

Process Appointment Encounter: Initial Consults

PURPOSE

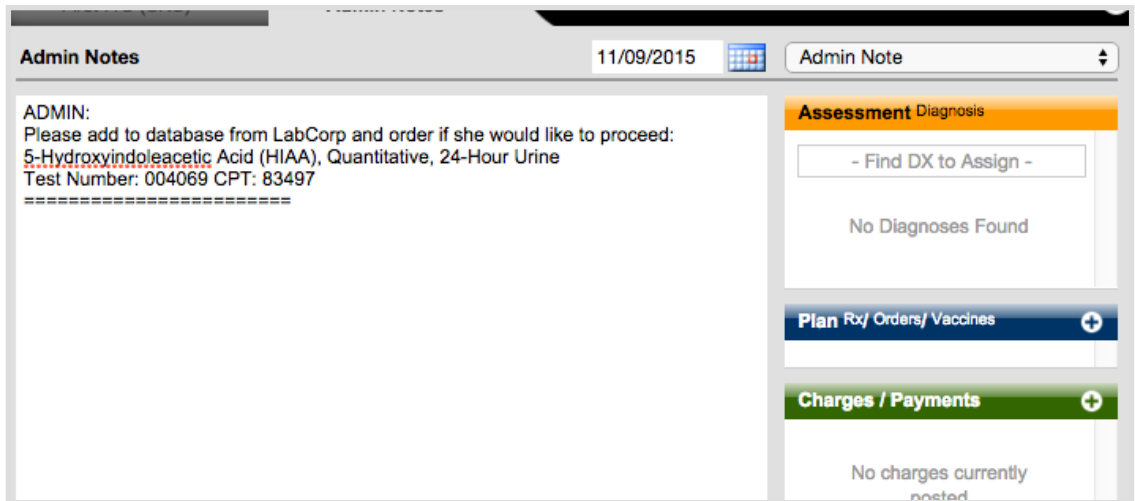
1. Improve the quality of work within the clinic.
2. Reduce number of errors and omissions.
3. Move encounters quickly and efficiently through the flow of the practice.
4. Provide information and documentation to patients so they have a clear understanding of what happens next and when.
5. Provide instructions to patients to help complete testing with reduced frustration and increased adherence to test preparation recommendations.

PROCEDURE

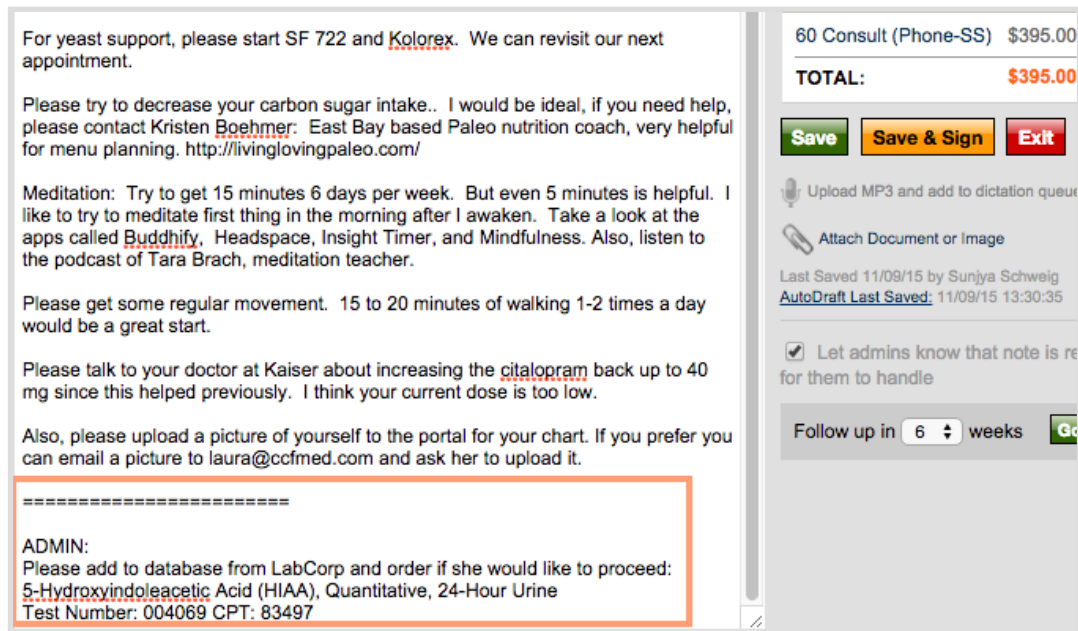
Create Estimates and Send Post-Appointment Notes

