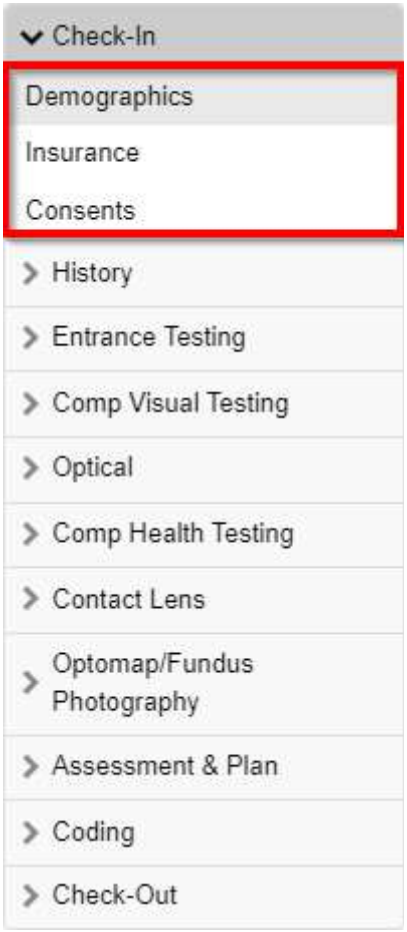
Navigating Through an Encounter

The image on the **left** shows the available Workflow Steps within an encounter. The image on the **right** shows Workflow Screens within a Workflow Step. Each step will have one or more screens



When you start an encounter, you will automatically be brought to the Demographics screen located in the Check-In Workflow Step. Let's learn more about each Workflow Step and the Screens that reside in the encounter

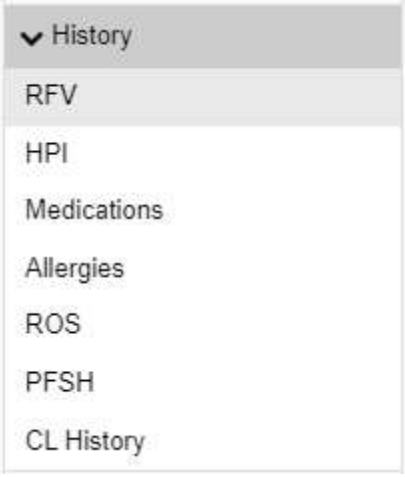
Check-In Workflow Step

- **Demographics**: Update demographics information for the patient
- **Insurance**: Update/add insurance for the patient
- **Consents**: Upload signed consent forms such as HIPAA, ABN, Insurance SOF, etc.

Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

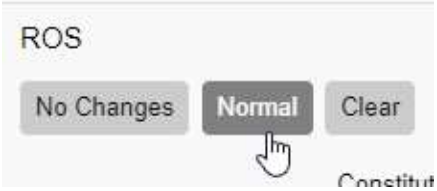
History Workflow Step & Screens

Please note that the Workflow Steps & Screens could be different from what you're seeing while the encounter templates are being finalized



- **RFV (Reason for Visit)** – Enter the patient's reason for visit here; please see the RFV video in the Google Classroom for more information on this screen
- **HPI (History of Present Illness)** – Document patient HPIs; please see the HPI video in the Google Classroom for more information on this screen
- **Medications** – Add and review the patient's current medications; please see the Medications video in the Google Classroom for more information
- **Allergies** – Add and review the patient's allergies; please see the Allergies video in the Google Classroom for more information
- **ROS (Review of Systems)** – Document the patient ROS within this Screen. Each system has dropdown options available

ROS Call Out: Selecting the 'Normal' button on the ROS screen will autofill all systems with a Negative finding for quick documentation



- **PFSH** – Document the patient's ocular history, family history, and social history (the *No Problems* buttons will populate a No/Negative/None finding for each section)
- **CL History** – This is where you document what the patient is currently wearing for contact lenses (what did they wear to the appointment?) – there is also a History tab on this screen where you can capture lens age, supply remaining, wear time, etc.

Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

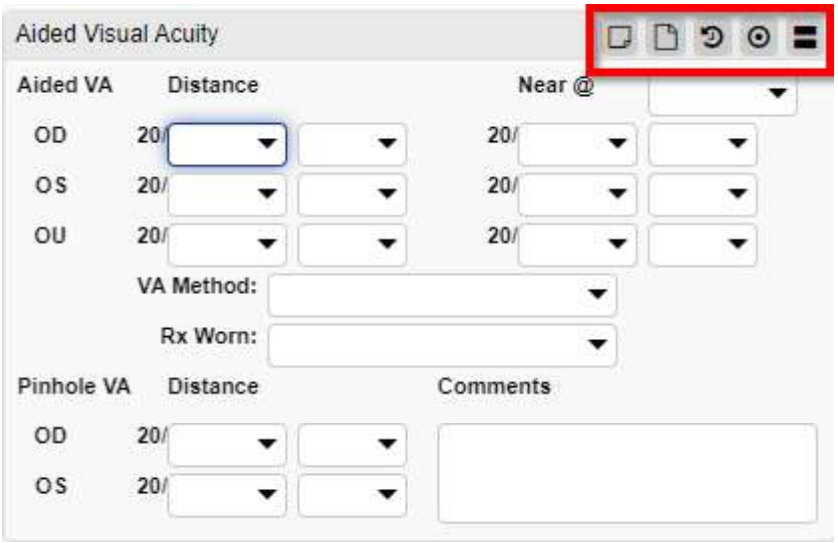
Entrance Testing Workflow Step & Full Entrance Screen

Tests available on this screen

- Aided Visual Acuity
- Uncorrected Visual Acuity
- Pupils
- EOMs
- Confrontation/Automated fields
- Cover Test
- NPC
- Color
- Stereo
- Blood Pressure
- Minimal Documentation

Please note that the number of tests listed could be different than what you're seeing while the encounter templates are being finalized

Test Buttons Call Out: All tests in RevolutionEHR have action buttons at the top. The buttons allow you to add a note about the specific test, upload any files pertinent to the test, view the test history, test results normal, and OD = OS. Hover your cursor over the action button for a description.



Quick Note:

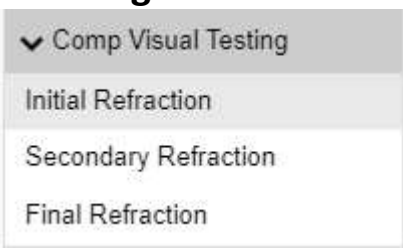
The **Test History** button will only show data if there was data previously entered into the specific test. If nothing shows up, it means no data has been previously entered for the test

Data Entry Practice!

1. Enter made up test data for Uncorrected and Corrected VAs
2. Select the Normal button on the EOMs test – what does it populate?
3. Enter made up cover test findings in Cover Test
4. Enter made up pupil findings in the Pupils test for OD only. Use the = button on the test to populate the same OS findings

Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

Comp Visual Testing Workflow Step & Screens



- **Initial Refraction** – Document the patient's lensometry, autorefraction, keratometry, retinoscopy, and a technical refraction
- **Secondary Refraction** – Document additional refractive needs; refraction – distance, refraction – nearpoint, cycloplegic refraction, phorias, vergences, and accommodation/near add
- **Final Refraction** – This is where you document the patient's final Rx – **please enter made up data in this test**

Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

Optical Workflow Step & Eyeglass Review Screen

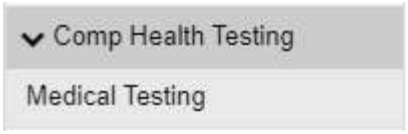
The Eyeglass Review screen is where you will create and authorize eyeglass prescriptions. Please review the Google Classroom topic labeled Eyeglass Prescriptions to learn how to create an eyeglass prescription

Data Entry Practice!

