This Test Drive is intended to help you document a simple sick visit. Step-by-step instructions and screen shots are provided so that you can be sure you are on the right track. More information on using EncounterPRO-OS is available on the website: [www.encounterpro.org/wiki](http://www.encounterpro.org/wiki)

There are two Test Drive users created in the starter database:

- Nurse Patty passcode: 0220
- Doctor Pedia passcode: 0222

1. **Login**

Double-click the EncounterPRO-OS icon on the desktop. The EncounterPRO-OS login screen appears.

Start EncounterPRO-OS
Login to EncounterPRO-OS

**Step 1:** Select the login icon in the upper right of the screen (nurse with physician). A number pad appears.

**Step 2:** Enter the access code for the user you wish to log in as.

**For this example, log in as Nurse Patty: 0220**

The Office View appears. The initial database has one patient in the office in Exam 5. There may not be any patients in the Office View of your installation when you are performing the Test Drive.

**Note:** You may see a message alerting you that a recent backup was not found. This is expected when you first download the application. Your network administrator should make sure that your database is backed up nightly and this alert would need immediate attention, if it appeared at a live practice.

**Important:** Do NOT use the Windows close control to exit any of the EncounterPRO-OS screens. Use the Cancel, OK, I'll Be Back or other EncounterPRO-OS user interface buttons to exit a screen.
Typically practices integrate EncounterPRO-OS with their billing and scheduling system (PMS). This allows the front desk person to check the patients in through the PMS and they will automatically appear in the EncounterPRO-OS Waiting Room. For the purposes of this test drive we will need to check the patient in manually.

**Step 1:** Select the Charts tab on the right side of the Office View. The Charts screen appears.

**Step 2:** Enter the search criteria for the patient:

**For this example, enter P in the Last Name field.**

**Step 3:** Tab out of the field or select Search. A list of matching patients appears.
Step 1: Select Warren Phillips1. The Patient Demographics screen appears.

Note that the phrase “This is a testing/training patient and NOT a real person” appears at the top of the screen. You can practice with these test patients to get familiar with the EncounterPRO-OS application.

Step 1: Select the New Encounter button (first button on the bottom menu). The Create New Encounter screen appears.

Step 2: Select the bar for Encounter Owner.

For this example, select Dr. Pedia from the list of users.

Accept the remaining default settings (Office Visit Established Patient) then select Finished.

Step 3: Select which waiting room the patient is in: Well or Sick. Select Sick. The Patient Demographics screen reappears.

Step 4: Select Finished. The Charts screen reappears.

Note: This manual check in process is not necessary when EncounterPRO-OS is installed and integrated with a PMS system.
The first part of the encounter is generally documented by a nurse or other member of the clinical staff. You should be logged in as the nurse, Nurse Patty (0220).

We will bring the patient into a treatment room, document the vital signs, any patient-reported allergies, and the chief complaint then turn the encounter over to the provider.

**Step 1**: Select the Office tab on the right side of the screen. The Office View appears.

**Step 2**: Select (click) in an empty examination room. The treatment room screen appears.

**Note**: If the exam room has "Dirty" under the room name, that notifies the staff that the room needs cleaning from the previous patient. Select anywhere in that room and select the Cleaned button to make the word "Dirty" disappear.

**For this example, select (click) anywhere in the space for Exam 1.**

**Step 3**: Select the Get Patient button in the lower right of the screen. The Patients Waiting List appears.

**Step 4**: Select the name bar of the patient that you checked in, then select Finished. The Child Vitals screen appears. (There may be a slight delay.)
Step 1: Enter the Chief Complaint. Select the gray bar next for the Chief Complaint. The Chief Complaint screen appears.

Step 2: To document symptoms, either type the information in the white text area or select from the pick list on the left. As you select symptoms, they appear in the white text box on the right of the screen.

For this example, select the following from the pick list:
- Fever
- Cough
- Congestion

Step 2: To assign a duration or onset to the symptom, select the number, the unit of measure (minutes, hours, days, etc.) then select either the Onset or Duration button.

For this example, select:
- 3
- Days (may already be darkened)
- Onset

Step 3: To document any pertinent negatives or absent symptoms, select No, next to a symptom on the left.

For this example, select No Vomiting

Step 3: Select OK. The Child Vitals screen reappears.
Step 1 Enter the vital signs for the patient. You can select each field and type in the data or select the button to the right of a field to display a number keypad for easy data entry.

You can enter data in either English or Metric units. Select the button that reads Eng or Met to toggle from one method to the other.

For this example, enter the following:

- Wgt: 40 lbs
- Hgt: 42 inches
- Temp: 101 F (Axillary)
- HR: 77 bpm
- RR: 22 rpm

Note: A red ! appears next to the Temperature. This is a visual cue to alert you when the data entered for a field is outside the normal range.

