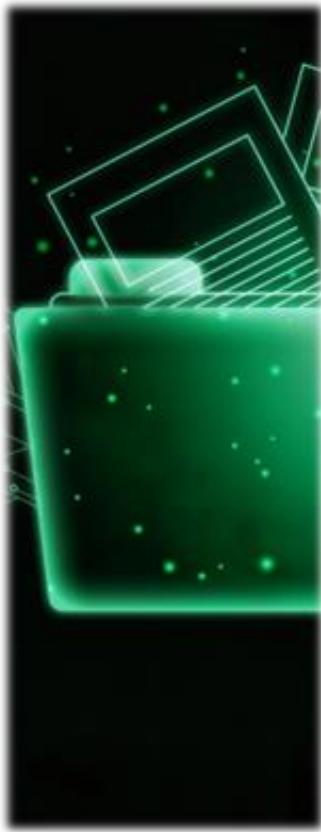


Charting, Labs, Imaging, & Medication Data



Quick Links:

- [Documenting Calls](#)
- [Note Documentation in Ubiquity](#)
- [Encounter Documentation in Ubiquity](#)
- [Creating & Using Hash Keys](#)
- [Meaningful Touch](#)
- [Offline Documentation](#)
- [APC Ordering Labs and Diagnostics](#)
- [Using the Quest Lab Portal](#)
- [Trident Care Referral Response](#)
- [Health Gorilla](#)
- [LabCorp](#)
- [NewCrop](#)
- [RightFax](#)

Training Tip:

Landmark is not able to assist with picking up a specimen ordered by a community provider.

Training Tip:

PCCs will transfer the call to an available APC / RN or send an email triage if no one is available.

Training Tip:

Please review the additional video trainings linked above for more information on the various lab portals used by Landmark.

Documenting Calls

Links & Resources:

Refer to the linked Ubiquity tutorial to explore basic functions of the application, including documentation procedures.

The Ubiquity application should be open and ready to search patients when an incoming call is received.

 [Link – Ubiquity Overview](#)

[Ubiquity.pdf](#)

- Search patients
- Open charts
- Review patient engagement status
- Identify Alert Care patients
- Locate the patient's Landmark (Care) Team
- Create notes
- Finalizing a note
- Accessing chart documents
- Managing appointment schedules

 [Link – Ubiquity HPSI Tab Overview](#)

[Ubiquity - HPSI Tab.pdf](#)

Training Tip:



You can review any open notes pending finalization using the speedometer icon in the upper-left side of the window. Check this section before signing out at the end of your shift

All calls associated with Landmark patients require documentation in Ubiquity.

- Notes must follow a specific format:
 - Font: Calibri
 - Font Size: 11 pt

Standard Note Template:

Patient verifications completed: Name, DOB, call back number, visit address

Acuity/Intensity:

Last seen face to face/Reason:

Pertinent Medical Hx:

CC:

HPI:

Assessment: OLDCARTS (onset, location, duration, character, alleviating/aggravating, radiation, time, severity)

Pertinent positives:

Pertinent negatives:

Attempted/outcomes:

Vitals:

Plan:

Patient advised to call Landmark Health anytime with any additional questions or concerns. Call 911 with emergent symptoms.

A note should be entered after each phone call on the patient's behalf and include:

- The category of phone call
- Patient's reason for calling
- Any actions you took to resolve the patient's request
- Any APC or provider who accepted a warm transfer

When to use Notes & Encounters:

Documentation Type:	Who can Create:	Why:
Notes	Entire LM1 Team	<ul style="list-style-type: none"> • Notifications triage • documenting callbacks without answering
Encounters	NP, PA, DO, MD	Clinical management of the patient

Note Documentation in Ubiquity

Notes can be clinical or nonclinical in nature. Notes are going to be created for every patient interaction UNLESS an encounter is required (see 'Encounter' below).

Call Center Notes Reports get generated and sent to the markets.

- From there, the NCMs will review the reports and follow up as necessary. This takes the place of having to send an email to the markets.

Attention – Telephonic UV Encounter Documentation

If a Telephonic UV encounter is subsequently created and finalized during the same call by the APC for the same chief complaint, the note should be deleted.



