copy the ratio for the right eye to the left eye. You can tap **Copy to OD** to copy the ratio for the left eye to the right eye.

5. In **OD optic discs normal** and **OS optic discs normal**, you can accept the default value or edit these fields with your findings

6. In **OD opthalmoscopic exam of optic discs** and **OS opthalmoscopic exam of optic discs**, select abnormal findings, if any.

7. In **Lens Used**, type the name of the lens used for the exam.

> NOTE This is a sticky field. If you change it, your change will be retained for the logged in user.

8. When you have finished recording findings, tap **Done with Exam**.

Recording Impressions, Morphologies, and Plans

In this chapter:

You can use the Ocular Exam Room to record your impressions, document the morphology, and select the treatment plans to be used for the patient.

Recording an Impression

You can access the Impressions drawer and record your impressions from the Ocular Exam Room. This section tells you how:

▶ **To record an impression**

1. In the Ocular Exam Room, tap the Impressions drawer to open it.

   The Impressions drawer displays your top 10 most commonly used impressions.
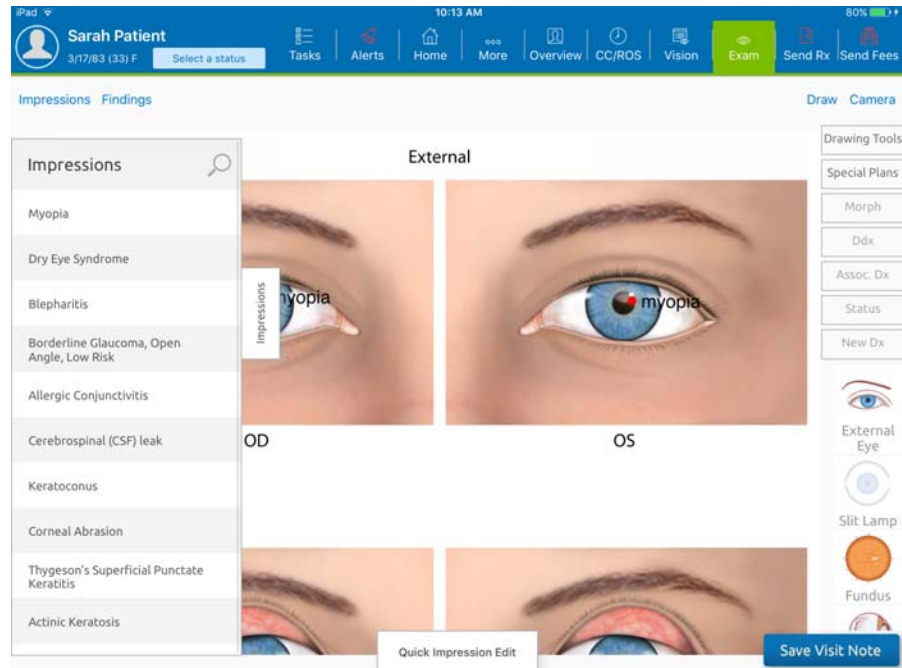
2. Select one of the impressions or tap the magnifying glass to search for an impression by name or by ICD 9 code.

NOTE	You can search for systemic diagnoses on the Impressions tab. Tap the magnifying glass on the Impressions tab and then type the first few characters of the diagnosis you want to search for. Tap **Complete Diagnosis Search** to display additional systemic diagnosis based on the search text you entered.

   Based on the impression you select, the image in the Ocular Exam Room will display one of nine diagrams, whichever is most relevant to the diagnosis: external eye, slit lamp, fundus, gonioscopy, face, head, cross section, and neonatal fundus. You can switch diagrams by tapping a diagram on the right side of the screen. Swipe up to view more diagrams.

   After you select an impression, the Morphologies and Plans drawers open. The ICD-10 Expert button turns blue if more information is required for the impression you selected.

3. In the Findings/Impressions section, make a selection to classify the diagnosis.

> **NOTE** It is not required to select a classification of your diagnosis. Selecting a classification is recommended as it will assist you with your coding.

– **New Dx** indicates that this is the first time you are diagnosing the patient with this impression in Eyefinity EHR.

– **Status** indicates that you have previously seen the patient for this impression

– **Ddx** indicates that one of several diagnoses are possible for the impression. For example, you may record the impression of Conjunctivitis but cannot specify whether it is Allergic, Bacterial, or Viral Conjunctivitis.

– **Associated Dx** indicates that you want to associate another diagnosis with this impression. For example, you may record the impression of Myopia and want to associate this diagnosis of Astigmatism.

> **NOTE** Associated Dx will display in blue for some diagnoses. It is recommended that, when it is displayed in blue, that you tap the button and review the information. For example, if the diagnosis is diabetes, you may want to document that the patient uses insulin.

Recording the Morphology

Based on the impression you selected, the Morphologies drawer shows a list of morphologies related to the impression. You can select from the list of morphologies or enter details for a custom morphology.

- To record the morphology, 86

▶ ## To record the morphology

1. In the Ocular Exam Room, tap **Morph** to open the Morphology drawer.

NOTE	You cannot select a Morphology unless an Impression is first selected.
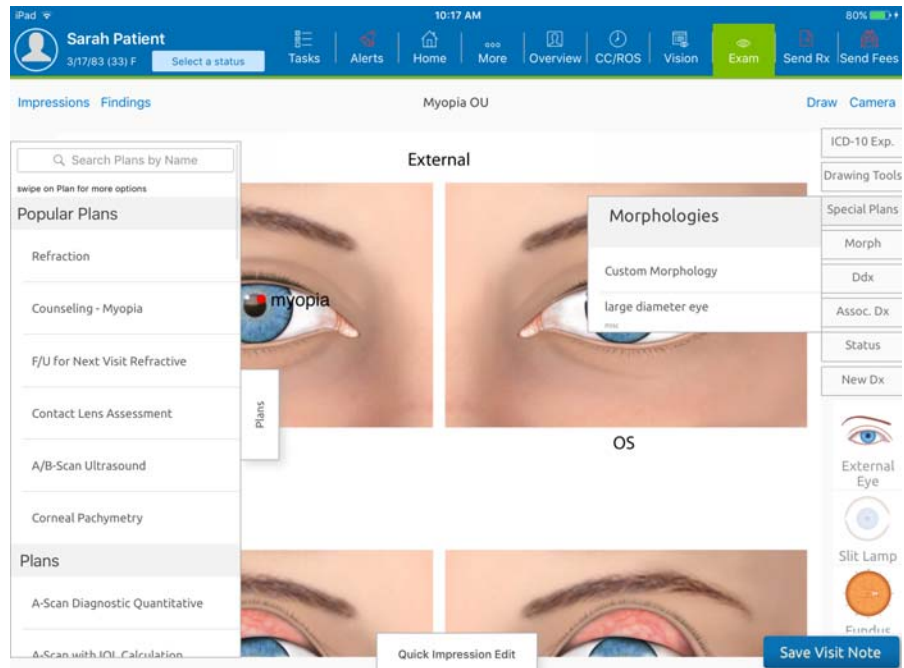
2. Select one or more of the morphologies listed or tap custom Morphology to add to this list.

3. If you tap custom morphology, type the information for the morphology. Select whether the morphology is a **Positive indication**.

4. Select the body system the **Morphology relates to**.

5. Select whether you want to **Always remember this morphology**. If you select Always remember this morphology, this will permanently be a morphology for this impression only.

6. Tap **Done**.

7. Tap the location where you see the morphology on the Eye diagrams. This overrides the default statements in the Exam Set for the given system.

NOTE	• You may need to close drawers to tap on the Eye diagrams.
	• Tapping the location on the Eye diagram does not record a specific location in your note. It will simply indicate OD, OS, or OU in your note.
	• Tapping the location on the Eye diagram is important for ICD-10 coding.
	• If you need to document different morphologies for the right and left eye, you must deselect the first morphology, select the new morphology, and tap the new location,

8. If you make a mistake, you can tap Undo in the upper right corner of the Eye diagram to remove the dot you last entered.

9. Tap **Morph** to close the Morphology drawer.

Recording the Plans

Based on the impression you selected, the Plans drawer shows a list of plans related to the impression. You can select one or more plans from the list.

- To record the plan(s), 87

▶ To record the plan(s)

NOTE	You cannot select a Plan unless an Impression is first selected.

1. In the Ocular Exam Room, tap Plans to open the Plans drawer.

    On the Plans drawer, Popular Plans displays your most commonly used plans for the impression.

NOTE	At first, Popular Plans will be empty until Eyefinity EHR learns what plans you prefer for an impression.
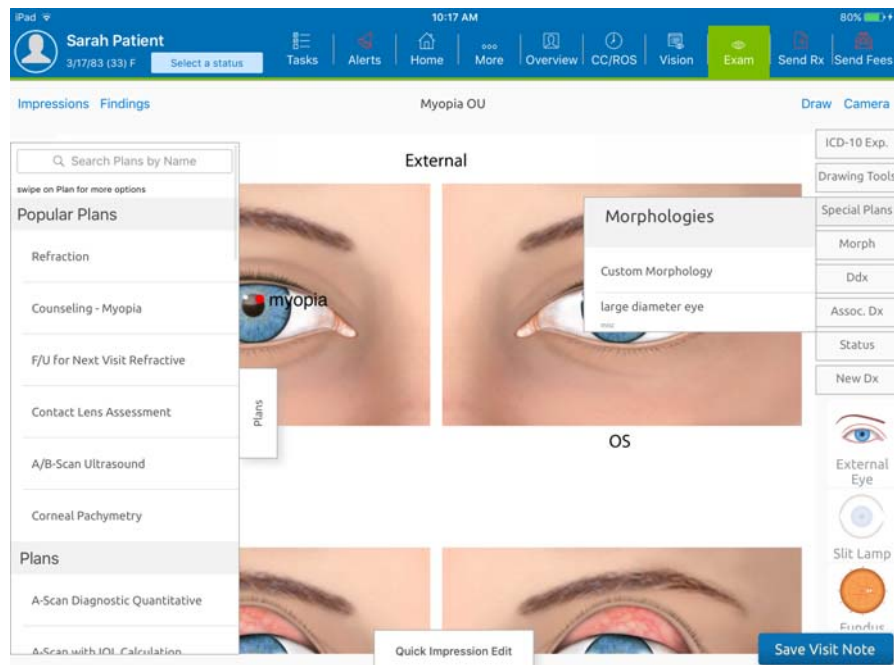
2. Select from the Popular Plans or scroll through the list and select another plan.

NOTES	• You can search for a plan by name by typing the first few letters of the plan name in the Search box. Eyefinity EHR only searches the plans associated with the impression.
	• If the are plans you do not use, you can hide them in the Plans list. Swipe left on the plan you want to hide. Choose if you want to **Hide Everywhere** to hide the plan for all impressions or **Hide** to hide the plan for this impression only. The plan will be listed in the Hidden Plans section of the Plans list. To show a hidden plan, locate the plan in the Hidden Plans section. Swipe left on the plan and tap **Show**.

The Details screen appears. The Details screen differs based on the plan you select. For more information, see "Entering Details for Common Plans" on page 89.

3. Enter the details for the plan and tap **Done**.

The Plans drawer on the Ocular Exam Room appears.

4. Select more plans until you have selected everything you've done related to the impression.

5. Tap the Plans drawer to close it.

6. If there was only one impression and the exam is complete, tap **Save Visit Note** to save your changes. If there was more than one impression, open the Impressions drawer to diagnose another condition.

Entering Details for Common Plans

Within Eyefinity EHR there are hundreds of plans. This section shows how to enter details for many commonly-used plans.

NOTE	Any plan with an asterisk (*) requires that the location on the diagram be selected before any details can be documented.

▶ **To use the Bandage/Therapeutic Contact Lens plan**

1. On the Plans drawer, tap **Bandage/Therapeutic Contact Lens**.

   The Slit Lamp Eye diagram appear.

2. Tap the location of the impression on the Eye diagrams.

NOTE	• You must select the location on the diagram be selected before any details can be documented.
	• The Glyph Slider may appear which allows you to scale and rotate the location of the condition.

The Details screen appears.

3. Select the **Indication(s)**.

    If any post-operative medications will be administered, tap **Medications**. If you want to review the patient's consent, tap **Consent**. If you want to review or edit the patient's post-care instructions, tap **Post-care**.

4. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

• **Medications**

NOTE	This tab is not used to prescribe medications. It is used for documentation purposes only.

5. Tap **Medications**.

The Medications screen shows a list of medications.

Tap to the right of the text box for the **Post Op Meds** that will be administered to the patient.

Type the instructions for using the medication in the text box.

• **Consent**

Tap **Consent** to review a description of the patient's consent.

• **Post-care**

Tap **Post-care** to review a description of the post-operative care instructions given to the patient.

▶ **To use the Contact Lens Assessment plan**

1. On the Plans drawer, tap **Contact Lens Assessment**.

The Details screen appears.

2. Type the **Price**, if necessary.

3. Select a level for the **Contact Lens Fitting Fee**.

NOTE	• You can enter a price of zero dollars.
	• If you select a level, the level will be sent to your practice management system when you finalize charges.

At the bottom of the screen are additional options related to the contact lens assessment. All of these options are set to normal. You only need to record any abnormal findings.

4. When you have finished entering details for the plan, tap Done to return to the Ocular Exam Room.

-   **Fit**

    Tap **Fit**.

    The Fit screen shows a list of possible fitting problems.

    Select the fit for the right and left eye.

-   **Comfort**

    Tap **Comfort**.

    The Comfort screen shows a list of comfort levels for the contact lenses.

    Select the comfort level for the right and left eye.

-   **Vision**

    Tap **Vision**.

    The Vision screen shows various problems with the clarity of vision provided by the contact lenses.

    Select the clarity of vision for the right and left eye.

-   **Lens**

    Tap **Lens**.

    The Lens screen shows various problems that may affect the contact lenses.

    Select any problems with the lenses for the right and left eye.

-   **Ocular health**

    Tap **Ocular Health**.

    The Ocular Health screen shows a list of ocular health problems that may affect the patient.

    Select any ocular health problems for the right and left eye.

-   **Other**

    Tap **Other**.

    Type any other information regarding the contact lenses for the right and left eye.

-   **Plan**

    Tap **More** and then tap **Plan**.

    Select the Plan.

    Select the recommended soft lens and RGB lens.

    Select the Care Recommendations.

- **Parameters**

  Tap **More** and then tap **Parameters**.

