Input Health COVID-19 Tool User Guide for On-Call Clinicians

Last Updated May 14, 2020

For additional support, please contact the Local Support Team in your area

South West, please contact info@partneringforquality.ca

Waterloo Wellington, please contact info@ehealthce.ca

Erie St. Clair, please contact ESCvirtualcare@lhins.on.ca

Please note, this document is continuously being updated. For the most current version, please visit https://www.swpca.ca/44/COVID-19_PHN_Resources/.

Partnering for Quality
Working together to improve health outcomes

Adapted by the Partnering for Quality Program

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1) Log In

Log into
https://lmcovid19.inputhealth.com/

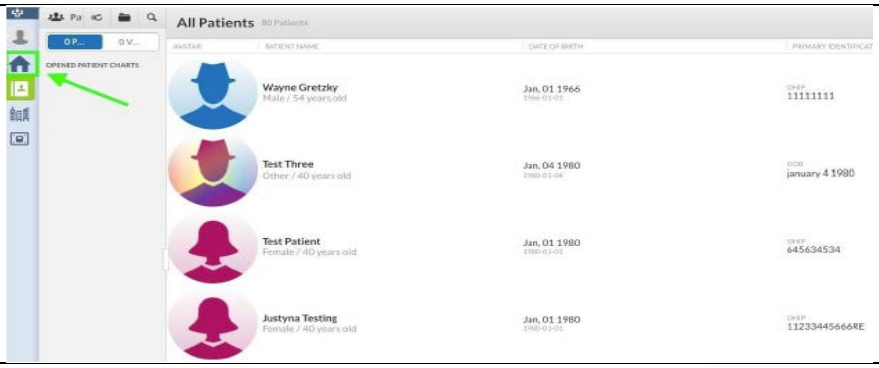
Select "**Staff**"

Enter your username (your email address) and password to log in

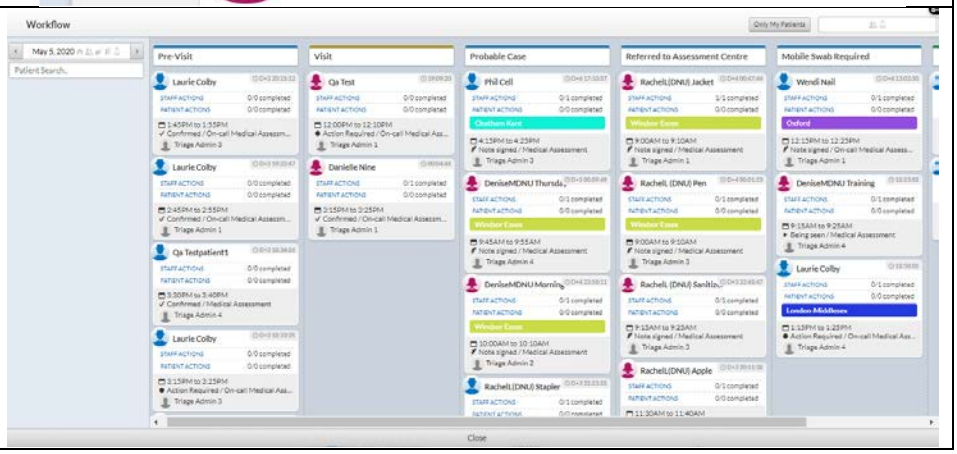
2) Open Workflow/Patient Chart

To start an encounter with a patient click on the **"Home"** icon on the top-left-side. This will open **"Workflow"** in a new window.

Workflow is the only tab you need to access for the purpose of the COVID tool.



The default view in **Workflow** shows all patients in their various phases of care (definitions for the various phases can be found on page 8).