Expected time frame: Within 24 hours of appointment

1. From the patient dashboard, click on the encounter to open it. Make sure the title of the encounter has the clinician's initials. Highlight the title and right-click to copy it. Go back to the task and paste it after the patient's name, removing "Encounter for" and "is ready for review."
2. Scroll down to the bottom of the encounter to see if the clinician made any admin notes for you.
3. If there are admin notes, highlight and right-click to copy them.
4. Right-click on the encounter and choose "create sub-note of this SOAP."
5. Title: Admin Notes
6. Note categorization: Admin Notes
7. Delete all the default text in the body of the note and put "ADMIN," then enter down and draw a line.
8. If there were clinician admin notes, below where you typed ADMIN, right-click to paste the notes. Read the notes and complete the request. See other WPs as needed (Add CPT Options to the Database, Add Charges to the Database, Add Supplements to the Database).
Note: If the note is about the patient getting a discount, step 14 below will explain.



- Go back to the encounter. Delete “ADMIN,” the admin notes, and the line above it (so only the clinician appointment notes should remain in the body of the encounter). Delete everything in the orange box in the example below:

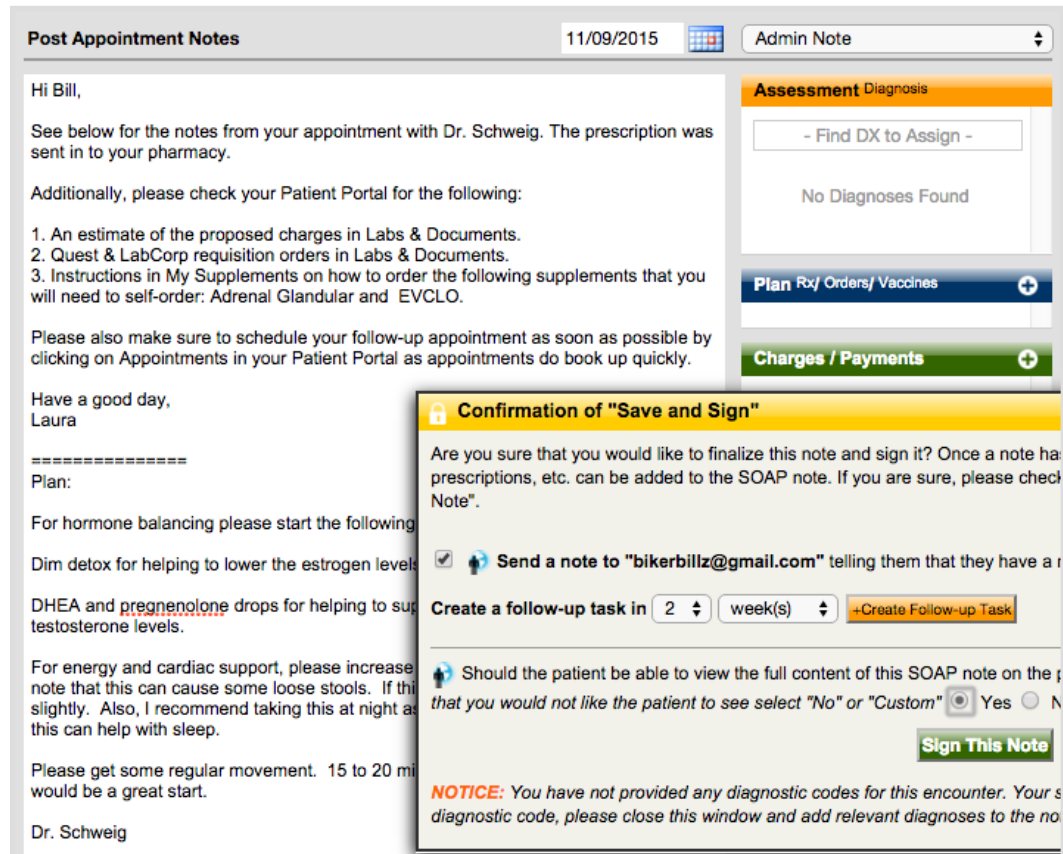


- Read the Plan notes of the encounter to make sure everything mentioned in the note was added to the Plan box. If not, send the task back to the clinician to ask for clarification.
- After reading the note, also make sure any handouts the clinician referenced were added to the chart. If not, add them. **Add Handouts.**
- Each item from the Plan box will need to be added to the Charges box (if applicable) in the same order as they appear in the Plan box by clicking on the “+” in the green Charges box.