  Select the Change Parameters for the right and left eye.

- **Monovision**

  Tap **More** and then tap **Monovision**.

  Select whether the contact lenses are for monovision for the right and left eye.

- **Lens Counseling**

  Tap **More** and then tap **Lens Counseling**.

  In the Education Checklist, tap to the right of the text box for the items on which the patient was counseled.

  In the text boxes, type the details of the counseling the patient received.

▶ To use the Counseling plan

1. On the Plans drawer, tap **Counseling**.

   The Details screen appears.

2. Select whether you want full counseling or abridged counseling to appear in the visit note.

NOTE	Eyefinity EHR recommends using abridged counseling which prevents large blocks of counseling text from being rendered in the note. This makes scrolling through exams easier and quicker. Full counseling will still be rendered on anything patient-facing, such as patient handouts or the Patient Portal.

3. Tap to the right of the text box for each **Counseling Block** you reviewed with the patient. Edit the counseling block with your counseling instructions, if necessary.

4. Tap **Done** to return to the Ocular Exam Room.

▶ **To use the Epilation plan**

1. On the Plans drawer, tap **Epilation**.

   The Details screen appears.

2. Select the type of **Procedure(s)** performed.

3. Select the **Location** where the procedure was performed.

   At the bottom of the screen are additional options related to the type of procedure performed. All of these options contain a procedure note, patient consent, and post-care instructions. You only need to edit an option to record any abnormal information.

4. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

- **Forceps**

  If epilation forceps were used, tap **Forceps** to review a description of the Forceps Note, the patient's Consent and Post-care Instructions.

- **Cryotherapy**

  If cryotherapy was used, tap **Cyrotherapy** to review a description of the Cryotherapy Note, the patient's Consent and Post-care Instructions.

- **Electrosurgery**

  If electrosurgery was used, tap **Electrosurgery** to review a description of the Electrosurgery Note, the patient's Consent and Post-care Instructions.

- **Laser**

  If a laser was used, tap **Laser** to review a description of the Laser Note, the patient's Consent and Post-care Instructions. You can also select the Laser Type, Spot Size, Power, Pulse duration and Total Shots.

▶ **To use the Extended Opthalmoscopy plan**

1. On the Plans drawer, tap **Extended Opthalmoscopy**.

   The Details screen appears.

2. Select the **Location** where the ophthalmoscopy was performed.

3. Select the **Status** of the ophthalmoscopy.

4. Type the reason why the ophthalmoscopy was a **Medical Necessity**.

   At the bottom of the screen is an additional option that allows you to indicate how to bill for the procedure.

5. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

- **Billing**

    If the ophthalmoscopy was performed bilaterally, select whether to bill as one line item or two line items.

▶ **To use the External Photos plan**

1. On the Plans drawer, tap **External Photos**.

    The Details screen appears.

2. Select the **Location** where the external photos were taken.

3. Type whether there was any **Other Indication**.

4. Select the **Reliability of the Study**.

    At the bottom of the screen there are additional options that allow you to enter findings, and an assessment and plan. There is also an option that allows you to indicate how to bill for the procedure.

5. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

- **Findings**

  Tap **Findings**.

  The Findings shows a list of the potential findings for the right and left eye. The default is set to normal.

  Select your findings for the right and left eye.

- **Assessment and Plan**

  Tap **Assessment and Plan**.

  Select the **Assessment** for the external photos.

NOTE	Some insurance plans will not reimburse for external photos assessed as baseline for future comparison.

  Future Plans shows a list of procedures and treatments. Tap to the right of the text box for the procedures or treatments that could be performed for the patient in the future. Edit the descriptions of the plans, if necessary.

- **Billing**

  Tap **Billing**.

  Select whether you'll bill the patient for the professional component, the technical component, or both.

▶ **To use the Follow-up for Next Visit plan**

1. On the Plans drawer, tap **F/U for Next Visit**.

   The Details screen appears.

NOTE	• Every impression has its own unique Follow-up plan.
	• Do not use the Follow-up drawer in the Ocular Exam Room to create follow-up visits.

2. Select the **Follow-up time Frame**.

NOTE	If you select a follow-up time frame, it will be sent to your practice management system when you finalize charges.

3. Select the **Plan for next visit** as diagnostic or both.

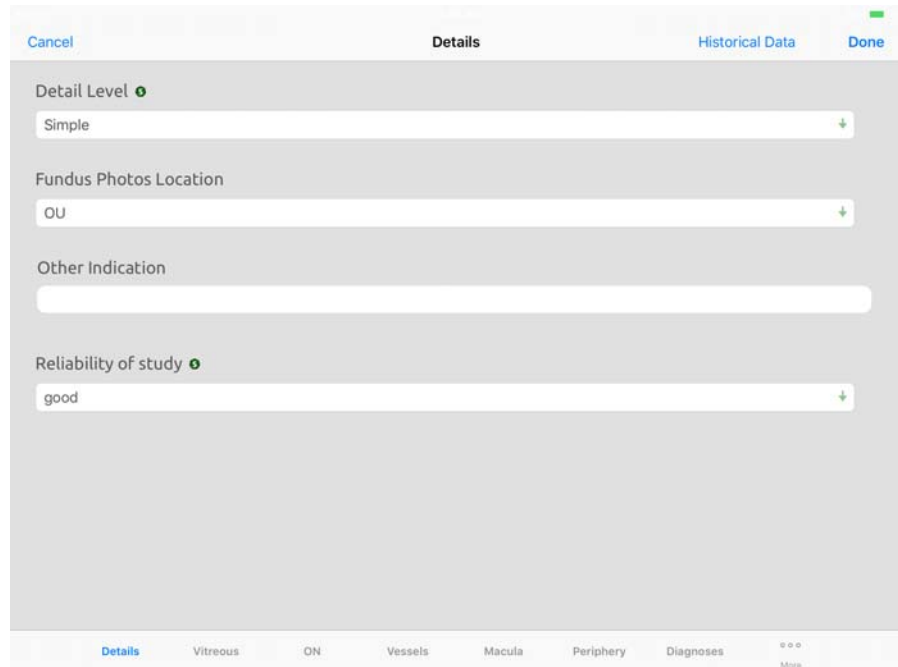 | NOTE | You should only select treatment if you will treat the patient in some way during the follow-up visit. |
   |------|---|

4. Type the **Protocols** to be followed on the next visit for the right and left eye, if desired.

5. Tap to the right of the text box for the protocols to be followed on the next visit.

   At the bottom of the screen there are additional options that allow you to specify the exam, diagnostics, and procedures you want to perform for the patient's next visit. There is also an option that allows you to enter information for following up with another physician.

6. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

*   **Exam**

    Tap **Exam**.

    Tap the exams you want to perform for the patient on the next visit.

*   **Diagnostics**

    Tap **Diagnostics**.

    Tap the diagnostics you want to perform for the patient on the next visit.

*   **Procedures**

    Tap **Procedures**.

    Tap the procedures you want to perform for the patient on the next visit.

*   **Laser**

    Tap **Laser**.

    Tap the laser procedures you want to perform for the patient on the next visit.

*   **Refractive**

    Tap **Refractive**.

    Tap the refractive procedures you want to perform for the patient on the next visit.

*   **Follow-up another Dr**

    Tap **Follow-up another Dr**.

    Select the **Follow-up time frame**.

    Type the **Name of Physician** to follow up with.

    Type any **Instructions** for the patient.

▶ **To use the Fundus Photos plan**

1. On the Plans drawer, tap the **Fundus Photos** plan.

    The Details screen appears.

2. Select the **Fundus Photos Location** as the right, left or both eyes.

3. Type any **Other Indication**.

4. Select the **Reliability of study**.

    At the bottom of the screen there are additional options that allow you to specify findings for various structures of the eye. All of these options are set to normal. You only need to record any abnormal findings.

    The are also options that allow you to select how the patient will be billed and to enter and an assessment and plan.

5. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

-   **Vitreous**

    Tap Vitreous.

    Select the condition of the **Vitreous** for the right and left eye.

-   **ON**

    Select the condition of the **Optic Nerve** for the right and left eye.

-   **Vessels**

    Select the condition of the **Vessels** for the right and left eye.

-   **Macula**

    Select the condition of the **Macula** for the right and left eye.

-   **Periphery**

    Select the condition of the **Periphery** for the right and left eye.

-   **Diagnoses**

    Select the **Diagnosis** for the right and left eye.

-   **Assessment and Plan**

    Tap **More** and then tap **Assessment and Plan**.

    Select the **Assessment** for the fundus photos.

NOTE	Some insurance plans will not reimburse for external photos assessed as baseline for future comparison.

    Future Plans shows a list of potential procedures and treatments. Tap to the right of the text box for the procedures or treatments that could be performed for the patient in the future.

-   **Billing**

    Tap **More** and then tap **Billing**.

    Select whether you'll bill the patient for the professional component, the technical component, or both.

▶ **To use the OTC Regimen plan**

1. On the Plans drawer, tap **OTC Regimen**.

   The Details screen shows a list of **OTC** regimens.

2. Tap to the right of the text box for the OTC regimens the patient will follow. Edit the description of the OTC regimen, if necessary.

3. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

▶ **To use the Prescription plan**

1. On the Plans drawer, tap **Prescription**.

   The Details screen shows a list of the medications you most commonly prescribe.
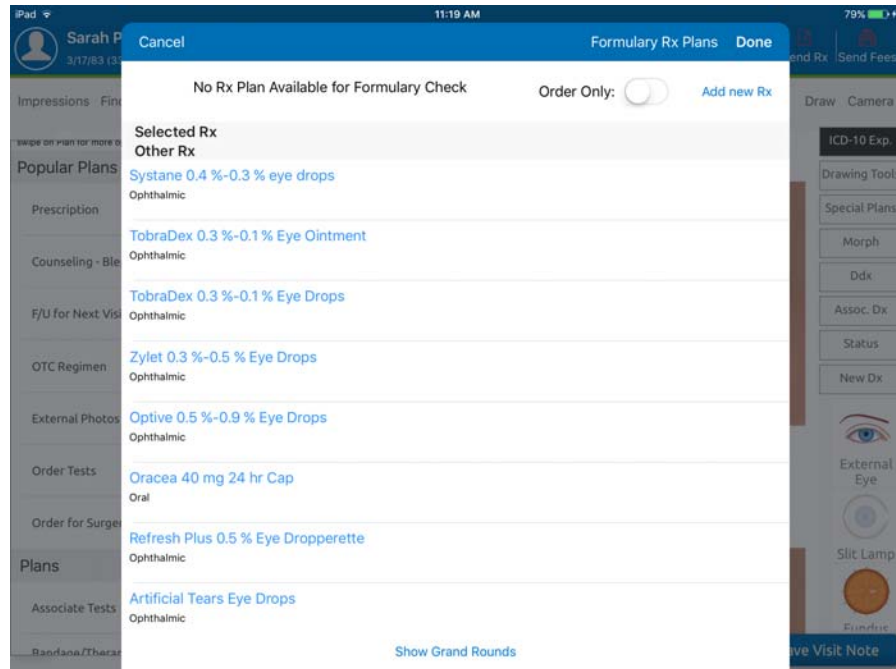
2. Select the medication you want to use or tap **Add new Rx** to search for a new medication.

NOTE	• Over the counter medications should not be prescribed on this window. This window is for therapeutic medications.
	• You can tap **Show Grand Rounds** to see a history of the medications you have prescribed for the impression, the medications other doctors in your practice have prescribed for the impression, and what all doctors in the Eyefinity EHR network have prescribed for the impression.

3. If the **Drug Interaction(s)** button is displayed, you can tap it to display a list of drug interactions based on the patient's medications and allergies.

4. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

▶ **To use the Permanent Punctal Occlusion plan**

1. On the Plans drawer, tap **Permanent Punctal Occlusion**.

   The Details screen appears.

2. Select the **Anesthesia** used.

3. Select **Complications**, if any.

   At the bottom of the screen are additional options that allow you to enter details about the procedure. You can also view the patient consent and view or edit the post-care instructions.

4. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

- **RUL, RLL, LUL, LLL**

  Tap the appropriate location.

  Select the **Punctal Occlusion Company.**

  Select the **PUNCTAL Occlusion Method**.

  Type the **Punctal Serial/Lot Number**.

  Select the **Punctal Dilator**.

- **Laser**

  Select the **Laser** type.

  Select the **Spot Size**.

  Select the **Fluence**.

  Select the **Pulse duration**.

  Type the number of **Total Shots**.

- **Consent**

  Tap **Consent** to review a description of the patient's consent.

- **Post-care**

  Tap **More** and then tap **Post-care** to review a description of the post-operative care instructions given to the patient.

- **Billing**

  Tap **More** and then tap **Billing**.

  Select the **CPT Modifier**, if any.

▶ **To use the Reassurance plan**
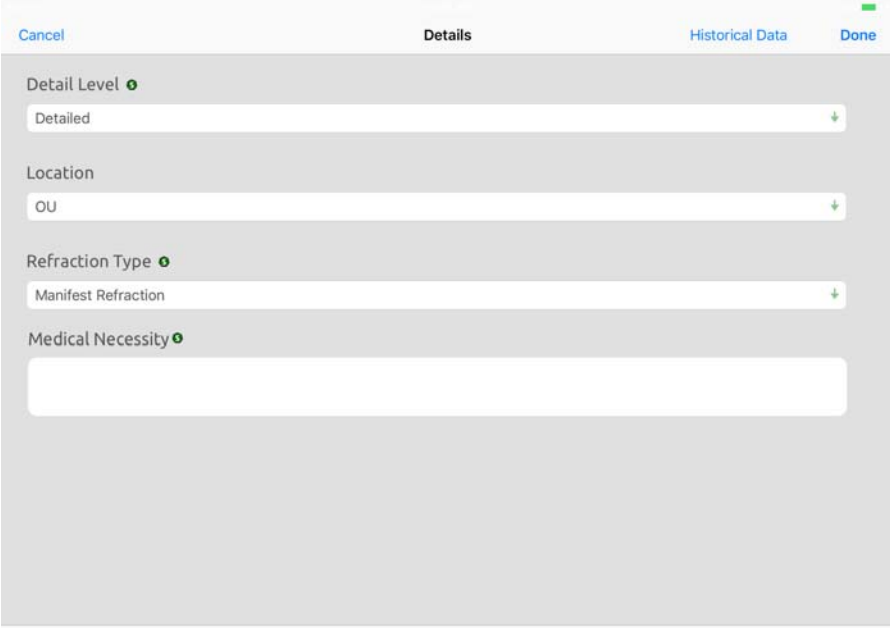
1. On the Plans drawer, tap **Reassurance**.