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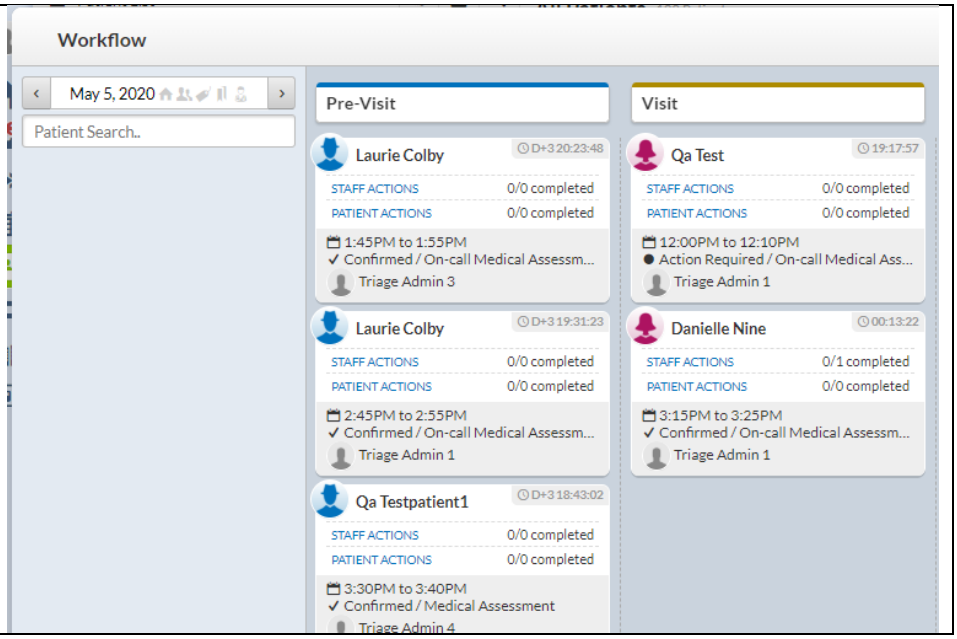
As mentioned above, the Workflow tab will show patients waiting for a virtual visit. Patients will first enter the system under the “Pre-Visit” Phase, but will be subsequently moved to the “Visit” phase by the Admin Coordinator.

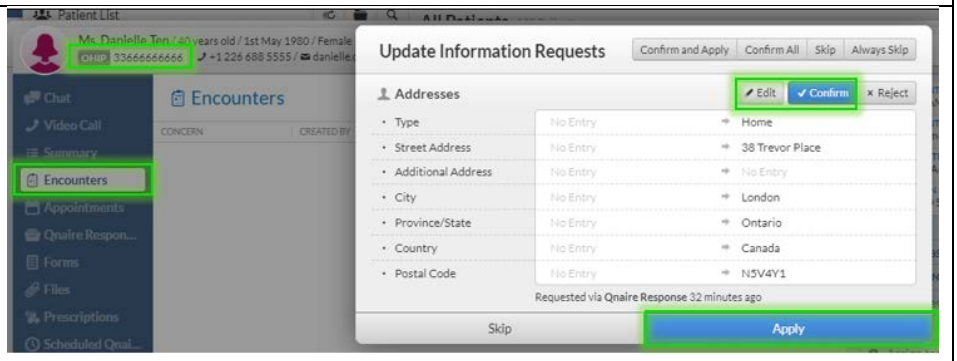
At this time the Administrative Coordinator will send you an email notifying you that you have a patient waiting in the “Visit” Phase, and indicate their initials. . If you prefer a text message, you will need to respond to the first notification and provide your # for any future patients.



3) Completing Your Encounter

To begin a visit with a patient, click **“Encounters”** on the left side of the chart. It will ask you to confirm the patient’s demographics.
Once confirmed, click **‘Confirm’** and **‘Apply’** if the information is correct, or **‘Edit’**, if it is not.

