NorthShore University HealthSystem

EPICCARE AMBULATORY MEDICAL RECORD

Ambulatory Chart Abstracting

Participant's Guide

Ambulatory Chart Abstracting
Syllabus

Objectives:

Participants will have the knowledge to perform the following after successful completion of the Abstracting course. Using a Clinical Summary form and a Patient History Record, participants will be able to:

I. Log into Epic.
II. Perform an accurate patient search.
III. Create an Abstract Encounter.
IV. Document allergies.
V. Enter medications.
VI. Enter past medical and surgical history.
VII. Providers only – update a Problem List.
VIII. Document family history.
IX. Document social history.
X. Enter prior immunizations.
XI. Document external results.
XII. Enter past vital signs.
XIII. Complete the Abstract Encounter.

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What is Abstracting?

It is the process of manually entering historic (already documented) patient information either from a paper chart or office-based electronic medical record into Epic. An Abstract Encounter is the point of entry for this information. It is most beneficial if data is abstracted prior to a doctor's appointment so that the information can be reviewed during the office visit.

Abstracting is not the same as scanning. Scanning involves creating an image of a print document and entering it into the chart. Some providers prefer that labs or outside diagnostic testing results be scanned into Epic. Scanning requires additional equipment, an additional training course and is at the practice manager's discretion.

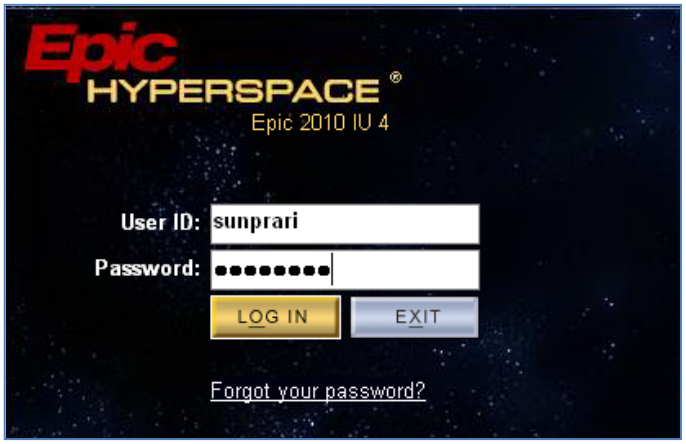
What is an Abstract Encounter?

An Abstract Encounter allows historic patient information to be carefully entered into the Epic EHR so pertinent health data is readily available. This information may be entered by physicians, *designated* clinical staff and abstractors. Each office identifies specific information to be abstracted into Epic. Some offices will use Clinical Summary sheets or a specific Abstracting form to identify the specific information to be documented.

Getting Started with an Abstract Encounter

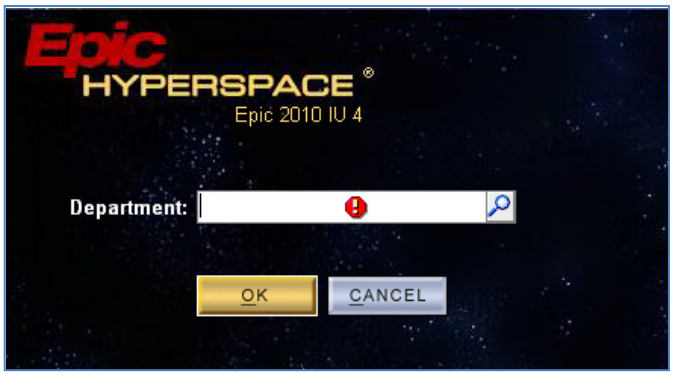
Log in to Epic Hyperspace

1. Enter your User ID.
2. Enter your Password.
3. Click **LOG IN.**



The Epic Hyperspace Login Department window displays.

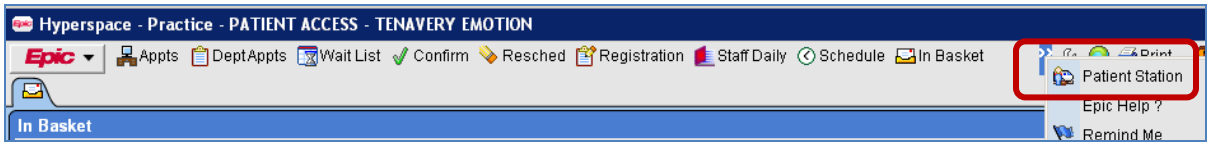
4. Ensure that your default log in department displays correctly. If not, change to the correct department. Be sure that you are logging into the Department for which you are abstracting. Do NOT log into your home department, unless appropriate.
5. Click **OK**.



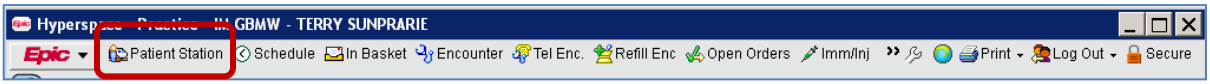
Initiating an Abstract Encounter

The Abstract Encounter is most often used to enter patient information into the electronic medical record *before* the patient comes to the office for a visit. Details are clarified and reviewed during the visit.

1. Click **Patient Station** from the Epic Speed Bar.



Abstractor view: Patient Station accessed by clicking chevron on Epic toolbar.



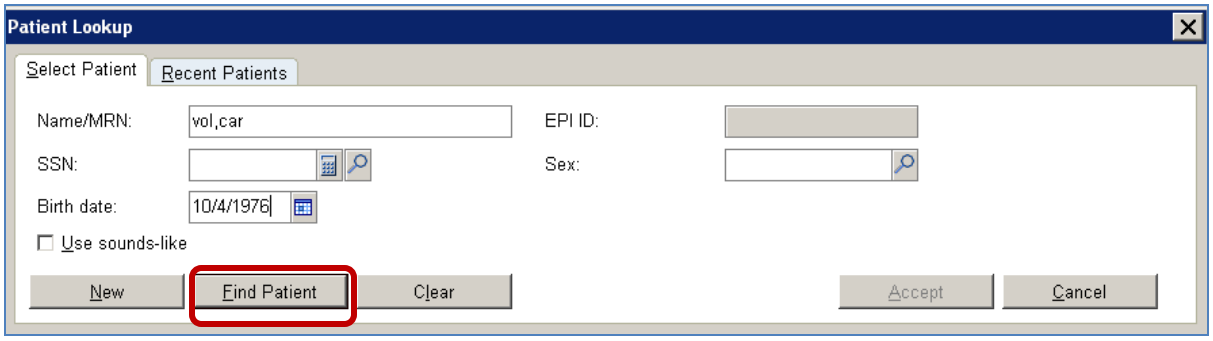
Clinical view: Patient Station on Epic toolbar.

2. Find the patient by using the "3,3" method and birth date.

   A. To do this, type the first 3 letters of the patient's last name, comma with *no* space, and the first three letters of the first name. For example, Carolyn Volcanic would be found by entering **vol,car**.

   B. Enter her birth date.

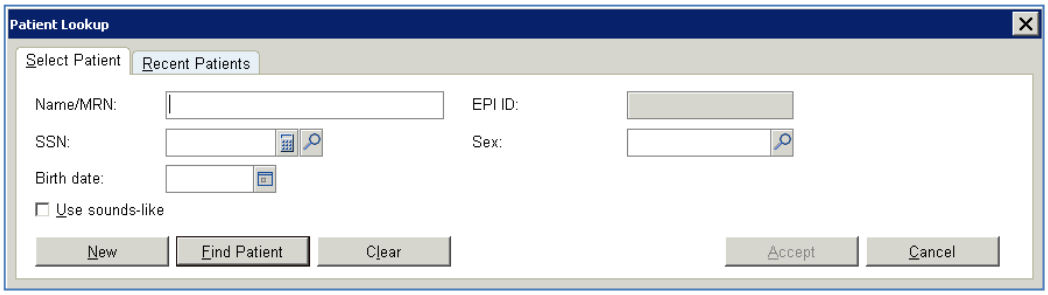
   C. Click **Find Patient**.