1. Enter made up data into the Final Refraction with Prism test located on the Final Refraction screen **bonus points to those who already did this!
2. Create and authorize an eyeglass prescription ****only providers can authorize prescriptions; employees who are not an authorized provider can create a prescription, but it will only be in pending form until a provider authorizes it**

Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

Comp Health Testing Workflow Step & Medical Testing Screen



Tests available on this screen

- Slit Lamp
- Fundus
- Optic Nerve
- IOP Tests: icare Tonometry, GAT, IOP Untestable, Tonopen, NCT
- Pachymetry
- DPAs Used
- Amsler Grid
- Examining Techniques
- Tear Film

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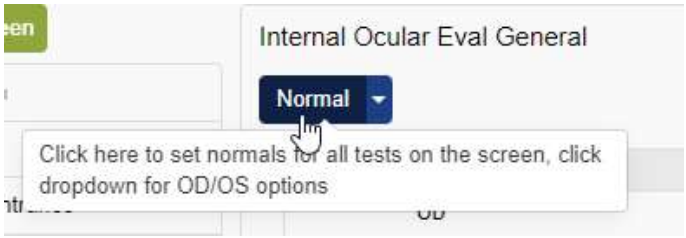
Quick Data Entry Practice!

1. On the Medical Testing screen, select the Normal button on the Slit Lamp test. Under the Iris dropdowns, select a color and then select the OD = OS button (=).

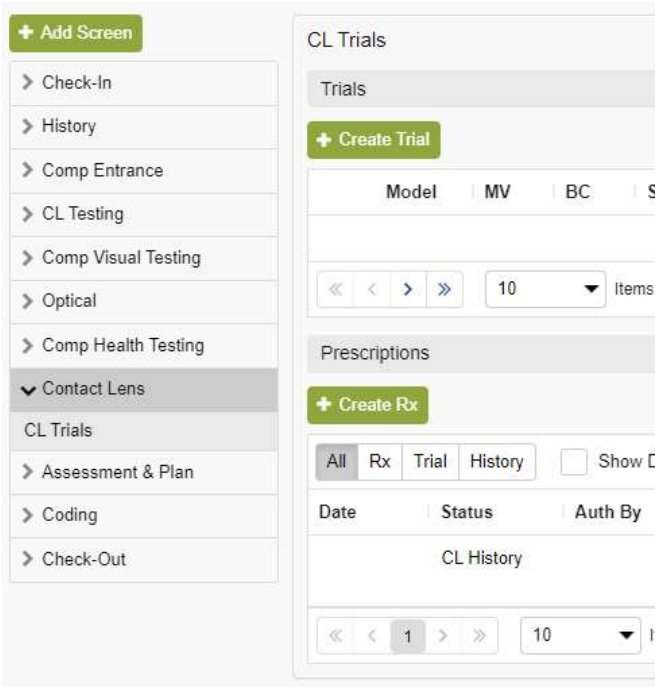
2. On the Internal Ocular Eval General screen, select the Normal at the top of the screen.



Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

Contact Lens Workflow Step & CL Trials Screen

The CL Trials screen is where you will add trials and authorize contact lens prescriptions. Please review the Google Classroom topic Provider/Tech – the assignment is labeled Contact Lens Trials & Prescriptions for more information



Create CL trials here!

Authorize contact lens prescriptions here!

Data Entry Practice!

1. Create a biofinity contact lens trial - within the Create Contact Lens Trial screen, select the Performance tab on the top of the screen. This is where you can document the trial lens movement, over refraction, notes, and VAs
2. Authorize the biofinity contact lenses - select Create Rx, on the Create Contact Lens Rx screen, select the blue View History button and then select the Biofinity CL trial. Review dispensing information, schedules, comments, prescribed items, and the electronic delivery of Rx options. Select Save & Authorize to authorize the contact lens prescription

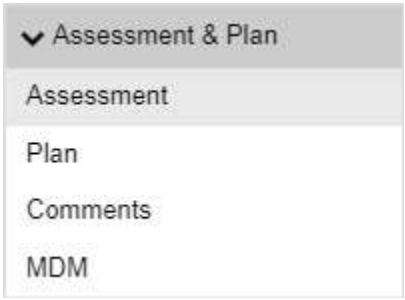
Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