Notes:

- Plan box items that are pink, gray, or green will not be added to the Charges box.
 - **Blue** items are added only for certain clinicians, except when they request for the patient to go straight through LabCorp and use their insurance (will be noted in the admin notes).
 - After adding all the **blue** items, you must also add a charge for “venipuncture.”
 - The item’s name in the Charges box will match exactly how its name appears in the Plan box.
 - If Optimal PC (caps) were recommended, we always order a quantity of two because that is a one-month supply.
13. Go back to the patient dashboard and review the Admin Notes box to see if there is a note that the patient receives a discount. If not, skip to step 15.
 14. Add another item to the Charges box that is an “adjustment.” Enter the amount as negative, and in the “notes about this charge box,” put an explanation for the discount (such as “per clinician’s initials”).
 15. Highlight everything in the note below the “P” or “Plan” and right-click to copy it.
 16. From the patient dashboard, right-click on the encounter and choose “create sub-note of this SOAP.”
 17. Title: Post Appointment Notes (*Note: There is an example of a Post Appointment Note below after step 21.*)
 18. Note categorization: Admin Notes
 19. Delete all the default text in the body of the note and put your Post Appointment Note message (which is slightly different to be tailored for each clinician). This is the note that will tell the patient the next steps they need to take, as well as how to find all the information, instructions, and documents in their Portal, so please be detailed and specific. Make sure you tell the patient (at minimum) the following information:
 - See below for the notes from your appointment with [clinician’s name].
 - *If an Rx was ordered:* The prescription was sent in to your pharmacy. -OR- Please upload a pharmacy to your Patient Portal so your prescription can be sent.
 - *Whichever items apply:* Please check your Patient Portal for the following:
 - i. An estimate of the proposed charges in Labs & Documents.
 - ii. Quest & LabCorp requisition orders in Labs & Documents.
 - iii. Instructions in My Supplements on how to order the following supplements that you will need to self-order: [list self-order supplements]
 - iv. A Lyme consent form and a Biotoxin Illness Survey in Questionnaires.

- v. Please see below at the bottom of this message in “Other Plans & Recommendations” for instructions on how to monitor your basal body temperature.
- 20. Underneath your signature, enter down one line, draw a line, enter down another line, type “Plan:” then enter down one line and right-click to paste the clinician’s notes. Make sure the clinician’s name is typed at the bottom of the note.
- 21. Click “save & sign” and mark to send a note to patient and “yes” that the patient should be able to view the full content of this SOAP, then click “sign this note.” Example below:



- 22. Close the Post Appointment Notes and go back to the encounter.
- 23. Hover on My Links, then choose Generate Estimate for Patient.
- 24. Briefly review how the estimate looks. If an adjustment was made, you will need to change it to show a “-” instead of a “+.” If you ordered multiples of any item you will need to click on the name to notate that two were ordered. Example below, **outlined in orange**:

Kolorex <i>Nature's Sources (60 gels)</i>	11/09/2015	\$49.99
Ther-Biotic Complete (Caps) <i>Klaire Labs (120 vegcaps)</i>	11/09/2015	\$79.95
Optimal PC (Caps) [2 @ \$29.95] <i>Seeking Health (100 softgels)</i>	11/09/2015	\$59.90
CARD TO BILL: ***** - 2550 (01/16)		ESTIMATE: \$876.29
Shipping Address		Billing Address

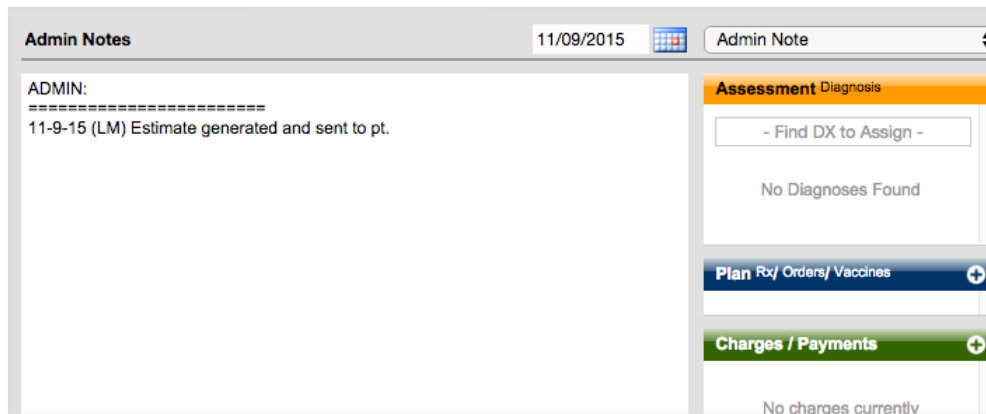
25. Review the credit card information listed on the estimate. If it has expired, you will need to request the updated expiration date and security code from the patient when you send the estimate. Example below, **outlined in orange**:

Kolorex <i>Nature's Sources (60 gels)</i>	11/03/2015	\$49.99
Ther-Biotic Complete (Caps) <i>Klaire Labs (120 vegcaps)</i>	11/03/2015	\$79.95
Optimal PC (Caps) [2 @ \$29.95] <i>Seeking Health (100 softgels)</i>	11/03/2015	\$59.90
CARD TO BILL: ***** - 2550 (04/08)		ESTIMATE: \$876.29
Shipping Address		Billing Address