Be sure you are using the accepted NorthShore standards for locating patients in Epic. NorthShore Patient Search Methods are outlined on the following page.

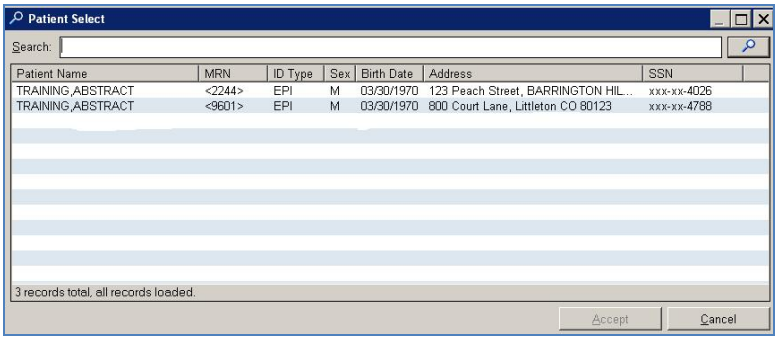
NorthShore Patient Search Methods

According to NorthShore policy, you must perform each **NorthShore Patient Search Method** in the order they appear below. This is to ensure you do NOT create duplicate patient records.

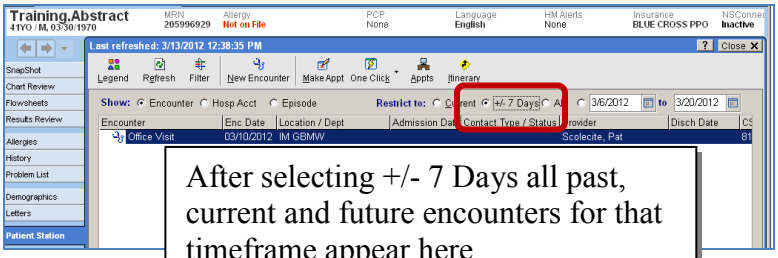


1.	**3,3 & DOB**	In the *Name/MRN* field, type the first three letters of the patient's last name, comma, and first three letters of the patient's first name. In the *Birth date* field, type the patient's date of birth.
2.	**Check for typos**	Make sure the **3,3 and birth date** are correct and that the 3,3 is in the right order (lastname,firstname).
3.	**Last Name (3) and Birth date**	Enter only the first three characters of the patient's last name in the *Name/MRN* field and enter the patient's **birth date**. ***Note: This is a critical search for PEDS patients who may be in the system under the first name Babygirl, Babyboy, etc.***
4.	**Social Security # Only**	If you have a social security number for the patient, enter it in the *SSN* field.
5.	**Different Last Name (3) and Birth date**	Ask if the patient could be in the system under a different last name (i.e., a maiden name). If so, search using the first three characters of the different last name in the *Name/MRN* field and the birth date. ***Note*: This is a critical search for PEDS patients who may have been registered under a different last name at birth, and/or women whose marital status has changed.**
6.	**Full Last Name and Use Sounds Like**	Enter the patient's **FULL last name** and check the **Use sounds-like** box to search for alternate spellings.

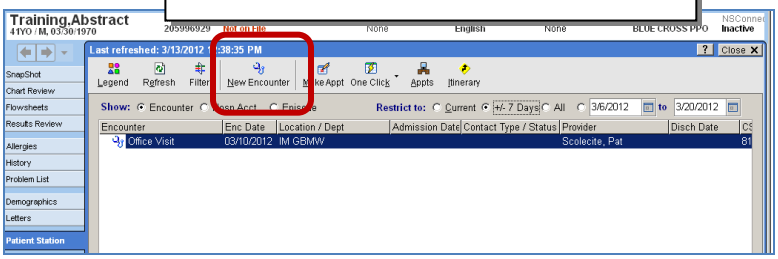
1. Select the correct patient. Be cautious when searching for patients with similar names. If there is a patient with the same name and birth date, use a second method of identifying such as an address.



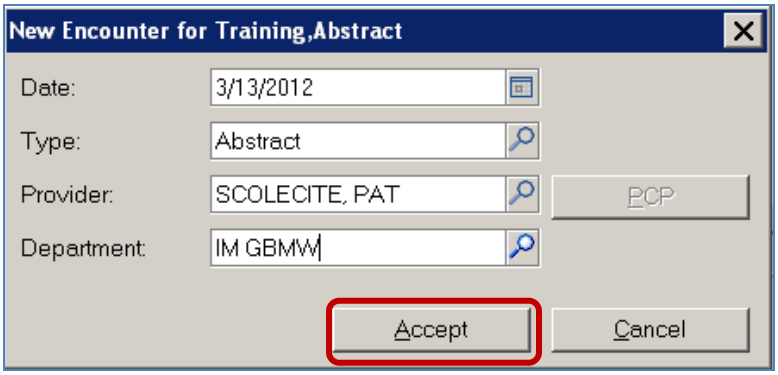
2. After selecting the correct patient, select +/- 7 Days option to determine if there is an existing open abstract encounter.



3. If there isn't an existing Abstract encounter, click **New Encounter**.

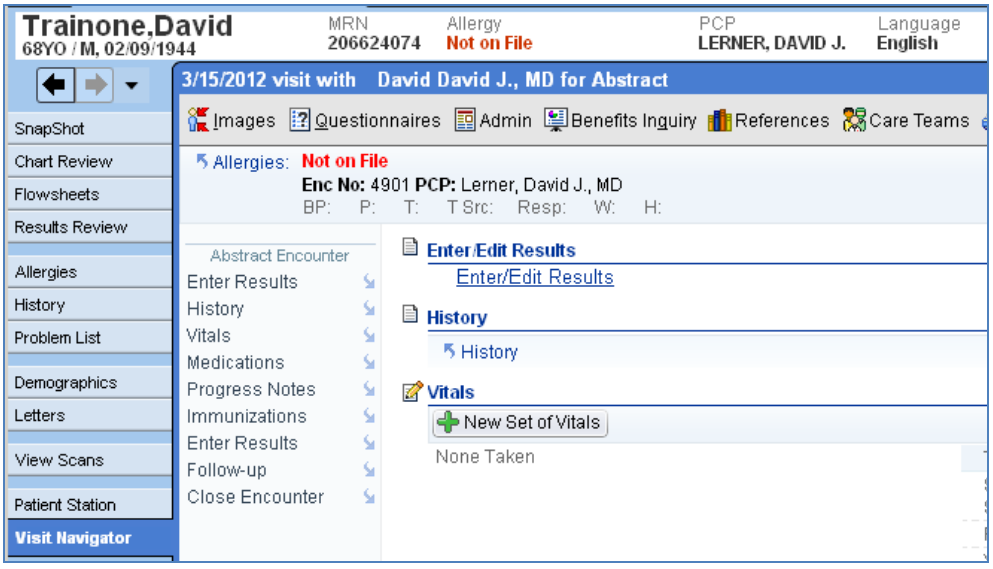


4. The New Encounter window displays.
5. The *Date* can be adjusted, if desired.
6. In the *Type* field enter "Abstract".
7. Enter the *Provider* name.
8. The *Department* is where the provider sees the patient.
9. Click **Accept**.



The Abstract Encounter displays. Activities (far left column) and Abstract Encounter sections will differ based on user role.

Clinical View

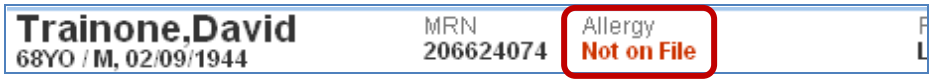


Abstractor View

Entering Allergies

Allergy status must be reviewed at least annually in order to prescribe medications. The Patient Header always displays allergy information.

