Nat’s short cuts for Epic: tips, etc. for INPATIENT mostly, a few outpt pointers.

Bring this with you to training and personalization.

These comments may not make sense until you have had your training and a chance to practice in Epic. Consider bringing this paper to your personalization lab where they can help make sense of some of these topics. While geared towards physicians, this can be relevant for nursing. Please make this a wiki and add / subtract what you find works for your group.

GRAB YOUR TERRITORY IN EPIC / Pre- go live

- Outpatient – grab your dot for scheduling. Otherwise your clinic will assign all colors and you will not have a personal dot to use. This may be for “my part is done, can close once staff does their stuff, etc.”
- Inpatient – where do you want to write your check out notes to the night person? Residents? I recommend Plan Notes. It is visible on the Summary tab in Overview and easily printed. In training you can also use your specialty section.
  - For us – docs use Plan Notes, nurses / nutrition / etc use Treatment Team notes.
  - Primary Care Team Sign Out Notes (and others in this section of the list) do not show up on the overview tab – thus you will click more. It can be used and printed on lists – I found it faster to use one of the fields on Overview.
  - Read your nurse’s sign-out (we used the Treatment Team Notes for nursing—sometimes they may have non-urgent questions here and save you a page later) While these do not become part of the chart, we can always find them.
- Before Go-live go into real Epic (Production) and read up on some of your own patients. Their data will already be in Epic. You can add PMH, PSH, Soc hx. Old labs and vitals may already have crossed over. Practice looking for information on a few patients that you know well to start getting used to seeing Epic screens. Avoid the temptation to add meds, allergies – this can mess you up for go-live. Don’t do it unless your go-Live team says too!
- Playground is fake Epic – good for practice, NOT personalization. You will be in tears if you build all your templates in Playground because they will not exist in the real world (Production).

Go LIVE TROUBLE SHOOTING TIPS

- **Use the search icon to hunt for anything in the upper right. Instead of leaving my current screen, I will search for creatinine, a1c, gfr, echo and it pulls these past several values for comparison. It will look at the whole chart.**
- Partial words in problems, history, even meds and orders: “pulm em” “chr ren ins” “levaq”
- Adjust your screens. Practice shrinking, expanding, finding your buttons.
- Make sure your log in is correct for your area. If you are outpt – log in as outpt even when you are seeing hospital patients.
- Use Patient Station over Patient Search. Patient Station lets you choose an encounter (i.e. recent hospitalization) or you can simply open the chart. Patient Search is only that – a search. In Personalization, consider getting rid of Patient Search on your screen (in Production = Live).
- I use PMH for detail and things in the past (both inpt and outpt) and the problem list for “the now.” For example, I may put their Hep C treatment hx in PMH because someone may take it off their problem list since they are cured. If their viral load comes back positive, it now becomes a problem. This is a learning curve because the problem list becomes the main item in Epic. Even chronic stuff – if it is relevant (they are on meds or treatment – it goes into the problem list). For example, MVA with fractures or a collapsed lung and sepsis in 2013 goes into PMH. Their diabetes type 2 and their Celiac disease goes into the problem list because they are likely on diabetes medicines and still cannot chow down on gluten.

- The idea is to make the Problem List your details. You can flip things from Problem List to the PMH. Clean these up regularly. Right click delete is great. Everyone is responsible for the problem list – primary care, specialties, etc.

- Make sure your home access works before Go-Live. Mac, PC, etc. Download the right Citrix, etc. that you need to access it.

Inpt:
- Set up your Summary Tab – see below.
- When reconciling meds and ordering new meds – pay attention to next dose (next day or this evening). Remember to click “reviewed” any chance you get.
- Ordering labs – you may need to click on phlebotomy to get these done. If you don’t, the lab may not be done and the nurses do not necessarily see the order without looking in order history.
- Set up your screens (see below on the Summary Tab)
- If unsure about eRxing prescriptions print them. E-Rx requires the right pharmacy to be entered and that is not always the case.
- Consults – know the person and the team – when you order plop these in and the patient should show up on the work que for that person. Otherwise the consultant may not realize you needed them for that patient. If you have a non-Epic group (in the office / outpatient setting) call that referral / consult so they know to come in and see the patient.