Optomap/Fundus Photography Workflow Step & Screen

- Document your fundus photo findings using the Universal Fundus Photography test

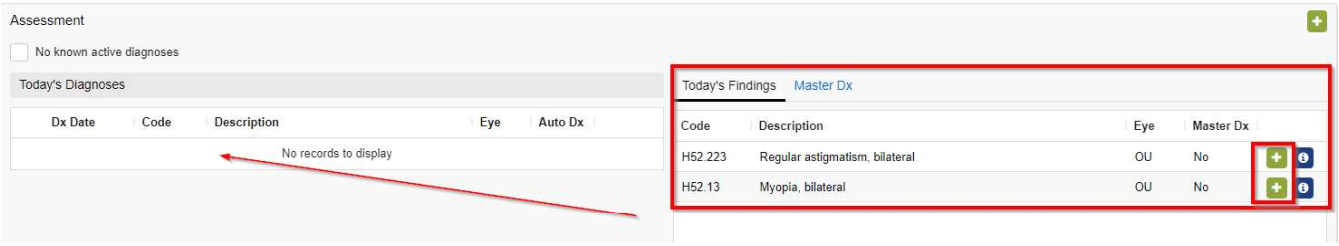
Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

Assessment & Plan Workflow Steps & Screens



- **Assessment** – This is where you add diagnoses pertaining to the encounter. Since you've documented findings in the Final Refraction test, this should have auto populated refractive diagnoses to the Today's Findings section
- **Plan** – The Plan screen will display your diagnoses from today's visit. Here you will be able to document what was discussed, as well as education, and any recommendations you talked about with the patient

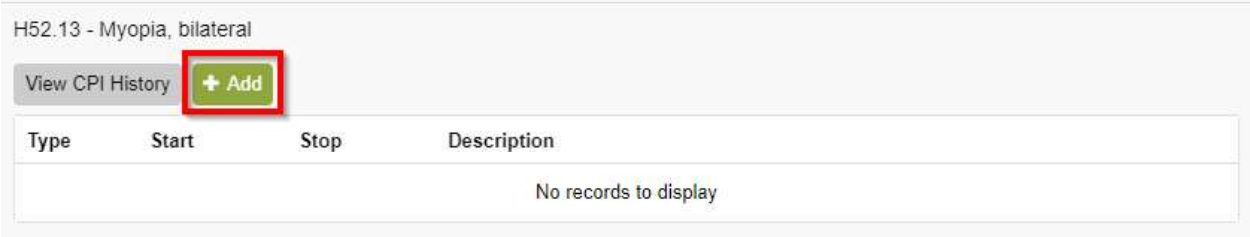
- **Comments** – The Comments screen can be used to document any additional information that is needed. Keep in mind that patients are able to see any comments put into their chart
- **MDM** (Medical Decision Making) – The MDM screen can be used to document medical decision making if necessary



