

Quantum™

Quantum™ Electronic
Health Record
Frequently Asked
Questions

Table of Contents

Quantum™ EHR 4

What is Quantum EHR? 4

What are the current capabilities of Quantum EHR? 4

Is Quantum EHR an EMR? 5

Can I have Quantum EHR without ePrescribing? 5

Will Quantum EHR support the use of laboratories other than those owned and operated by Quest Diagnostics?..... 5

If my practice already uses a practice management system, do I need to change it?..... 5

What if I need additional equipment for my office? 5

How do I get started? 5

How does Quantum EHR prepare a physician to demonstrate Meaningful Use? 6

I'm ready to attest for Meaningful Use. What registration or certification information will I need? 6

How do I find the Quantum EHR Certification ID? 6

How can I find Meaningful Use reports from previous years? 6

Why don't I have access to the Meaningful Use Reports for both stages?..... 7

Clinical Notes 8

What is a SOAP Note?..... 8

Is a SOAP Note the same as a clinical note? 8

Is a Note in Progress the same as a SOAP Note? 8

I started a SOAP Note, but do not need it; can I delete it? 8

Can I edit a clinical note once I finalize it? 8

In Review of Systems, how many "others" can I create per system? 8

In the SOAP Note, are there character limits for the *Review of Systems* and *Physical Exam*?..... 8

Can I record more than one set of vitals for a patient for one visit?..... 9

Under what circumstances will orders display in the Plan section of a SOAP Note? 9

How do I remove an Order from a SOAP Note?..... 9

Can I print *Patient History*? 9

What is the difference between adding a comment to the patient summary and adding a patient problem? . 9

Can I add the Diagnosis Codes from my SOAP Note to *Patient Problems*? 9

Can I search for patients with a specific diagnosis code? 9

What information will be shown in the *Recent Vitals* module?..... 9

For what ages does Quantum EHR populate growth charts? 10

Is the Radiology Order sent electronically? 10

What is the order number on a Radiology Order? Can it be changed? 10

Why can I not edit my Radiology Order? 10

Can I add a Radiology Order written outside of the system? 10

Do supplies display in the SOAP Note like medications? 10

What is a Master template? 10

Can I edit a template? 10

Can I delete templates? 10

If a template is edited, what happens to SOAP Notes that are in progress? 11

What happens if a user switches templates during a SOAP Note? 11

Does an *Encounter* template have to include *Review of Systems, History, and Physical Exam* templates? 11

Can *Review of Systems, Physical Exam, History, and Encounter* templates have the same name?11

How many line items can I add into *Review of Systems, History or Physical Exam* sections? 11

Can I rename or create a section in the template? 11

Can templates be set as default? If so, what is the hierarchy for templates in a SOAP Note?..... 11

Who is able to manage templates?..... 11

Am I able to denote the responsible provider on a SOAP Note?..... 12

Do I have the ability to mark a SOAP Note as an urgent or emergent situation? 12

When adding a diagnosis can I add ICD10 and SNOMED codes/descriptions? 12

Billing.....13

Can I edit the codes that are listed in the Billing Details? 13

Why don't all diagnoses and procedures appear in the Billing Details? 13

Why does the Servicing Provider list in Billing Details include Clinicians? 13

Where does the insurance information come from for Billing Details? 13

Why do I need to associate diagnoses to some procedure codes? 13

I modified the Billing template but the Billing Details show the prior template. Why? 13

Document and Patient Management14

What is an *Amendment Task* used for?..... 14

Can I upload my own documents? Can I upload multiple documents simultaneously?..... 14

Can I make changes to uploaded documents?..... 14

I just assigned a document to the wrong patient. Can I delete it? 14

Can I fax documents that have been uploaded? 14

In patient demographics there is a place to indicate patient consent, what does this consent apply to?..... 14

What is the Care Team tab for? 14

Do I have to encrypt a file exported from *Clinical Data*? 14

Point Of Care Testing (POCT)15

What is POCT? 15

Is this the same as the results that we receive from Quest today?..... 15

Do I have to sign up for POCT, and, if so, how?..... 15

Where can I find more information on POCT?..... 15

Direct Exchange domain address17

How to create a Direct Exchange domain address.....17

Quantum™ EHR

What is Quantum EHR?