Step 3: Select Done. The Current Medications screen appears.
Step 1: Any medications previously documented or associated with an open assessment (diagnosis) appear in the list.

Step 2: To add a new medication to the list, select the Add Meds button. The Select Prescription drug(s) screen appears.

Step 3: Select the prescription medications that the patient/parent reports to you. You can select more than one. As you select medications, they appear in the Selected Items list.

For this example, select Multivitamins. The Multivitamins ordering screen appears. A popup prompts you to select the package for this medication.

Select Tabs.

Step 4: You may not have all the information if this medication was ordered by another provider. If possible, select the Package, the Dose, and the Frequency. Select the gray bar for each field and select from the available options.

For this example, select:

- Dose: 1 Tab
- Frequency: QD – every day
- Leave the remaining fields blank.
Step 5: Select Finished. A popup prompts you to select how long the patient has been taking the medication. Use the numbers and time periods to enter the appropriate time period, or select Clear if you do not know, then select OK.

For this example, select 3, then Months, then OK.

The Select prescription drug(s) screen reappears with the medication in the Selected Items list.

Step 6: Select Finished, the Current Medications screen reappears with the new medication in the list.

Step 7: Select Finished. The Allergy Assessments screen appears.
**Step 1:** If the patient reports no allergies, select the button for Other Options, then select 1-Touch NKA. This will put a comment in the chart, “Patient/parent reports no known allergies.”

**Step 2:** If your patient reports an allergy, select the button for New Allergy. A selection screen appears.

- If the allergen appears on the short list on the left, select it, otherwise select the Description button and search for the name of the allergen, then select OK.
- A pop-up appears to allow you to select the severity of the allergic reaction.
- Select Mild, Moderate, or Severe. A screen appears to allow you to document specifics about the allergic reaction.
- Select from the pick list on the left or type in the reaction, then select OK. The Allergy screen reappears with the new allergy and the reaction.
For this example:

- Select Penicillin from the short list, then OK
- Select Moderate as the Reaction title
- Select Hives and Fever from the pick list to describe the reaction, then OK.

**Step 3:** Select Finished. The Child HPI with ROS screen appears.
**Step 1:** There are several options for documenting the HPI and ROS.

For this example, select the <Drill Down> bar to the right of Sick Questions ROS.

On the Sick Questions ROS, select a No for pertinent negatives and Yes for those symptoms that the patient is experiencing today.

For this example, select Yes for:

- Sore throat
- Ear pain
- Runny nose
- Cough
- Congestion
- Abdominal pain
- Headache
- Poor appetite
- Fever

**Step 2:** Select Finished. The Child HPI with ROS screen reappears with the information you entered to the right of Sick Questions ROS.

**Step 3:** Select Finished. The Child PFSH screen appears.
**Step 1:** The Child PFSH screen is used to document the Past Medical, Family and Social History. If any previous PFSH information was documented for this patient, it will appear here in the white text area.

**Step 2:** Select the Add Info button display the Review/New Results menu:

- Reviewed with No Changes. This gives you credit in the E & M coding for reviewing the history.
- Reviewed with Changes. This gives you credit in the E & M coding for reviewing the history and opens the data entry screen to allow you to make updates or corrections.
- New Results. This opens the data entry screen to allow you to enter new information.

For this example select the Add Info button, then New Results from the menu.

**Step 3:** The PFSH data entry screens are in a format called a Drilldown screen. Categories are listed on the left and each has a corresponding bar on the right with `<Drilldown>`. To enter information about a category (on the left), select the `<Drill Down>` bar to the right of that category to go to the next level of that observation.

For this example, select `<Drilldown>` to the right of Birth History.
As you drilldown into each level, you will see other categories and <Drilldown> options.

For each of the items below, select the <Drilldown> to the right of Birth Location/Hospital. Select Hospital from the pick list on the left, then type St. Joseph’s in the text box. Select OK.
For this example, select <Drilldown> next to Type of delivery/complications. Select Vaginal.

Drilldown screens will commonly have a set of four navigation buttons in the lower right to help you move through the drill down screen:

- **Top** takes you to the initial observation screen
- **Up** takes you up one level
- **Next** takes you to the next observation on the same level
- **Prev** takes you to the previous observation on the same level

For this example, select Up. Then select <Drilldown> for Birth complications, select None, then continue selecting Next until you reach Hep B given at birth. Select No, then Up.
You can now review all the information you entered for the Birth History. If you needed to make changes or add additional information to the Birth History you could use the <Drilldown> bars to do so.

**Step 4:** Select Top and review all information entered in the PFSH for all categories. When you have both Top and Finished on a screen **always** choose Top first so that you can review your information.

**Step 5:** Select Finished. The Child PFSH screen reappears with the information you entered.
Any data considered "abnormal" appears in red on the Child PFSH screen. The PFSH is a "persistent history," that is, it will continue to display all information entered at each subsequent visit.