  Check with your group about your workflow here.

<table>
<thead>
<tr>
<th>Inpatient consult to Cardiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult: From:</td>
</tr>
<tr>
<td>Priority:</td>
</tr>
<tr>
<td>Reason for Consult?</td>
</tr>
<tr>
<td>Did the ordering provider contact the consulting MD?</td>
</tr>
<tr>
<td>Which provider team?</td>
</tr>
<tr>
<td>CARDIOLOGY ASSOCIATES</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

- OB – Medical pt on OB floor shows up with OB tabs (or vice versa, OB pt without the OB tabs) – call nurses on OB and have them change the “patient status” to either medical or OB. If you have a medical patient (example with pyelonephritis who is not pregnant)
and you are seeing OBX, pre-op, post-op, Labor tabs, you must get their status changed to do the attending work. (There are work-arounds and these can cause other trouble

- X-ray – need to enter info in the Reason for Exam, sometimes radiology does not see the longer comments area. This depends on your radiology program (many do not have the comments cross over).

### XR Chest PA and Lateral

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority:</td>
<td>Routine</td>
</tr>
<tr>
<td>Frequency:</td>
<td>1 time imaging</td>
</tr>
<tr>
<td>Starting:</td>
<td>1/26/2018</td>
</tr>
<tr>
<td>First Occurrence:</td>
<td>Today 1452</td>
</tr>
<tr>
<td>Scheduled Times:</td>
<td>Show Schedule</td>
</tr>
</tbody>
</table>

- This tends to work but limited text size

<table>
<thead>
<tr>
<th>Reason For Exam</th>
<th>This may not cross over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

- During go live is sometimes appears that patients get “lost” during transfers – from surgery to PACU, from NICU to floor to CT. From ED to floor. OTF = off the floor. If you change your mind about where a patient is going i.e. they can go to a medical bed vs ICU, let a human know (and put it in Epic).
- Bill when you see the patient, open the note, check labs (especially if you know they are staying like NICU).
- Babies – double check the weight. During go-live sometimes these weights are off because numbers are flipped. If the baby did not ‘look’ like their weight, ask for a re-check on weight.

Outpt

- Referrals outside Epic may get lost as we learn the work flow– especially if a responsible referral clinic or person has not been put into the system. Know what the work flow is for referrals that are not in Epic (docs outside of the system).
- Print rx’s if not sure about the e-RX or the pharmacy.
- In baskets – learn how to check someone else’s and to set up your “on vacation” message. Before you leave, else your partners may harm you on return if you just attach your workload to theirs.
- You can send yourself a future in-basket message on a pt as a reminder – for example, “needs ct lung in March” by changing date to March 2. Epic will then plop it into your basket on that date. Let Epic remember for you.
- Growing your preferences will be a huge help. Find an expert to copy.
- Patient can email you in Epic. Sometimes they figure out your regular email. Always use Epic – avoid using regular email for patients. It will bite you.
LISTS: (inpt)