   The Details screen appears.

2. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

▶ **To use the Refraction plan**

1.   On the Plans drawer, tap **Refraction**.

     The Details screen appears.

2.   Select the **Location** where the refraction was performed.

     Type the reason why the refraction was a **Medical Necessity**.

     At the bottom of the screen is an additional option that allows you to override your visit billing with an S-code.

3.   When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

•   **S-Codes**

     Tap **S-Codes**.

     Select whether you want to **Override EM Visit Billing** with an S-Code.

▶ **To use the Suture Removal plan**

1. On the Plans drawer, tap **Suture Removal**.

2. On the Eye diagram, select the location of the sutures.

NOTE	You must select the location on the diagram be selected before any details can be documented.

The Details screen appears.

3. Tap to the right of the text box for the instructions the patient will follow. Edit the descriptions of the instructions, if necessary.

4. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.

▶ **To use the Treatment Regimen plan**

1. On the Plans drawer, tap **Treatment Regimen**.

   The Details screen appears.

2. Type whether the patient is to **Continue Regimen**, **Modify Regimen**, or **Discontinue Regimen**.

3. Select whether the **Treatment Regimen** is OTC, prescription or both.

4. Type the details for the **OTC Regimen**, if any.

5. Type the details for **Samples Given**, if any.

6. Type any **Other Instructions**.

7. When you have finished entering details for the plan, tap **Done** to return to the Ocular Exam Room.
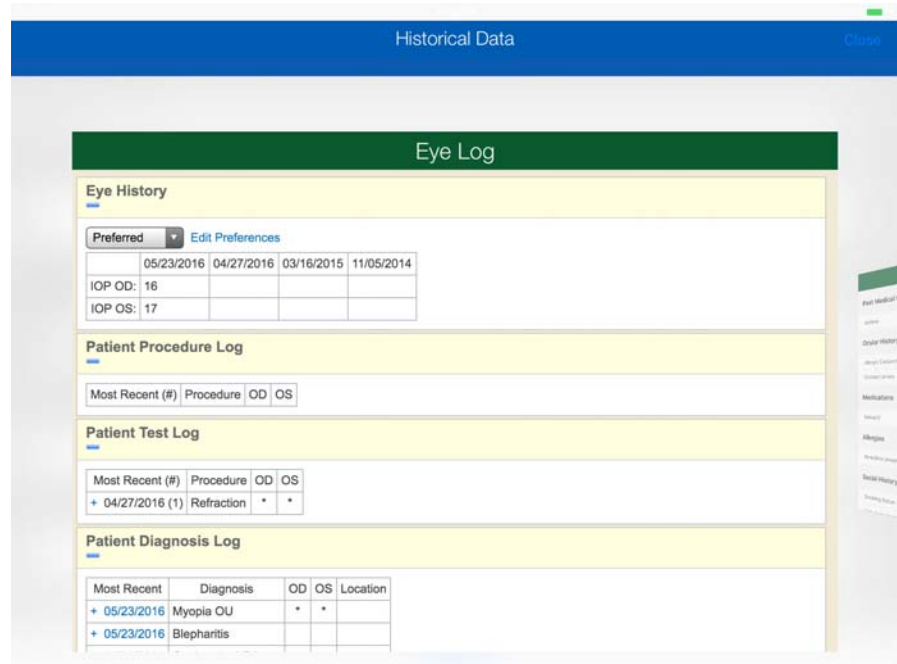
Viewing Historical Data

As you record your impressions and plans, you may want to review the information from the patient's past visits. From within each plan, you can choose to view the historical data for a patient.

-

▶ **To view historical data for a patient**

1. Access a plan.

2. Tap **Historical Data**.

   The Eye Log appears.

The Eye Log shows a history of the findings for the patient over past visits, the most recent procedures and tests performed, the most recent diagnoses, and the most recent follow-up visit.

NOTES	• In the Eye History, you can tap **Preferred** to make a one-time selection of the items that are displayed. This can help you target specific information for comparison.
	• Tap **Edit Preferences** to define the items that are displayed by default. After you have made your selections, tap **Save as Default Preferences**.
	• You can also access the Eye Log from the Action Bar on the Patient Chart and Visit Overview screen. Tap **More** and then tap **Eye Log**.

3. Swipe left to display the Patient Clipboard Summary.
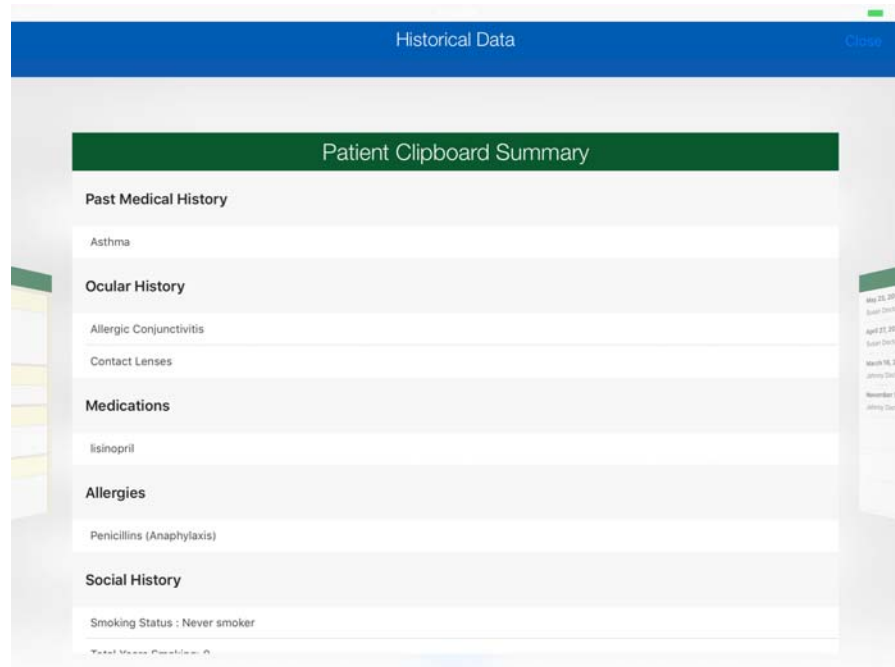
The Patient Clipboard Summary shows the patient's most recent medical and ocular history, medications, allergies, and social and family history. The Patient Clipboard Summary also shows the date the history was last reviewed.

4. Swipe left to display a history of Patient Visits.
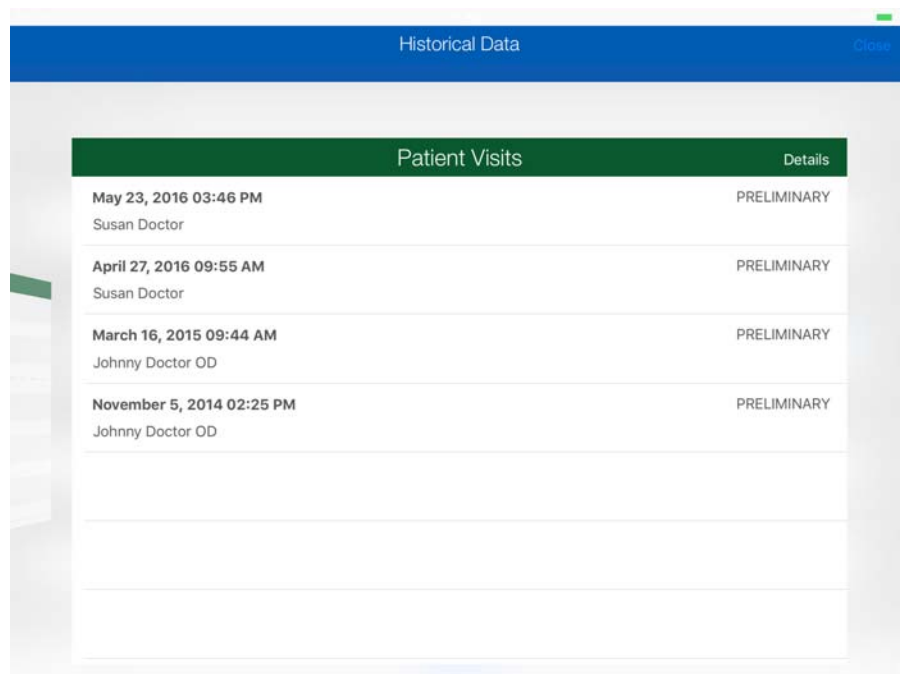
The Patient Visits screen lists the date and time of the patient's previous visits, the doctor seen, and whether the visit is preliminary or finalized. Tap

Details to display the most recent visit note as a PDF file. Thumbnails of other visits are displayed along the top of the screen. Tap the thumbnail to view that visit note as a PDF file.

NOTES	• If you have the ability to print from your iPad to an AirPrint printer, you can tap **Print** to print the displayed visit note.
	• You can also access the a history of patient visits from the Action Bar. Tap **More** and then tap **Past Notes**.

5. Tap **Done** to return to the Historical Data screen.

6. Tap **Close** to return to the plan.

Viewing Progress Notes

As you record the impressions, morphologies, and plans for a patient, you may want to get an overview of all of the information that has been entered for the patient during this visit, including the history, eye exam, and ocular exam. You can use the Progress Notes tab in the Ocular Exam Room to get an overview of the patient visit.

- To view progress notes for a patient, 111

▶ **To view progress notes for a patient**

1. Access the Ocular Exam Room.

2. Tap the **Progress Notes** tab.

   The Progress Notes appear as a PDF file.

The Progress Note shows the patient history, eye exam, and ocular exam data that has been recorded for the patient for this visit.

3. Scroll through the pages to review the progress note. Unpinch your fingers to enlarge the progress note. Pinch your fingers to reduce the size of the progress note.

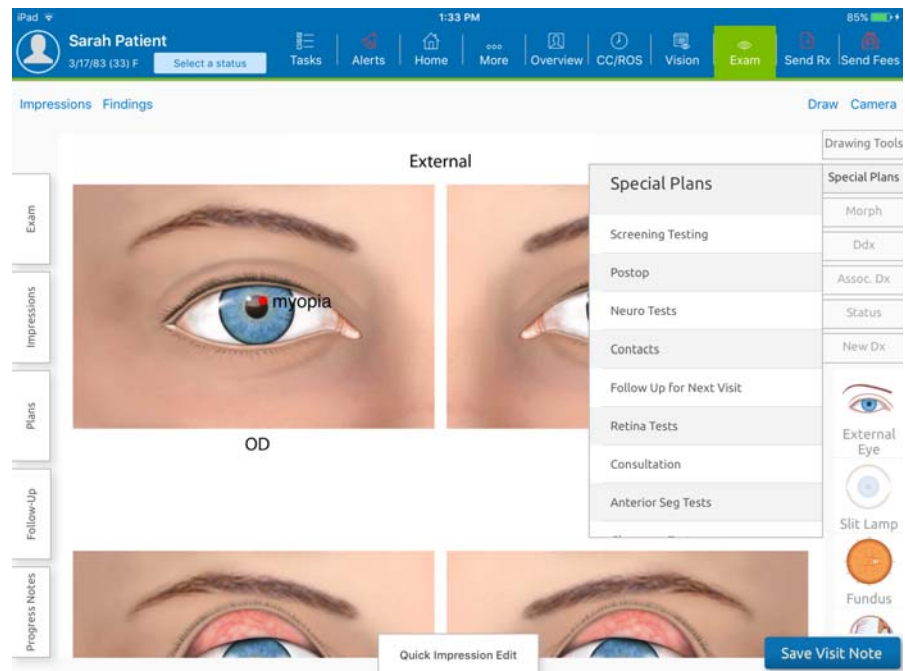4. Tap the **Progress Note** tab to close the progress notes.

Using Special Plans

You can use a special plan instead of using an impression.

• To use a special plan, 112

▶ **To use a special plan**

1. Access the Ocular Exam Room.

2. Tap **Special Plans** on the right side of the screen.

    The Special Plans drawer displays a list of special plans.

3. Tap the special plan you want to use.

    The Plans drawer opens.

4. Select the test you want to perform.

5. Enter the details for the test and tap **Done**.

    The Plans drawer on the Ocular Exam Room appears.

6. Select another test or tap the Plans drawer to close it.

7. Tap **Save Visit Note** to save your changes.

Resuming an Impression or Plan

Until an exam is finalized, you can return to an impression and add additional morphologies or plans or remove morphologies and plans.

- To resume an impression, 113
- To resume a plan, 113

▶ **To resume an impression**

1. Access the Ocular Exam Room.

2. Tap **Quick Impression Edit**.

   The Quick Impression Edit window opens and the Impressions drawer shows the impressions and plans selected for the patient.
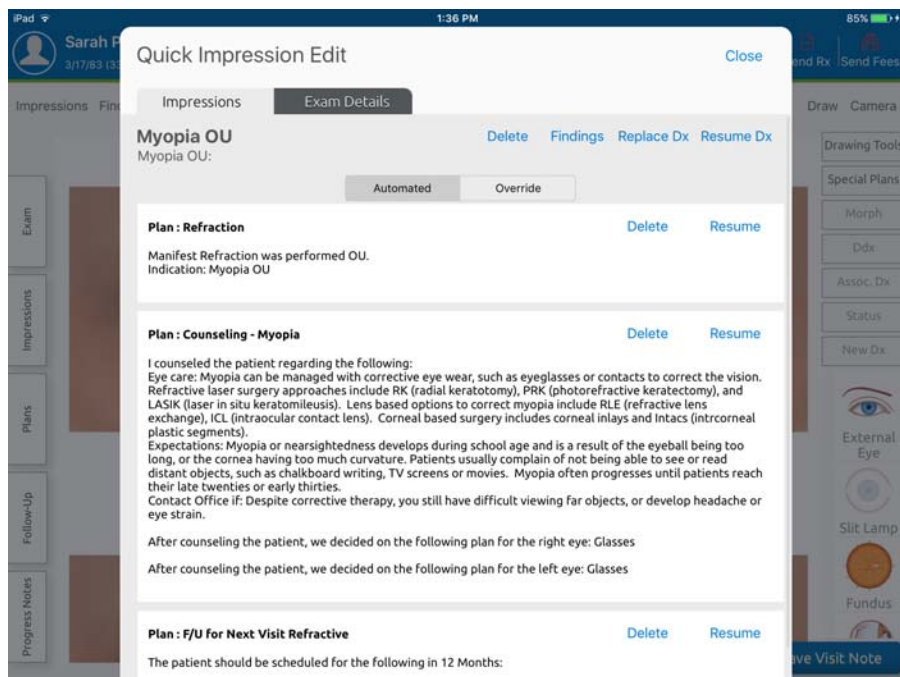
3. Tap **Resume Dx** for the impression you want to resume.