Not on File = no one has addressed allergies.



No Known Allergies = the patient does not have any known allergies.

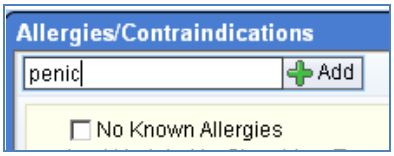
Allergen Name = known allergens are listed in red in descending severity.

To note Allergies:

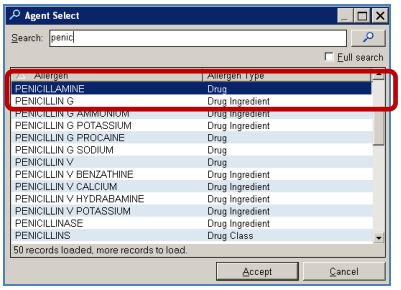
1. Click the **Allergies** activity.

2. If the patient does not have any allergies, select the No Known Allergies box.

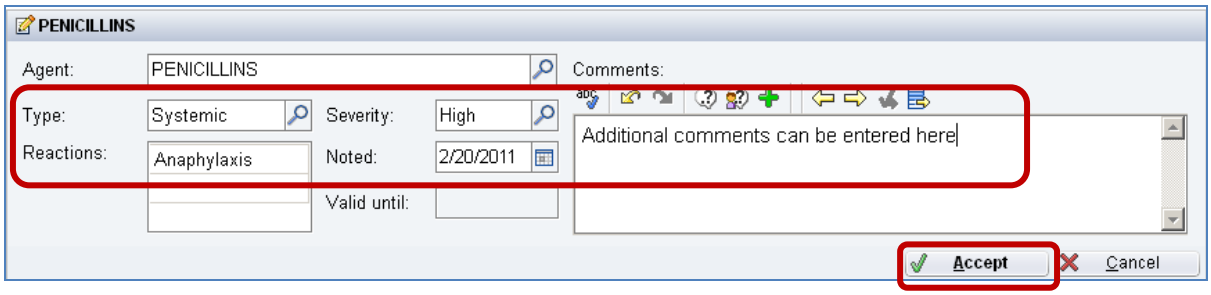
3. To note the patient's allergies, type the allergen in the search box and press **ENTER**.



4. Select the correct allergen.
   Selecting the broadest type "Drug Class" is the most comprehensive.
5. Click **Accept**.



If additional information is known, it can be added.



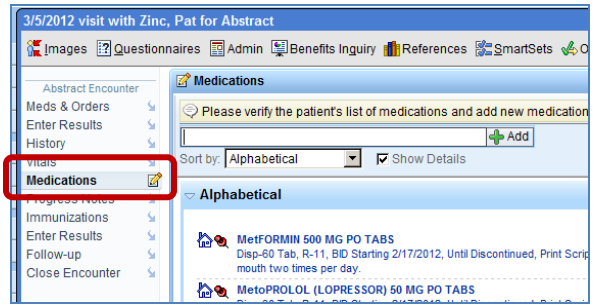
6. **Type**: select the type of reaction.
7. **Reactions:** select the patient's reactions to the allergen. Additional reactions can be added by clicking the empty row below.
8. **Severity:** indicate the level of severity. Allergies listed with a high severity also have a yellow banner – the yellow banner is not visible on the header though.
9. **Noted:** change to the date the allergy was noted or, if unknown, the date of the last office visit.
10. **Comments:** additional comments can be added if needed.
11. When complete, click **Accept**.

    Click the **Visit Navigator** activity to return to the Abstract Encounter.

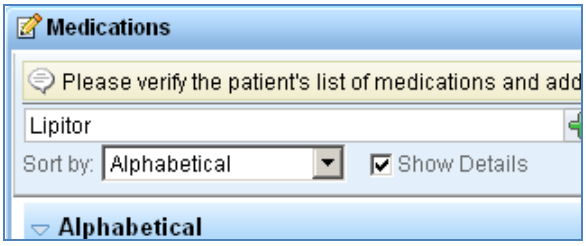
Entering Historic Medications

Entering the patient's historical medication is a very important part of the abstracting process.

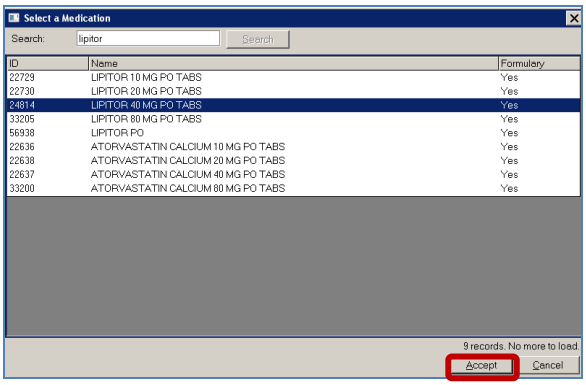
1. Click **Medications** in the Abstract Encounter navigator.



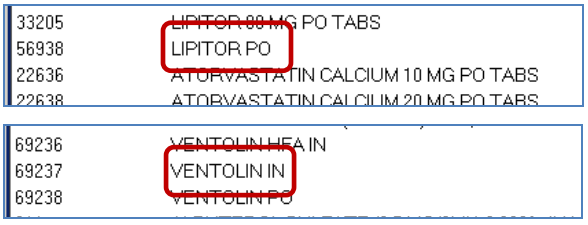
2. Enter the medication name in the search field and press **Enter.**



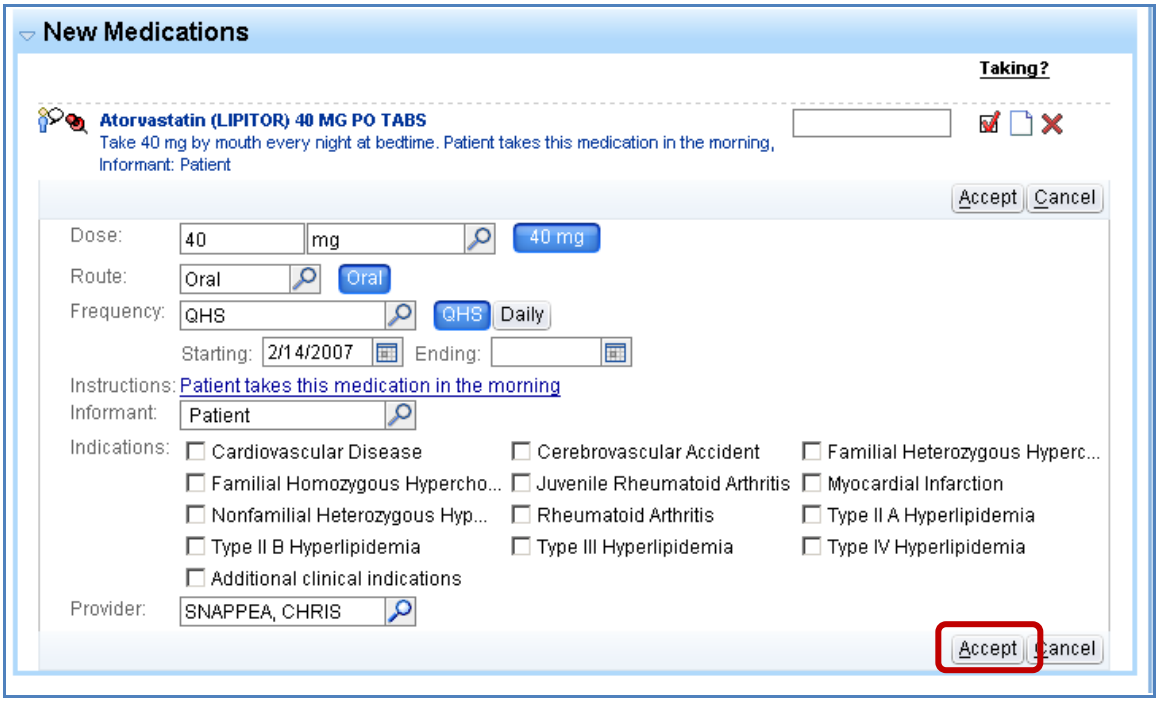
3. Select correct strength if known. Then click **Accept**.