- Print the list if you like paper: Be patient – there is a 10 second delay before it prints.
  - Order your list first (room #) every time. Otherwise pts. are out of order and you are running all over the hospital.
  - Actions (upper right screen), chose print list. Prints out traditional table list. Landscape is best.
  - Patient Report – choose NAME Rounding Report and enter your printer. (use partial printer name, should pull up the closest choices). Prints multi page report with pts., meds, allergies, sticky notes, etc. This can be a thick list and is small font. Can be a paper way to review the biggies (meds, allergies, problems) on paper. You cannot adjust the font on this one.
  - Other lists: right click to print your list and the select what items you want printed. Click “add a blank column to write comments” to keep a blank box for written notes.
- **Make yourself an ED List / surgery / medical / etc.– optional.** Or check the track board (making an ED list with name, pcp, etc. can make it easier to figure out who is your patient). A good list to check before leaving the hospital.
- Always admit to an attending AND a team: A person and your group (Residency Team and Dr. Awesome). Team = patients. Individual docs = lost patients. Epic assigns a patient to a team list based on Treatment Team that we assign to the patient. Remember your babies – add our newborns to this list. Consults too. You need both. (The attending for billing and your team for the team list). Designate the team as primary. Nurses use these designations to figure out who to page.
- Shared lists: Do NOT share with everyone. Only the folks who need it. Otherwise someone on Epic (ok, me) will prank you and add every single patient in the system to your list. You might be rounding on 800 people.
  - You have to add docs to the shared lists – it will not be automatic. When new residents / MDs/ PAs/ NPs come, remember to update it.
  - If you cannot find a patient, look in the department lists below.
  - **NAME of your Residency Rounding Team = The List.** Both faculty and residents make their own lists. The residents control format of their check out list (faculty avoid messing with theirs). If you wish to alter for yourself, copy this list into your own and rename it please. Do not alter this list – this one is for the residents to make as useful as possible for their check out and their service. Faculty makes their own. Residents, don’t mess with someone else’s list.
  - **Discharged (NAME) Team Follow Up:** You can drag and drop patients here that have follow ups for the hospital service. Consider Newborns who need to come in for bilirubin (as a back up – call the parents if baby did not come in) on the weekend. Team, check it daily and remove folks once done. Epic will deposit labs in in-baskets, but this is a safety net for patients who need follow up that is not automated.
    - Develop a work flow for your follow up in both of your systems if you are not Epic in the follow up world.
- Lists are one of Epics best parts – make teaching lists (studies), follow up lists, interesting case presentations, etc.
Results Review tab (the big buttons on the left of your screen)
This tab can be “moody.” I recommend setting it to the following: Results since conception and start with Date Range Filter enabled. Click Set Default and Accept.

This will show you results: labs, imaging, micro and more. The trick with then results review tab is that Epic shortens the view to the most recent labs of that flowsheet: on day x these labs were done – you may not see that D-dimer from yesterday. If you hit back, you may suddenly see the D-Dimer that was not visible at first (because Epic shrunk the view). You can find these by clicking on the lab type (the plus by the type – Ex: Lab Results -> Blood -> hematology -> Toxicology to drill down and find it.

Discharges: Start at admission or the next day.
1. Start the HOSPITAL COURSE and pend it / save. That way everyone can work on it while the pt is in house. The hospital course is the summary part of your “dictation” where you tell what happened. Leave the discharge meds, admit / dc date / etc. to the template Epic provides. I do recommend listing necessary outpatient follow up. Make it easy for the follow-up outpatient doc to do what they need to do – remember, they may NOT have Epic access.
2. Day of discharge – complete the hospital course and sign it. Only when hospital course is signed can you pull it into the discharge summary. The person doing the DC summary must be the person who signs the hospital course. Then do the discharge summary using your templates.
   a. When you personalize, consider copying from your list of Epic experts (op reports, CS, newborn discharge summary, etc.).