4. The Ocular Exam Room appears and the Plans and Morphologies drawers are open.

5. Select the plans you want to associate with the impression and enter details for the plans,

6. Select one or more morphologies you want to associate with the impression.

7. Tap **Save Visit Note** when you have finished.

▶ **To resume a plan**

1. Access the Ocular Exam Room.

2. Tap **Quick Impression Edit**.

   The Quick Impression Edit window opens and the Impressions drawer shows the impressions and plans selected for the patient.

3. Tap **Resume** for the plan you want to resume.

   The Details page for the plan appears.

4. Enter the details for the plan.

5. Tap **Done**.

   The Ocular Exam Room appears.

6. Tap **Save Visit Note**.

Deleting Impressions and Plans

Until an exam is finalized, you can return to an impression and remove impressions and plans.

- To delete an impression or plan, 114

▶ To delete an impression or plan

1. Access the Ocular Exam Room.

2. Tap **Quick Impression Edit**.

   The Quick Impression Edit window opens and the Impressions drawer shows the impressions and plans selected for the patient.

NOTE	To review the findings from the ocular exam, tap the **Exam Details** tab. Any abnormal findings are displayed in red.

3. Tap **Delete** for the impression or plan you want to delete.

NOTE	If you delete an impression, all of the plans associated with the impression are also deleted.

4. Tap **Close** to return to the Ocular Exam Room,

Deleting a Morphology

Until an exam is finalized, you can return to an impression and remove a morphology.

- To delete a morphology, 114

▶ To delete a morphology

1. Access the Ocular Exam Room.

2. Tap **Quick Impression Edit**.

   The Quick Impression Edit window opens and the Impressions drawer shows the impressions and plans selected for the patient.

3. Tap **Findings** for the impression associated with the morphology.

4. The Edit Diagnosis Findings window displays a list of morphologies associated with the impression.

Edit Diagnosis Findings		
Morphology / Finding	Location	Action
Abnormal tear break-up time		⊖
Tear debris		⊖
	Done	

5. Tap the orange circle for the morphology you want to delete.

6. Tap **Done** to return to the Ocular Exam Room.

Using the Cancer Log

Some states require providers to track the progress of cancerous lesions and treatments for their patients. You can use the Cancer Log to track the history of diagnosis and treatment.

- To add a lesion to the cancer log, 115

▶ **To add a lesion to the cancer log**

1. Access the patient chart or the patient overview.

2. Tap **More**.

3. Tap **Cancer Log**.

4. The Cancer Log opens and shows a history of the diagnosis and treatment related to cancer.

NOTE	To filter the list, tap **Show Filter**. Enter the search criteria and then tap **Apply Filters**. To clear your search criteria, tap **Reset**.

5. Tap **Add New Lesion**.

6. Enter the details for the lesion.

7. Tap **Save** to add the information to the list.

Viewing and Editing the Outcomes of Past Visits

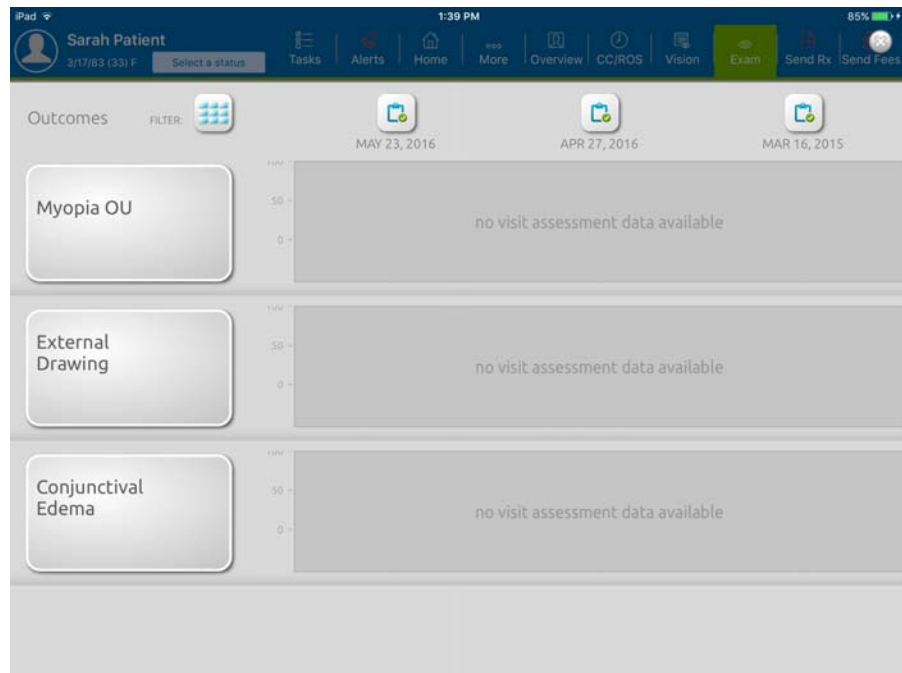You can view and edit the outcomes of past visits.

- To view and edit outcomes, 115

▶ **To view and edit outcomes**

1. Access the patient chart or the patient overview.

2. Tap **More**.

3. Tap **Outcomes**.

The Outcomes screen shows patient diagnoses on the left side of the screen, assessment data to the right of each diagnosis and thumbnails of past visits at the top of the screen.

NOTE	• Tap a diagnosis to see the most current visit notes about that diagnosis. To view the note for another diagnosis, tap **View** and select the diagnosis.
	• Tap a thumbnail to view the detail for that visit note.

4. Tap the Filter.

5. Use the toggle buttons to show or hide a diagnosis.

6. After you have the diagnoses displayed for which you want to record an outcome, tap the outcome.

7. Select the date of the outcome.

Viewing and Printing Patient Education Handouts

You can view and print patient education handouts.

• To view and print patient education handouts, 116

▶ **To view and print patient education handouts**

1. Access the Visit Overview screen.

2. Tap **More**.

3. Tap **Patient Education**.

4. The Patient Education window shows the tests, medications and problems about which the patient needs to be advised.

5. Tap an item to display a patient education handout.

NOTE	If you have the ability to print from an AirPrint printer, tap **Print** to print the Patient Education handout.

Using the Drawing Tools

7

In this chapter:

There are two ways you can create drawings on the Eye diagrams in the Ocular Exam Room.

- You can access glyphs by accessing the Ocular Exam Room, tapping Drawing Tools, and then selecting a plan.
- You can access the Drawing Board by tapping More on the Action Bar and then tapping Drawing.
- You can access Drawing Tools by accessing the Ocular Exam Room and tapping Draw.

Creating Glyphs

You can use glyphs to create drawings. The drawings can be stored in the visit note.

▶ **To create glyphs**

1. Access the Ocular Exam Room.
2. Tap **Drawing Tools** on the right side of the screen.
3. Select the type of drawing you want to create.

NOTE	You can only use each type of drawing once per day per patient exam. For example, you can create a drawing using the external drawing and a separate drawing using the fundus drawing in the same patient exam on the same day, but you cannot create two drawings using the external drawing in the same patient exam on the same day.

4. From the Plans tab, select the **Plan** that you want to use.

5. Tap the location on the Eye diagram where the disease is present.

6. The Glyph Slider appears which allows you to scale and rotate the location of the condition.
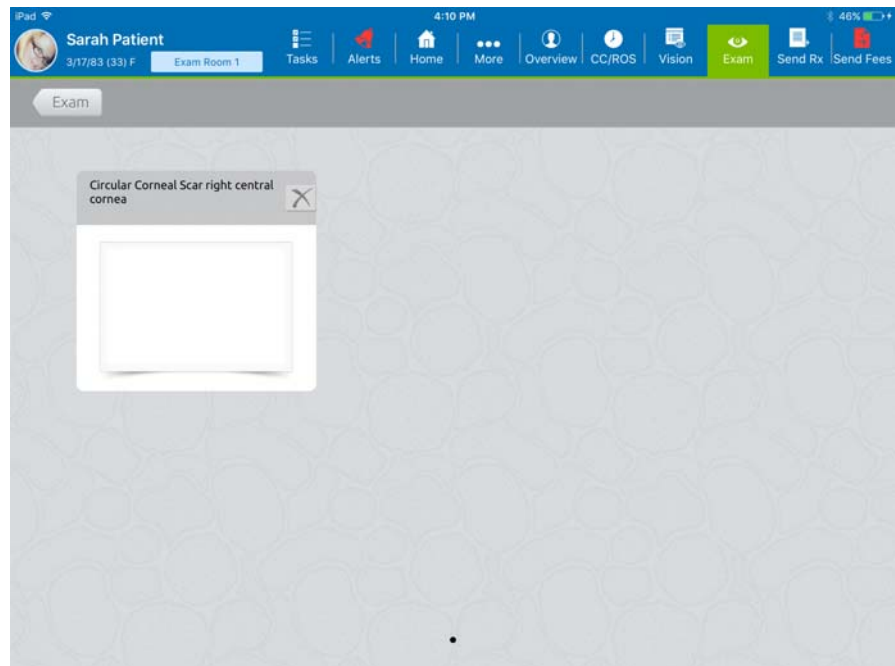
Deleting Glyphs

You can permanently delete a glyph from a patient's visit note.

▶ To delete a glyph

1. Open the visit that contains the glyph you want to delete.

2. Access the Ocular Exam Room.

3. Tap the **Findings** link in the upper left corner of the screen.

   The Findings screen appears.

4. Tap the **X** of the glyph you want to delete.

5. Tap **Exam** to return to the Ocular Exam Room

Explanation of the Drawing Board Interface Elements

Tools   Size   Color Palette

Brightness, Custom Color
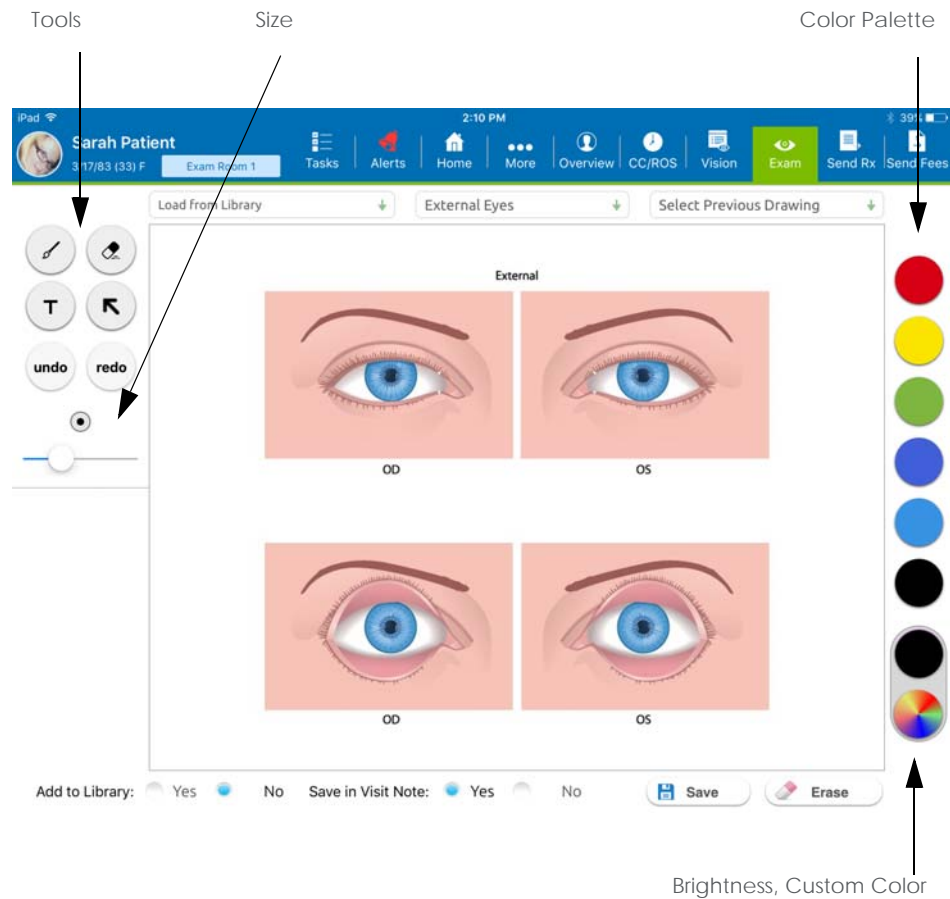
Creating Drawings Using the Drawing Board

You can use the Drawing Board to create and modify drawings. The drawings can be stored in the visit note or in the drawing library.

- To create drawings, 121

▶ **To create drawings**

6. Access the Ocular Exam Room.

7. Tap **More** on the Action Bar and then tap **Drawing**.

8. If you want to modify a previous drawing, select the drawing from the **Select Previous Drawings** drop-down.

9. Select the **Tools**, **Size**, **Brightness** and **Colors** that you want to use.

10. Draw on the eyes to indicate where the disease is present or type the text you want to add to the drawing.

| NOTE	If you make a mistake, tap **undo** to delete your last change or use the eraser to remove the last item you drew.