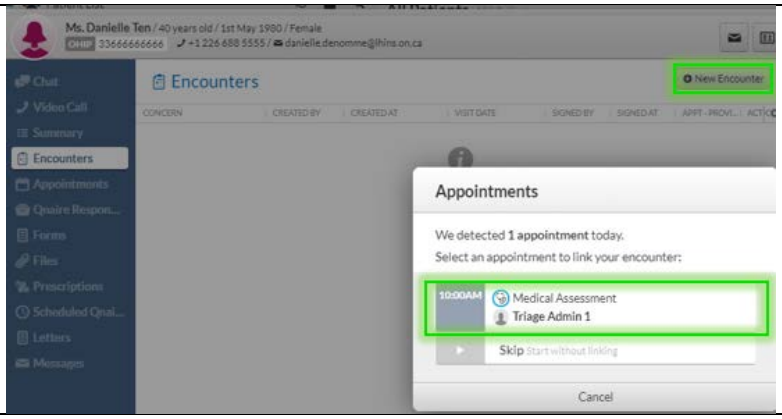
It is suggested to confirm the patient’s OHIP number located at the top left of the screen as well to ensure you get paid.

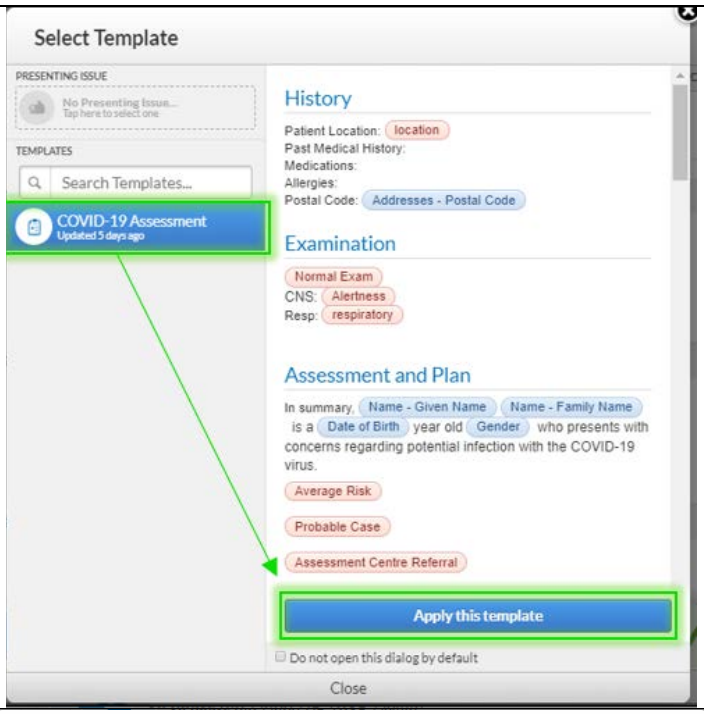
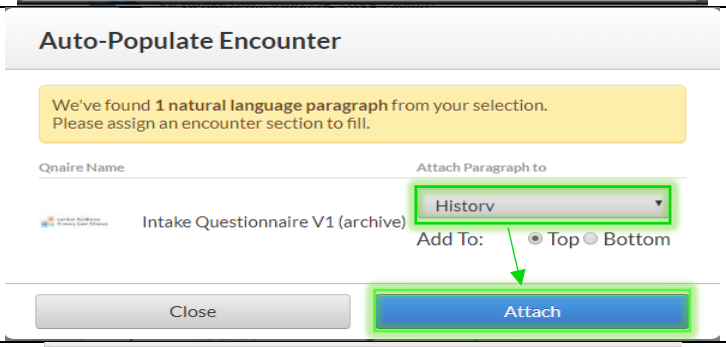