Non-Clinical

Appointment Cancellations
Provider ETA Requests

UB Note Category

Landmark First Patient Call
Administrative



Clinical

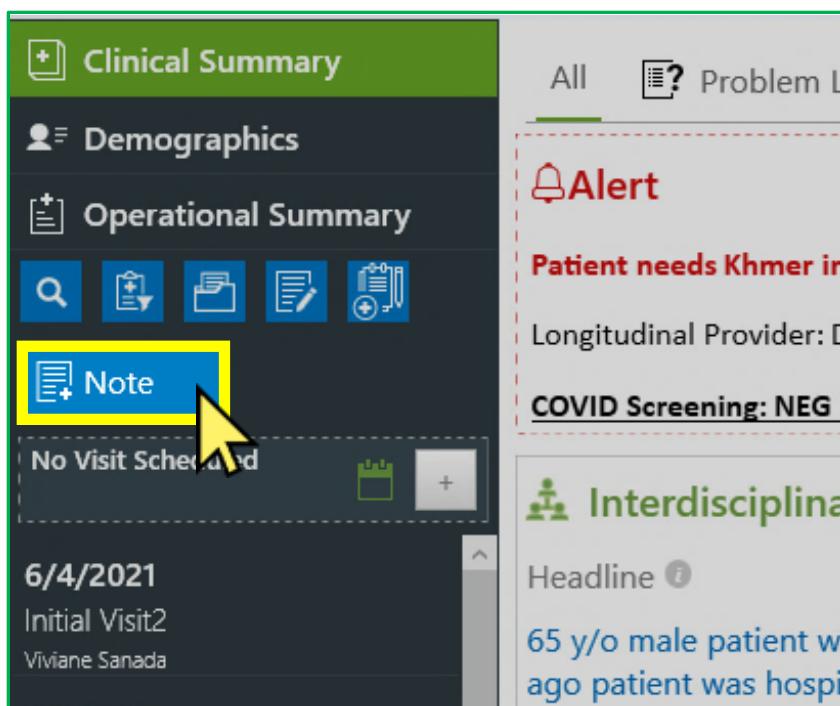
Triage and handoff to market to manage
(Without providing management / Treatment)
Callbacks that do not answer
Unengaged patient with a clinical concern
Follow-up calls with consultants / family
Family / Caregiver call with patient not present

UB Note Category

Landmark First Patient Call
Clinical

Creating a Note:

1. Open the patient's chart and select the blue "Note" button from the left-side panel.



You will be directed to select a category and subcategory for your note. Additional supplementary information should be checked based on the nature of the call.

The screenshot shows the 'Select Forms' dialog box. At the top, it displays patient information: BKIKU CUZTUPYU (1574084), 68 yrs, (6/18/1953), Female, (011) 388-1100, BCBSMA xxx580104011, Eligible, New England, Risk - Complexivist, Acuity D-Low, Intensity 1, and status Full Code Engaged. The dialog box has two main sections: 'Core' and 'Supplementary'. In the 'Core' section, 'Case Note' is selected. In the 'Supplementary' section, numerous checkboxes are available for various assessments and tools, such as Advance Care Plan, Behavioral Health Risk Assessment, Call Landmark First Checklist, Columbia-Suicide Severity Rating Scale (C-SSRS), Cornell Scale for Depression in Dementia, Functional Status, Health Risk Assessment NYC, Human Factor Assessment NCQA, Human Factor Survey (Non-NCQA), Immunizations, MAHC 10 - Fall Risk Assessment Tool, Manic Episode, Mini Nutritional Assessment, Opioid Risk Assessment, Pain Assessment in Advanced Dementia Scale, Phone Call, Post-Discharge Assessment, Pre-IV Welcome call, Quality Measures, Quality of Life Monitoring, Schizophrenia, Social History, and Visit Scheduler. At the bottom, there are buttons for < Prev, Next >, Discard Changes, Close, Save & Close, and Start.

2. Select “Landmark First – Patient Call” as your note category.

- Select “Clinical” as your subcategory.

New Note

Note Details

Note Date:

Category:

--Select--
!

--Select--
Landmark First - Patient Call
Landmark First - Care Coordination
Landmark First - Documents

Alex Dominguez X

Alex Dominguez (1553789), 43 yrs, (9)

Landmark First - Patient Call-(8/5/2021)

Note Details

Note Date:

Category:

Landmark First - Patient...
▼

Sub Category:

--Select--
▼

--Select--
Clinical

3. After selecting your category, check appropriate supplementary information on the right side of the window. When ready, click ‘Start’.

Note Details

Note Date:

Category:

Telephonic
▼

Sub Category:

-
▼

Select Forms

Core

Case Note

Supplementary

<input type="checkbox"/> Social History	<input type="checkbox"/> Behavioral Health Risk Assessment
<input type="checkbox"/> Advance Care Plan	<input type="checkbox"/> Mini Nutritional Assessment
<input type="checkbox"/> Human Factor Assessment Tool	<input type="checkbox"/> Post-Discharge Assessment
<input type="checkbox"/> Pre-IV Welcome call	<input type="checkbox"/> Human Factor Survey (Non-NCOA)
<input type="checkbox"/> MAHC 10 - Fall Risk Assessment Tool	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Human Factor Assessment NCOA	<input checked="" type="checkbox"/> Phone Call
<input type="checkbox"/> Visit Scheduler	<input checked="" type="checkbox"/> First Checklist
<input type="checkbox"/> Quality of Life Monitoring	<input type="checkbox"/> Current Score for Depression in Dementia
<input type="checkbox"/> Pain Assessment in Advanced Dementia Scale	<input type="checkbox"/> Opioid Risk Assessment
<input type="checkbox"/> Quality Measures	<input type="checkbox"/> Functional Status

< Prev
Next >
Discard Changes
Close
Save & Close
Start

4. Complete your documentation according to the templates provided in this section. When finished, check the appropriate “Note Type” and “Contact Type” boxes and click “Save and Close”.