Quantum EHR is the next generation of functionality developed in our system that enables providers in the ambulatory setting to create, manage, and disseminate a complete clinical picture of the patient. The key differentiator of this solution is that it is not designed to replace practice workflow (like a majority of the EMRs in the market); it is designed to facilitate clinical transactions and enhance clinical workflow by providing only the key clinical capabilities needed by the provider. The ultimate goal is to deliver an easy-to-use, affordable web-based solution that offers anywhere, anytime access and can be up and running in minimal amount of time.

What are the current capabilities of Quantum EHR?

Along with special features available for women's health providers, Quantum EHR offers a wide range of standard capabilities, including:

- Electronic lab order and results management
- Secure clinical messaging
- ePrescribing and medication management
- Clinical documentation tools
- Document management, imaging, scanning, and support
- Patient encounter documentation (SOAP Notes, history management, vitals, and progress notes)
- Secure mobile access via our iPad®, iPhone® and Smartphone apps
- Personal health record (PHR) integration
- Patient contact reminders
- Clinical decision support
- Support for creating radiology orders, ordering lab tests, and receiving results electronically
- Enhanced reporting and informatics
- Optional practice management module
- Multi-system interoperability
- A nationwide network of more than 200,000 physicians in 80,000 physician offices
- Electronic management of scanned and imported paper documents
- Electronic recording and tracking of patient demographics, history and health status
- Longitudinal patient reports of lab and med history, and practice-wide informatics reports (by syndrome, diagnosis, and more)

Is Quantum EHR an EMR?

Yes, by definition, Quantum EHR is an Ambulatory EMR. However, Quantum EHR was designed to provide only the key point-of-care capabilities, as opposed to replacing the entire workflow of the practice.

Can I have Quantum EHR without ePrescribing?

No. Quantum EHR requires ePrescribing.

Will Quantum EHR support the use of laboratories other than those owned and operated by Quest Diagnostics?

Yes. Quantum EHR offers access to universal lab orders and result capabilities, including a custom-made interface to Quest Diagnostics® and optional interfaces to any other reference or hospital laboratory systems.

If my practice already uses a practice management system, do I

need to change it?

There is no need to change if you are satisfied with your existing practice management system. We can interface to your existing system. Retail rates will apply.

What if I need additional equipment for my office?

Quest Diagnostics has developed a partnership with Hewlett-Packard (HP) to meet the unique hardware needs of small physician practices.

To support EHR adoption, HP offers flexible financing options from HP Financial Services to help practices move forward with implementation until ARRA subsidies are received. HP also offers hardware services to support a seamless EHR installation or upgrade, including end-to-end assessment and implementation.

How do I get started?

To learn more, do either of the following:

- Call to speak directly with a sales representative 888.835.3409
- Go to <http://care360.questdiagnostics.com/Healthcare-Software-Get-Started.cfm>

What is a SOAP Note?

The SOAP Note (an acronym for subjective, objective, assessment, and plan) is a method of documentation that records the outcome of a patient visit, as well as relevant information:

- Subjective. The history or state of experienced symptoms in the patient's own words. Typically all pertinent medical history, surgical history, family history, and social history along with current medications and allergies are recorded.
- Objective. This data includes vital signs; findings from physical examinations such as posture, bruising, and abnormalities; results from laboratory tests; and measurements such as age and weight of the patient.
- Assessment. A quick summary of the patient with symptoms/diagnosis.
- Plan. This is what will be done to treat the patient's concerns.

Is a SOAP Note the same as a clinical note?

Yes, a clinical note is a finalized SOAP Note.

Is a Note in Progress the same as a SOAP Note?

Yes, a SOAP Note that has not been finalized is referred to as a Note in Progress within Quantum EHR.

I started a SOAP Note, but do not need it. Can I delete it?