11. In **Add to Library**, choose whether you want to add the drawing to the Library.

> | NOTE | Drawings saved in the Drawing Library will be available to display in other patients' charts as well as the current patient. The Drawing Library is user specific, not patient specific. |

12. In **Save in Visit Note**, choose whether you want to add the drawing to the current Visit Note.

13. Tap **Save** to return to the Ocular Exam Room.

Explanation of Interface Elements for the Draw Tool

Tools   Size

Color Palette   Brightness, Custom Color
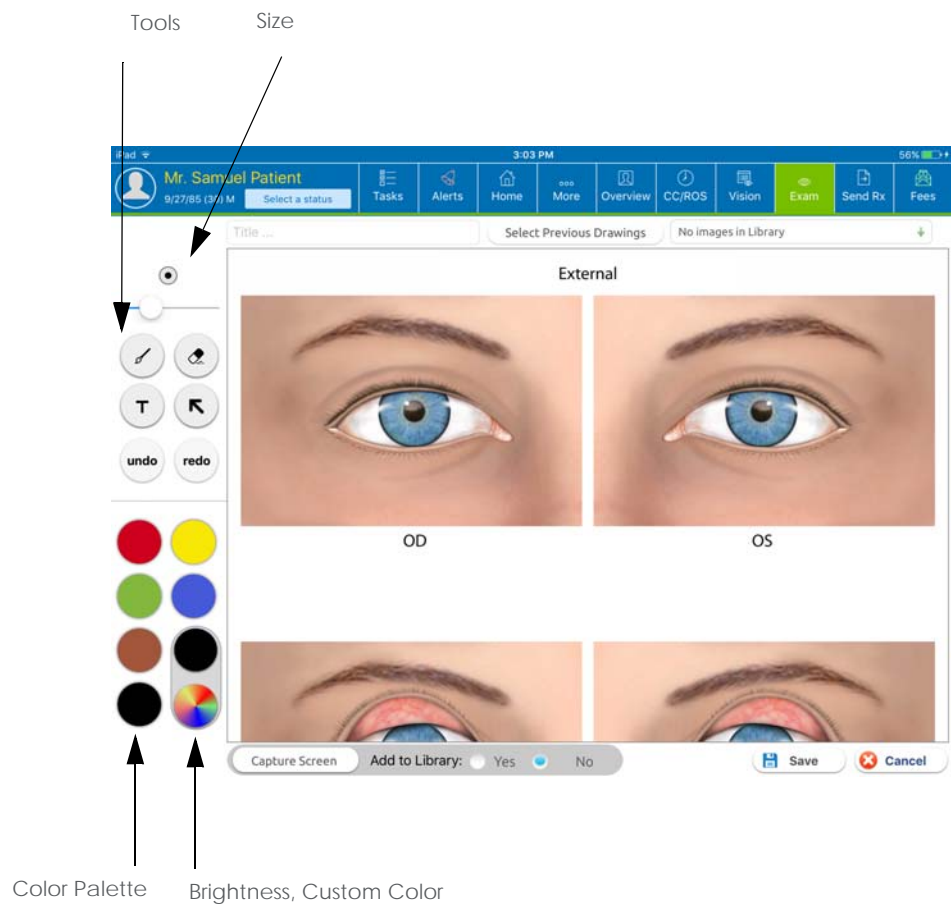
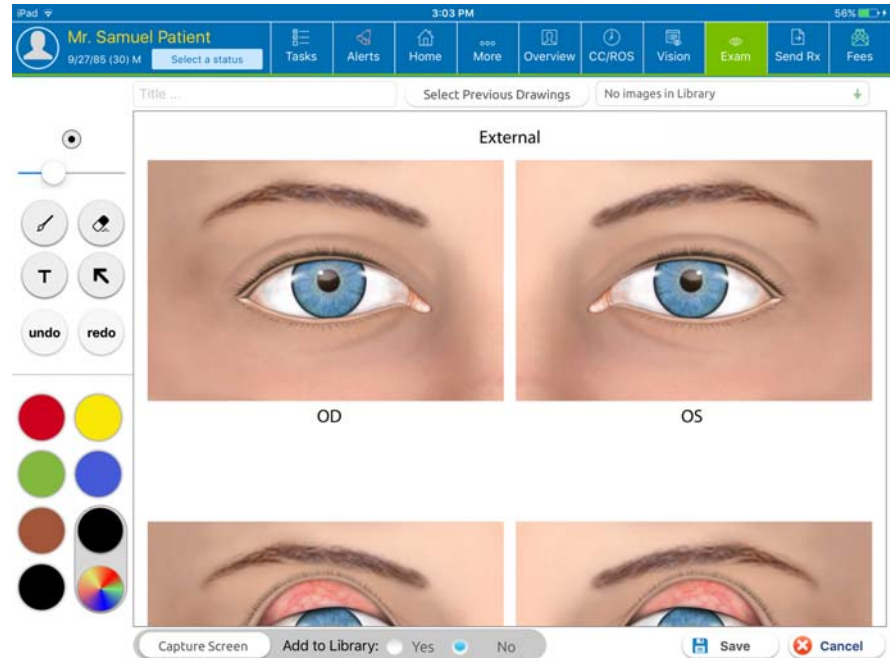## Creating Exam Drawings Using the Draw Tool

You can use the drawing tools to create and modify drawings. The drawings are stored with the visit note and can also be stored in the drawing library.

- To create exam drawings, 123

▶ **To create exam drawings**

1. Access the Ocular Exam Room.

2. Tap the **Draw** link on the upper right side of the screen.

   The Drawing Tools appear.

3. Enter a **Title** for the drawing.

4. If you want to modify a previous drawing, select the drawing from the **Select Previous Drawings** drop-down.

5. Select the **Tools**, **Size**, **Brightness** and **Colors** that you want to use on the left side of the screen.

6. Draw on the eyes to indicate where the disease is present or type the text you want to add to the drawing.

NOTE	If you make a mistake, tap **undo** to delete your last change or use the eraser to remove the last item you drew.

7. In **Add to Library**, choose whether you want to add the drawing to the Library.

NOTE	Drawings saved in the Drawing Library will be available to display in other patients' charts as well as the current patient. The Drawing Library is user specific, not patient specific.

8. Tap **Save** to return to the Ocular Exam Room.

   Drawings are accessible under the Drawings hyperlink in the Ocular Exam Room.

Deleting Exam Drawings

You can permanently delete an exam drawing from a patient's visit note and from the drawing library.

-

▶ **To delete an exam drawing**

1. Access the Ocular Exam Room.

2. Tap the **Drawings** hyperlink.

   A list of drawings for the exam appears.

3. Tap **Edit**.

4. A red circle appears to the left of each drawing.

5. Tap the red circle for the drawing you want to delete.

   A red Delete button appears.

6. Tap **Delete** to delete the drawing.

7. Tap **Done**.

8. Tap anywhere outside the list of drawings to close the list.

Viewing Historical Drawings

You can view and compare all of the drawings associated with patient visit notes.

-

▶ **To view historical drawings**

1. Access the Ocular Exam Room.

   > **NOTE**   You can also access historical drawings from the Action Bar.
   > Tap **More** and then tap **Historical Drawings**.

2. Tap the **Drawings** hyperlink.

   A list of drawings for the exam appears.

3. Tap **Historical Drawings**.

4. Thumbnails of the patient's drawings appear.
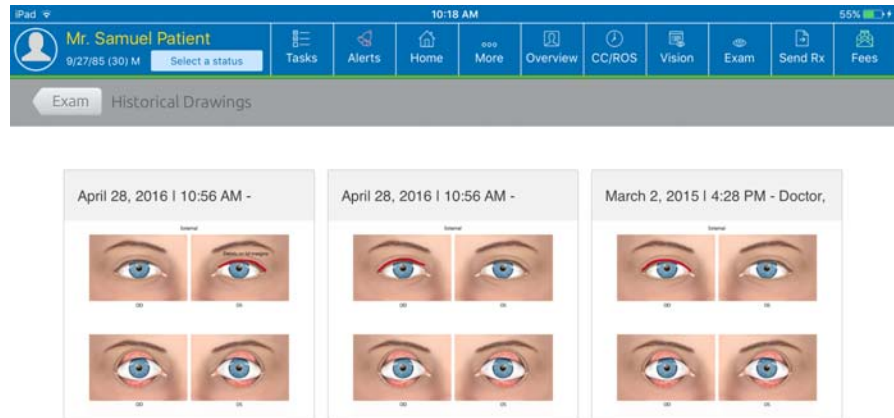
5. Tap a thumbnail to view it in detail.
6. Tap **Exam** to return to the Ocular Exam Room.

Using the Camera

In this chapter:

Taking Photos of a Patient

Normally the patient's information is edited in the practice management system; however, you can use the iPad to take a photo of the patient in Eyefinity EHR.

▶ **To take a photo of the patient**

1. Access the Patient Chart.
2. Tap **More**.
3. Tap **Edit Patient**.

   The Patient Basics tab of the Patient Information window appears.

4. Tap **Take Photo**.

5. Take a photo of the patient.

6. Tap **Use Photo** to add the photo to the patient's chart or tap **Retake** to retake the photo.

> **NOTE** You cannot take several photos and choose the best one. Eyefinity EHR uses the last photo taken.

7. Tap **Save**.

Taking Photos for a Patient Visit

You can use the iPad camera to take photos for a patient visit.

- To take photos for a patient visit, 128

▶ **To take photos for a patient visit**

1. Access the Ocular Exam Room.

2. Tap the **Camera** hyperlink at the top of the screen.

3. Use the iPad to take a photo of the patient.

4. Tap **Use Photo** to continue or tap **Retake** to retake the photo.

The Camera Details window appears.
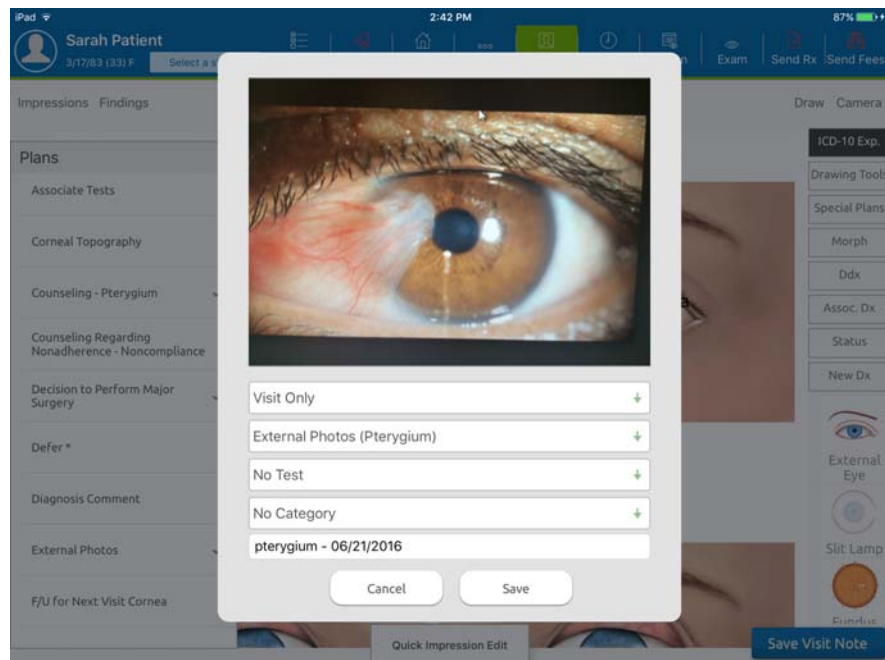
5. Select the visit to which the photo applies.

6. Select the plan to associate with the photo. Typically you will associate the photo with an External Photo, Fundus Photo, Slit Lamp Photo or Disc Photo plan.

7. In the image title, type a description of the photo. For example, you may want to type the date, indication and location, such as 07/22/16 pterygium OD.

8. Tap **Save** to save the photo as an attachment to the Visit Note and return to the Ocular Exam Room.

Viewing Photos

You can view, compare and print the photos taken during patient visits.

▶ **To view photos for a patient**

1. Open the patient chart or the patient overview screen.
2. Tap **More**.
3. Tap **Photos**.

   The Image Comparison screen opens and displays thumbnails of all the photos taken for the patient.
4. If you want to search for a specific image, select the **Category** and **Date** from the drop-down menus.
5. Tap the thumbnails for the images you want to compare. The images are displayed in the lower portion of the screen.
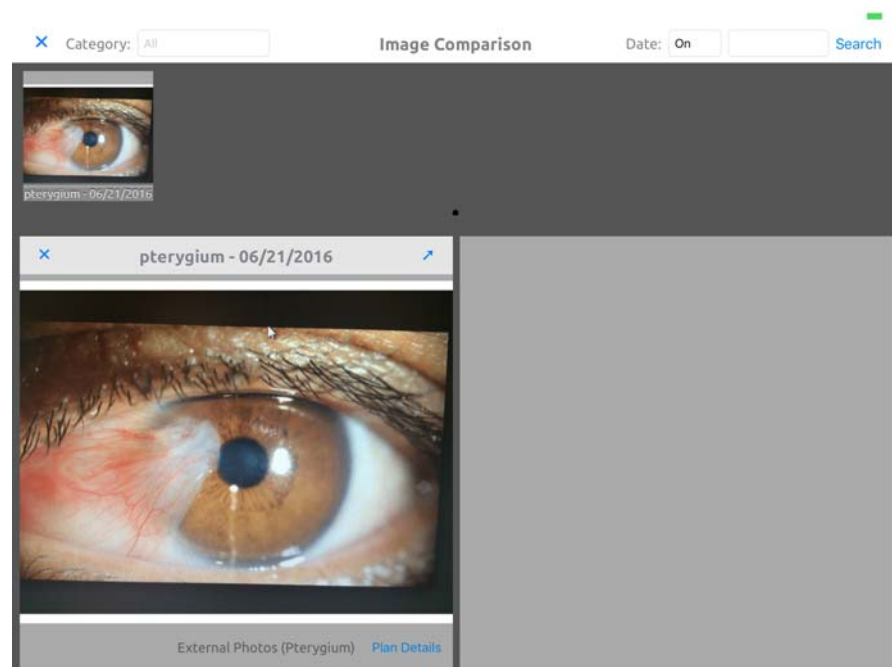
6. Tap the arrow to expand an image.
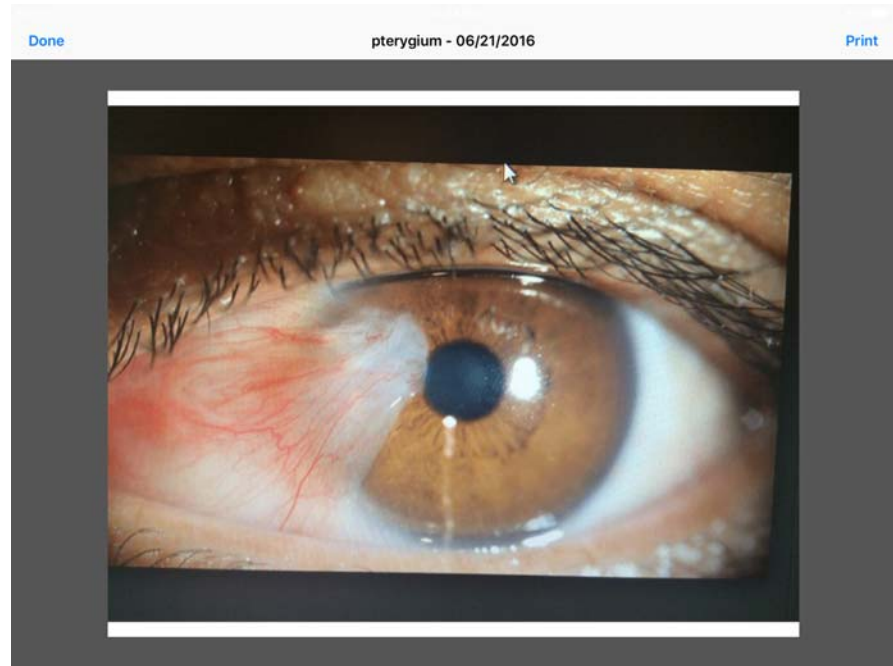
7. Tap **Print** to print the image or tap **Done** to close the image and return to the Image Comparison screen.