The screenshot shows the 'Case Note' tab selected in the top navigation bar. The left panel contains patient verification details and medical history. The right panel is titled 'Did any of the following apply to this note?' and contains two sections: 'Note Type' and 'Contact Type', each with multiple checkboxes. A yellow box highlights the 'Open' dropdown in the top right corner of the main content area. At the bottom are standard save and close buttons.

5. Once finished, you must ‘finalize’ your note. This is like signing the note.

- On the right panel, click the dropdown list under ‘Open’ and select ‘finalized documentation’.

The screenshot shows the 'Case Note' entry screen. The 'Note Status' dropdown has 'Finalized Documentation' selected, indicated by a yellow box and a cursor pointing at it. The left panel displays patient information and note details. The right panel includes a 'Jump To' section with a 'Case Note' link.

Click ‘Update’ when finished.

The screenshot shows the 'Case Note' entry screen after finalization. The 'Note Status' dropdown now shows 'Finalized Documentation' with an 'Update' button highlighted by a yellow box and a cursor. The left panel displays patient information and note details. The right panel includes a 'Report Generation' section and an 'Outstanding Mandatory Tasks' link.

Opening an Addendum:

Addendums can only be made in notes. If an addendum needs to be made to an encounter, provider will need to request the encounter to be sent back to them emailing the Coding Department at hbmc_landmarkcoding@optum.com.

1. Select appropriate note.

A IIZROPZI-UTOZTD X

Patient A IIZROPZI-UTOZTD	Staff Sunni Kneeland	Note Date 2/16/2023 11:03:11 AM Created On: 2/16/2023 11:03:49 AM CST	Category Landmark First - Patient Call	Sub Category Clinical	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
------------------------------	-------------------------	--	---	--------------------------	---

Case Note

Case Note
Received phone call from pt's dtr Susan who reports pt has had painful urination since Thursday. She is requesting to speak with APP. Call transferred to LM1 APP.

Tags
• Note Type Call(s) completed, Call(s) completed - Family/friend
• Contact Type Family/friend

Acuity C-Moderate Full Code Engaged

Note Status Finalized Documentation Update

Addendum Open

Outstanding Mandatory Tasks 0

Jump To Case Note

2. Click on “finalized documentation” and choose “Addendum Open.”
 - Once this is done, the note can be edited.

A IIZROPZI-UTOZTD X

Patient A IIZROPZI-UTOZTD	Staff Sunni Kneeland	Note Date 2/16/2023 11:03:11 AM Created On: 2/16/2023 11:03:49 AM CST	Category Landmark First - Patient Call	Sub Category Clinical	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
------------------------------	-------------------------	--	---	--------------------------	---

Case Note

Case Note
Received phone call from pt's dtr Susan who reports pt has had painful urination since Thursday. States pt was seen for UV on Friday and urine specimen obtained at that time. She is requesting to speak with APP. Call transferred to LM1 APP Betsy.

Tags
• Note Type Call(s) completed, Call(s) completed - Family/friend
• Contact Type Family/friend

Acuity C-Moderate Full Code Engaged

Note Status Addendum Open Update

Addendum Versions Version 2 Report Generation

Outstanding Mandatory Tasks 0

Jump To Case Note

3. Once edits are completed, chart will need to be finalized again. Click “finalized documentation” and then “Update.”

A IIZROPZI-UTOZTD X

Patient A IIZROPZI-UTOZTD	Staff Sunni Kneeland	Note Date 2/16/2023 11:03:11 AM Created On: 2/16/2023 11:03:49 AM CST	Category Landmark First - Patient Call	Sub Category Clinical	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
------------------------------	-------------------------	--	---	--------------------------	---

Case Note

Case Note
Received phone call from pt's dtr Susan who reports pt has had painful urination since Thursday. States pt was seen for UV on Friday and urine specimen obtained at that time. She is requesting to speak with APP. Call transferred to LM1 APP Betsy.

Tags
• Note Type Call(s) completed, Call(s) completed - Family/friend
• Contact Type Family/friend

Acuity C-Moderate Full Code Engaged

Note Status Finalized Documentation Update

I, Sunni Kneeland, NP have electronically signed this note on 2/16/2023 11:10 AM Central Standard Time

Addendum Versions Version 2 (2/16/2023 11:10 AM) Report Generation

Outstanding Mandatory Tasks 0

Jump To Case Note

Encounter Documentation in Ubiquity

Encounters will be used any time you are practicing medicine, making medical decisions, or making a new recommendation to an existing plan of care. Creating an encounter will subsequently create an Episode of Care which will trigger an alert to the patient's care team that there has been an acute change in the patient's baseline and will require follow-up. Below are some situations where an encounter will be used:

- LM1 APC is providing treatment/medical management.
- Starting new medications.
- Sending RX to patient's pharmacy, including bridge refills.
- Manipulation of a current medication.
 - Holding of medication.
 - Giving additional dose of medication.
 - Changing dosage.
 - Medication bridge refill.
- Sending patients to the ED – opens UEOC.
- You are using your advanced degree to practice medicine.
- Urgent or emergent test results that need follow-up.
- Updating or implementing a new plan of care.
- Follow up on vitals, including blood glucose.
- Adding a new diagnosis.