Tricks
• Click the little time mark (the little clock) to avoid reading the same note / lab / result over and over. Do this on every view: summary, labs, notes. Train yourself to only look for new stuff and always click the clock.
• Editing / adding notes after discharge. Click on the More Activities tab and choose Encounters, then Encounter. Load more and look for the “Date Hospital Encounter, Department.” Always choose the one with the floor location like Ortho, etc. (not x-ray, O.R., radiology suite unless you are the radiologist – note your patient may have several other encounters in the system beyond the admission). Chose that hospital encounter and you have your work tabs (admission, orders, notes) appear on the left.
• Finding Sticky notes and Plan Notes on discharged patients. Same as above – click on summary and there they are. These are linked to the specific encounter / hospitalization (outpt stickies are different and tend to stay with the patient for you)
• History, problems: right click on problem to delete. Clean these up please.
• Problems: always need a principal problem for admission. It helps to click Present on Admission as well for our case mix index (helps document our complexity).
- *Use the search icon to hunt for anything in the upper right. I love this part – and you will too.*
- Iphone / android / pad apps good for looking stuff up. You cannot order on these apps (yet, it is coming), but they are great for on call, during rounds for a quick lab and medicine check.
  - Phone apps let you take pictures directly into a patient chart – and the image does not get stored on your device. This is nice to use for cellulitis, post op wounds, rashes, etc. You can then pull the image into your note. Remember to title the image correctly though.
- Get Citrix Receiver on your pad to use full Epic for orders. Be careful because “fat finger syndrome” can make ordering on smaller screens difficult.
- For more efficient walk rounds – have laptop / ipad where someone can enter orders or at least put to-dos in the sticky notes for the list. Be aware of ID / C. diff / contact precautions on your computer though.
- Dragon works – if it is funky, chances are it is a server problem, sign out and try later. Chances are it is NOT the computer.
- When leaving for the day, always reboot your computer (click the windows ball and hit restart) – clears out the cache / memory and can fix a lot of slowness.
- Avoid note bloat in your daily progress notes – referring to specific labs is ok, pulling in every lab and scan since admission is not. For crying out loud, don’t do this. If you wish to pull in a relevant lab – use your short cuts: Note these can vary- you can look them up in tips sheets or the Red Book. Let Epic store the data, only use what you need in your notes.
- RESIDENTS: Holding orders work best as favorites vs order sets: Make a folder labelled “holding.” Add in your top orders: Place patient in bed, code status (I built one each for DNR, full, partial so I can just check the box without any adjustments), nutrition (diabetic, cardiac, clears), telemetry, pulse ox / oxygen, nurse notify (call on call when patient arrives to the floor). These get the patient a bed and you can see them later when appropriate. Always run this by your upper level. You can copy other people’s favorite order set.
- Careful with smart phrases for the physical exam – murmurs, edema, etc. You don’t want to be the one who causes your next day partner to do an endocarditis work up on a roaring V/VI murmur that wasn’t there yesterday because you used a smart phrase stating “no murmurs.” Or POD 2, when their Whipple was a week ago. Same thing in the outpatient world – newborns don’t have “good dentition.” You will be endlessly teased by co-workers. Or you should be.
- Check what the patient got in the ED – use the ED Clinical Summary. Especially for antibiotics and urgent meds (did the newly diagnosed PE get Lovenox?). For sign out, (RESIDENTS) please check out clearly if you ordered medications / labs ongoing or if the team needs to order (did you do a one time Leva dose and the team needs to order, or did you order for the hospitalization).
- Pharmacy consults are great for antibiotics, renal issues, Coumadin.
- Sign your printed prescriptions. About 80 % of pharmacies accept the electronically signed printed signature, but some do not. Even though they are required to accept printed prescription, some may not and your patient may not get the medication. If you print, hand sign until you know the printed one is fine.
- Know your stat’s controlled medicine rules. Epic rx’s will likely be set up to comply with your state (or will be soon). Check your state about narcotic rules and document that you checked that database.
(RESIDENTS) ED – residents, the ED is on a different module. Include the ED attending’s name in your note. Currently we are having trouble with ED notes from residents going to the correct ED attending.

Peds – newborn bilirubin – click on the full lab result and scroll down. There is a link to the bilitool which pulls in birthdate and does your math. Nice.

ATTENDING workflow for documentation:

Work through the admission after the resident:
1. Cosign place pt in bed order. Look under the cosign button. Not everything is in your in-basket because the admitting person may be post call. You have to sign off the admitting ADT before the patient can be discharged. NEW attendings – check for co-sign orders, you may have to sign for your partner if they rotated off.
2. Remember to click the “mark as reviewed” button for problems, allergies, meds, history. This is a CMS must do. It will not happen unless you click it (it is not automatic when you edit said problems, allergies, medications). In newborns, you have to review this too.
3. Review the problem list: make sure there is a principal problem and that all relevant problems are checked “present on admission.”
4. Avoid “Make me the author” and avoid editing a resident note if you can. The editor tends to become the author and the resident will not get credit for the visit in Epic reports. If it is minor, add the correction / blurb to your note.
5. Check your inbox daily on service, and a few times per week when off – coding questions, signing orders (nutrition, PT, place patient in bed).
6. Co-sign FL2s, home health for your residents when you can. Residents cannot sign these without an attending (Medicare issues). Use a template for your home health certification note (someone in your group will have made one)
7. Watch for copy / paste and bloat. “Will start antibiotics” when they have been on antibiotics for 3 days look bad.
8. Consider making residents present 1-2 patients without the computer up. It helps them develop “brain maps” for items like BMPs, etc. They can rely on the computer after they develop those brain maps. You want them to know that a K of 7 is not normal without having to check the computer.