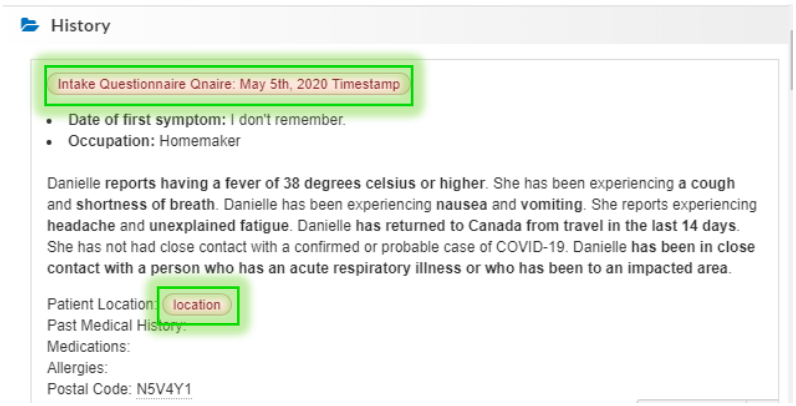
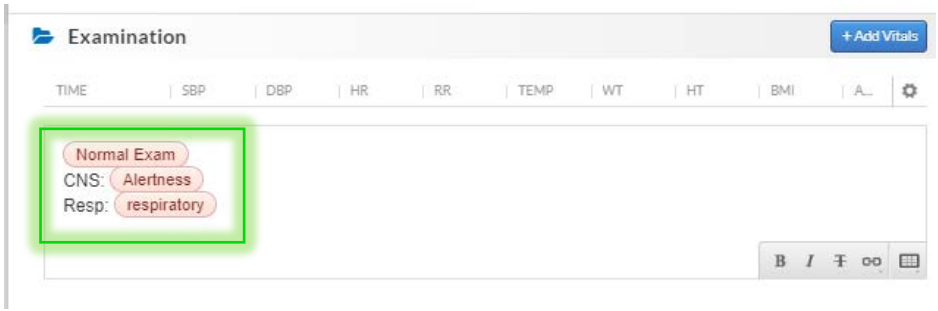
Click **“New Encounter”**

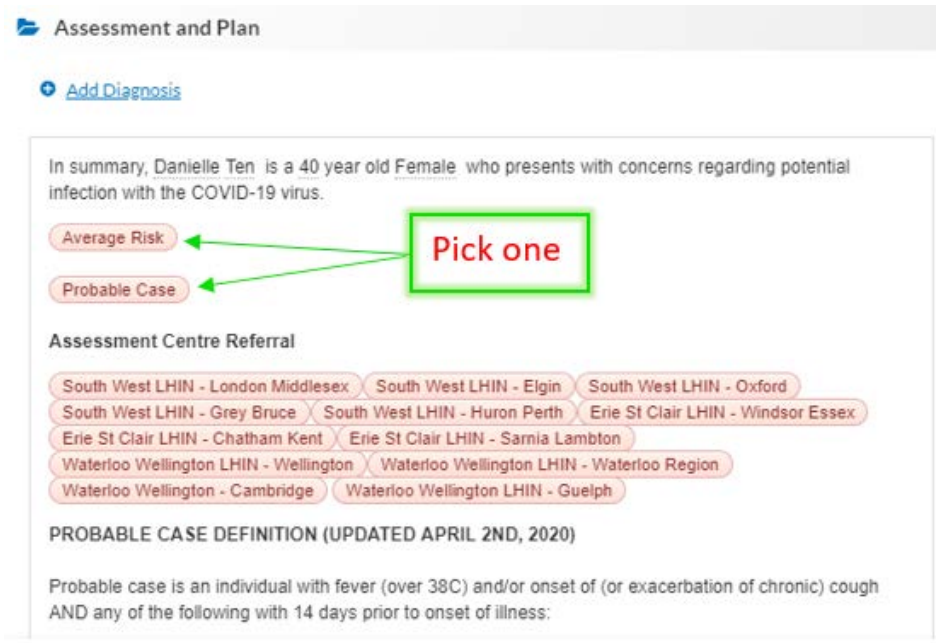
If the patient is unattached, when starting a new encounter the on-call Clinician they will have to link it to **Triage Admin 1**.

