Northern Light Health

From the Office of Clinical Informatics

Quick Reference Guide (QRG)
Behavioral Health Medication Management

August 10, 2020

This Quick Reference Guide (QRG) reviews the medication management follow-up appointment.

Common Buttons & Icons

	Sign icon
Document Medication by Hx	**Document Medication by Hx**
	Orders for Signature Tray
Sign/Submit	**Sign/Submit** button
Save & Close	**Save & Close** button
Add as Chronic	**Add as** drop-down

Complete the BH Ambulatory Comprehensive Intake Form

➢ **From the Ambulatory Organizer:**

STEP 1: Click the patient's name to navigate to the chart.

STEP 2: Establish your relationship to the patient.

STEP 3: Review the blue banner bar to confirm you have the right patient, date/time, and location of the appointment.

STEP 4: Navigate to the Ambulatory Workflow MPage.

NOTE: The intake form can also be accessed through the Forms component of the Clinic Workflow MPage.

STEP 5: Navigate to the Vital Signs component.

STEP 6: Click the **Vital Signs** component drop-down arrow.

STEP 7: Click the BH **Ambulatory Comprehensive Intake** form.

STEP 8: Complete the sections necessary for your clinic by clicking the needed sections down the left-side pane.

- Sections with an asterisk have required documentation.
- Information not captured elsewhere can be documented within the Nursing HPI section using freetext.
- Click a header to note all items in a grid at one time.

STEP 9: Enter or update the dates and times as needed.

NOTE: The current date and time auto-populate when opening the form.

STEP 10: Click the **Sign** icon once documentation is complete.

Document Medication History

➢ **From within the BH Ambulatory Comprehensive Intake form:**

STEP 1: Click **Document Medication by Hx** within the Current Medication List section of the form.

STEP 2: Right-click the medication.

STEP 3: Click **Add/Modify Compliance** in the menu.

STEP 4: Use the respective fields to update compliance and document last dose date/time.

NOTE: Follow steps 2-4 for all medications.

STEP 5: Click **Document History** at the bottom of the Document Medication by Hx window when all medications are reviewed and documented.

Document Allergies Component

➢ **From within the patient's chart:**

STEP 1: **Navigate** to the Inpatient Workflow if you are not already there.

STEP 2: Click the **Allergies** component.

STEP 3: Use the Add Allergy icon to add allergies or click the No Known Allergies button as appropriate.

STEP 4: Click Complete Reconciliation once complete.

Review and Document the Problem List

➢ **From within the patient's chart:**

STEP 1: Navigate to the Ambulatory Workflow.

STEP 2: Click **Problem List** to bring up the component for documentation.

STEP 3: Review and update the patient's chronic problems as needed.

STEP 4: Use the Add Problem field as needed to add either This Visit or Chronic problems. A list of options will populate as you being to type.

NOTE: Before starting your search use the Add As drop-down to have a problem added as Chronic or This Visit problems to the patient's chart.

STEP 5: Click the appropriate problem to be added from the populated list.

STEP 6: Click the appropriate button to note as a This Visit Problem, Chronic or both as needed.

NOTE: When clicking the Resolve hyperlink, it will bring up a window that allows you to document a problem as resolved.

Document the Provider Workflow

- **From the Ambulatory Organizer:**

STEP 1: Click the patient's name that you need.

STEP 2: Click the **Clinic Workflow** MPage within the patient chart.

- When completing the components, the information flows over to the prenote.
- Components are not shared between multiple users and the information entered is only on the person's screen who is documenting.

STEP 3: Click the **Chief Complaint** component from the Component list.

STEP 4: Click the freetext field and enter the Chief Complaint information.

STEP 5: Click **Sign** when complete.

STEP 6: Navigate to the Problem List.

STEP 7: Utilize the search box to populate the necessary diagnosis as needed.

NOTE: Entering more specifiers will assist in selecting the most applicable diagnosis.

STEP 8: Click the appropriate diagnosis.

STEP 9: Designate the problem as This Visit or Chronic, or both using the respective buttons.

STEP 10: Navigate to the Subjective/History of Present Illness (HPI) component.

STEP 11: Enter a comment as needed.

NOTE: There are available hpi autotext available.

STEP 12: Review and update the comment for accuracy.

STEP 13: Click **Save** once complete.

STEP 14: Navigate to the Mental Health component.

STEP 15: Document as appropriate.

NOTE: There are available autotext.

STEP 16: Review and update for accuracy.

STEP 17: Click Save.

STEP 18: Chart any other relevant information to the respective components being sure to save and/or sign the individual component as needed.

Document Behavioral Health Quick Orders

- **From the Patient chart using the Behavioral Health Provider View**

STEP 1: Navigate to the Behavioral Health Quick Orders MPage.

STEP 2: Click the appropriate order(s) needed.

STEP 3: Click the **Orders for Signature Tray**.

STEP 4: Review and Modify orders as appropriate.

STEP 5: Click **Sign**.

Chart an Outpatient Medication Reconciliation

- **From the Patient chart using the Behavioral Health Provider View:**

STEP 1: Navigate to the Home Medications component within the Clinic Workflow MPage.

STEP 2: Click **Outpatient** within the Home Medications Component.

STEP 3: Reconcile the listed medications.

STEP 4: Click **Sign**.

Add Patient Education

- **From the Patient chart:**

STEP 1: Navigate to the Patient Education component within the Clinic Workflow MPage.

STEP 2: Click the education you wish to add if it is listed.

STEP 3: Search for additional education using the More Options button.

STEP 4: Scroll down the component to verify that the education you want is added.

NOTE: You have the ability to choose a language outside of English. Click the Education Language drop-down arrow at the bottom of the component. Select the language preferred.

Create the BH Office Note

- **From the Clinic Workflow MPage within the patient's chart:**

STEP 1: Scroll down the Component list on the left-side.

STEP 2: Click **BH Office Note** hyperlink.

NOTE: Information pulls in based on prior documentation.

STEP 3: Document the **Date of Service** field.

STEP 4: Review the information that was pulled in, making edits as needed.

NOTE: Remember, any component that does not have documentation will not flow over to the note.

STEP 5: Click **Save and Close** if you are the scribe.

NOTE: If you are the scribe:

- Forward the note to the appropriate individual.

STEP 6: Click **Sign/Submit** if you are the provider.

STEP 7: Alter Type and Title of the note only if it is applicable to your clinic. They should not need to be changed.

STEP 8: Review and update the date and time as needed.

STEP 9: Click Sign.