No. A Note in Progress can be marked erroneous so it no longer appears in the Notes in Progress list for a patient. If the note has not been finalized it can be moved to the correct patient using *Move Clinical Activities*. If you have created a dummy patient chart for erroneous SOAP Notes and uploaded documents, you can delete information in all sections of the SOAP Note and then use *Move Clinical Activities* to place the document in that dummy patient chart.

Can I edit a clinical note once I finalize it?

No. You may add addenda to the note, but you cannot edit any of the fields.

In Review of Systems, how many “others” can I create per system?

There is no limit.

In the SOAP Note, are there character limits for the *Review of Systems* and *Physical Exam*?

Yes, there are specific character limits for both:

- *Review of Systems*. When selecting “Yes” for an item, a free text field for further explanation is displayed. There is a 200-character limit for this field. Each section has an *Additional Comments* field and each of these have a 2000-character limit.
- *Physical Exam*. Each section has an *Additional Comments* field with a 2000-character limit.

Can I record more than one set of vitals for a patient for one visit?

Yes, you can record vitals as needed while the SOAP Note is in Progress. For each new entry, click on *vitals* and enter desired vitals. To edit an existing set of vitals, click in vitals section and change or correct information as needed.

Under what circumstance will orders display in the Plan section of a SOAP Note?

Orders will display in the most recent un-finalized note that has been started within 48 hours of the filed lab order.

How do I remove an Order from a SOAP Note?

Orders can be removed from an un-finalized SOAP Note by clicking in the *Lab Orders* section and click the *Remove Lab Order* link. Removing the order from the SOAP Note does not remove it from the patient's chart; it only removes it from the SOAP Note view.

Can I print *Patient History*?

Yes, *Patient History* can be selected for printing, exporting, messaging, or faxing.

Note: using *Quick Select* will not automatically select Patient History items. They must be manually selected.

What is the difference between adding a comment to the patient summary and adding a patient problem?

A patient problem is a diagnosis/condition that can be identified by an ICD-10 code. It could also be a free text entry. Comments is an area in which you can document information regarding the patient (e.g., *afraid of needles, do not take BP on right arm, etc.*).

Can I add the Diagnosis Codes from my SOAP Note to *Patient Problems*?

Yes. Once you have entered and saved your diagnosis codes in the SOAP Note, click on the *Copy* link.

Can I search for patients with a specific diagnosis code?

Yes, the ability to execute a search by ICD-10 code or description has been added to Informatics Query. Start your search by selecting Report and Informatics Query. Note that date restrictions/ranges do not apply to this query.

What information will be shown in the *Recent Vitals* module?

The most recent set of vitals in the past 18 months will be displayed here. Clicking View All will display all

vitals posted in the past 18 months for the patient. If no vitals have been entered, the module will be empty.

For what ages does Quantum EHR populate growth charts?

Care 360® EHR populates growth charts for patients aged birth – 24 months; 2–5 years of age; and 2–20 years of age.

Is the Radiology Order sent electronically?

The Radiology Order can be finalized and printed, as well as electronically faxed. The provider's signature will be applied to the order if it has been provided to Quest via ePrescribing.


What is the order number on a Radiology Order? Can it be changed?

This number is automatically generated by our database and is sequential in our database. It cannot be changed.

Why can I not edit my radiology order?

You can only edit an order for 7 days after it is finalized. After 7 days, you must create a new Radiology Order.

Can I add a Radiology Order written outside of the system?

A new item *Radiology Order* has been added to the *Radiology* menu available from a patient's summary. Clicking the item launches the *Add Documented Radiology Order* dialog box, where users can enter order information including the *Order Date*; *Result Status*; *Procedure*; *Diagnosis*; *Ordering Provider*; and *Instructions*. *Order Date* and *Ordering Provider* are required fields. For *Result Status*, users can select *Open* to indicate the order has been written and provided to the patient; *Result Pending* to indicate the order is in progress; *Results* to indicate that the provider organization has received results for the order; or *Canceled*. For *Diagnosis and Procedure*, users can enter free-text or select items from the database. Manually entered radiology orders (except those with a *Canceled* status) display in the lists with all other radiology orders, for example the *Radiology Orders* section of the patient summary and view all radiology orders page. Manually entered orders are identified by the *Annotated/Manually Entered* icon .