**Step 5:** Select I'm Finished. The Office View reappears. There is now a green service bar labeled "Preview Encounter" next to the patient's name bar. This is the end of the nurse's part of the workflow and the patient is ready for the provider.

Log out as the nurse. Select the Logoff tab at the bottom right of the screen. The login screen reappears.
The next part of the encounter is generally documented by a physician or extender, such as a nurse practitioner or physician’s assistant. You should log in as Dr. Pedia (0222).

We will review the data gathered by the Nurse, review the patient’s history, perform a physical exam, diagnose a new problem, treat the new problem, and approve the encounter.

**Step 1:** Select the login icon in the upper right of the screen. A number keypad appears.

**Step 2:** Login as Dr. Pedia by entering 0222. The Office View appears.

You can tell at a glance that Dr. Pedia has a patient in Exam 1, because the patient's name is in green (Dr. Pedia's personal color). Also, since there are no pink service bars, this indicates that the nurse is finished with her tasks. The green service bar indicates that the next task is assigned to Dr. Pedia, again because it is in the doctor's personal color (green).
**Step 1:** Select (click) in the area for Exam 1. The treatment room screen appears. There should be a service bar labeled Preview Encounter in green.

**Step 2:** Select the service bar for the Preview Encounter. The Review of Today’s Encounter appears.

**Step 4:** Scroll down and review all the information from today’s encounter that was documented by the nurse.

Note that the Immunization Status and Health Maintenance Status also appear on this report.

**Step 5:** Select Finished. The Patient Chart appears.

- Review today’s encounter
Viewing the Patient’s Chart

The information from today's visit appears in blue text. If there had been information from a previous visit, such as an open assessment, that would appear in black text.

Selecting either the text or the small icons to the left of the text will let you navigate to the dashboard screen and data entry screens for those items.

Scroll down to find the General Pediatric Physical in blue text.

Documenting the physical examination

**Step 1:** Select the small icon to the left of the General Pediatric Physical entry on the chart. The General Pediatric Physical screen appears. This screen presents the user with physical examination data entry screens which encompass 20 body systems.

**Step 2:** The General Pediatric Physical is a “drill down screen” that allows the user to drill down on the right side of each specific data element to fill in the appropriate information. Select or touch the area marked <Drill Down> to display the next level of results for data entry. You may have to drill down several layers for complex histories.
For this example,

- Select <Drill Down> to the right of Constitution. The next level of the drilldown appears.
- Select <Drill Down> to the right of General Appearance. A new group of selections appears.
- Select Ill-appearing

Step 3: Use the navigation buttons in the lower right to move through the drill down screen:

- **Top** takes you to the initial Physical screen
- **Up** takes you up one level
- **Next** takes you to the next observation on the same level
- **Prev** takes you to the previous observation on the same level

For this example, select the Next button to go to the next observation under Constitution, Build & Development and select one or more of the result bars, such as Thin, then select Next. Select one or more results for each of the observations, selecting Next until you reach the end of the observations for Constitution (Ability to Communicate). When the Next button is no longer available, select Up to review your selections.
Step 4: Continue to use the <Drill Down> bars and navigation buttons to move to the observations that you want to document for this patient’s physical examination.

For this example:

- Select Top to go to the top level of the Physical
- Select <Drill Down> for Nose, Mouth, Throat
For this example, <Drill Down> for Nasal Drainage, then select the results:

- Bilateral
- Yellow
- Purulent

**Step 5:** When finished documenting the physical, select the **Top** button.

**Step 6:** Review your documentation of the physical exam. Select Finished. The Patient Chart reappears.
**Step 1:** Select the New Sick DX (Red DX) button on the right side of the Patient Chart. The Select Sick Assessments screen appears.

**Step 2:** If the assessments you need for this patient appear in the short list, select it. (You can select multiple assessments if needed.) Each assessment chosen will appear in the Selected Items box.

If the assessment does not appear on the short list, use the Description or ICD code search options to locate the desired assessment. Be sure to note whether the search is using the Begins With or Contains search option.

**For this example, select Bronchitis, acute and Cough.**

**Step 3:** Select OK. The treatment list for the first assessment appears. The assessment name and ICD-9 code appear at the top of the screen.

Each assessment (problem) and its corresponding ICD-9 code has an associated treatment plan in EPRO. Like in other areas of the application, there can be common treatment plans for the practice, and personal treatment plans for each provider.
**Step 1:** Select the treatments which you want to order for the current assessment (named at the top of the screen). The treatment plan can include an almost limitless number of treatment categories, but typically includes treatment groups for: Office Procedures/Injections, Prescription Medications, Labs/Tests, Encounter Instructions, Follow-ups, and Referrals.