26. Review the shipping address listed. If it is an international address, you will need to request a US address from the patient when you send the estimate.
27. Review the shipping address listed. If it is a New York state address and testing has been ordered, you will need to request an address outside the state from the patient when you send the estimate.
28. Click “save form.”
29. Leave the title as it defaults and the document type as Invoice.
30. Attach to Note: change to “[Do Not Attach to SOAP].”
31. Allow patient to view in Portal: leave checkmarked for yes. (This ensures that the estimate is in the Portal, even if you forget to send the estimate notification message.)
32. Click “save to pt chart” and then close the estimate.
33. Save the encounter and close it (do NOT “save & sign”).
34. From the patient dashboard, click “invoices” in the orange tabbed section at the bottom to find the estimate you just created, then click to open it.
35. Under Notify Patient, click on “notify by portal.”
36. In the “send notice about this document via portal” box that appears, choose the message from the dropdown menu that begins “the estimate from your recent appointment is ready.”
37. Remove the “***[For IC encounters]***” but leave the paragraph that follows.

38. Remove the “**[list dates/times for CR]**” and instead list at least five available appointments from the [Case Review Opportunities](#) Google spreadsheet.
39. If there were any items in the Plan box of the encounter that are gray, you will need to add a message here to address those items so that patients are aware of why they are not on the estimate. Example:

NOTE: Your clinician has also recommended a SIBO breath test from Commonwealth Labs. We will order this test kit for you, but it is not included on your estimate because it is a self-paid test. Once we receive your estimate approval, we will provide you with detailed instructions for all of the recommended testing, including further information about how to pay for this test.
40. Add any messages about updated credit card information or shipping addresses.
41. Put your signature at the bottom.
42. Save changes.
43. If there were Quest or LabCorp tests ordered (that will not go through Professional Co-op), please see the **Lab Ordering Procedures** document and create the requisition(s) for the patient now.
44. Back in the Admin Notes of the encounter, make a note that you sent an estimate to the patient along with Quest/LabCorp reqs, then save the note (do NOT “save & sign”).



45. Close the chart.
46. Go back to the task, and in the notes, delete “This note is ready for administrative review.” Instead, add your date/initial stamp and write the same thing as the Admin Notes: “Estimate generated and sent to pt.”
47. Set the Due Date for two weeks from today. DO NOT set a reminder.
48. Leave the task assigned to yourself and “accept edits to this task.” Example below.

Nudge the Encounter When Pt Does Not Respond (#1)

Expected time frame: Two weeks after the estimate was generated if patient has not responded

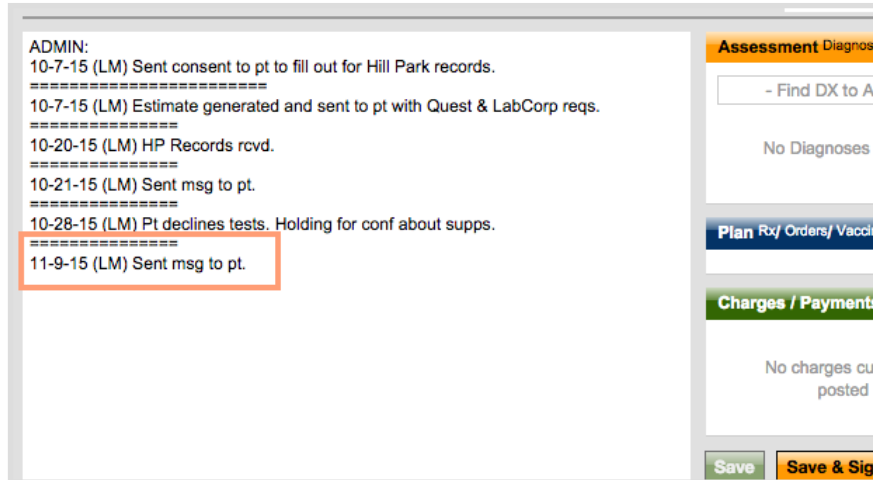
1. From the patient dashboard, hover on Tasks, then choose “show patient’s portal history.”
2. Review the message history to make sure that patient has not responded to the estimate (in case it was missed).
3. Click “compose a new message.”
4. Title: Appointment Estimate
5. Message:

Good morning, [patient’s first name],

We’re hoping by now that you’ve had time to review the estimate for your appointment with [clinician’s name] on [date]. Please respond to this message to let us know how you would like to proceed with the items listed or if there are any questions we can answer for you about the estimate. If you are not ready to move forward with the recommendations at this time, please feel free to let us know and you will be charged for the appointment fee only.