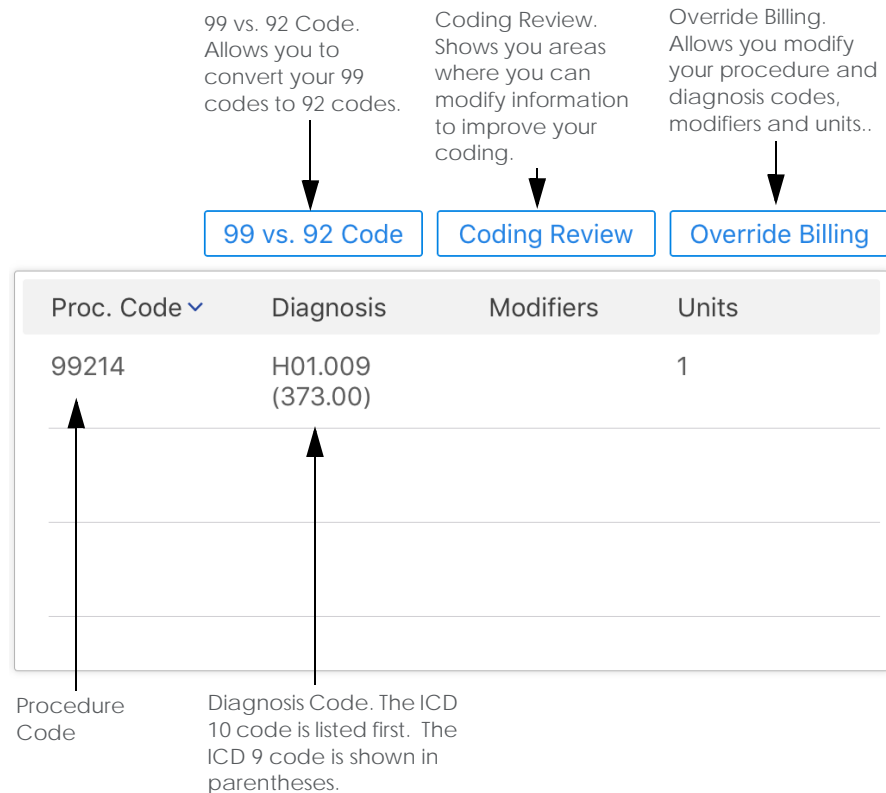| NOTE	If you have the ability to print from an AirPrint printer, you can print the photo.

Coding and Finalizing

9

In this chapter:

As you record HPI, review of systems, procedures and diagnoses, Eyefinity EHR populates the billing area of the Visit Overview screen with suggested billing codes.

As a provider, you are responsible for what is billed. You can use the options available in the billing area to override the suggested billing codes.

Explanation of Interface Elements

99 vs. 92 Code. Allows you to convert your 99 codes to 92 codes.

Coding Review. Shows you areas where you can modify information to improve your coding.

Override Billing. Allows you modify your procedure and diagnosis codes, modifiers and units..

| 99 vs. 92 Code | Coding Review | Override Billing |

Proc. Code ⌄	Diagnosis	Modifiers	Units
99214	H01.009 (373.00)		1

Procedure Code

Diagnosis Code. The ICD 10 code is listed first. The ICD 9 code is shown in parentheses.

Converting 99 Codes to 92 Codes

You can convert 99 codes to 92 codes for billing purposes.

- To convert 99 codes to 92 codes, 132

▶ To convert 99 codes to 92 codes

NOTE	Eyefinity EHR defaults to the Eye Code 92 code as long as your documentation supports the code. You won't have a conversion button if you don't have the proper documentation.

1. Access the Visit Overview screen.
2. Tap **99 vs. 92 Code** in the billing area of the screen.

   A list of suggested 92 codes appears.
3. Tap the 92 code you want to use.
4. Tap **99 vs. 92 Code** to close the list.

Reviewing the Coding

You can review the coding for an exam and view suggestions for improving your billing.

- To review the coding, 132

▶ To review the coding

1. Access the Visit Overview screen.
2. Tap **Coding Review**.

   If you have a 99 code, a list of suggestions for improving your coding appears.

   If Eyefinity EHR defaults to the 92 code, the Encounter form appears. For more information on the Encounter form, see "Viewing Note Outputs" on page 134.

Overriding the Billing

You can override a suggested billing code, bill visit based on time, or override the entire bill including procedure codes, CPT codes, modifiers, and units.

- To override a suggested billing code, 132
- To bill a visit based on time, 133
- To override the entire bill, 133

▶ To override a suggested billing code

1. Access the Visit Overview screen.
2. Tap **Override Billing**.
3. Select **Override Suggested Billing Code**.

   The Override Suggested Billing Code window appears.
4. Select the billing code you want to use.

5. Tap **Override Code** to override the billing code or tap **Clear Override** to cancel.

6. The Visit Overview screen appears and shows the billing code you selected.

▶ **To bill a visit based on time**

1. Access the Visit Overview screen.

2. Tap **Override Billing**.

3. Select **Bill visit based on time**.

   The Enter Visit Time and type window appears.

4. Type your time spent in minutes.

5. Select the percent of time counseling or Coordinating Care.

6. Select the Visit Type.

7. Tap **Bill by Time** to override the billing codes with time spent or tap **Clear Bill by Time** to cancel.

8. The Visit Overview screen appears.

▶ **To override the entire bill**

1. Access the Visit Overview screen.

2. Tap **Override Billing**.

3. Select **Override Bill**.

   The Override Bill screen appears.

4. In **ICD**, tap the eraser to remove an ICD-10 Code or enter the ICD-10 Code you want to use.

NOTE	If you want to change the order of the ICD-10 Codes, tap Change Order. Tap and drag the gray rectangle next to the ICD-10 Code you want to move. When you are done reordering the ICD-10 Codes, tap **Done**.

5. In **CPT Code**, tap the eraser to remove the row for a CPT Code or enter the CPT Code you want to use.

6. Type the **Modifiers**, **Diagnosis Pointers** and **Units**.

7. Select the insurance you want to bill.

NOTE	If you make a mistake and want to start over with the original codes, tap **Populate From Visit**. Your changes are deleted and the ICD-10 and CPT codes are populated based on the codes from the exam.

8. Tap **Override Code** to override the billing codes or tap **Clear Override** to cancel.

9. The Visit Overview screen appears and displays your changes.

Viewing Note Outputs

You can view the Note Outputs to get an overview of the patient's chart, the vision exam, and the ocular exam. You can also view the patient's bill, prescriptions, orders, image interpretations, and patient handouts.

-

▶ **To view Note Outputs**

1. Access the Visit Overview screen.

2. Tap **Note Outputs.**

   The Available Notes screen appears and the preliminary Visit Note is displayed.

The Visit Note shows the patient history, eye exam, and ocular exam data that has been recorded for the patient for this visit.

NOTE	If you have the ability to print from your iPad to an AirPrint printer, you can tap **Print** to print the displayed visit note.

3. Tap **Encounter Form**.

   The Encounter Form appears.

The Encounter Form shows all of the billing data that has been recorded for the patient for this visit, including the CPT codes and description of service, modifier information, and diagnosis code.

4. Tap **Bill**.

   The patient's bill appears.

The patient bill shows the bill that will be sent from the practice management system for this visit.

5. Tap **Rx**.

The patient's medical prescription appears.
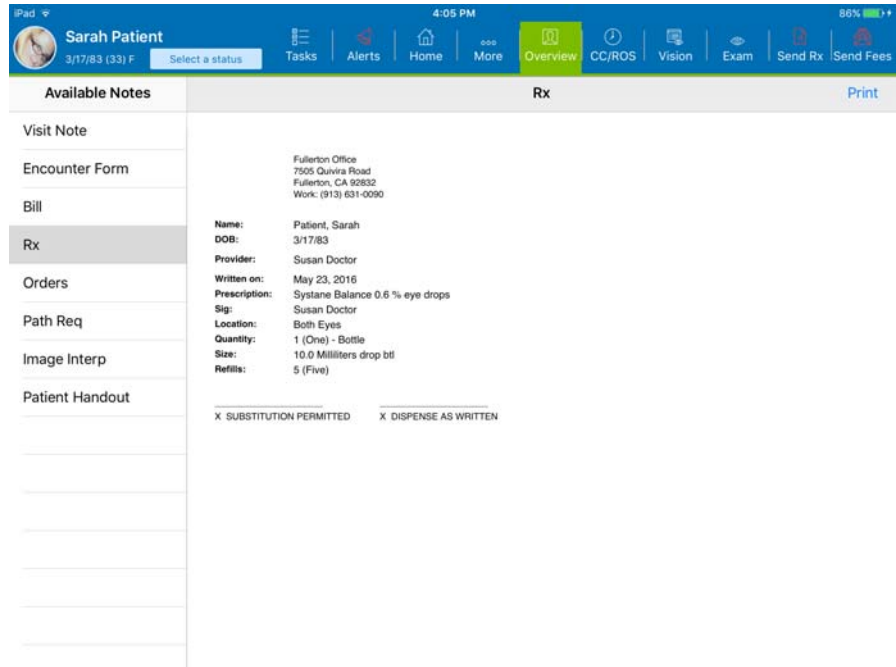
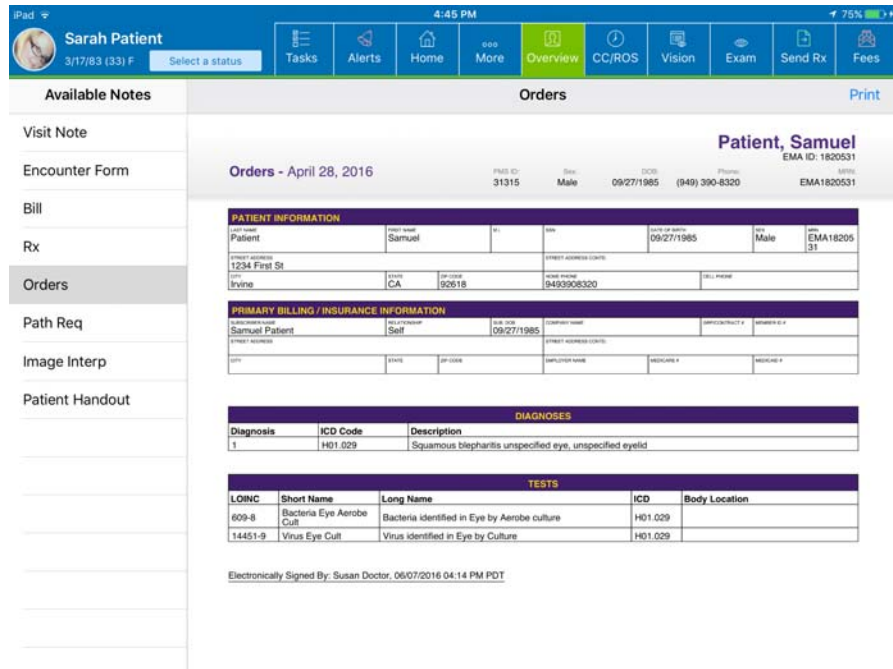The Rx screen shows the medical prescriptions created for the patient for this visit.
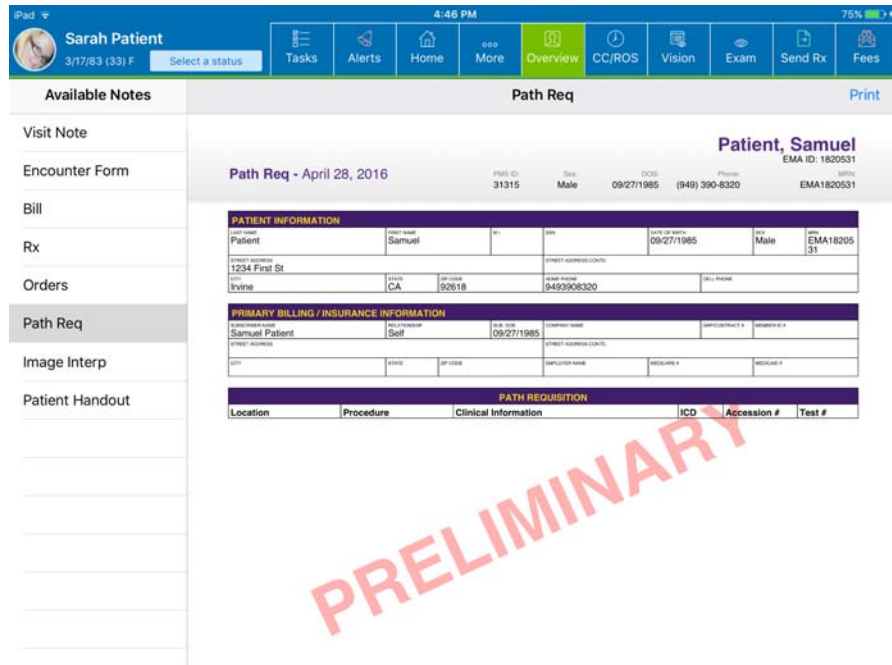
6. Tap **Orders**.

The patient's orders appear.