Urgent Visit Types & Documenting Them:

Telemedicine Encounter with Abbreviated Documentation

 Home Audio Only	 Telemedicine Video
<ul style="list-style-type: none">• Phone only• No UE	<ul style="list-style-type: none">• Video visit without UE

Same Encounter as Face-to-Face

 Urgentivist Extender Telephonic	 Urgentivist Extender Video
<ul style="list-style-type: none">• Video unavailable	<ul style="list-style-type: none">• UE hired or contracted• Visit facilitated with video

Example – Urgent Visit Types Selection in Ubiquity

The screenshot shows the 'Facility' dropdown menu open, displaying a list of options: Assisted Living Facility, Audio Only - Home, Audio Only - Other, Custodial Care Facility, Group Home, Home, Homeless Shelter, Nursing Facility, Office, Skilled Nursing Facility, Temporary Lodging, and a placeholder '--Select--'. To the right, a 'Select Forms' panel is visible, divided into 'Core' and 'Supplementary' sections. The 'Core' section contains three checked boxes: 'History of Present Illness', 'Physical Exam', and 'Surgical History'. The 'Supplementary' section contains five unchecked boxes: 'Administered Medications', 'Call Landmark First Checklist', 'Columbia-Suicide Severity Rating Scale (C-SSRS)', 'Edmonton Symptom Assessment System', and 'Immunizations'. At the bottom of the screen, there are several small icons representing different functions or tools.

Assisted Living Facility
Audio Only - Home
Audio Only - Other
Custodial Care Facility
Group Home
Home
Homeless Shelter
Nursing Facility
Office
Skilled Nursing Facility
Temporary Lodging
--Select-- ▾

Facility:
Landmark Medical of Cali ▾

Facility Name: Bosworth 00 X
ID: 6101, 49 yrs, (11/16/1973), Male, (619) 636-1889 BSCP

Select Forms

Core

History of Present Illness

Surgical History

Physical Exam

Supplementary

Administered Medications

Call Landmark First Checklist

Columbia-Suicide Severity Rating Scale (C-SSRS)

Edmonton Symptom Assessment System

Immunizations

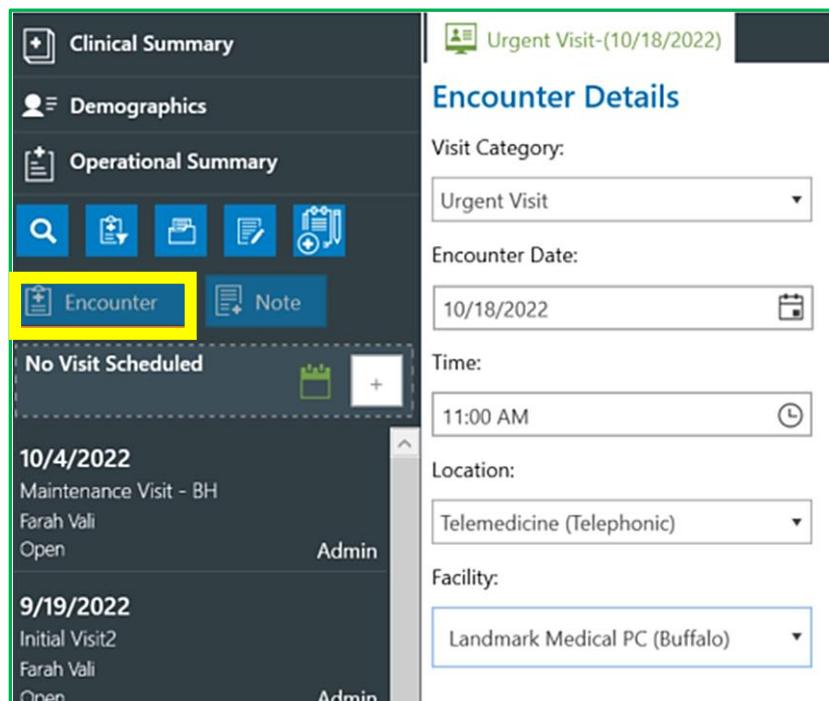
File icon
Question icon
Warning icon
Edit icon

Type here to search

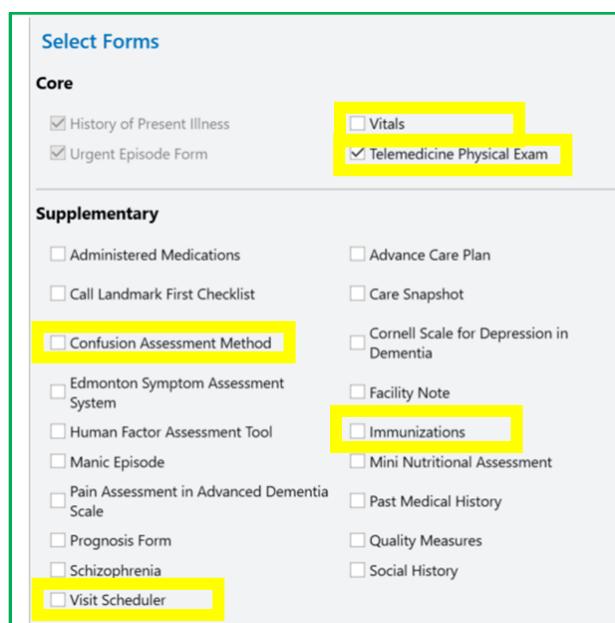
Creating an Encounter for UEUV or Telephonic UV (TeleUV):

An encounter can be opened in Ubiquity from the left-side panel above recent notes:

- When prompted to select a location, do not select “Telemedicine Video”.
- The facility is auto-populated and should never be changed.



