Quanum®
Electronic Health Record (EHR)

Documenting a Patient Visit

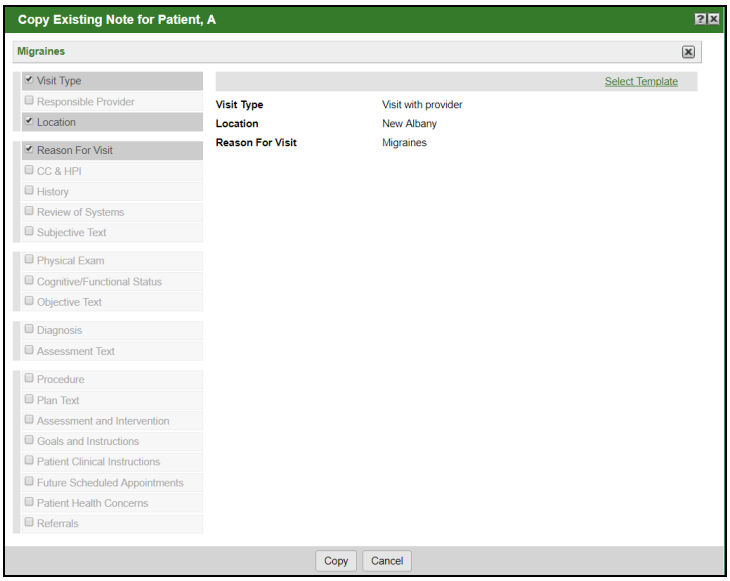
To capture information for a patient visit, Quanum® Electronic Health Record (EHR) utilizes the Subjective, Objective, Assessment, and Plan (SOAP) note format. Users may modify a patient's encounter note until another user finalizes the note.

Start a New Encounter Note

1. Click *Patient* > *Patient Visit* > *Start New Note*.
2. If you want to change the name of the encounter note, click the name, type a new name in the box that appears, and then click *Save*.
3. Type or select a *Date of Service*, *Associate User*, visit type, *Responsible Provider*, *Location*, *ICD* code set, and encounter template.
4. Select the *Urgent/Emergent Situation* check box, if applicable.
5. Select the *Patient Declines Summary* check box, if applicable.
6. Document the patient visit in the encounter note.

Start an Encounter Note by Copying an Existing Encounter Note

1. Locate and view the encounter note from which you want to copy data into a new note.
2. Scroll down to the bottom of the page and click *Copy Note*.



3. Review the template associated with the encounter note. If you do not want to use this template for the new note, click the *Select Template* link and choose the appropriate template.

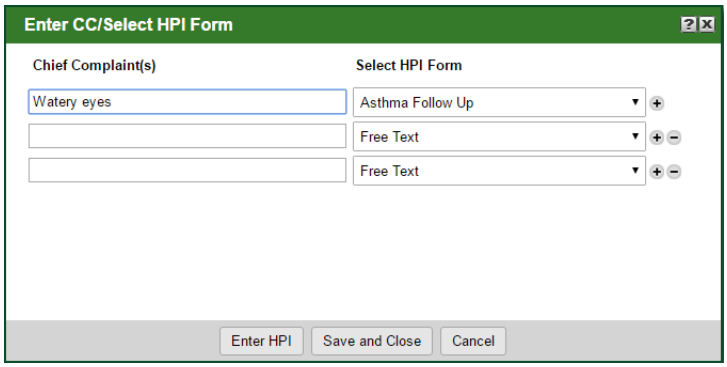
   Note: If the template contains diagnoses and/or procedures, these will be automatically added to the new note (in addition to the diagnoses and/or procedures that are being copied over).

4. Review the information available for copying into the new encounter note and clear check boxes for any content that you do not want to copy into the new encounter note.
5. Click *Copy*.
6. If you want to change the name of the encounter note, click the name, type a new name in the box that appears, and then click *Save*.
7. Type or select a *Date of Service*, *Associate User*, visit type, *Responsible Provider*, *Location*, *ICD* code set, and encounter template.
8. Select the *Urgent/Emergent Situation* check box, if applicable.
9. Select the *Patient Declines Summary* check box, if applicable.
10. Document the patient visit in the encounter note.