4. If the medication dosage is unknown, select the name and route of the medication only.

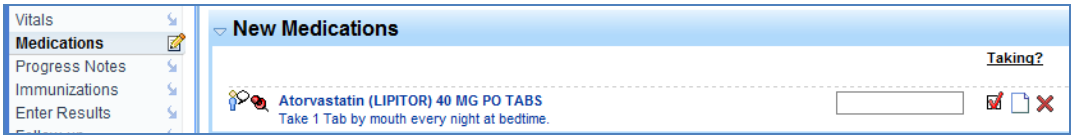


The Medication Details screen displays. As a general rule, Abstractors do not adjust any of the information. Clinical staff and providers can adjust information such as dose, route, frequency, start date and so forth, if known.



5. Click **Accept**.

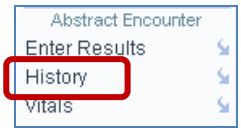
- The medication appears on the Medications list.



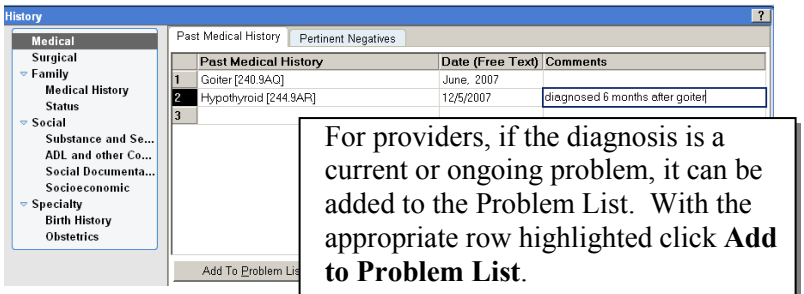
- The  indicates the medication is historical and patient reported.
- Red checkmarks in the *Taking* column automatically display and indicate actively taking medications.

Entering Patient Medical and Surgical Histories

1. Click **History** from the navigator.

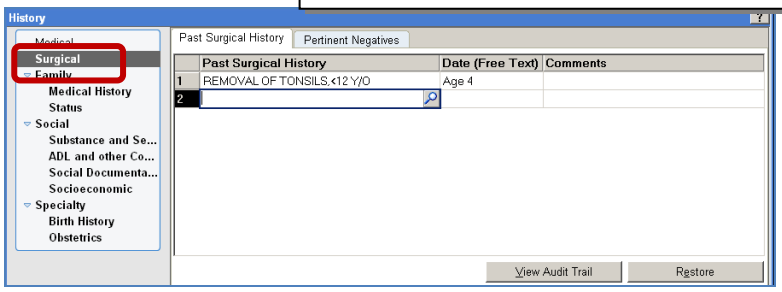


2. Complete the columns. Enter diagnosis or ICD-9 code. Enter date of onset, if known. Comments can be added, if appropriate.



For providers, if the diagnosis is a current or ongoing problem, it can be added to the Problem List. With the appropriate row highlighted click **Add to Problem List**.

3. Click **Surgical**.
4. Enter the surgical procedure or CPT code. Enter Date if known. Comments can be added if appropriate.

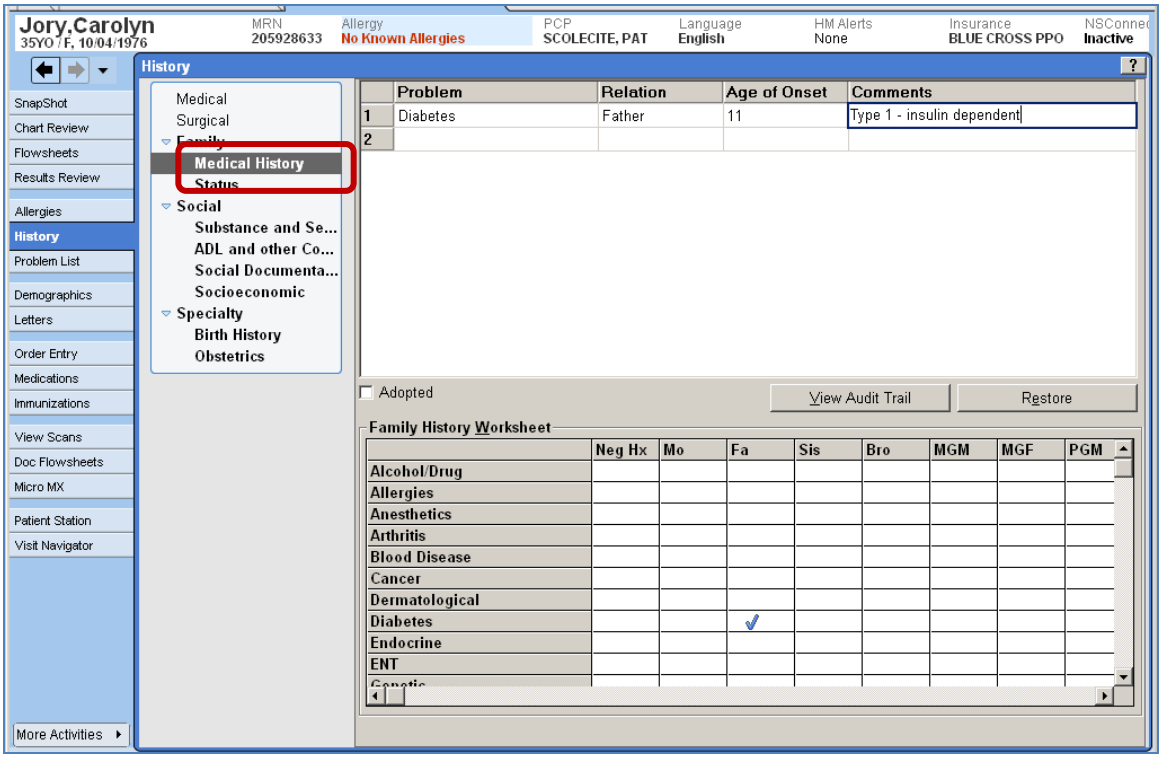


Family History and Status

There are two sections in Family History: Family Medical History and Family Status.