Do supplies display in the SOAP Note like medications?

Not at this time.

What is a Master template?

Master templates are the system templates loaded into the application for you to use when creating custom templates for your organization. Multiple templates are combined to form the *Master Encounter Template*.

Can I edit a template?

Yes, you may select an existing template to edit. Upon saving an existing template, you will be prompted to choose between replacing the existing template and saving under a different name to create a new template. If you enter a new template name prior to hitting save, it will save without any pop ups.

Can I delete templates?

Yes, but you cannot delete a section template that is currently in use by an Encounter template. When you click Delete, a dialog box appears displaying the name of the encounter template that it is currently being used. You cannot edit or delete a master template.

If a template is edited, what happens to SOAP Notes that are in progress?

If the *Review of Systems*, *History*, or *Physical Exam* section has been started, then the old template is retained.

If the *Review of Systems*, *History*, or *Physical Exam* section has not been started, then the updated template would be used.

What happens if a user switches templates during a SOAP Note?

The user will see a dialog box stating “Are you sure that you want to switch to a new template?” If you switch, *Histories* must be re-reviewed and you must re-enter all data for *Review of Systems* and *Physical Exam*.”

Does an Encounter template have to include *Review of Systems*, *History*, and *Physical Exam* templates?

No, but to create the encounter template, you must select at least one these or you will not be able to save the encounter template.

Can *Review of Systems*, *Physical Exam*, *History*, and *Encounter* templates have the same name?

Review of Systems, *History*, and *Physical Exam* templates cannot have the same name within the same organization. An error message will display upon save if there is a duplicate. However, an *Encounter* template can have the same name as *Review of Systems*, *History*, or *Physical Exam* template.

How many line items can I add into *Review of Systems*, *History* or *Physical Exam* sections?

You may add an unlimited number of line items. Line items have a 255 character limit.

Can I rename or create a section in the template?

Not at this time.

Can templates be set as default? If so, what is the hierarchy for templates in a SOAP Note?

Yes, as follows:

- Your personal default is set in *General Preferences*
- The organization default is set in *Organizational Preferences*

If neither is set, a default template containing as many items as are available for the patient’s gender is used.

Who is able to manage templates?

Users with provider, clinician, and clinical office staff roles are able to manage templates by default. If you wish to restrict a user’s access, please contact support.

Am I able to denote the responsible provider on a SOAP Note?

Yes, you can pick the responsible provider from the provider drop down if the visit with provider option has been selected at the top of the SOAP Note.

You can also choose to use the “associate user” field to make these notes in progress appear for the provider on the Quick View page when the provider logs into Quantum EHR.

Do I have the ability to mark a SOAP Note as an urgent or emergent situation?

Yes, by selecting the *Urgent/Emergent Situation* check box, users can now indicate that the patient's medical condition is urgent or emergent, where time is of the essence, and a delay in treatment would jeopardize the patient's health status. The *Urgent/Emergent Situation* check box is found in the header of the started SOAP Note.

When adding diagnosis can I add ICD-10 and SNOMED codes/descriptions?

Yes, when adding or editing a diagnosis from a SOAP Note, users can now include both ICD-10 and SNOMED codes/descriptions for the same diagnosis. The corresponding ICD-10 or SNOMED will be automatically selected when adding a diagnosis. The user may choose to remove either code if they would like for only one to be displayed.

Billing

Can I edit the codes that are listed in the *Billing Details*?

Yes, click *Admin > Manage Templates* and then the *Billing* tab. Please note: there is only one *Billing* template per organization. There is no way to return the default template once changes are made.

Why don't all diagnoses and procedures appear in the *Billing Details*?

Only diagnoses with ICD codes and procedures performed in office with CPT and HPCPS codes will populate.

Why does the Servicing Provider list in *Billing Details* include Clinicians?

Clinicians are included to account for NPs and PAs that do not have prescribing rights but may be able to bill for services under their own name.

Where does the insurance information come from for *Billing Details*?

The insurance information is taken from the patient's demographics billing tab and is typically entered when placing a Lab Order, or mapped from Quantum PMS.