Add Subjective Information to an Encounter Note

1. Click *Care Type*. Indicate the care type and add additional information, as needed. Click *Save*.

   If the care type is set to *New Patient Visit (Never Seen by Provider)*, *Referral*, or *Transitional Visit*, click *Summary of Care* to begin tracking the receipt and incorporation of a summary of care.
2. Click *Reason for Visit*. Type a reason, then click *Save*.
3. Click *CC & HPI*. Type a chief complaint and select an HPI form. Click *Enter HPI*, complete any applicable fields, and then click *Save*.



4. Click *Problems*. Review items in the *Quanum® Active Problems* list as follows:
   - Click ✕ to deactivate a problem
   - Click ◀ to move items from the *Other* list to the active list.
   - Click *Add ICD-10* to associate an ICD-10 code with the problem.
   - Click *Add a Problem* as necessary.

   When finished reconciling, click *Save*.
5. Click *History*. Click *Yes* or *No* next to each applicable item.
   - To specify additional information, click an item, then type information and click *Add* > *Continue*.
   - To add a line item, use the *Other* box.

   When finished, click *Save*.
6. Click *Allergies/Adverse Reactions*. Review items in the *Quanum® Active Allergies/Adverse Reactions* list as follows:
   - Click ✕ to deactivate an allergy
   - Click ◀ to move items from the *Other* list to the active list.
   - Click *Add an Allergy/Adverse Reaction* as necessary.

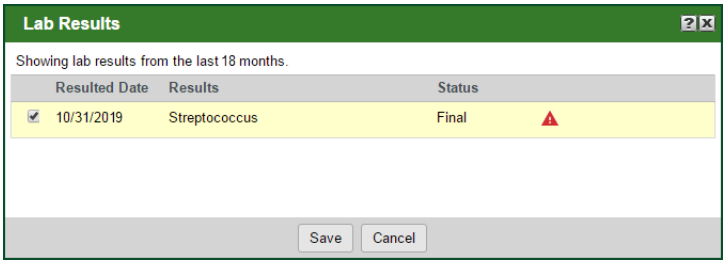
   When finished reconciling, click *Save*.
7. Click *Active Medications*. Review items in the *Quanum® Active Medications* list as follows:
   - Click ✕ to deactivate a medication, choose a deactivation reason and then click *OK*.
   - Click ◀ to move items from the *Other* list to the active list.
   - Click *Add a Reported Med* as necessary.

   When finished reconciling, click *Save*.
8. Click *Review of Systems*. Click a system, then click *Yes* or *No* next to each item, adding notes as needed. Click *Save*.
9. Click *Subjective Text*. Type subjective notes, and then click *Save*.

Add Objective Information to an Encounter Note

1. Click *Vitals*. Type or select any vitals, add comments as applicable, and then click *Save*.
2. Click *Physical Exam*. Click a category. Select any options that apply to the patient, optionally type in the text boxes, and then click *Save*.
3. Click *Cognitive/Functional Status*. Type the SNOMED description in the *Cognitive Status* and *Functional Status* boxes and click a match, or enter free text, and then click *Save*.
4. Click *OB Data*. Define applicable data for the patient, and then click *Save*.
5. Click *Pregnancy Flowsheet*. Type or select information for any items, and then click *Save*.

   Note: The *OB/GYN* premium service must be active at your organization and pregnancy record information must be enabled in order to add OB/GYN information.
6. Click *Lab Results*, select the check box next to each lab result that you want to include, and then click *Save*.



7. Click *Implantable Devices*. Click *Add Implantable Devices*, as necessary, to add implanted devices not already on the list. Next, select the check box next to each implanted device that you want to include in the encounter note and then click *Save*.
8. Click *Objective Text*. Type your observation of the patient, and then click *Save*.

Add Assessment Information to an Encounter Note

Note: If your encounter note is populated with diagnoses (via the template), review and remove any that are not applicable.

1. Click *Diagnosis* and then click in the *Code/Description* box. Do one of the following:
   - Select a patient problem or past medical history item (and associate an ICD-10 code, if applicable).
   - Type 3 or more characters of the code or description and click the match.
   - Type the diagnosis as free text.