Similar to creating a note, you will need to add supplementary information to the encounter as well:



Supplementary Checks:

- Telemedicine – Physical Exam
- Check “Visits” patient reports BP, Temperature, O₂, Glucose, Pulse
- Check “Confusion Assessment Method” for patients with AMS.
- Check “Immunizations” if updating.
- Check “Visit Scheduler” if scheduling a visit or if the market needs to schedule.

You can go back to add supplementary checks if you discover more information.

HPI:

Common Symptoms
--Select--

Time Spent (in minutes)

- <10 10-19 20-29 30-39 40-49
- 50-59 60+

Post Discharge Visit Yes No

Medication Reconciliation Yes No

Reason
--Select--

Medication Changes Made at this visit(e.g., dose adjustment, new prescription)*

Yes No

Avoided Admission/ER Visit

Max character limit is 30,000.

ER Avoidance Acute hospital admission avoidance
 Readmission avoidance Behavioral or Psychosocial admission

< Prev Next > Discard Changes Close Save & Close Save

Assessment & Plan (A&P):

Add Problems

Search

All **Addressed (1/16)**

Last Addressed - 01/27/2023

Current Calendar Year Past Calendar Year

Add to Care Snapshot Addressed in Current Visit Add Snomed

Diagnosis Profile

LM1 does not use Diagnosis Profile. This is generally used by the markets

Assessment stable unstable suboptimal Improving

Rationale

- previous diagnosis lab result physical exam medication history

Plan

- continue therapy modify therapy patient education followup PCP followup specialist
- social worker pharmacist dietician behavioral health

Plan Details

DM2, stable, A1C unknown. Will request records. Her PCP recently increased her glimepiride from 1 mg 1 tab daily to 1.5 tab daily. She continues on Metformin 500 mg BID. Encourage ADA diet, exercise.

< Prev Next > Discard Changes Close Save & Close Save

PCP Communication:

#PCPCommunication MUST be used here

PCP Phone Call

Call Attempted? Yes No
You should call PCP after every visit just to inform them of the pt's situation. This does not mean that you need to speak with them directly.

Name: [REDACTED]

Status: Successful Call Left Message No Answer

Specialist Phone Call

Call Attempted? Yes No

Name: --Select--

Status: Successful Call Left Message No Answer

< Prev Next > Discard Changes Close Save & Close Save

PCP Communication (Call Attempted):

- If “No”, then document why a call was not attempted. Examples include:
 - Holiday
 - Weekend
 - No PCP Listed
 - After Hours

Call Attempted?

Yes No

Name: --Select--

Status: Successful Call Left Message No Answer
 Incoming Call Email\Message

Date & Time: Enter date Enter time

Notes: Afterhours call placed to PCP. Message left with answering service.

Call Attempted?

Yes No

Name: --Select--

Status: Successful Call Left Message No Answer
 Incoming Call Email\Message

Date & Time: Enter date Enter time

Notes: Call placed, spoke with Dr Jones' nurse, Sandy, to notify pt started on abx for cellulitis. Requested office call pt for f/u appt.

< Prev Next > Discard Changes Close Save & Close Save

Urgent Episode of Care:

Next visit in 2 to 4 days Next visit in 5 to 7 days Next visit in 8 to 10 days

Follow-up items for longitudinal team:
THIS IS WHERE YOU WOULD INDICATE THAT THE PT HAS GONE TO THE ER
Please f/u pt admission status. Please obtain/upload pt hospital record.

IDT Referrals :
 Social Work ⓘ Behavioral Health ⓘ Dietician ⓘ Pharmacist ⓘ Ambassador ⓘ

Please provide reason behind recommended referral. This does not trigger an auto-referral, but will be sent to longitudinal care team to review. Longitudinal care team will be responsible for initiating appropriate referrals to IDT.

Urgentivist Extender : Select...
Name of Agency :

< Prev Next > Discard Changes Close Save & Close Save

Visit completed by:

Who should communicate with patient next business day?*

Provider ⓘ NCM ⓘ No next day follow-up required

Recommended next provider Home Visit*

Next visit in 2 to 4 days Next visit in 5 to 7 days Next visit in 8 to 10 days

Follow-up items for longitudinal team*

E.g., check wound for s/s of infection, additional lasix if dry weight > 200lbs, lung sounds, refer to VN

IDT Referrals
 Social Work ⓘ Behavioral Health ⓘ Dietician ⓘ Pharmacist ⓘ Ambassador ⓘ

Urgentvisit Extender:
Name of Agency:

Do not fill in both text fields:

- If a Landmark hired UE, leave the “Name of Agency” field blank.
- If a contracted agency, type the name of the agency, but leave the “Urgentivist Extender” field blank.