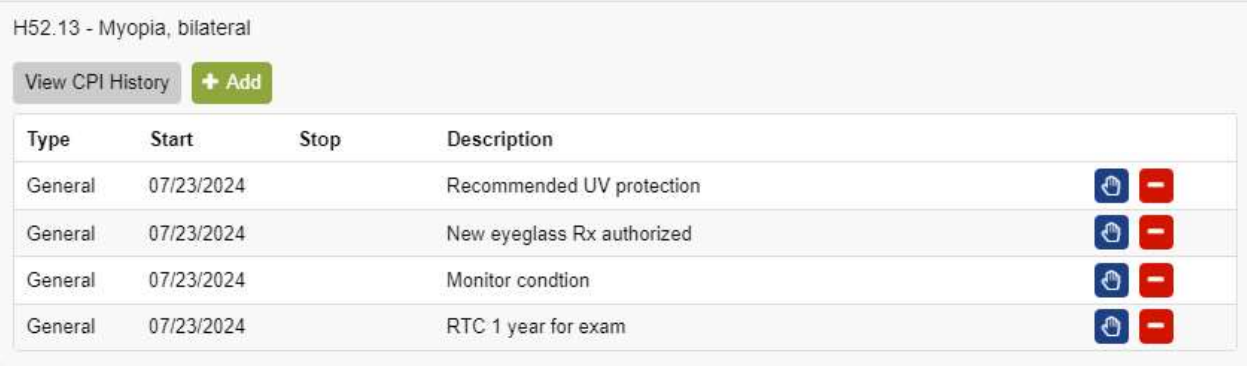
On the Assessment screen, add the findings from Today's Finding to Today's Diagnoses using the green + add button next to each diagnosis. *If you need to add additional diagnoses, select the green + add button in the upper right and you'll be able to search by description or the ICD-10 code*

Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen**

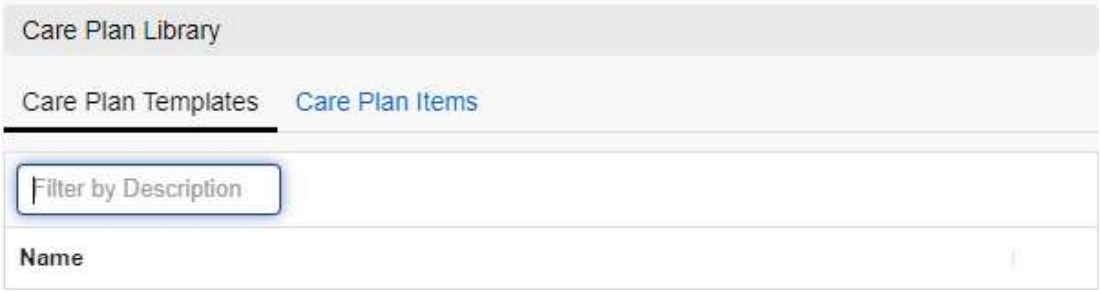
On the Plan screen, document what was discussed with the patient. Use the + Add button to type your care plan



Example care plan for reference:



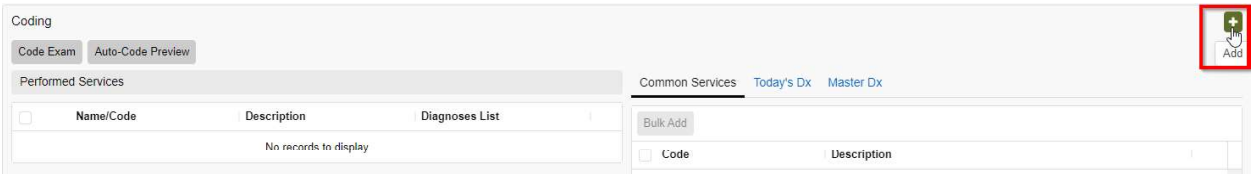
Quick Call Out: Care Plan Items & Care Plan Templates will be available soon! Be on the lookout for the Care Plan Items & Care Plan Templates; once they are added, they will display on the Plan screen under Care Plan Templates. ****Providers, please see the 'Providers Only' topic in the Google Classroom for your assignment!**