Family Medical History

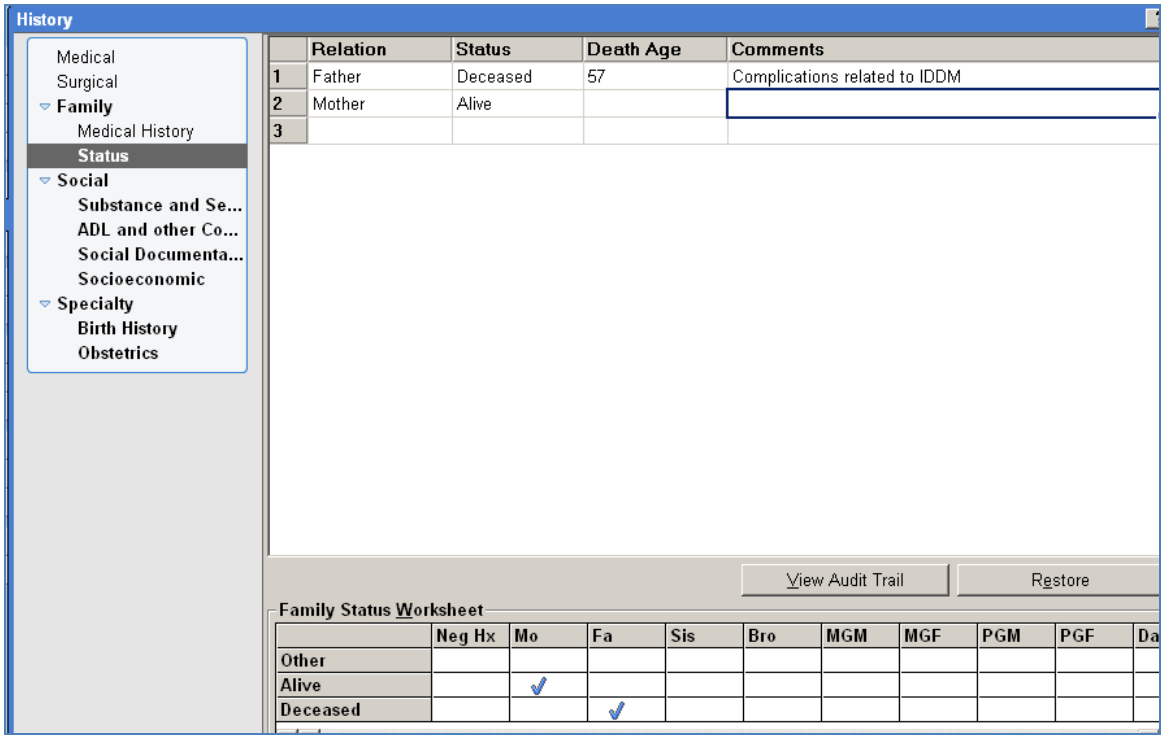
1. Under **Family,** click **Medical History**.



2. Use the Family History Worksheet grid to quickly enter data. Click in the cell at the *intersection* of a family member and problem to create a list. More detail can be added in the Age of Onset and Comments columns.

Family Status

1. **Family Status** is used to document whether family members are alive or deceased.



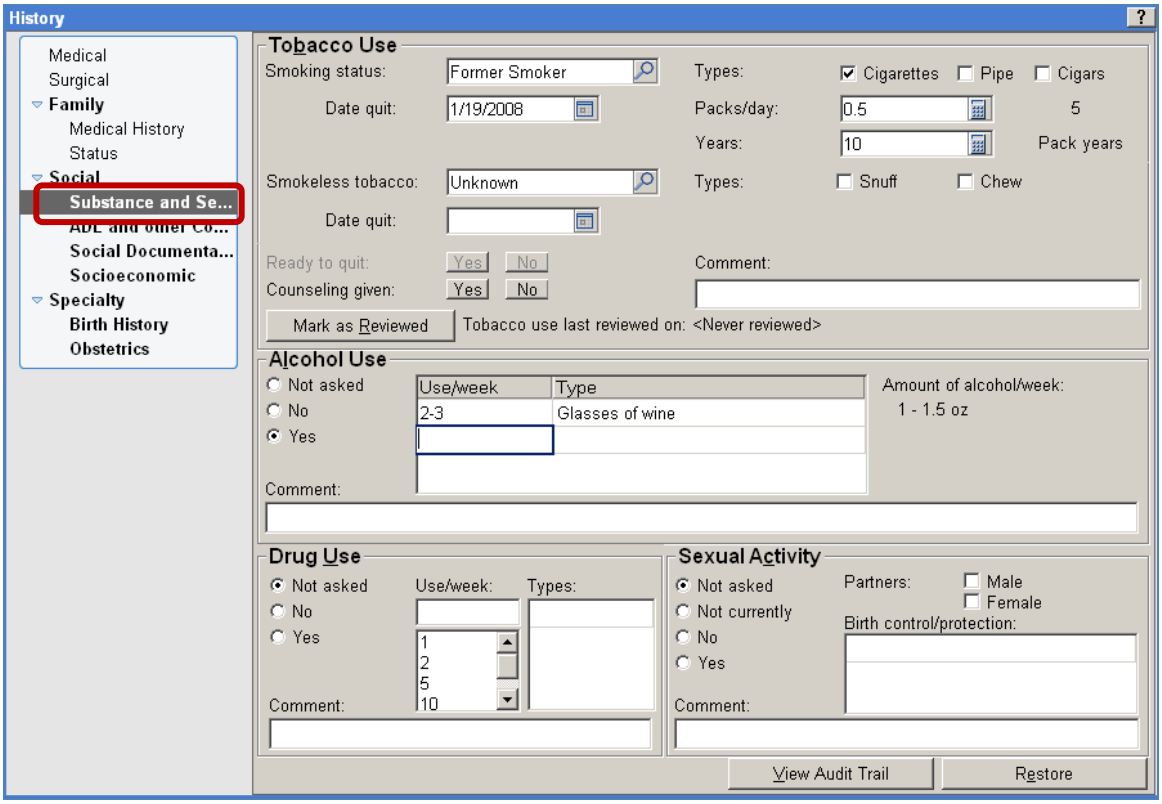
2. Click in the cell at the *intersection* field. Similar to Family Medical History, additional information can be added in the Death Age or Comments column.

Social History

Social History encompasses patient information pertaining to tobacco, alcohol, drugs, sexual activity, activities of daily living (ADLs) and socio-economic data. This section is optional for abstraction.

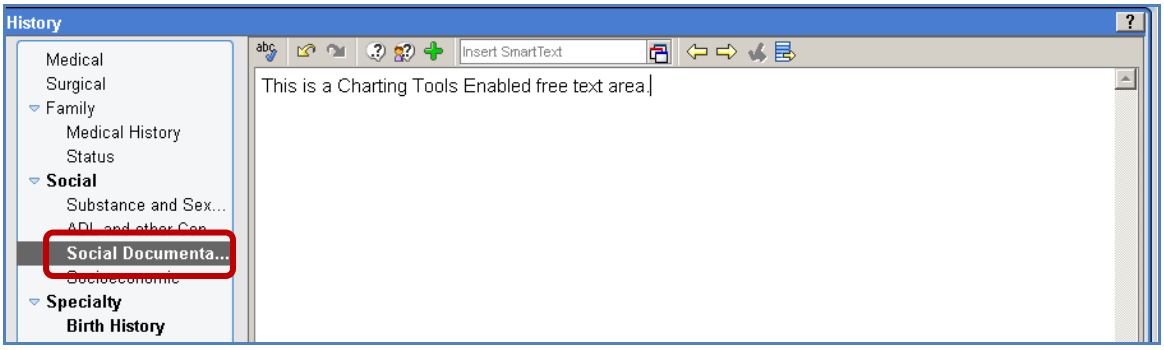
Substance and Sexuality

1. Click **Substance and Sexuality** under the Social History section. It is divided into 3 sections: Tobacco Use, Alcohol Use, and Drug Use.
2. Enter the available information in the appropriate section.