[Your name]

6. Click “send this message to patient’s portal.”
7. Click to open the Admin Notes of the encounter. Draw a line, add your date/initial stamp, and note that you sent a message to the patient.



ADMIN:
 10-7-15 (LM) Sent consent to pt to fill out for Hill Park records.
 =====
 10-7-15 (LM) Estimate generated and sent to pt with Quest & LabCorp reqs.
 =====
 10-20-15 (LM) HP Records rcvd.
 =====
 10-21-15 (LM) Sent msg to pt.
 =====
 10-28-15 (LM) Pt declines tests. Holding for conf about supps.
 =====
 11-9-15 (LM) Sent msg to pt.

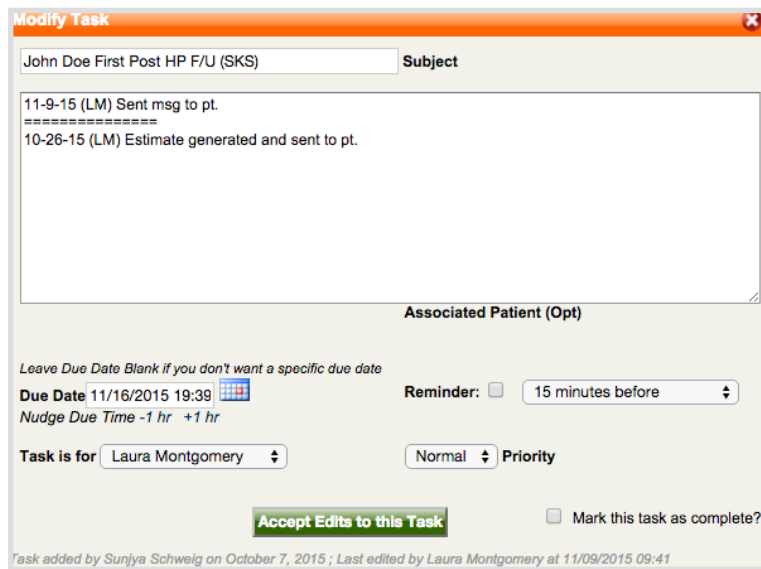
Assessment Diagnosi
 - Find DX to As
 No Diagnoses I

Plan Rx/ Orders/ Vaccin

Charges / Payments
 No charges cur
 posted

Save Save & Sign

8. Save the Admin Notes (do not “save & sign”).
9. Close the chart.
10. In the task, add your date/initial stamp, and note that you sent a message to the patient. Draw a line.
11. Set the due date for one week from today. DO NOT set a reminder.
12. Leave the task assigned to yourself and “accept edits to this task.” Example below.



Modify Task

John Doe First Post HP F/U (SKS) Subject

11-9-15 (LM) Sent msg to pt.
 =====
 10-26-15 (LM) Estimate generated and sent to pt.

Associated Patient (Opt)

Leave Due Date Blank if you don't want a specific due date
 Due Date 11/16/2015 19:39
 Nudge Due Time -1 hr +1 hr

Reminder: 15 minutes before

Task is for Laura Montgomery Normal Priority

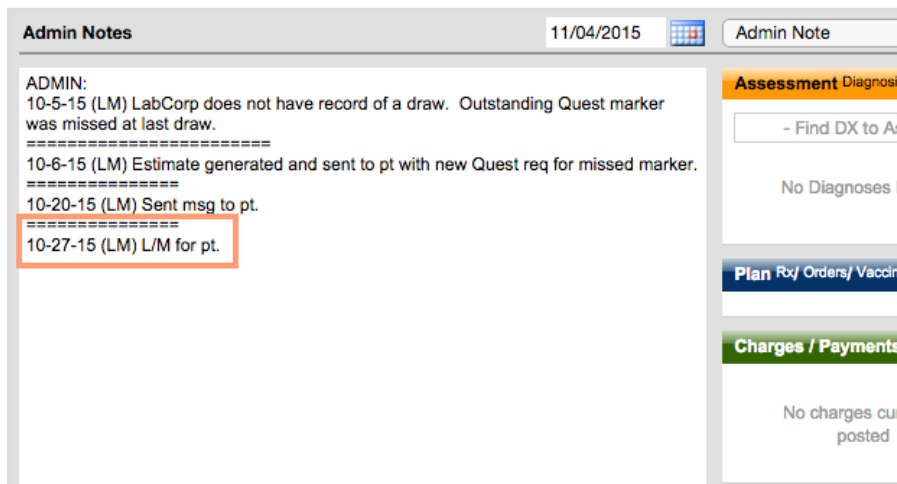
Accept Edits to this Task Mark this task as complete?