The Orders screen shows any test or surgery orders created during this visit.
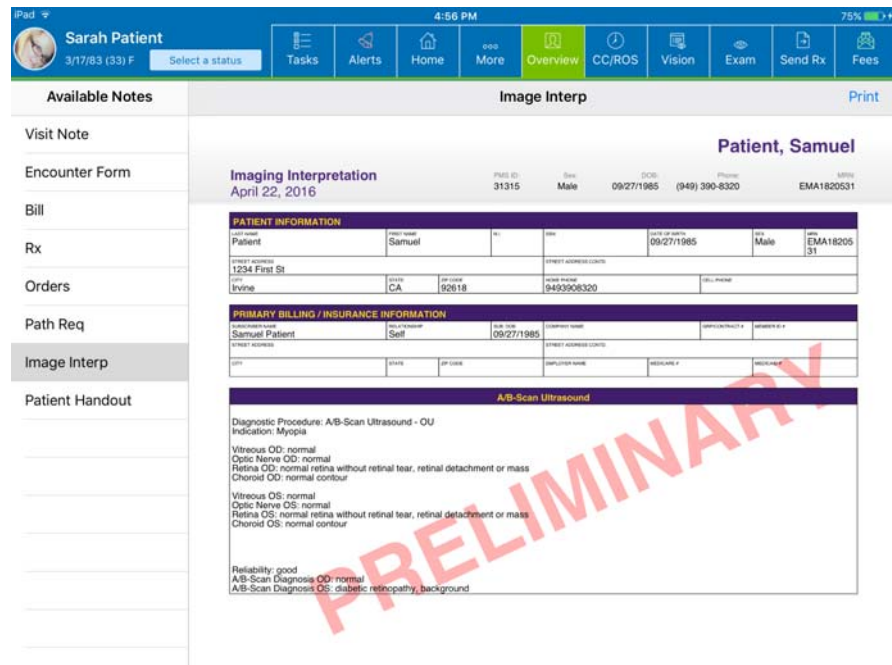
7. Tap **Path Req**.

   The patient's pathology request appear.

   The Path Req screen shows any pathology requests created for the patient during this visit.
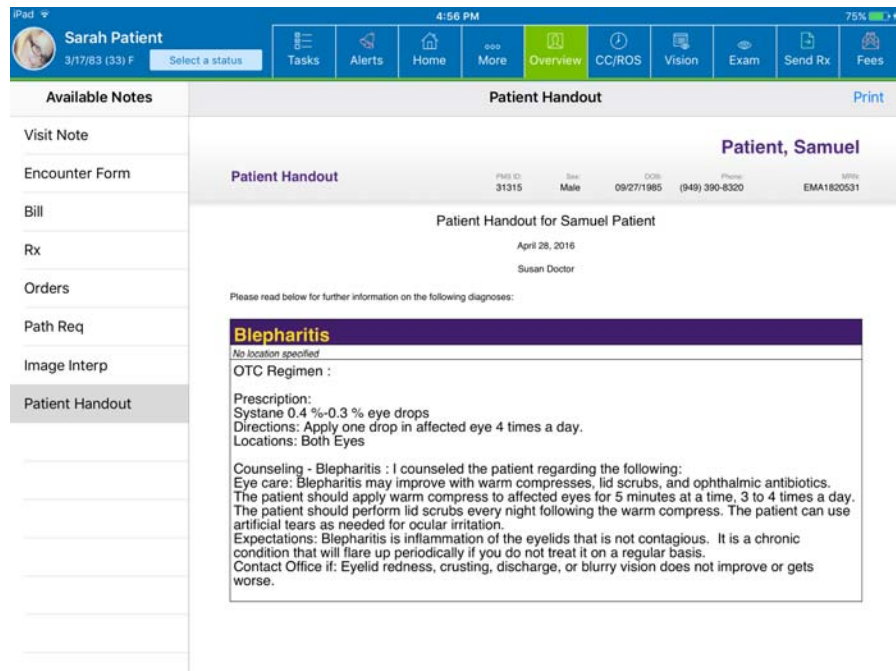
8. Tap **Image Interp**.

   The patient's image interpretation appear.

   The Image Interp screen shows the image interpretations for tests performed during this visit.

9. Tap **Patient Handout**.

The patient handout appears.

The patient handout shows patient education information to be provided to the patient for this visit. These are the counseling statements from the counseling plan selected in the Ocular Exam Room.

Sending fees

Fees are automatically sent to the practice management system when you finalize a visit; however, you can also manually send the fees to your practice management system.

NOTE	If you manually send fees to the practice management system and later finalize the visit, the fees are not re-sent to the practice management system. You can only send fees once per visit.

▶ **To send fees to the practice management system**

1. Access the Visit Overview screen.

When there are fees available to send, the Fees button is red.

2. Tap **Send Fees** on the Action Bar.

NOTE	You can also send fees by tapping **More** on the Action Bar and then tapping **Send Fees**. After you send the fees, the button changes to **Charges Sent**.

The message, "Sending data to PMS," appears and the Send Fees button turns green. After you send the fees once for a visit, you cannot send them again for the same visit.
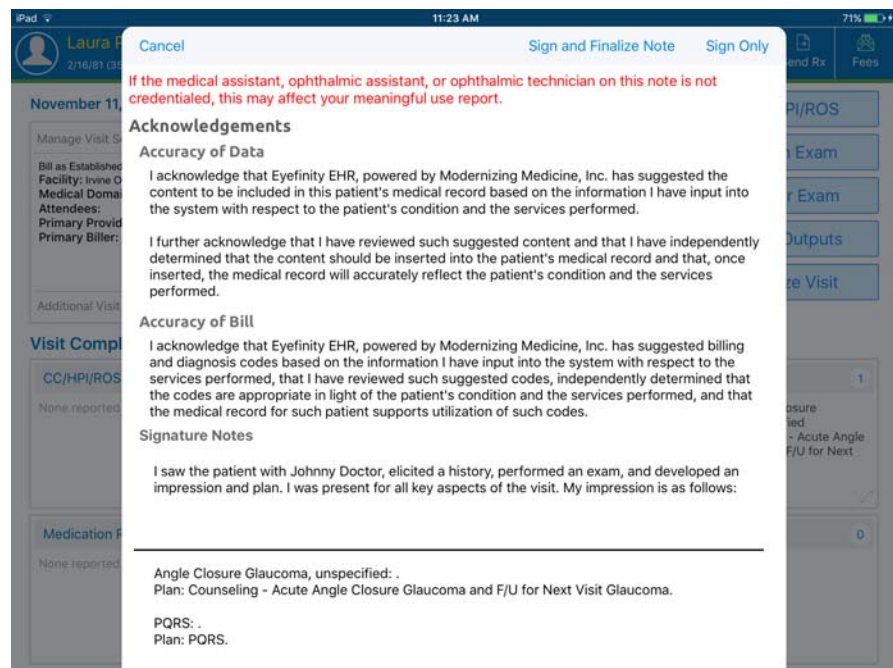
Finalizing a visit

You can finalize a visit from the Visit Overview screen, the patient's chart, or from the Home screen.

- To finalize a visit from the Visit Overview screen, 139
- To finalize a visit from the patient's chart, 139
- To finalize a visit from the Home screen, 140
- To finalize multiple visits from the Home screen, 140

▶ To finalize a visit from the Visit Overview screen

1. Access the Visit Overview screen.

2. Tap **Finalize Visit**.

   The Acknowledgments window appears.

3. Read the acknowledgment and tap **Sign and Finalize Note** to finalize the note or **Sign Only** to sign the note without finalizing it.

NOTE	• If you finalize a visit and have not previously sent the fees to the practice management system, the fees will be sent when the visit is finalized.
	• If you finalize a visit and have not previously sent the prescription(s) to the practice management system, the prescription(s) will be sent when the visit is finalized.

▶ To finalize a visit from the patient's chart

1. Open the patient's chart.

2. On the Notes tab, tap **Finalize** for the visit you want to finalize.

   The Acknowledgments window appears.

3. Read the acknowledgment and tap **Sign and Finalize Note** to finalize the note or **Sign Only** to sign the note without finalizing it.

▶ **To finalize a visit from the Home screen**

1. Access the Home screen.
2. Tap the Notes tab.
3. Tap **Views** and select the appropriate option to show a list of preliminary visits.
4. Tap **Finalize** for the visit you want to finalize.

   The Acknowledgments window appears.
5. Read the acknowledgment and tap **Sign and Finalize Note** to finalize the note or **Sign Only** to sign the note without finalizing it.

▶ **To finalize multiple visits from the Home screen**

1. Access the Home screen.
2. Tap the Notes tab.
3. Tap **Views** and select the appropriate option to show a list of preliminary visits.
4. Tap **Select**.
5. Tap the visits you want to finalize.
6. Tap **Finalize**.

   The Acknowledgments window appears.
7. Read the acknowledgment and tap **Sign and Finalize Note** to finalize the notes or **Sign Only** to sign the notes without finalizing them.

Assigning a visit

If you have associate physicians and need to have a senior physician cosign the visit note, you can assign a visit to the senior physician from the Home screen.

▶ **To assign a visit from the Home screen**

1. Access the Home screen.
2. Tap the Notes tab.
3. Tap **Views** and select the appropriate option to show a list of preliminary visits.
4. On the visit you want to assign, tap the name of the doctor to whom the visit is assigned or tap Not Assigned if no doctor is assigned to the visit.

   The Assign Notes window appears.
5. Select the doctor to whom you want to assign the visit.

▶ **To assign multiple visits from the Home screen**

1. Access the Home screen.

2. Tap the Notes tab.

3. Tap **Views** and select the appropriate option to show a list of preliminary visits.

4. Tap **Select**.

5. Tap the visits you want to assign.

   The Assign Notes window appears.

6. Select the doctor to whom you want to assign the visits.

Cosigning a visit

If you have associate physicians and need to have a senior physician cosign the visit note, you can cosign the visit note on the patient's chart.

- To cosign a visit from the patient's chart, 141

▶ **To cosign a visit from the patient's chart**

1. Open the patient's chart.

2. On the Notes tab, tap **Cosign** for the visit you want to cosign.

   The Acknowledgments window appears.

3. Read the acknowledgment and tap **Sign and Finalize Note** to finalize the note or **Sign Only** to sign the note without finalizing it.

Amending a visit

If a visit note has been finalized and you need to add or change information on the chart, you cannot change the information directly; however, you can add a note to the patient's chart.

- To amend a visit from the patient's chart, 141

▶ **To amend a visit from the patient's chart**

1. Open the patient's chart.

2. On the Notes tab, tap **Amend** for the visit you want to change.

   The Chart Note Amendment window appears.

3. Type the **Note Amendment Title** and **Note amendment Body**.

4. Tap **Save** to add the amendment to the visit note.

Emailing and Faxing

<div style="text-align: right">

10

</div>

In this chapter:

Faxing Auto-letters

Eyefinity EHR allows you to create autoletters—templated correspondence that includes details from patient exams. Autoletters can be faxed from the Visit Overview.

Before you can pull patient information into autoletters and fax them, you must first create autoletter templates Only administrators can create autoletter templates, and they can only create them on the web application. Every template is available to all providers.

In addition, before you can send autoletters to a referral provider, the referral provider's contact information must be recorded in the web application.

▶ To send an autoletter

1. Open the Visit Overview screen. For more information, see "To open a visit from the patient's chart" on page 38.

2. Tap **More** and tap **Auto Letter**.

   The Fax Details screen opens.

3. In the **To** text box, type the first few letters of the provider's name. Select a referral provider from the suggested list.

4. Select a **Template**.

   The text editor displays the autoletter text, complete with the exam data.

NOTE	The autoletter text is not editable.

5. Toggle the options below the text editor on or off as needed. These options append additional pages to the fax:

– **HIPAA Cover sheet.** A cover page with a legal statement about the confidentiality of contents of the fax.

– **CCD.** A human-readable version of the continuity of care document (CCD). The CCD is usually sent electronically through direct messaging.

– **Summary.** Summary of the impression and plan. this information may already be included in the autoletter template.

– **Body Diagram.** This check box is currently not functional.
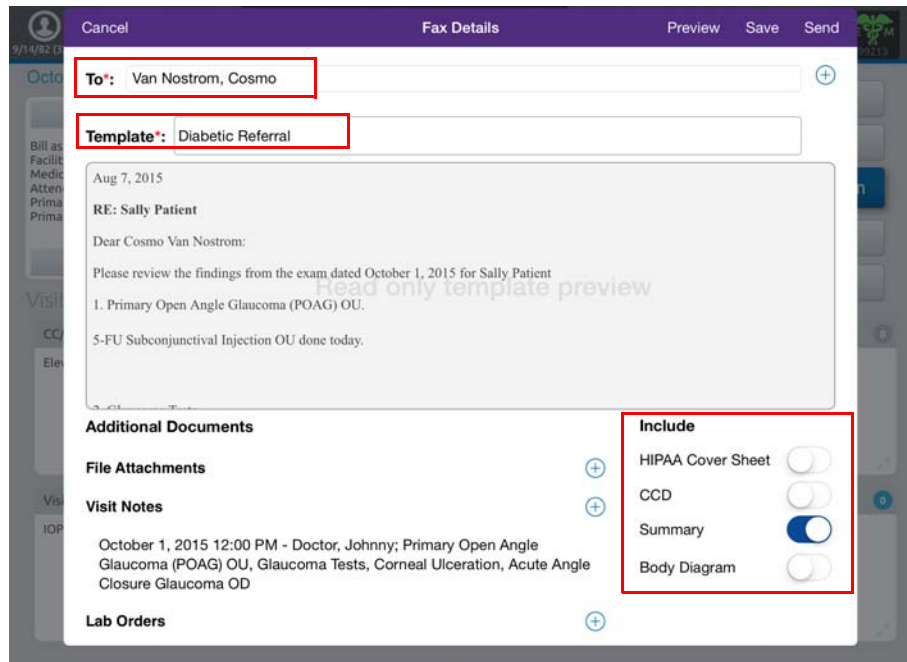
6. Tap **Preview** to view the fax.