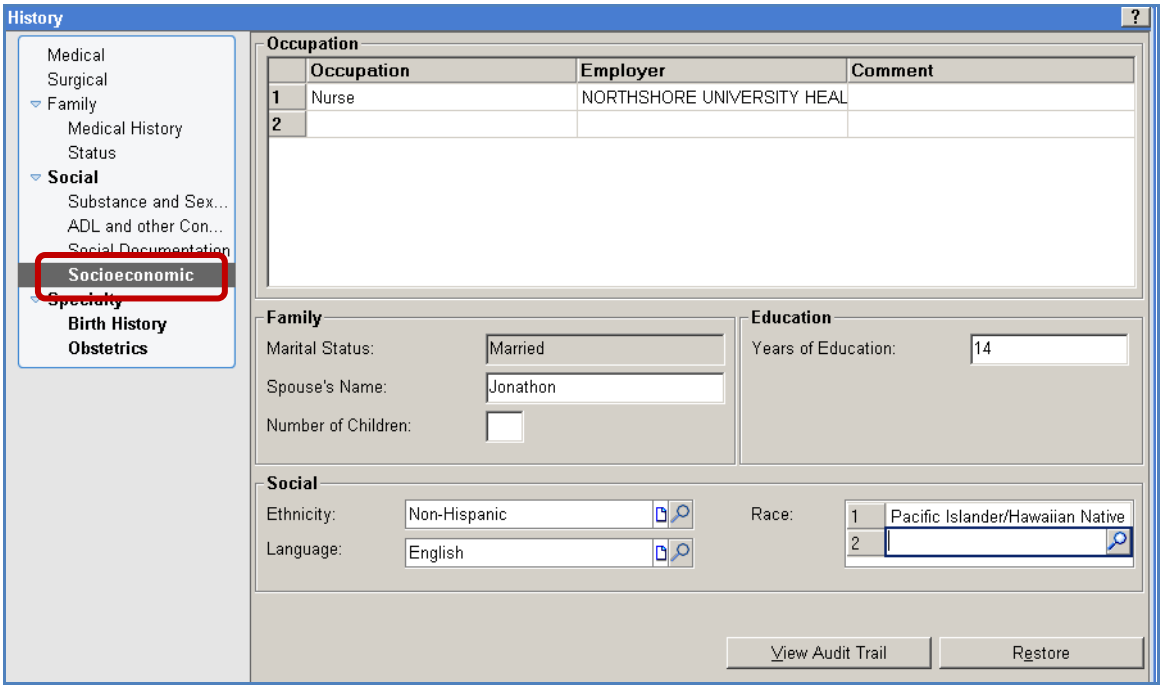
Social Documentation

1. Click **Social Documentation**. This free text field can be used for any type of information, such as family or social issues, etc.



Socioeconomic

1. Click **Socioeconomic**. This field is completed during the registration process.
2. Note that more Demographic information is available by clicking the **Demographics** tab in the Activities column.

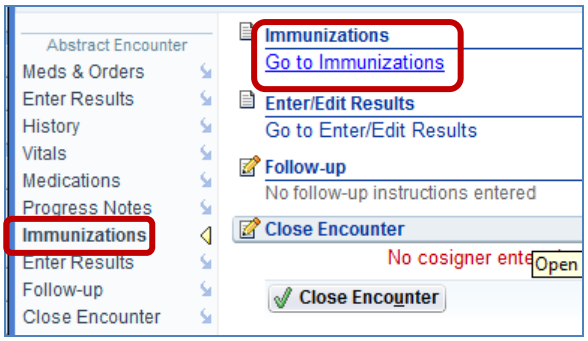


> **! Clinicians will review and update social history information at the beginning of each patient visit.**

Immunizations/Injections

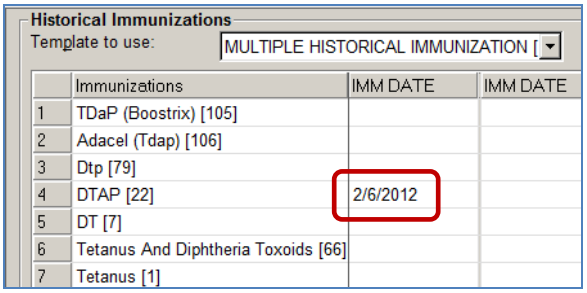
Historic immunizations and injections are entered here. Childhood vaccinations, tetanus shots, pneumonia and flu shots, etc., given prior to this visit may be entered to document the Administration History.

1. Click **Immunizations** from the navigator.
2. Click **Go to Immunizations** hyperlink.



3. Click **Historical Admins.**

4. Enter immunization dates in the correct immunization row.
5. Click **Accept**.

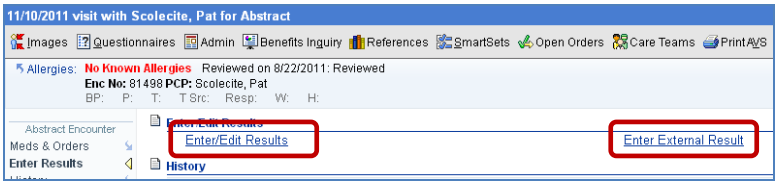


Entering External Results

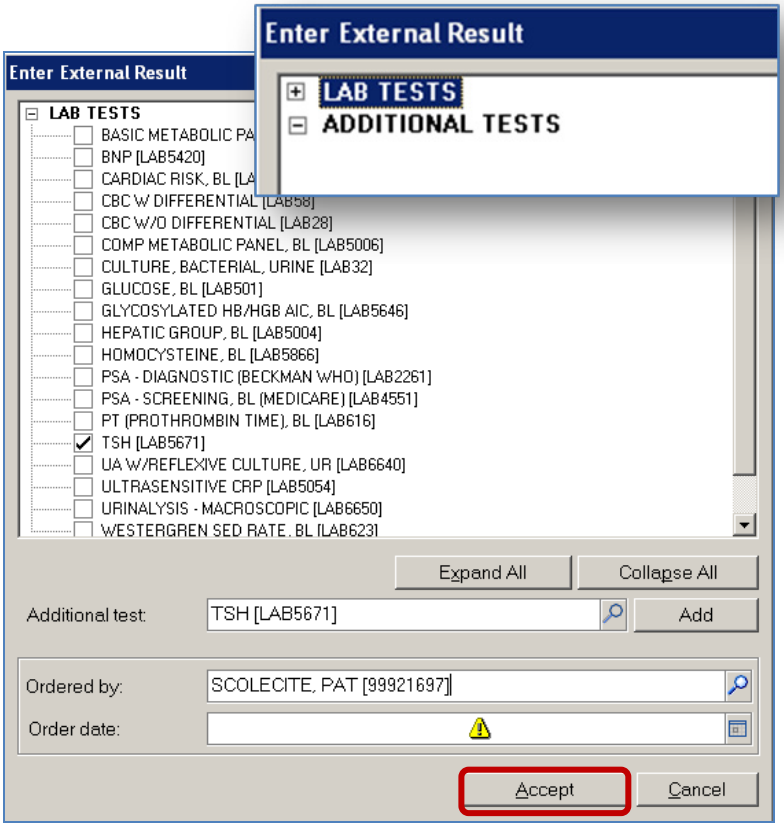
Past non-NorthShore test results can be abstracted into Epic. Some test results may include Laboratory, Radiology, Nuclear Medicine, EKG interpretations, and Mammograms.

Test results from outside agencies can be entered using the External Results function.