Task added by Sunjya Schweig on October 7, 2015 ; Last edited by Laura Montgomery at 11/09/2015 09:41

Nudge the Encounter When Pt Does Not Respond (#2)

Expected time frame: One week after nudge #1 message above was sent (three weeks after the estimate was generated) if patient has not responded

1. From the patient dashboard, hover on Tasks, then choose “show patient’s portal history.”
2. Review the message history to make sure that patient has not responded to the estimate (in case it was missed).
3. Call the patient. (Please remember that we cannot accept estimate approvals over the phone, so you will need to ask the patient to send a message through their Portal to approve of the estimate.)
4. Click to open the Admin Notes of the encounter. Draw a line, add your date/initial stamp, and note that you called the patient and the outcome:



The screenshot shows the 'Admin Notes' window for a patient on 11/04/2015. The notes are as follows:

- ADMIN: 10-5-15 (LM) LabCorp does not have record of a draw. Outstanding Quest marker was missed at last draw.
- 10-6-15 (LM) Estimate generated and sent to pt with new Quest req for missed marker.
- 10-20-15 (LM) Sent msg to pt.
- 10-27-15 (LM) L/M for pt.** (This note is highlighted with an orange border in the original image)

On the right side of the interface, there are sections for 'Assessment Diagnosis' (with a '- Find DX to As' button and 'No Diagnoses F'), 'Plan Rx/ Orders/ Vaccine', and 'Charges / Payments' (with 'No charges cur posted').

5. Save the Admin Notes (do not “save & sign”).
6. Close the chart.
7. In the task, add your date/initial stamp and note that you called/left a message for the patient. Draw a line.
8. Set the due date for one week from today. DO NOT set a reminder.
9. Leave the task assigned to yourself and “accept edits to this task.” Example below.

Nudge the Encounter When Pt Does Not Respond (#3)

Expected time frame: One week after nudge #2 message above was sent (four weeks after the estimate was generated) if patient has not responded

1. From the patient dashboard, hover on Tasks, then choose “show patient’s portal history.”
2. Review the message history to make sure that patient has not responded to the estimate (in case it was missed).
3. Click “compose a new message.”
4. Title: Appointment Estimate
5. Message:

Hi, [patient’s first name],

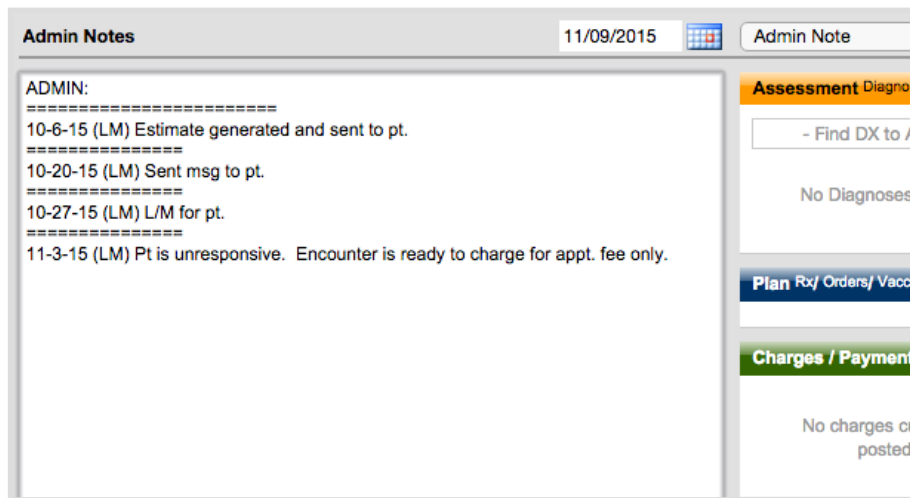
We did not hear back from you in response to the estimate from your Initial Consult appointment, so we have removed all items from the estimate order and are only holding you responsible for the Initial Consult appointment fee of \$245. Should you decide later that you wish to move forward with the Case Review process and testing, please contact our office.

Your card on file ending in [last four digits of card] will be charged for this fee.

[Your name]

6. Click “send this message to patient’s portal.”
7. Click to open the encounter.
8. Right-click on each recommended test in the Plan box and choose “Remove (pt will not fill).”
9. Right-click on each item in the Charges box to change the price to \$0.

- Click to open the Admin Notes of the encounter. Draw a line, add your date/initial stamp, and note that the patient is unresponsive and encounter is ready to be charged for appointment fee only.



- Save note and close (do not “save & sign”).
- Close the patient’s chart.
- In the task, add your date/initial stamp and send to Shannon with the following message: “Encounter is ready to charge for appt. fee only. Complete after [clinician’s initials] signs.”