Why do I need to associate diagnoses to some procedure codes?

When you have more diagnoses codes than Procedure and E&M codes, the system cannot determine appropriate associations automatically.

I modified the *Billing* template but the *Billing Details* show the prior template, why?

The system recognizes the template that was in place at the time the billing details were started and saved.

Document and Patient Management

What is an *Amendment Task* used for?

This is used for documenting changes to a patient's summary. In addition to documenting what information was changed, users can also capture who requested the change, and manage the task's status. Users can add amendment tasks from all areas of the application where general tasks and patient contact reminder tasks can be added.

Can I upload my own documents? Can I upload multiple documents simultaneously?

With Quantum EHR you can manually upload documents you have created or scanned. There is an option to use a separately installed program, *AutoReceive*, to upload documents automatically or upload multiple documents at one time from a "hot" folder. If you are interested in *AutoReceive*, contact support for more information.

Can I make changes to uploaded documents in Quantum EHR?

No, once a document is uploaded to Quantum EHR you cannot edit it. You must edit the document externally, then upload the newly edited version to Quantum EHR.

I just assigned a document to the wrong patient, can I delete it?

No, once a document is assigned to a patient it cannot be deleted. It can be moved to the correct patient using *Move Clinical Activities*. If you have created a chart for erroneous SOAP Notes and uploaded documents, you can use *Move Clinical Activities* to place the document in that chart.

Can I fax documents that have been uploaded?

Yes, you can fax uploaded documents of the following document types; all electronically received and uploaded .pdf, .xml, .jpg, .gif, .png, .bmp, .wmf, .tif, and .txt files.

In patient demographics there is a place to indicate patient consent, what does this consent apply to?

Consent applies to sending clinical documents regarding the patient outside of your organization. If your patient does not consent to share clinical data with other healthcare professionals and you attempt to message or fax that patient's clinical data, you will be warned that the consent is not set to yes in Quantum EHR. If you wish to proceed you will need to list the provider that authorized the messaging or faxing of the data and select a reason for acting against the consent setting.

What is the *Care Team* tab for?

Care Team tab is available while viewing or editing a patient's demographics. You can use this tab to specify information about any individuals who have been involved in the patient's care.

Do I have to encrypt a file exported from Clinical Data?

Yes. All exported files must now be encrypted and delivered in .zip format. Previously, you could export unencrypted files and specify that they be compressed using .zip or .jar. The Files are now exported in .xml using the Consolidated Clinical Document Architecture (CCDA) format. This change complies with Meaningful Use 2014 guidelines.

Point of Care Testing

What is POCT?

POCT is a way for physicians to document lab results for tests that they perform in their office for CLIA waived tests.

Is this the same as the results that we receive from Quest today?

No. These are different in that they are for tests that are being performed in the office and not at a Quest lab.

Do I have to sign up for POCT and if so, how?

Yes. You have to complete the online enrollment form which is located under FAQ and Forms.

Help > FAQ and Forms > POCT Enrollment Form

Where can I find more information on POCT?

For additional information they can view the eLearning within the *Online Training Library* under *Help* within Quantum EHR.

Direct Exchange domain address

How to create a Direct Exchange domain address

To create Direct Exchange addresses, your organization must continue to subscribe to the Direct Exchange premium service, which is enabled by default for all Quantum EHR organizations.

Additionally, one organization user with the Provider, Clinician, or Clinical Office Staff role must visit *Admin > Direct Exchange Enrollment* to set up a domain name for use in your organization's Direct Exchange addresses and complete an enrollment form for Direct Exchange.

Once the enrollment form has been submitted, the individual identified in the form as the organization's Direct Exchange representative will be contacted by the certificate authority DigiCert® to complete identity verification steps. Identity verification must be completed in order for DigiCert to grant the certificate required for the organization to send and receive Direct Exchange messages.

You can have a Quantum Direct Messaging address and a Direct Exchange address; however, once the Direct Exchange address is created it will be the default address used for any new messages that you send. Users can send messages to you at either address, and replies to a message will reference the address to which it was originally sent. Additionally, all messages (regardless of which address is used) will appear in the messages Inbox.