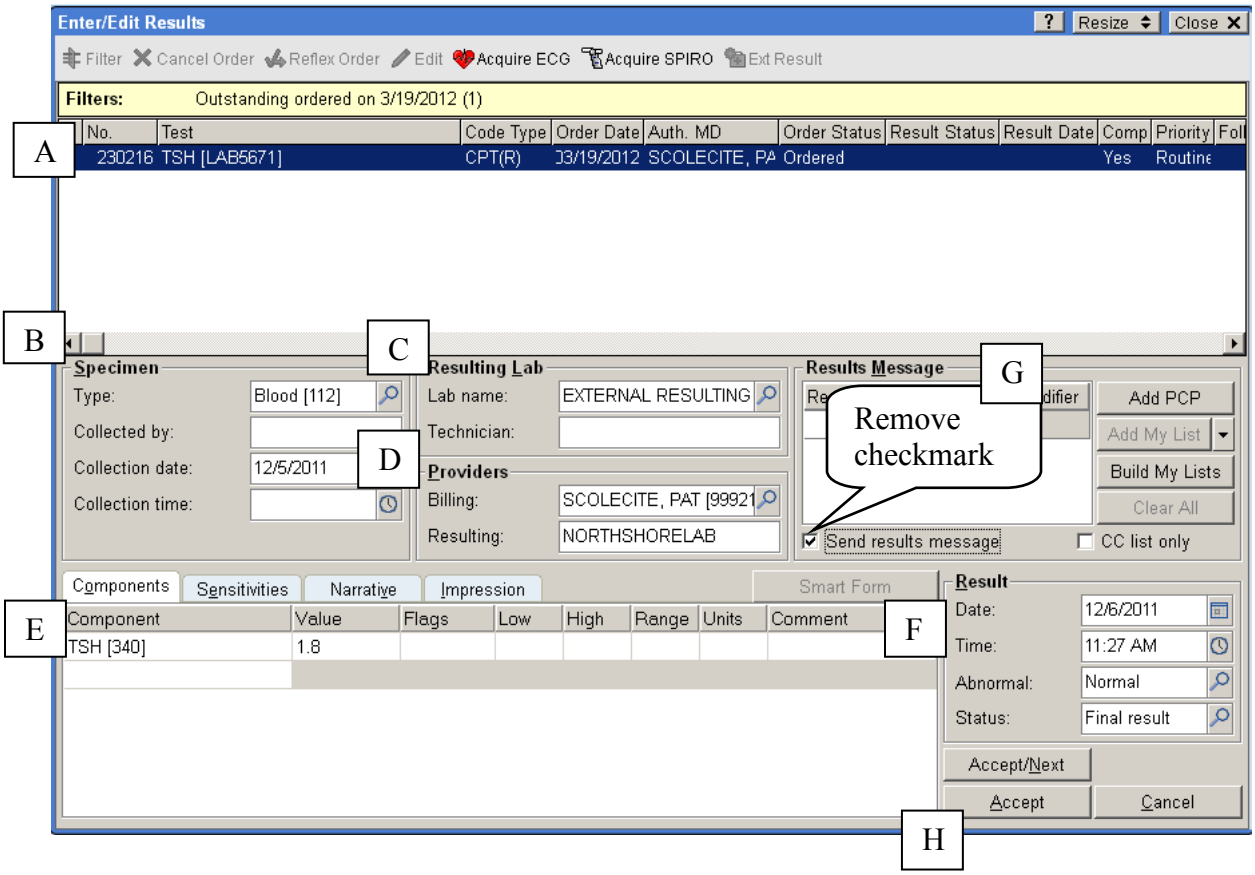
1. Click **Enter Results** in the navigator.
2. Click **Enter External Result** hyperlink.
3. A window appears. To enter a common Lab Test, click the '+' sign next to Lab Tests to expand the list.



4. Check the box beside the corresponding lab. You may select more than one lab. If a test is not listed, use the search tool in the Additional test field to locate the test.
5. Enter the name of the provider who ordered the test, if known.
6. Click **Accept**.



7. The **Enter/Edit Results** window displays.



A. Select or verify that the correct test is highlighted.

B. Specimen section: Enter the Type of specimen and the Collection date.

C. Resulting Lab section: Change the Lab name to External Resulting Agency to indicate it was completed outside of NorthShore.

D. Providers section: Billing is the name of the provider who ordered the test. It can be left blank if the provider is not listed in the system. Resulting will automatically default with NORTHSHORE LAB; you do not need to delete this.

E. Component tab: Enter the value of the test.

   Clinicians may enter additional information in the Narrative or Impression tabs.

F. Result section: Enter the Date the test was resulted. Enter Time if known. Specify if the test was Abnormal or Normal. Change the **Status** to **Final result**.

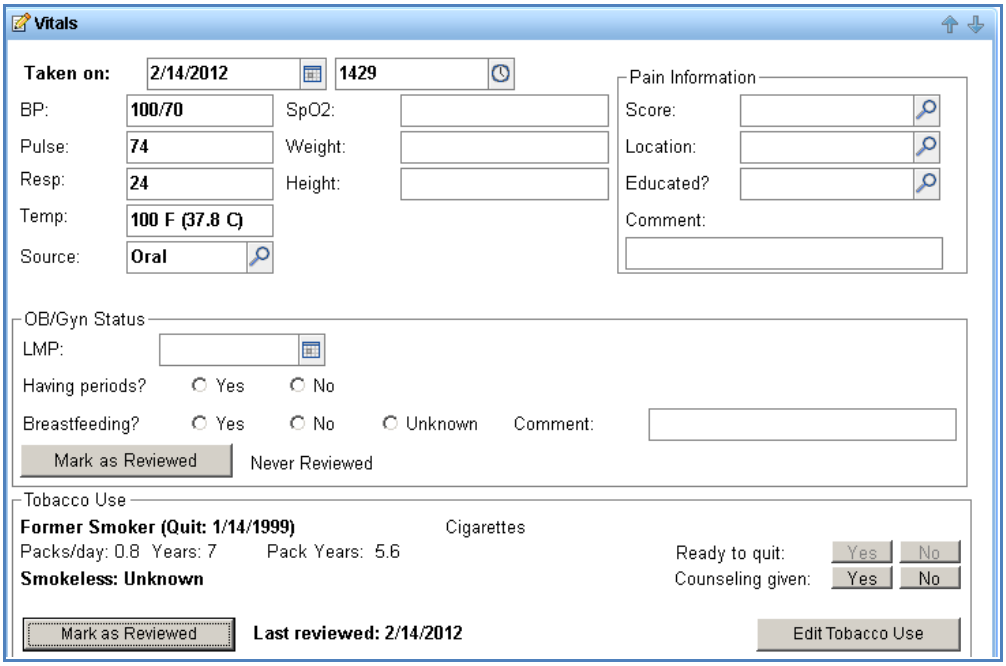
G. Once the result is marked "Final result" the system places a checkmark in the box next to "Send results message." Remove this checkmark, since these are historic results that the physician has already reviewed.

H. Click **Accept**.

Vital Signs

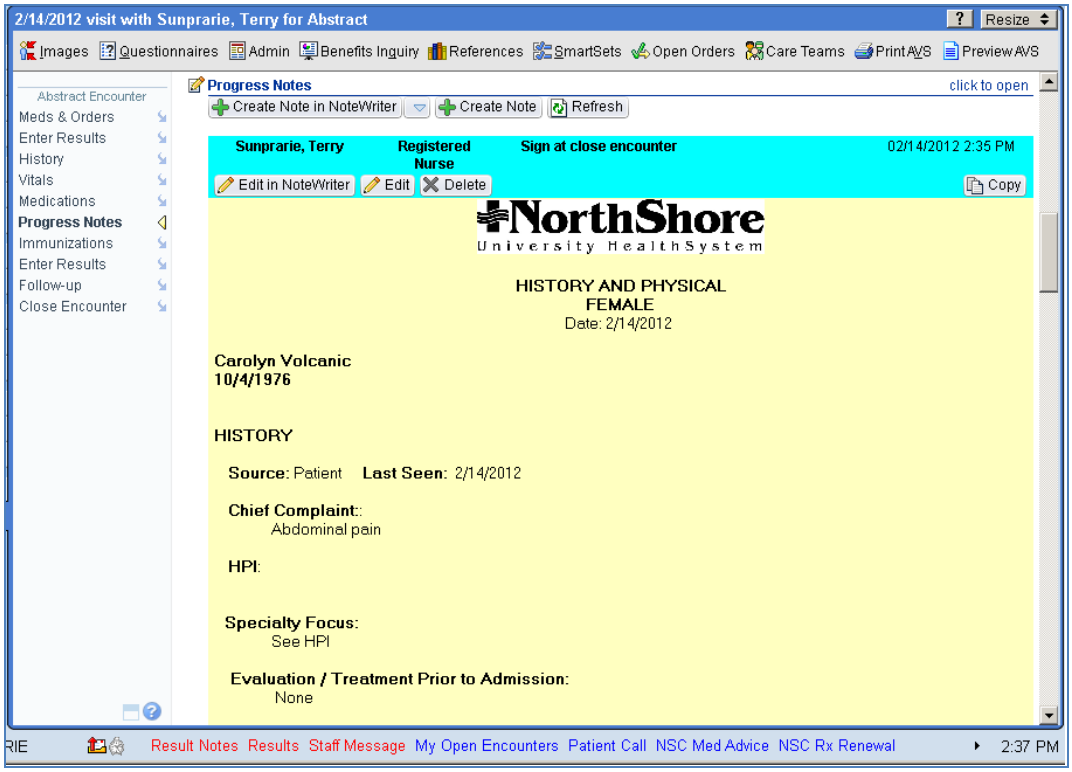
To enter past vital signs, click **Vitals** in the navigator or click **New Set of Vitals** within the Encounter.