Responding to a Patient’s Estimate Response

Expected time frame: Within 48 hours of when the patient sends a Secure Message to the PPQ

- Please see **Estimate Additions**, **Estimate Approvals**, and **Estimate Modifications**.
- Please see **Schedule Case Review**.

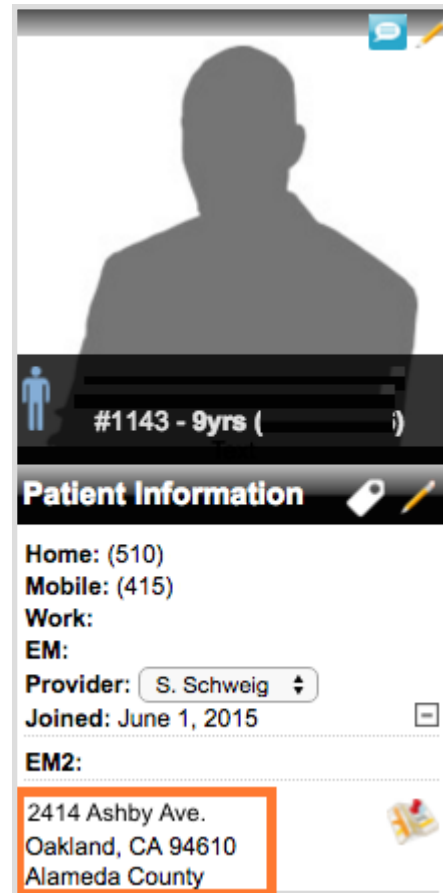
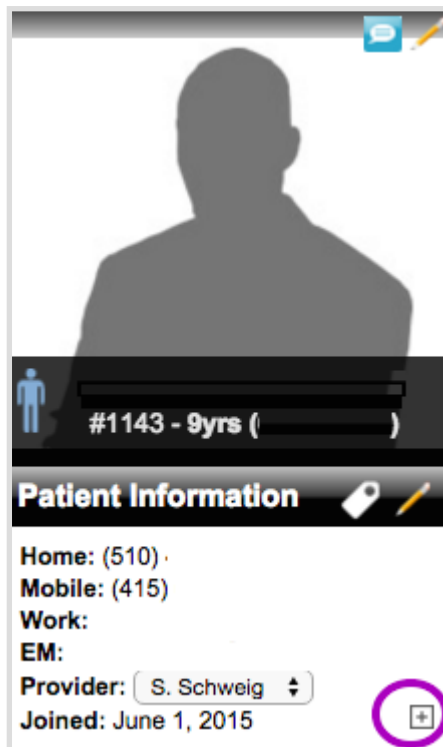
Finalize the Encounter

Expected time frame: Within 24 hours of when the patient’s credit card is charged

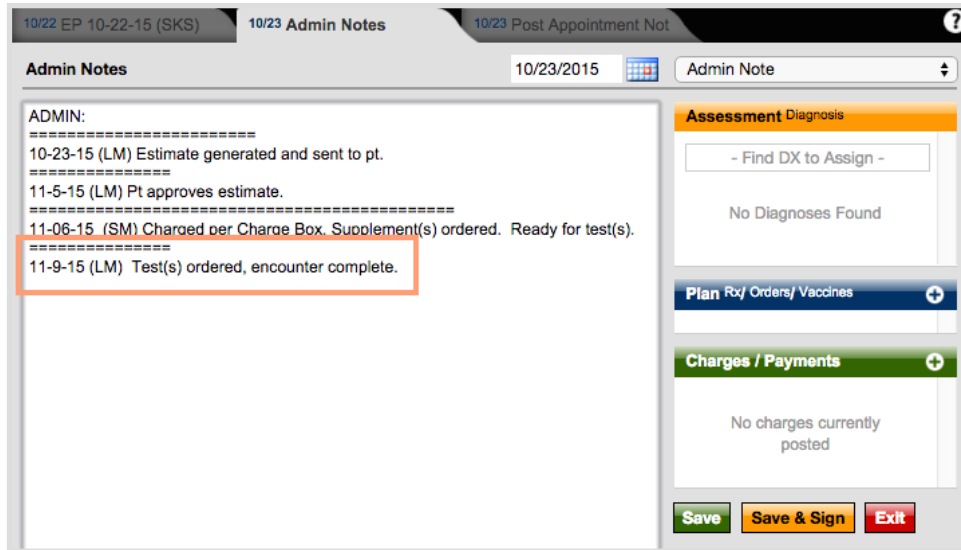
- Click to open the Admin Notes of the encounter to make sure Shannon noted that the patient’s credit card was charged. If the patient requested supplements, she should have also documented that these have been ordered (or, that some are back-ordered.)
- If testing was ordered, please continue to step #3. If no testing was ordered, please skip to step #6.
- Review the Admin Notes to make sure no other shipping address was requested for this order by the patient.