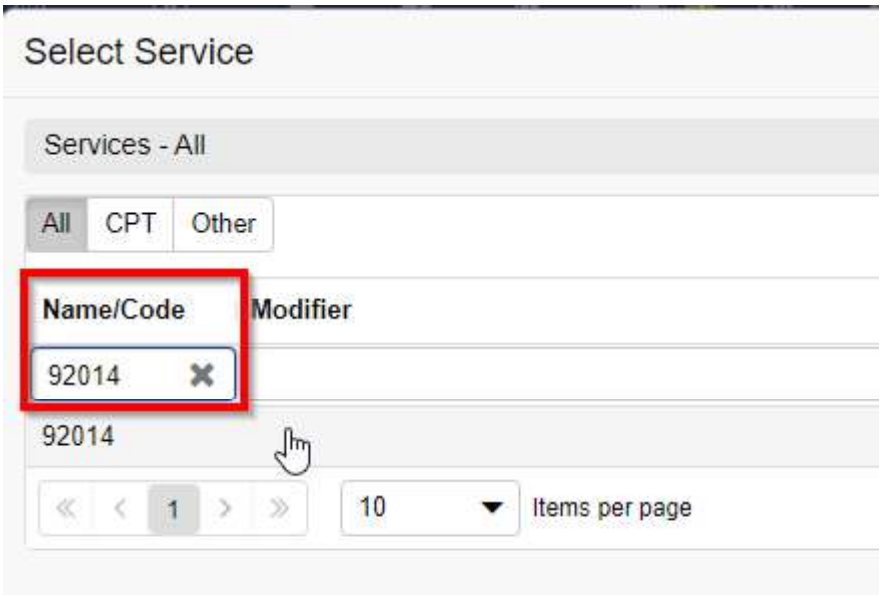
Use the blue Next button on the bottom of the screen to move forward throughout the encounter **especially if you are entering data on a screen - navigate to the Coding Workflow Step**

Coding Workflow Step & Screen

- **Coding** screen – Document what services were performed today; use the green + button in the upper right to add the service codes



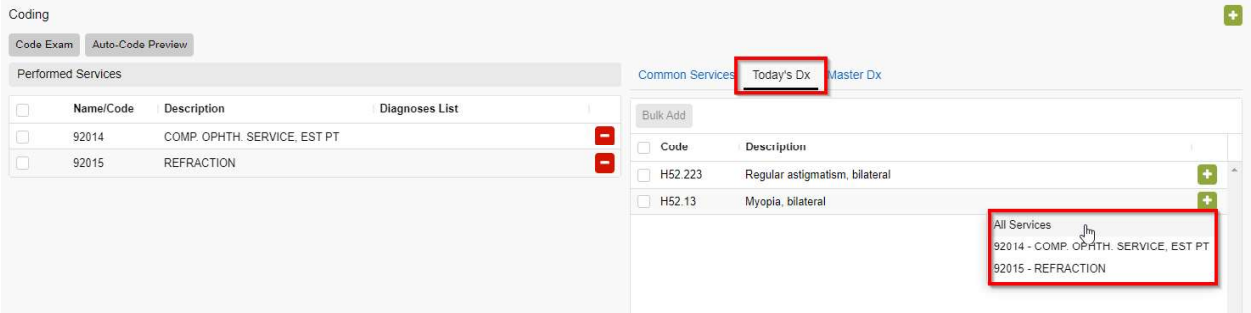
On the Select Service screen, click your cursor into the Name/Code field and search for a service



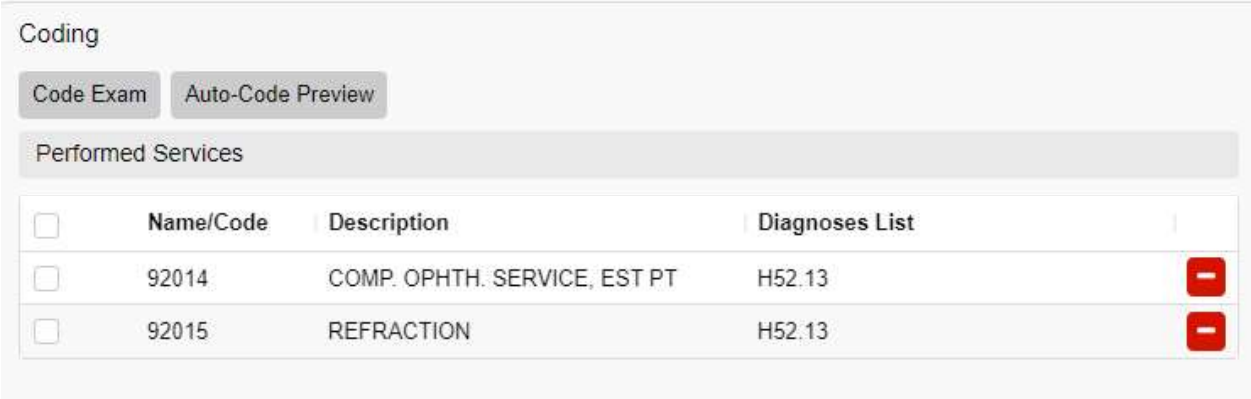
Single click the service code (like a line item) and it will populate into the Performed Services screen