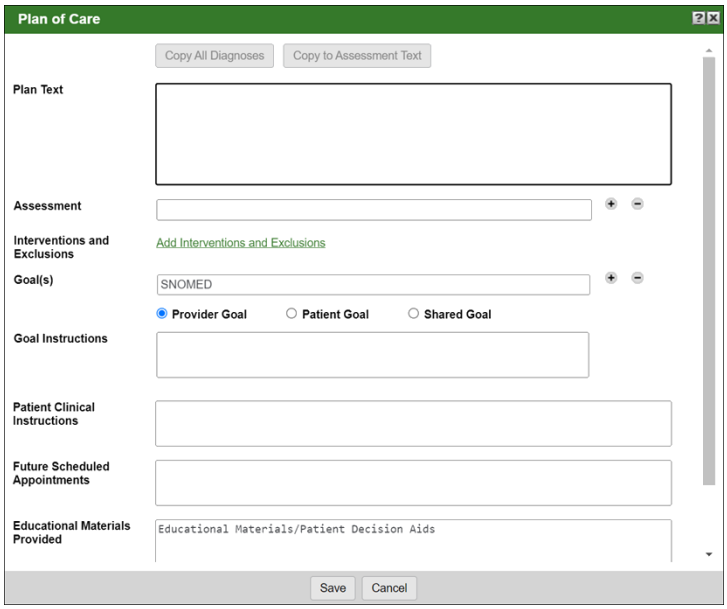
   When finished, click *Save*.

   Note: Select the *Primary* check box to mark a diagnosis as primary. To add a diagnosis, click ⊕. Click ⊖ to remove a diagnosis.
2. Click *Risk Evaluations*. As applicable, type *Free Text*, complete *Questionnaires*, and address *Evaluation Questions*. Click *Save*.
3. Click *Assessment Text*. Type assessment notes, do the following (as needed), and then click *Save*:
   - Click *Copy All Diagnoses* to copy any diagnoses that have already been entered into the encounter note into the *Assessment Text* box.
   - Click *Copy to Plan Text* to copy all *Assessment Text* into the *Plan Text* box (located in the *Plan of Care* section).

Add Plan Information to an Encounter Note

Note: If your encounter note is populated with procedures (via the template), review and remove any that are not applicable.

1. To place a lab order using minimal information, click *Lab Order*.
2. To write a radiology order, click *Radiology Order*.
3. To write a prescription, click *Prescription*.
4. Click *Procedure*. Click a code type in the list, and then type the code in the box. Add modifiers and complete any other fields, as needed. Click *Save*.
5. View any orders placed for the patient within the last 48 hours.
6. Click *Other OB Tests*. To mark a lab as recommended, select the check box next to it. In the dialog box, complete the fields, and then click *Continue*. Click *Save* to add your selections.
7. Click *OB Education Flowsheet*. Select the check box next to a topic to mark it as addressed. In the dialog box, complete the fields, and then click *Continue*. Click *Save*.
8. To access clinical education materials, click *Clinical Education*.
9. To access a leaflet for a medication, click *Medication Education*. Type a medication name at *Search*, and then click *Search Meds*. In the results, click next to a medication.
10. Click *Plan of Care* and do the following:
    a. Type or select *Plan Text*, *Assessment* information, *Interventions and Exclusions*, *Goal(s)*, *Goal Instructions*, *Patient Clinical Instructions*, *Future Scheduled Appointments*, *Educational Materials Provided,* and *Patient Health Concerns*.
    b. Click *Copy All Diagnoses* to copy any diagnoses already entered into the encounter note into the *Plan Text* box.
    c. Click *Copy to Assessment Text* to copy all *Plan Text* into the *Assessment Text* box (located in the *Assessment* section).
    d. Click *Save*.



11. Click *Referrals*. Type the reason and specify the provider or organization. Click *Save*.

Finalize an Encounter Note

When the encounter note is complete, click *Finalize and Sign*.

For help, contact the Help Desk at 1.800.697.9302

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