**Never select ‘Skip’ or it will not trigger a completed encounter. **



The **"Select Template"** box will pop up. ALWAYS attach the **"COVID-19 Assessment"** by clicking on it. This will appear blue. Click on **"Apply this template".**	
Attach the patients intake questionnaire responses to the encounter note template for you to reference during the call by clicking **"Attach"** Ensure the default settings **"History"** and **"Add to Top"** are selected.	
You will see the patients Intake Questionnaire is now listed at the top of the encounter. You can click on this at any time to review their answers or scroll to the History section of the encounter to view a summary.	

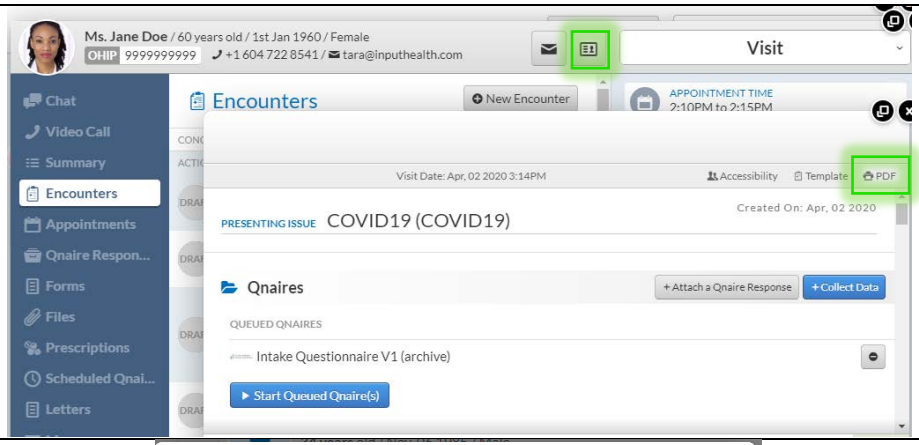
As you scroll down, you will then see the **"History"** section of the encounter. This section summarizes the patient's intake questionnaire they filled in. The two actions required in this section are to click the orange bubble to date stamp you have reviewed their history and to click on "**Location**" and select where this person is from. Use your clinical judgement to complete the most appropriate note based on your assessment of the patient's history (i.e. do they have asthma or underlying conditions?). This is also a good place the document 'call attempts' with dates/times so a record exists if the patient does not answer. You can place your cursor under the postal code and add your own notes as required.	
Under the **"Examination"** section complete your overall assessment of the patient during your virtual visit. In this section of the encounter select each of the three orange bubbles labeled **"Normal Exam", "Alertness" and "Respiratory".** When you select each of these bubbles, options will appear for you to select the most applicable answer from your examination with the patient. The selections you make will be stamped into the encounter note. At any time you can free text in this section to add additional information you observed or were told by the patient.	

Under the **"Assessment and Plan"** section of the encounter, based on the information you collected from your assessment thus far, you will select one of the orange bubbles and decide if this case is **"Average Risk"** or **"Probable Case".** This decision is based on your clinical judgment. You should only select one. If you happen to click more than one, you can delete one by using backspace to remove the text. From there, you select the **"Assessment Centre Referral"** by clicking the region the patient is from. It will give you a list of Assessment Centres for that region with their contact information. As mentioned above, please feel free to document any additional plans you have made with the patient (i.e.: Pt is to take temperature daily; Pt is to monitor symptoms daily etc.).	
If you are satisfied with the encounter and no further documentation is needed, **please make sure to SIGN the encounter at the bottom**. The encounter must be signed in order for the encounter to be marked as complete. If this is your first time signing an encounter, you will be walked through how to set up your electronic signature. It is not your responsibility to complete any other section of this encounter. Please leave the remaining sections blank.	