For IT and admin:
- Often with Epic we decrease printers – do this after go live and with warning. Work with medical folks (nurses, docs, coders, etc.) on what printers can go and have to stay. You would be surprised to what people print – articles, lists, etc. Check with users from each group before removing.
- Have 2-3 different laptop types available for your providers to choose. This will save you $. Too big or too little means they may destroy it (not on purpose, but user discomfort with hardware will cause drops, etc.). We have a variety of people on staff – folks who cannot use an arm, a few little people, etc. Have hardware that works for both IT and them, the end user.
• Remember lefties. Make sure mice and Dragon microphones have long enough cords to easily flip sides.
• Room set up – (ambulatory), remember patient AND provider safety. Patients are not always stable. Don’t set up hardware / screen so your doc is trapped in a room if a patient looses it. Also try and make it so the doc can more easily look at the patient when doing computer work (for attached hardware).
• Make it easy – plaster computer names, IT helpdesk numbers on screen savers and start up screens on every terminal.
• Password – limit changing to yearly or every 6 months. Make it complicated but avoid frequent changes. Otherwise users write it down and will be compromised.
• Policy for phones, etc., clearly describe employee monitoring / wiping of devices if lost, etc. Watch for jailbreaks / rooted phones. We get creative when desperate.
• [url]www.emailcharter.org[/url] Give the gift of EOM and NNTR. BLUF = Bottom Line Up Front. If the email blast requires scrolling, expect it not to be read – shorten it. Add a section called optional reading. For important blasts – go beyond email. Tweets, screen savers, posters, blogs, etc. Be selective and don’t spam. I have seen the most computer resistant docs learn how to set a rule to send emails from certain people to their trash (and then forget they did it).

Logistics of many folks working at the same time – trash, food, plumbing issues (don’t ask). We had PTO blackout and never had so many staff in the hospital at the same time. Hospitals prepare for higher patient load, but not higher staff load.
PERSONALIZATION: Smart texts

Consider smart texts:
Get the list of “experts” from your group and copy theirs – a few you like. Take this to personalization. Remember to EDIT what you copy and make it relevant to your practice.

If you write / type something more than 3x, consider making it a smart text (“broken record”). Keep a list of your smart texts until you have learned them. When you make smart phrases, name them in a pattern that you always use.
For example – your initials start it. Then type, then detail is an example. For me, nfl (don’t laugh, that’s me)
.nflpred = pre = precept. All my precept smarttexts have this. D = discussed.
.nflpres = precept, seen. Etc.

Consider making these / or finding similar in your system:

Use initials because it is easy to find and labels them as yours. Some groups agree on the same smart texts and phrases and may name them more generically. Common ones your system may have
- Home health attestation
- Sepsis and repeat sepsis exam
- Needs inpatient admission with greater than 3 night stay expected, etc.
- Consent
- Resident note attestations
- Medical discharges, OB, peds, surg

AGAIN – do not personalize in Playground. Playground does not exist. That is like picking the blue pill (Watch the Matrix if you don’t know the reference.