TeleUV Physical Exam Form:

Exam Limited by

- Telephonic
- Video

General Appearance

- Normal – unable to visualize d/t telephonic assessment
- Abnormal

Mental Status

- Normal – speech clear, answering/asking questions appropriately, seemingly alert and oriented
- Abnormal

Picture – describe what the picture is that has been uploaded to pt's chart.

Notes – Respirations unlabored. No audible wheeze/cough noted during conversation. Pt able to complete full sentences without difficulty or shortness of breath. Speech clear and concise. Seemingly alert and oriented.

Adding Medication Administration Forms to an Encounter:

[Link – Medication Administration and NDC Form Training](https://landmarkhealth.sharepoint.com/:p/r/sites/LM1APPS/_layouts/15/Doc.aspx?sourceid=%7BE8962AB4-A978-4102-8CC0-EFEF0CDEE50A%7D&file=Medication%20Administration%20and%20NDC%20training.pptx&action=edit&mobileredirect=true&DefaultItemOpen=1)

https://landmarkhealth.sharepoint.com/:p/r/sites/LM1APPS/_layouts/15/Doc.aspx?sourceid=%7BE8962AB4-A978-4102-8CC0-EFEF0CDEE50A%7D&file=Medication%20Administration%20and%20NDC%20training.pptx&action=edit&mobileredirect=true&DefaultItemOpen=1

1. Open an encounter.

- Any supplementary form can be added to the encounter at any time by clicking the "Encounter Info" tab immediately under the patient's name.

BFBFB PMPMG (1811202), 65 yrs, (10/17/1957), Female, (331) 333-5131 | HTA (PPO) | Eligible | Winston-Salem | Risk - Complexivist | Acuity B-High | Full Code | E

Urgent Visit-(8/1/2023)

Encounter Details <p>Visit Category: <input style="width: 100%; height: 25px; border: 1px solid #ccc;" type="button" value="Urgent Visit"/></p> <p>Encounter Date: <input style="width: 100%; height: 25px; border: 1px solid #ccc;" type="text" value="8/1/2023"/></p> <p>Time: <input style="width: 100%; height: 25px; border: 1px solid #ccc;" type="text" value="1:57 PM"/></p> <p>Location: <input style="width: 100%; height: 25px; border: 1px solid #ccc;" type="button" value="Urgentivist Extender (Vi...)"/></p> <p>Facility: <input style="width: 100%; height: 25px; border: 1px solid #ccc;" type="button" value="Landmark Medical of Nor..."/></p>	Select Forms <p>Core</p> <p><input checked="" type="checkbox"/> History of Present Illness <input type="checkbox"/> Facility Note <input type="checkbox"/> Past Medical History</p> <p><input type="checkbox"/> Surgical History <input type="checkbox"/> Social History <input checked="" type="checkbox"/> Vitals</p> <p><input checked="" type="checkbox"/> Physical Exam <input checked="" type="checkbox"/> Assessment & Plan <input checked="" type="checkbox"/> Urgent Episode Form</p> <hr/> <p>Supplementary</p> <p><input checked="" type="checkbox"/> Administered Medications <input type="checkbox"/> Advance Care Plan <input type="checkbox"/> Behavioral Health Risk Assessment</p> <p><input type="checkbox"/> Call Landmark First Checklist <input type="checkbox"/> Care Snapshot <input type="checkbox"/> Clinical Decision Support</p> <p><input type="checkbox"/> Columbia-Suicide Severity Rating Scale (C-SSRS) <input type="checkbox"/> Confusion Assessment Method <input type="checkbox"/> Diagnosis Assessment Tool</p> <p><input type="checkbox"/> Edmonton Symptom Assessment System <input type="checkbox"/> Functional Status <input type="checkbox"/> Human Factor Assessment Tool</p>
---	--

2. Two source options will be available on the form:

❖ **Landmark Stock:**

A medication was administered from your UE medication box.

(Example – Administered an injection of Solu-Medrol)

❖ **Patient Provided Medication:**

A medication from the patient's own stock was administered.

(Example – extra dose of patient's furosemide)

The screenshot shows a computer screen displaying a medical software application. At the top, there is a navigation bar with various icons and the text "AAAA AAADHDAM X". Below this is a patient summary box showing "AAAA AAADHDAM (1798687), 73 yrs, (9/29/1947), Female, (444) 444-4440 BCBSMA xxx1711107". Underneath the summary are tabs for "Encounter Info", "Progress Note", "HPI", "Social Hx", "Vitals", "PE", and "BHRA". The main area is titled "Point of Care". It has several input fields: a dropdown menu labeled "Source*" containing "Landmark Stock" and "Patient Provided Medication" (the latter is highlighted with a yellow box); an "NDC*" field with the value "00000-0000-00"; a "Units Administered" field; an "Administration Site" dropdown menu labeled "--Select--"; and a "Notes" text area. The entire "Source*" dropdown menu is also highlighted with a yellow box.