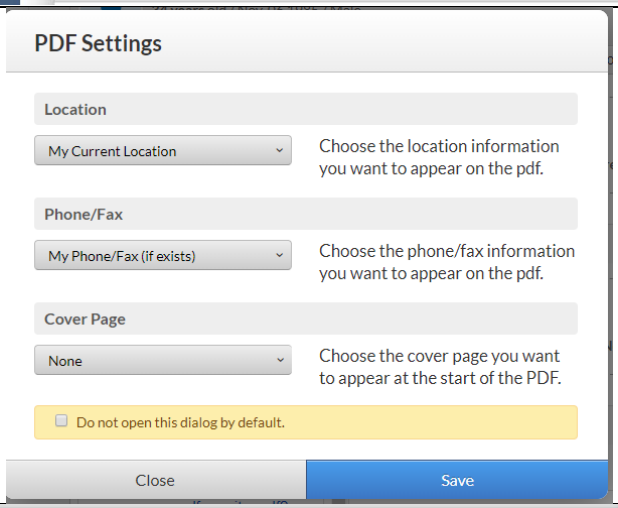
4) Sending the Encounter to the Primary Provider

If the patient has identified a primary provider in their intake questionnaire, the encounter should be faxed to the provider's EMR.

In order to fax a copy of the encounter note for your EMR & billing purposes and/or the patients Primary Provider, select **PDF** in the top right corner.



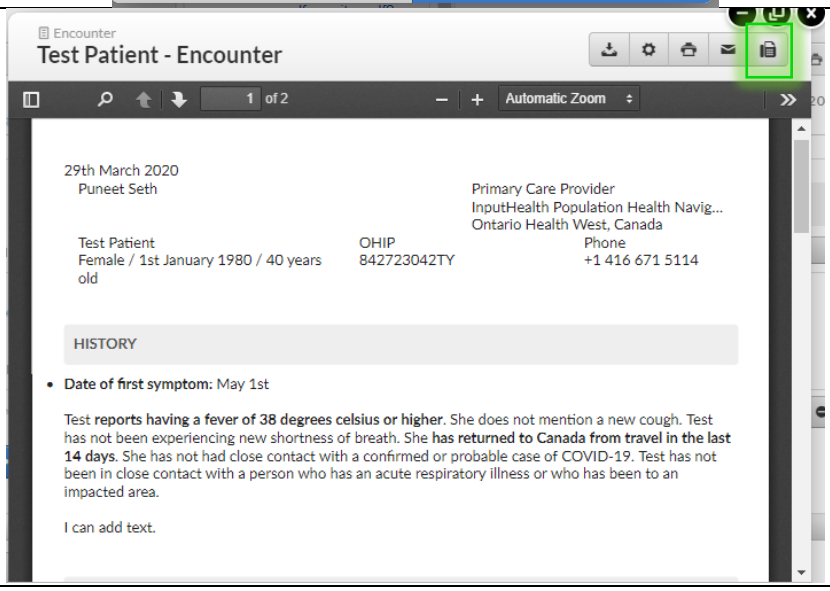
Select the appropriate settings based on the need and click **"SAVE".**



A PDF will be generated and pop up.

By selecting the **fax icon** at the top right the encounter can be faxed to the primary care providers office and scanned into the patient's chart for continuity of care.

**Note- If required, you can also select the mail icon and email the encounter to the patient for their record or to take to the assessment center with patient consent of **



The **Fax Encounter** screen will pop up.

You will then fill in their office fax number with a "1" before the 10 digit fax number and click **"SEND".**
Do not use any spaces, brackets or dashes in the fax number.