**Step 2:** Select the treatment group Prescription Medications to expand the group and see the medications listed.

Notice that there is a red A next to one of the medications. This is a visual cue letting you know that the patient has an Allergy or other Contraindication for that treatment. (In this case, it’s the allergy to Penicillin the nurse recorded.)

**For this example, select:**
- Cefzil Susp 30 mg/KG/Day
- Ventolin Syrup 0.1 mg/KG/Dose
- Education, bronchitis
- Follow-up if condition worsens (select the treatment group bar for Follow-up List to view the list of available Follow-ups).

**Step 4:** When you are finished ordering treatments for this assessment, select Finished. Since you ordered a prescription drug the Prescription Ordering screen appears.
Step 1: The Prescription Ordering screen allows you to make any adjustments to the prescription for this patient.

For this example, leave the Ventolin RX as it defaults, select Finished.

You will see an acknowledgement popup that confirms that the new RX was successfully ordered. Select OK.

For the Cefzil, change the package to Susp 125 mg/5 ml and change the Total Dispense to 220 ml (select the Total Dispense box, then Other Amount and enter 220 ml). Select Finished.

You will see an acknowledgement popup that confirms that the new RX was successfully ordered. Select OK.
**Step 1:** Since you ordered a follow-up for the Bronchitis treatment plan, the Edit Follow-up screen appears.

**For this example, leave the follow-up instructions as is, select Finished.**

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**✓ Complete the Follow-up**

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Since more than one assessment was selected, the treatment list for the next assessment appears.

**Step 1:** The treatment list for Cough appears. If any other treatments are required specifically for the cough, select it from the treatment list. Select the name of each treatment group to expand the list.

**For this example, select the Patient Instructions treatment group name, then select:**

- Cool mist humidifier
- Recommend to try Delsym for cough

**Step 2:** Select Finished. The Patient Chart reappears.

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**✓ Finish the treatment plan for remaining assessments**
Step 1: Select the Exit tab in the lower right of the Patient Chart. The billing information appears. This screen presents the recommended E&M visit code based on the 1997 Documentation Guidelines for Evaluation and Management and ICD-9 and CPT billing codes from the current encounter.

Step 2: Review the visit level and associated assessments and any billable items.

Step 3: Select I’m Finished to approve the encounter billing. This sends the patient’s billing information to the integrated billing and scheduling system.

Note: You will notice that the codes appearing in the charges box on the right of the screen are not the official ICD-9® or CPT® codes. Those code sets are copyrighted by the American Medical Association and cannot be distributed as part of the EncounterPRO-OS application. If you have purchased the required documents or user licenses from the AMA, you can enter those codes yourself through the EncounterPRO-OS configuration screens, or purchase that service through one of the EncounterPRO-OS Foundation partners.
5 Complete the Encounter

The provider has approved the encounter and the clinical staff will complete the remaining services. Select the Logoff tab on the Office View to log out as Dr. Pedia. The login screen reappears.

Select the Log in button and log in as Nurse Patty (0220).

The Office View appears. There are several service bars still waiting for Warren in Exam 1.

The service bar in pink is specifically for the clinical staff. The Follow-up is in the color for the Front Desk. There are also documents, in this case prescriptions, that need to be printed.

✔ Log back in as the nurse
/5 Complete the Encounter

✓ Dispatch the Prescriptions

**Step 1:** Select in the area for Exam 1.

Because the provider ordered two prescriptions, there are documents that need to be dispatched. You can dispatch the documents to the printer. (Electronic prescribing is an add-on module that must be purchased through a third-party).

**Step 2:** Select the icon for the documents (red exclamation point.) The Document Manager screen appears.

**Step 3:** Select the Send/Print All button, then Close.
There are two service bars remaining for this patient. One for scheduling the follow-up visit and one for printing the patient educational materials. You must complete all service bars before the patient can move to the Check-out room.

Select the service bar for Schedule Follow-up. (You may have to “take over” the service from the Front Desk role. Select Yes to take ownership of the service.)

Since this follow-up was not ordered for a specific time, only if condition worsened, you will not schedule an appointment. Select Finished.
Select the service bar for Education, bronchitis. A new window opens with the PDF file (you must have Adobe Acrobat Reader installed). You can print this information or simply close the new window.

The EncounterPRO OS will prompt you to note if you are finished with the education material. Select I’m Finished.

When there are no pending services for the patient, the encounter is closed and the patient goes to the Checkout Room.

We hope you enjoyed your Test Drive of the EncounterPRO-OS Pediatric EMR. More information on using EncounterPRO-OS is available free on the website at http://encounterpro.org/wiki.

EncounterPRO Healthcare Resources, Inc. is happy to provide this Test Drive to anyone interested in learning about the EncounterPRO-OS Pediatric EMR. If you would like information on educational opportunities and other services supporting EncounterPRO-OS, please visit EncounterPRO Healthcare Resources, Inc., at www.encounterpro.com.