Landmark Stock:

- ❖ Medication
- ❖ Required fields
- ❖ NDC
- ❖ Lot #
- ❖ Expiration Date
- ❖ Med Unit of measure
- ❖ Unit Administered
- ❖ Route (*required for some medications*)

Optional:

- ❖ Problems Addressed
- ❖ Notes

Patient Provided Medication:

- ❖ Medication
- ❖ Unit Administered
- ❖ Route (*required for some medications*)

Optional:

- ❖ NDC
- ❖ Lot #
- ❖ Expiration Date
- ❖ Problems Addressed
- ❖ Notes

3. NDC Documentation:

- After selecting a medication, the most common NDC will populate.
- You will need to verify this NDC is correct.
- If the NDC does not match up:
 - ❖ Select the correct NDC from drop down menu, or;
 - ❖ Type in the correct NDC.
- If the NDC is not listed on the medication package, select the default NDC.

Additional Guidelines:

- NDCs should be located on each medication:
- All NDCs are 11 digits:
 - ❖ 5-4-2 format.
 - ❖ Sometimes, the NDC on the medication doesn't include 11 digits and zeros need to be added.
 - XXXX-XXXX-XX = 0XXXX-XXXX-XX
 - XXXXX-XXX-XX = XXXXX-0XXX-XX
 - XXXXX-XXX-X = XXXXX-XXX-0X

Example – NDC Entries in Ubiquity

NDC on the medication

9877-2339-01

45534-843-03

35766-2443-1

What to type in Ubiquity

09877-2339-01

45534-0843-03

35766-2443-01

4. After all the information is entered, select the “+” to add the medication.

Entries can be edited and deleted using options to the right side of the medication name:

How do I document that I gave more than 1 medication to a patient?

Selecting “+” will allow you to add additional medications.

How do I document that I gave 3 tablets of levofloxacin with the same lot number to a patient?

Select the correct med unit of measure and type 3 under units administered.

How do I document that I gave 3 tablets of levofloxacin with a different lot number to a patient?

The screenshot shows the 'Medication' section of the software. At the top, there are fields for 'Source*', 'Medication*', 'NDC*', 'Lot#', 'Expiration Date', 'Date Administered', 'Med Unit Of Measure', 'Units Administered', 'Problems Addressed', 'Administered By', 'Route', and 'Administration Site'. Below this is a table listing medications administered. The first row is for 'LevoFLOXacin Oral 500 MG' with NDC 55111-0279-50, Lot# 12345, and Administered By Janelle Hazen. The second row is for another 'LevoFLOXacin Oral 500 MG' entry. A yellow box surrounds the entire medication list area. At the very top right of the encounter header, there is a 'New' button, also highlighted with a yellow box.

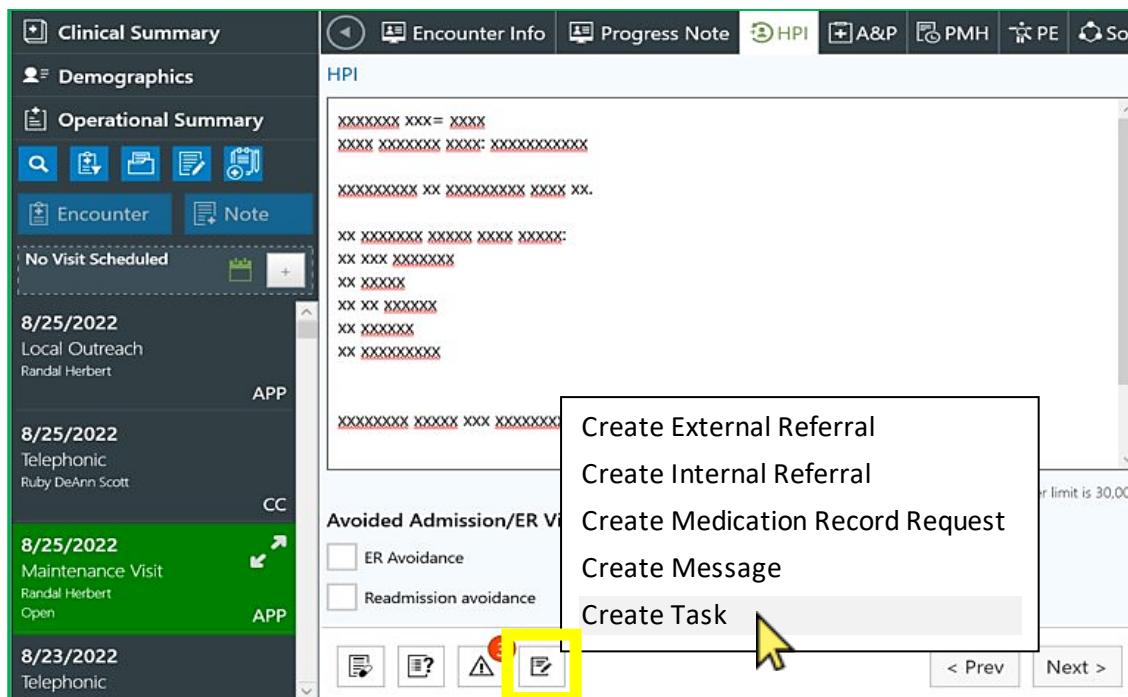
Source	Medication	NDC	Lot#	Expiration Date	Date Administered	Med Unit Of Measure	Units Administered	Problems Addressed	Administered By	Route	Administration Site
Landmark Stock	LevoFLOXacin Oral 500 MG	55111-0279-50	12345	4/30/2021	4/12/2021	Tablet	2	0	Janelle Hazen	Oral	-
Landmark Stock	LevoFLOXacin Oral 500 MG	65862-0536-50	67891	6/15/2025	4/12/2021	Tablet	1	0	Janelle Hazen	Oral	-

Can I edit the medications once the encounter is closed?