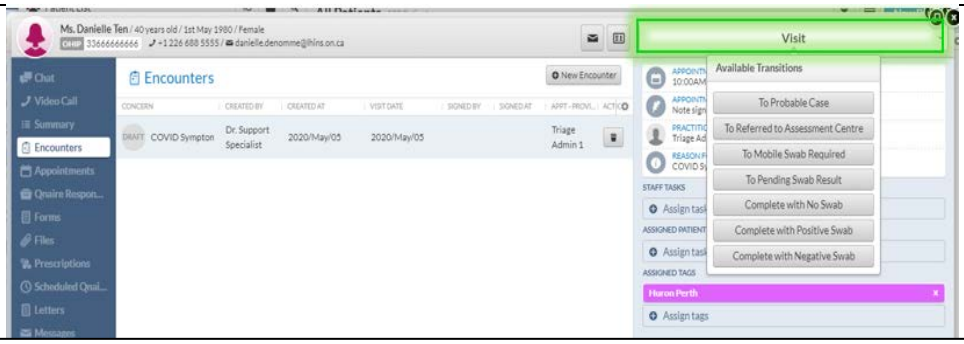
You may now use the (X) to close out of the encounter to bring to you back to the patient's chart.

5) Reporting a Probable Case:

Please note that this functionality is not used in every region. Please connect with your local support team for questions/concerns.
After you have completed your encounter, it is important to assign the patient to the correct phase based on your findings during your assessment.

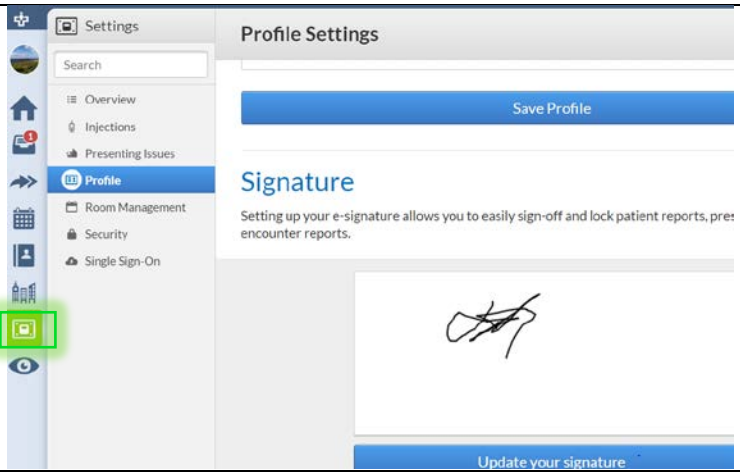
Click **"Visit"** on the top right side of the patients chart. Select the appropriate phase based on your clinical knowledge. Definitions of each phase can be found to the right.

This will be sent to the screening tool admin staff who will ensure the encounter is faxed to Public Health that day as required depending on the region.



Pre Visit – where patients enter the workflow, aka the "virtual waiting room".
Visit – patients with assessments currently underway, or those awaiting an assessment but primary provider/on call provider has been notified of their status.
Probable Case – those patients that meet the criteria of a "probable COVID-19" case as defined by the Ministry of Health and based on your clinical judgment. A complete definition of "probable case" can be found in the patient encounter.
Referred to Assessment Centre – those patients being referred an assessment centre for testing in their region based on the guidelines determined by the Ministry of Health. A complete list of the guidelines and assessment centre locations can be found in the patient encounter.
Mobile Swab Required – Patients deemed a "probable COVID-19" case that are unable to travel to an Assessment Centre and require a swab to be brought to them. *Not available in all regions*
Pending Swab Result – Patient can be moved to this phase if confirmation has be received that patient completed swab/testing and are awaiting results.
Complete with No Swab – Patient does not meet criteria for Probable Case that requires testing and no further action is required. Patient will leave the system.
Complete with Positive Swab – Patient swab results have been received and the patient is positive for COVID-19. Patient will leave the system.
Complete with Negative Swab - Patient swab results have been received and the patient is negative for COVID-19. Patient will leave the system.

Click the (x) on the top right of the patient chart to close the chart. You are done the encounter and have reported the information to the Public Health Unit (if applicable).	

CREATING or UPDATING YOUR SIGNATURE	
Go to settings (the icon identified in green). Choose 'profile", and scroll to the bottom of the page.	

select the option you prefer. For ease of use, we have used the **"I would like to have my e-signature generated for me".** If you choose to draw your signature, use your mouse pad and sign your name. Then **'update'** your signature.