   The Preview Fax displays the autoletter and any additional pages the recipient will receive.
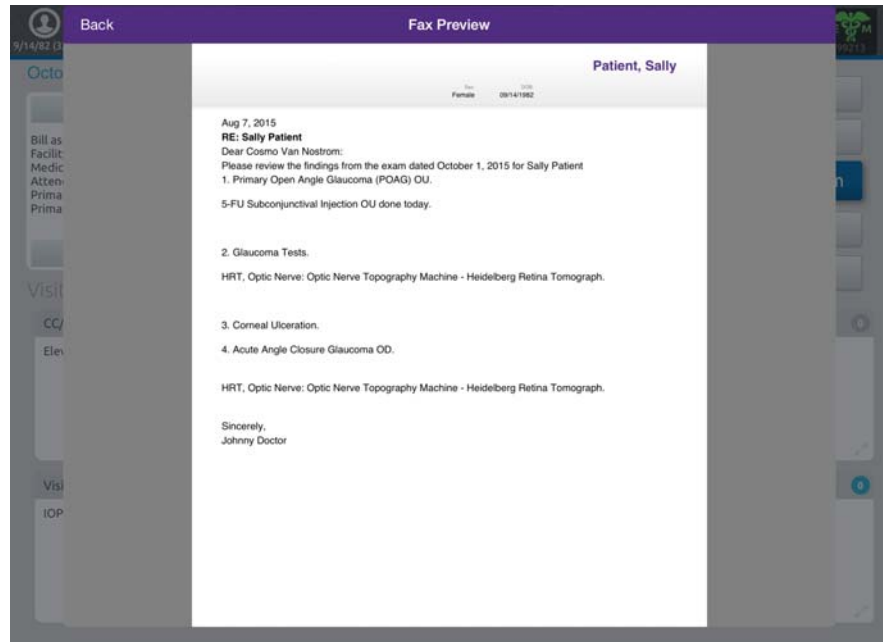
7. Tap **Back** to return.

8. Tap **Send** to fax the autoletter immediately, or tap **Save** to queue the autoletter to be faxed later.

NOTE	Queued faxes can be sent from the web application.

Using Intra-Mail

Before you can send IntraMail to another provider or staff, they must have an account in the web application.

▶ **To send an IntraMail message**

1. Open the Visit Overview screen. For more information, see "To open a visit from the patient's chart" on page 38.

2. Tap **More** and tap **Mail**.

NOTE	You can also access IntraMail from the Home screen by tapping the **Mail** button on the Action Bar.

The IntraMail screen opens.
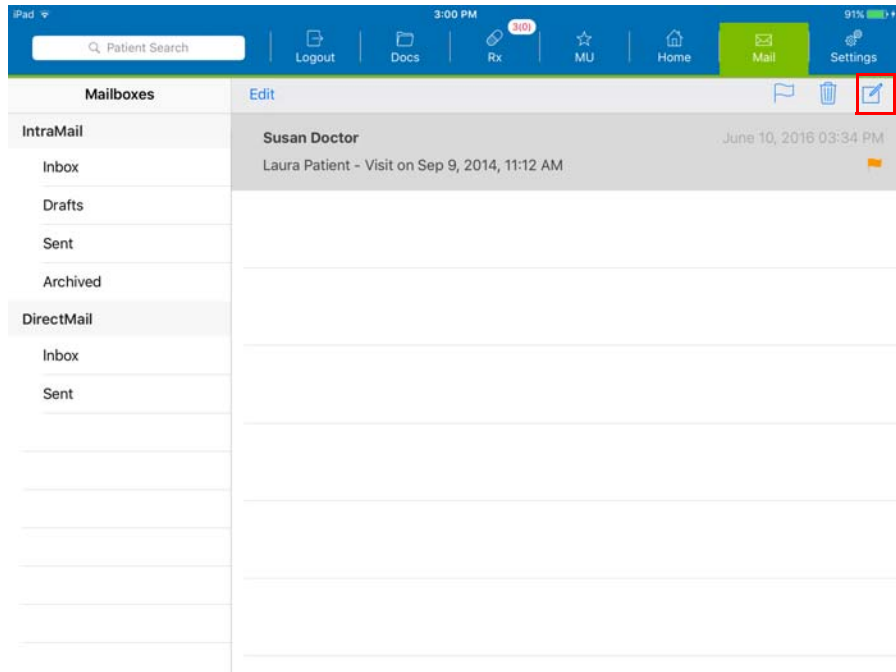
3. Tap notepad and pencil icon.

   The Intra Mail Message screen opens.

4. Tap the **To** text box and select a provider or staff member from the suggested list. You can also send a message to a patient.

5. Tap the **CC** text box and select a provider or staff member from the suggested list.

6. The **Subject** defaults to the patient name and visit date/time. Accept the default or type a new subject.

7. Type the text of your message.

8. Tap **Send** to send the message.

▶ **To read an IntraMail message**

1. Open the Visit Overview screen. For more information, see "To open a visit from the patient's chart" on page 38.

2. Tap **More** and tap **Mail**.

   The IntraMail screen opens to your Inbox. A blue dot appears next to new (unread) messages.

3. Tap one of the messages.

   The message opens.

4. Tap the patient name to open the patient chart for the patient or tap the Visit Overview to open the visit for the patient.

Using Direct Mail

Direct Mail enables you to send patient data to a receiving provider during a transition of care and send and receive secure messages from providers outside of your practice.

While you use IntraMail to securely send messages to providers, staff, and patients within your practice, use Direct Mail to securely send messages to providers outside of your practice. Direct mail messages look like email messages and patient records look like email attachments. The closed architecture of the system makes it secure and HIPAA compliant.

Before you can use Direct Mail, you must set up Direct Mail. Setting up direct mail is a two-step process. Each user must request a direct address, and one user must verify his or her identity on behalf of the entire practice.

Understanding the Terminology

While secure messages bear a resemblance to email, the two are not compatible. Understanding the technical differences between the two is not necessary, but it is important to understand some of the terminology used to distinguish secure messages. Use the table below to learn a few important terms.

Term	Definition
direct	*The protocol used to send encrypted messages.*
direct address	*The address other providers can use to send you secure messages.* The direct address looks like an email address. Share this address with providers outside of your practice.
HISP address	*Health information services provider.* This is another name for the direct protocol. Other providers may ask you for your HISP address; this is your direct address.
secure message	*An encrypted message sent from a person with a verified security certificate.* The message may contain a health-related question or a clinical summary.

Reporting on Meaningful Use

<div style="text-align: right; font-size: 3em;">11</div>

In this chapter:

Schedule CCDs for Patients

You can schedule CCDs (Continuity of Care Document) to be generated for all patients. After the CCDs have been generated as a zip file, you can access and download the file from the web application.

▶ To schedule CCDs

1. Open the Home screen.
2. Tap **MU** and tap **Port List**.

   The Create Portable List screen opens.
3. Tap **Schedule CCDs for All Patients**.

   A message appears to advise you that the CCDs have been scheduled to run overnight and will be available tomorrow.

Generate Referral Letters for Selected Patients

You can generate referral letters for up to 10 patients and send them to one of your contacts.

▶ To generate a referral letter

1. Open the Home screen.
2. Tap **MU** and tap **Port List**.

   The Create Portable List screen opens.

3. In the **Search** box, type the search criteria to locate the patient you want to refer.

   A list of patients matching the search criteria appears.
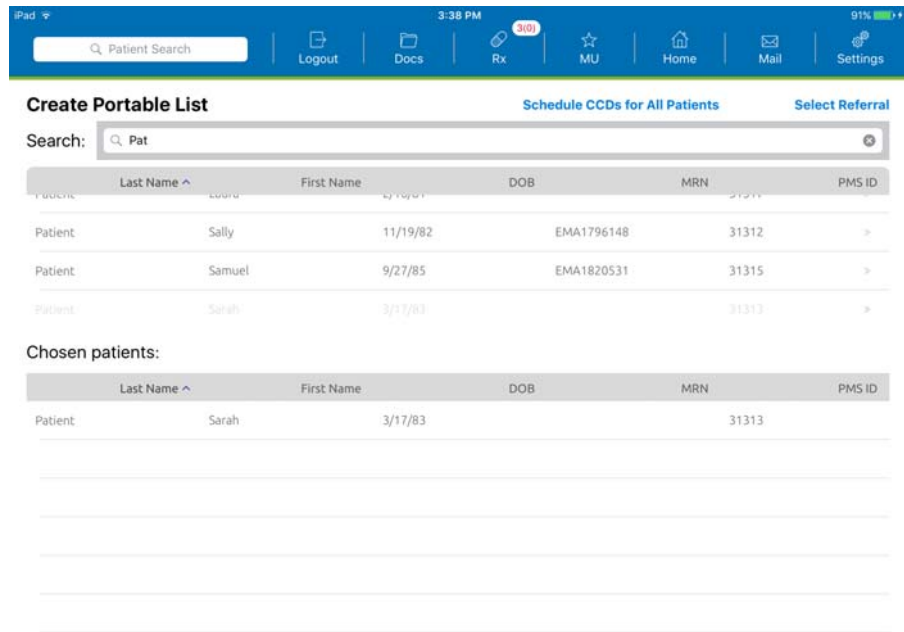
4. Tap the patient you want to refer. Repeat steps 3 and 4 until you have selected all of the patients you want to refer.

5. Tap **Select Referral**.

   The Send List window appears.
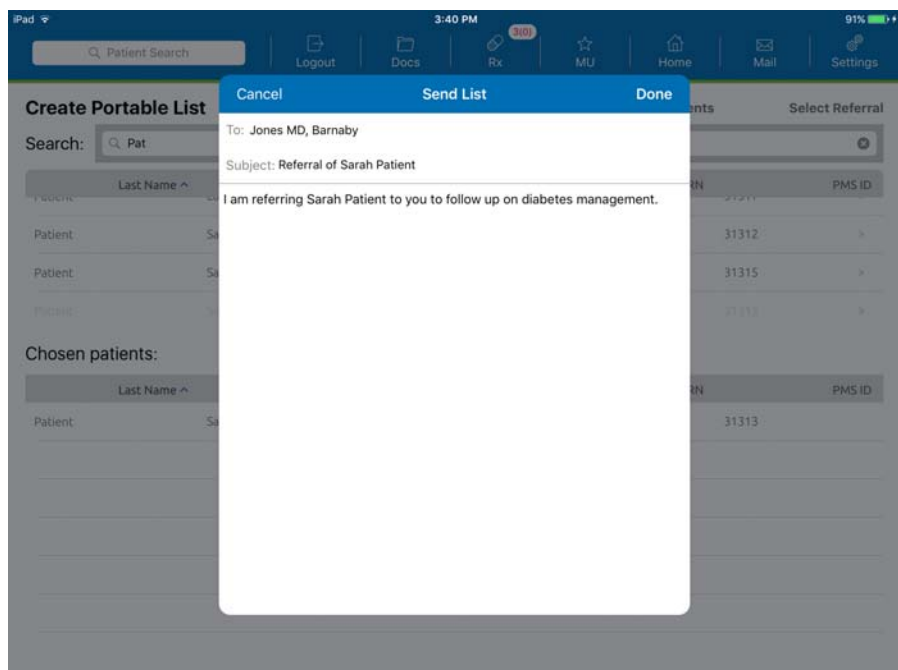
6. In **To**, type the first few letters of the contact you want to refer the patient to.

7. In **Subject**, type the subject of your message. In **Message**, type your message.

8. Tap **Done**.

   A message appears showing you have successfully sent your message.

Generate CQM Report

In addition to reporting meaningful use measures to CMS, you must also report clinical quality measures. Both meaningful use and clinical quality measures are required to qualify for payments under the EHR Incentive Programs.

Reporting clinical quality measures helps your practice meet meaningful use criteria. How you report CQMs depends on whether this is your first year demonstrating meaningful use:

- If this is your first year demonstrating meaningful use, you may attest to your CQM data manually through the EHR Registration and Attestation System or submit your CQM data to a registry electronically.

- If you have previously demonstrated meaningful use, you must report your CQM data to a registry electronically.

This section tells you how:

- To generate a CQM report, 151

▶ **To generate a CQM report**

1. Open the Home screen.

2. Tap **MU** and tap **CQM Rep**.

   The Clinical Quality Measure Reports screen opens.

3. Tap **Create New CQM Report**.

   The New CQM Report screen appears.

4. Select the **Report Stage**, **Provider** and **Report Year** from the drop-down menus.

5. Select a **Date Range Method** from the drop-down.

NOTE	Ensure that your visit notes are finalized throughout your attestation period. Closing the visit note without finalizing it results in the exam not counting toward some measures.

6. Select the Yes or No radio buttons for each item listed in the **CQM Measures List.**

7. Tap **Generate Report**.

   The Clinical Quality measure Reports screen shows the CQM report you generated and indicates if the report is processing.

8. After the report has finished processing, tap the name of the report.

   The clinical Quality Measure Report appears. Each CQM has a number and title.

   The Clinical Quality Measures report calculates the numerator, denominator, exclusions, percentage, and reporting rate for quality measures. If this is your first year demonstrating meaningful use, use the percentages displayed in the window during your attestation to report your CQMs

manually. The actual value of the percentage reported will not affect the incentive dollars for the EHR incentive program.

NOTES	• Providers may report zeros when attesting to the CQMs if a measure does not apply to the scope of their practice.
	• If you have the ability to print from an AirPrint printer, tap **Print** to print the report.

Generate Meaningful Use Report

You can run a Meaingful Use report at any time for any provider attempting to meet Meaningful Use. This should be done provider attesting to Meaningful Use

▶ **To generate a Meaningful Use report**

1. Open the Home screen.

2. Tap **MU** and tap **MU Rep**.

   The Meaningful Use Reports screen opens.

3. Select the **Report Stage**, **Provider** and **Report Year** from the drop-down menus.

4. Select a **Date Range Method** from the drop-down.

NOTES	• If this is your first year of meaningful use, your attestation period is only 90 days.
	• If you successfully attested to meaningful use in a prior year, your attestation period is the full calendar year.

5. Select the Yes or No radio buttons for each item listed in the **Meaningful Use Report Checklist.**

6. Tap **Get Summary Report** to display the report on the iPad or tap Get Summary Report (PDF) to display the report as a PDF file.

NOTE	If you have the ability to print from an AirPrint printer, tap **Print** to print the PDF file.

The Meaningful Use Summary Report displays your progress toward meeting meaningful use requirements:

– **Numerator**. The number of patients for which the meaningful use measure was performed.

– **Denominator**. The number of patients who fit the criteria specified by the measure.

– **Percent**. The percent of the patients who fit the criteria specified by a measure and for whom the measure was performed. the Numerator is divided by the Dominator to determine the percent.

– **Required**. The minimum percentage required to meet the measure.

– **Pass/Fail/Pass Alt**. Indicates whether you have met the measure (Pass), not met the measure (Fail), or pass by eligible exclusion (Pass Alt).

– **Status**. Indicates visually whether you have passed (check mark), or if you need to perform additional tasks to complete a measure (X).

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