Common Services Call Out!

Once your Common Services are set up, they will appear on the Coding screen under Common Services, making the coding screen even more efficient



Select Today's Dx, select the green + add button on one of your diagnoses and then select All Services to attach your diagnosis to your services



Your Coding screen should now have services and diagnoses attached to each service – it should look similar to the screen shot above depending on what services/dx you chose

PLEASE REVIEW THE CHECK-OUT VIDEO MADE BY TEAM VISION LOCATED IN THE GOOGLE CLASSROOM

Coding Screen Call Out!

The Coding screen is also where you will sign your encounter. The importance of signing encounters can be easy to overlook but the signing process should always be completed. A doctor's signature at the conclusion of an encounter is their attestation to the truthfulness and accuracy of the medical record. In other words, it is the doctor's word that what is in the chart actually took place. Without that verification in place, a third party is provided room to argue that the encounter never took place and recoup payment in an audit. Thus, it is very important to sign your encounters when your documentation has been completed

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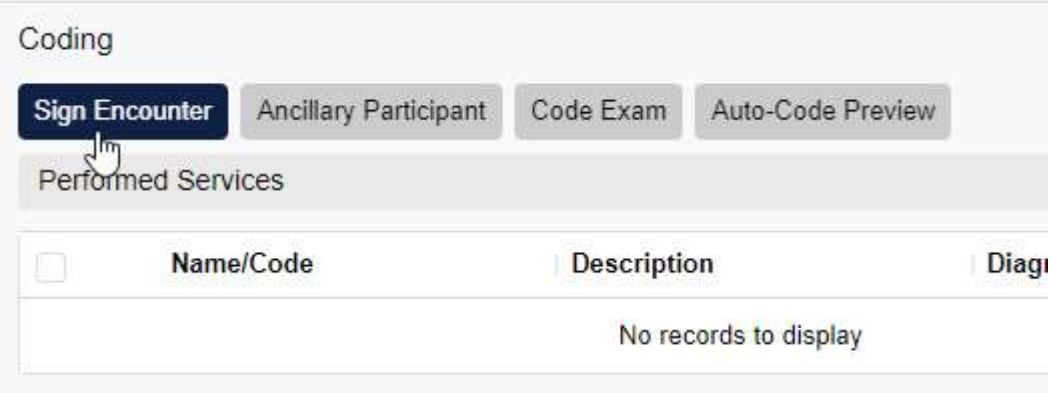
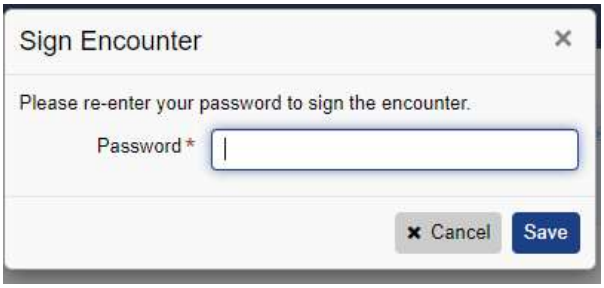
Signing an Encounter (providers only)

On the Coding screen, select Sign Encounter



In the Sign Encounter modal, input your RevolutionEHR password and select Save. The encounter is signed, and staff can begin Check-Out protocols



Congrats on completing the encounter walkthrough! Continue with Google Classroom implementation and practicing along in RevolutionEHR