Attestation resident notes:
- New admits
- Discharges
- Outpt seen with resident
- Outpt discussed
- Outpt procedure, present
- Medical student discussed, note edited/updated by myself (your institution’s requirement here)

Inpatient:
- Severity of illness
- Sepsis and repeat sepsis note (if lactate is >=2)
- Inpatient status, how many midnights
- Basic progress notes with *** for major aspects of physical exam

Ambulatory
- Are you a clicker and picker (note writer shortcuts) or type and template (smart phrases and smart texts)? Do you prefer key board shortcuts? Know what your preference is and your Epic trainer can help you personalize what works best.
- Use those *** for items you often vary. Careful to not template something you don’t do regularly (like on the exam – normal good dentition – this bites people when it is a newborn or someone with terrible teeth, etc.).
- Common warnings (consents, dangers, etc.). Declining of services (colonoscopy / vaccines / admissions).

Surgery and Proceduralists:
- Your common surgeries – template these.
- Daily note, post op day 1?
- Warnings / common side effects / pain expectations

Future Epic things to think about
- Patients will eventually get access to your notes. Use this to your and their advantage.
SUMMARY TAB in a patient chart: **Ask about this in PERSONALIZATION LAB** (Nursing – this can help you too)

Set up your Summary tab to be quick and useful. Here are a few I found helpful to keep in the summary tab. There are more for your specialty (transplant, chemo, renal, etc.).

HINT – When you “wrench” it to your favorites, use the description to name it what makes sense to you. Avoid “amb” as this means ambulatory / outpatient (unless you want it for your outpatient world). IP = inpatient.

<table>
<thead>
<tr>
<th>Epic name</th>
<th>Retitle / suggestion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitals Graph</td>
<td>(same)</td>
<td>Hover over point to get actual measurement, scroll down for table of numbers.</td>
</tr>
<tr>
<td>Overview</td>
<td>(same)</td>
<td>Looks at everything. Scroll down to get full use. At bottom, see scans done and ‘blood product administration history’ (not ordered, but what actually went in the patient). Various links to detailed flowsheets. Includes Plan Notes and Treatment Team Notes. If you are a scroller, this may become your favorite inpatient form.</td>
</tr>
<tr>
<td>ED Clinical Summary</td>
<td>(same)</td>
<td>Overview of what happened in ED – scans with reports, abx, etc. You can quickly see everything they got while in the ED.</td>
</tr>
<tr>
<td>Med history</td>
<td>Inpt MAR all</td>
<td>Includes all meds, even discontinued or single doses given to pt – look here for time / date.</td>
</tr>
<tr>
<td>Current Meds</td>
<td>Inpt Meds active</td>
<td>Only the active medications, time date given. If a medicine was given once or discontinued it will fall off of this list.</td>
</tr>
<tr>
<td>Meds &amp; allergies</td>
<td>Outpatient meds</td>
<td>Ambulatory meds before admission. This keeps you from having to click into the admission navigator to see their outpt list.</td>
</tr>
<tr>
<td>Labs</td>
<td>Labs since admit</td>
<td>If you need labs before admission go to the Results Review tab on the left and choose “since conception.” Then you can trend specific labs.</td>
</tr>
<tr>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
</tr>
<tr>
<td>------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fever</td>
<td>ID Summary</td>
<td>Temp, WBC graph, WBC trend, culture results, antibiotics and when given. Hover mouse over bullet for value. You can change the view to q8/12/24 hours at the top-right. A nice way to see if antibiotics got dropped, how many days on abx, etc.</td>
</tr>
<tr>
<td>Micro</td>
<td>Micro</td>
<td>Gives you all cultures during hospitalization (including various body fluids which do not show up under Fever)</td>
</tr>
<tr>
<td>Delivery Baby Chart</td>
<td></td>
<td>Everything baby, scroll down.</td>
</tr>
<tr>
<td>Delivery Mom Chart</td>
<td></td>
<td>Same for mom</td>
</tr>
<tr>
<td>Glucose</td>
<td>Inpt glucose</td>
<td>All glucose, insulin, time date given, easy chart view to figure out 24 hr insulin doses</td>
</tr>
<tr>
<td>Pain</td>
<td>Pain</td>
<td>All pain meds given, pain scores, also easy view to see what was given in 24 hours.</td>
</tr>
<tr>
<td>Peds Flowsheet</td>
<td></td>
<td>VS, weights, tele, I/Os</td>
</tr>
</tbody>
</table>