1. In the *Taken on* field, change the date to match the date the vital signs were taken.
2. Enter values in the corresponding fields.



Progress Notes

Progress Notes are another optional field. There may be an H&P that you would like entered as baseline information, for example. You may elect to summarize the patient's history from the paper chart available in the office. Each physician may choose what information, if any, to put in this field. It is Charting Tool-enabled.

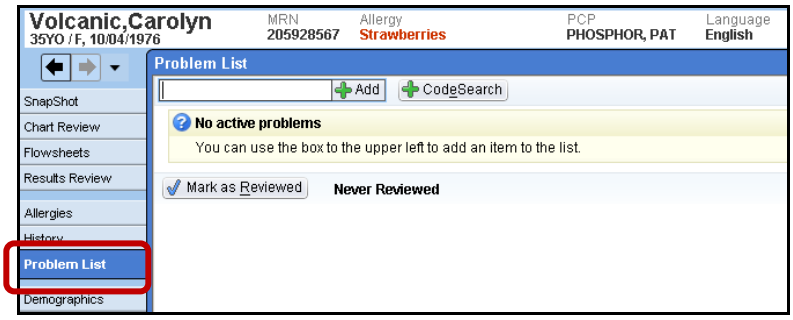


Provider Only: Entering Problems on the Problem List

Click **Problem List** to enter the patient's current or ongoing medical problems into the Abstract Encounter. The physician or his/her designee will have reviewed the patient's paper record and determined what problems need to be entered into the EHR.

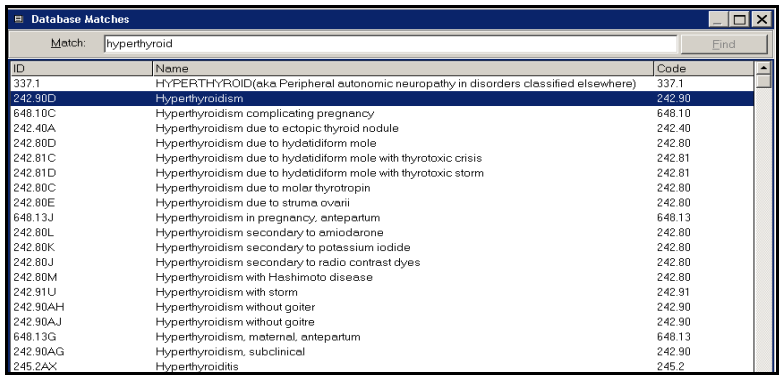
> **! The Problem List should only be documented by the provider.**

1. Open the **Problem List** section from the Activities column.

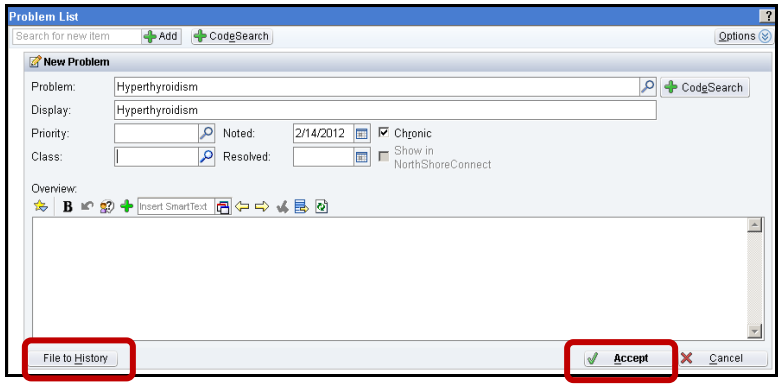


2. In the **Search for new item** field, enter the medical problem or ICD-9 code and click **Add**.

- Note the **Code Search** button is available if you are uncertain of the ICD-9 code.

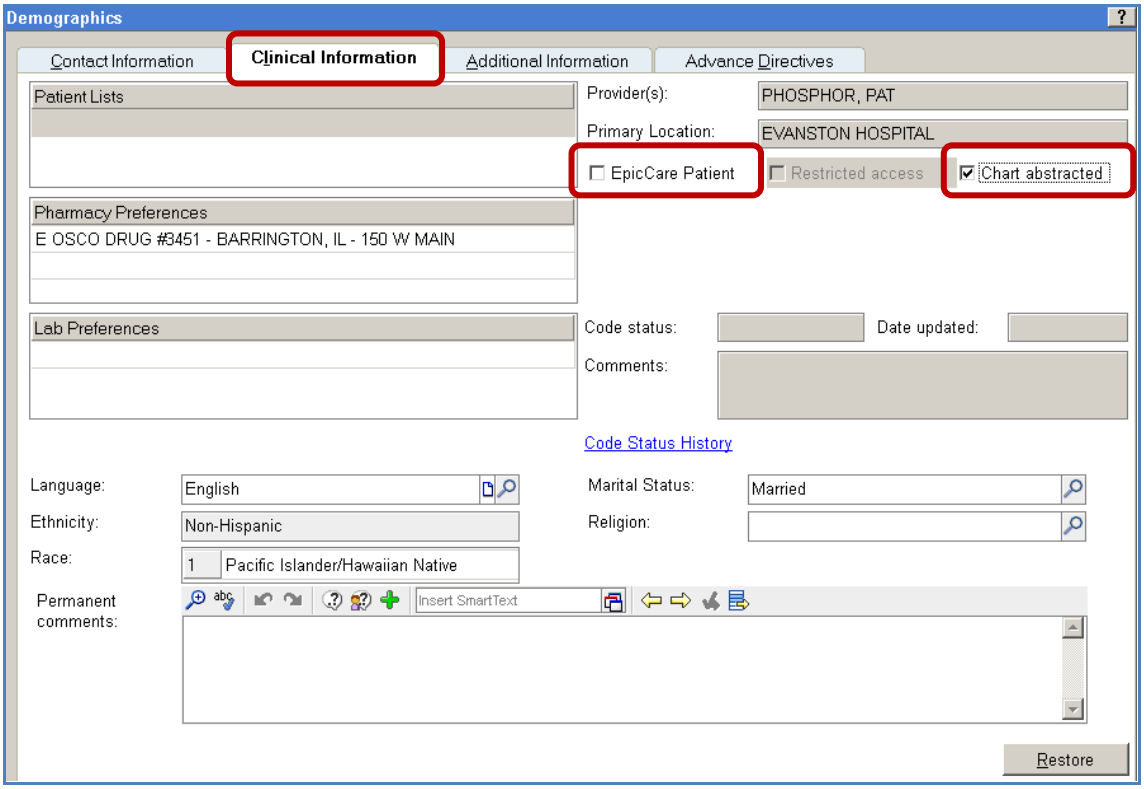


3. Select the appropriate diagnosis from the list and click **Accept.**
4. Complete the fields. Today's date defaults. In the Overview box, add comments, if needed.
5. Click the **File to History** button at the bottom left to automatically file the diagnosis and date in the patient's Past Medical History. Note that the comments do not transfer.
6. Click **Accept.**



Closing Abstract Encounters

1. Review the paper chart, the Clinical Summary, and other available data to determine the completeness of the information in the Abstract encounter.
2. Go to the **Demographics** tab in the Activities column.
3. Click the **Clinical Information** tab.
4. Check the **EpicCare Patient** box.
5. Check the **Chart abstracted** box.



6. Return to Visit Navigator and click **Close Encounter**.

Link to Online Module:

https://northshore.csod.com/catalog/SearchAdvanced.aspx