Note: If the address on file is the one to where everything will be shipped, it is helpful to expand the information displayed by clicking the “+” sign (circled in purple on the

left example below). The right example below shows how the address is displayed once expanded:



4. From the patient's dashboard, review the tests listed in the Open Orders box to make sure they match the items for which the patient was charged. (If not, right-click to abandon the orders patient did not want.)
5. Any tests that are yellow (kits) or gray (self-paid) are ordered by CCFM. For details of how to order each test, please see the **Lab Ordering Procedures** document.
6. Once the tests have all been ordered, complete any other outstanding items from the Admin Notes of the encounter (i.e., if a superbill was requested, patient needs a handout, etc.). See other WPs as needed (**Create Superbills, Add Handouts**).
7. In the Admin Notes, draw a line, add your date/initial stamp, and document the completion of the encounter:



8. Click “save & sign,” then “sign this note.” Close the Admin Notes.
9. Right-click on the encounter and choose “create sub-note of this SOAP.”
10. Title: Case Review Preparation
11. Note categorization: Admin Notes
12. Delete all the default text in the body of the note and use the following message to let the patient know all their purchased items are on the way:

Hi, [patient first name],
The following has been ordered per your request and should arrive in five to seven business days:

[list all tests for which the patient will receive kits]

Please check your Patient Portal for the following:

1. Labs & Documents to view the Open Orders and Test Details, which lists all of the tests that have been ordered for you. Clicking on the test name will show detailed information for each test, including the type of test, how you will get the test, how to prepare for the test, and payment and results information. It is important that you view this information prior to completing each test, since many tests have specific preparation instructions or forms that you will need to print out or complete to send back with your sample.

2. Labs & Documents to view instructions in the Open Orders and Test Details for the following tests you will need to self-order:

[list self-order tests]

3. Labs & Documents >> Forms (in the blue box on the bottom left) to print requisition orders for the following tests:

[list all applicable tests, whether kits will be received or not]

4. Questionnaires for five forms for you to complete.

[if applicable]

5. Labs & Documents >> Invoices (in the blue box on the bottom left) for your requested insurance invoice.

Your Case Review appointment is scheduled for [date] at [time] at [name of clinician]'s office. The office address is:

[address of clinician]

Please submit all completed documents no later than one week prior to your appointment. However, sooner is preferable. Note that some labs take several weeks to process, therefore it is important that you complete the testing as soon as you receive the kit(s) and/or requisition forms.

We understand that this is a lot of information and takes a lot of planning. Please let us know if you have any questions during this process and we will be more than happy to help.

Have a good day,
[Your first name]

13. Click "save & sign" and mark to send a note to patient and "yes" that the patient should be able to view the full content of this SOAP, then click "sign this note."

Case Review Preparation
11/11/2015
Admin Note

Hi Cristina,
The following has been ordered per your request and should arrive in 5-7 business days:

DD CSAP x3
Genova Organix Comp
NCNM SIBO

Please check your Patient Portal for the following:

1. Labs & Documents: view the Open Orders and Test Details, which lists all of the tests that have been ordered for you. Clicking on the test name will show detailed information for each test, including the type of test, how you will get the test, how to prepare for the test, and payment and results information. It is important that you view this information prior to completing each test, as many tests have specific preparation instructions or forms you will need to print out or complete to send back with your sample.
2. Labs & Documents: a LabCorp requisition order. You will need to print this out to take it with you to do your LabCorp testing.
3. Questionnaires: 5 forms for you to complete..

Your Case Review appointment is scheduled for 2/1/16 at 10:30 AM at Dr. Nett's office. The office address is:

125 Willow Road, Set 203
Menlo Park, CA 94025

Please submit all completed documents for your appointment. However, sooner is better to process, therefore it is important to receive the kit(s) and/or requisition forms as soon as possible.

We understand that this is a lot of information and we know if you have any questions please let us know to help.

Have a good day,
Laura

Assessment Diagnosis

- Find DX to Assign -

No Diagnoses Found

Plan Rx/ Orders/ Vaccines +

Charges / Payments +

No charges currently posted

Save
Save & Sign
Exit

Upload MP3 and add to dictation queue

Confirmation of "Save and Sign"

Are you sure that you would like to finalize this note and sign it? Once a note has been signed, prescriptions, etc. can be added to the SOAP note. If you are sure, please check the "Finalize Note".

Send a note to " **"** telling them that they have a new account.

Create a follow-up task in 2 week(s) +Create Follow-up Task

Should the patient be able to view the full content of this SOAP note on the patient portal? / that you would not like the patient to see select "No" or "Custom" Yes No Custom

Sign This Note

14. Close the patient's chart.

15. In the task for the encounter, mark the task as complete, then "accept edits to this task."