No, once the encounter is closed you will not be able to edit the medications administered to the patient. In order to edit the medications, an addendum must be submitted.

How to Create a New Task:

1. Open an encounter in Ubiquity. From the options at the bottom of the window, select the 4th icon which resembles a document and pencil:



2. Complete the New Task form:

- The form will default to “Task”.
- Enter the UE’s name in the “Assigned To” box.
- Select “High” from the “Priority” dropdown menu.
- The “Date” field will default to the current date.
- Fill in the Subject.
- Input the #UEVORB Hash Key.

The screenshot shows the 'New Task' dialog box. It has two radio button options: 'Task' (selected) and 'Referral'. The 'Task' section contains fields for 'Name*' (MBGKLA B MQCCQFOI), 'Due Date*' (4/5/2023), and 'Subject*' (#UEVORB). The 'Assigned To*' field is empty. The 'Priority*' dropdown is set to 'Medium'. Below these fields is a 'Task Notes*' area containing rich text tools and a note about the hash key. A 'Link to a Reference' section shows a link to 'Maintenance Visit (08/25/2022)'. At the bottom are 'Cancel' and 'Send' buttons. Yellow circles labeled 'a' through 'f' highlight specific fields: 'a' is on the 'Name*' input, 'b' is on the 'Assigned To*' input, 'c' is on the 'Priority*' dropdown, 'd' is on the 'Due Date' input, 'e' is on the 'Subject' input, and 'f' is on the hash key note.

- Complete the Hash Key Note.
- When finished, click “Send”.

The screenshot shows the 'Task Notes*' window. It includes rich text tools, a date/time field, and a note about the hash key. Below this is a detailed provider and patient information section. At the bottom are 'Cancel' and 'Send' buttons. A yellow circle labeled 'g' is on the rich text toolbar, and another yellow circle labeled 'h' is on the 'Send' button.

The new task will link to the UEUV encounter and the UE will receive the task in their Ubiquity’s Task Inbox.

Attention – Tasks Within Encounters

Do not open a task outside of the encounter as it will not be sent to the UE.

Creating & Using Hash Keys:

Hash Keys are used to assist with documentation:

- Hash Keys should be applied to all patient notes and encounters to improve documentation and patient outcomes.

Shared Static and Dynamic Hash Keys:

Created by Landmark First leadership, most begin with "#LM1".

Personal Static Hash Keys:

These hash keys are only able to be used by the creator, they all begin with "##".

A list of Static, Dynamic, and Personal Hash Keys can be found in Ubiquity:

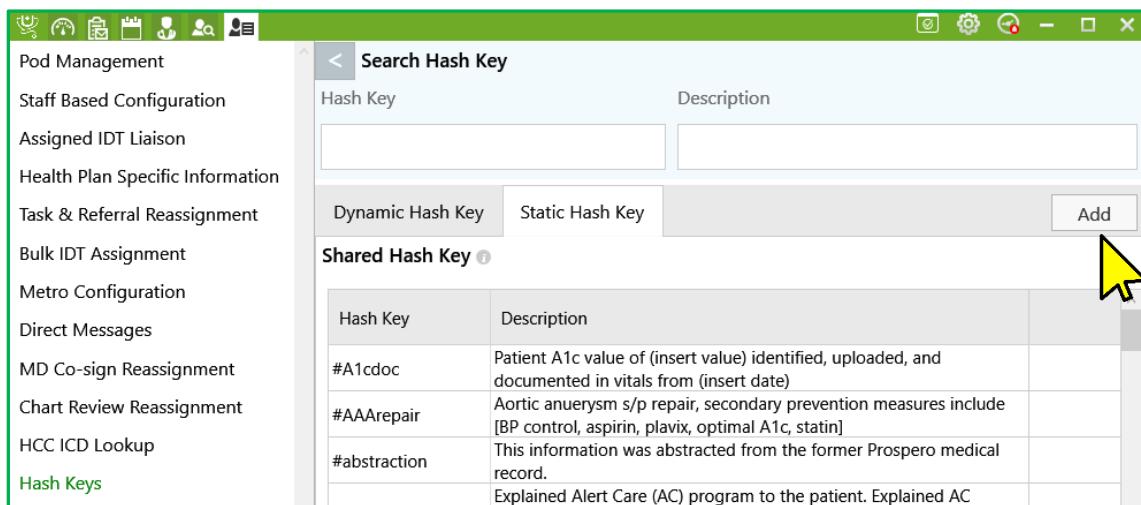
The screenshot shows the Ubiquity software interface. At the top, there's a green header bar with various icons. Below it, a main window titled 'Hash Keys' has a 'Signature' tab selected. On the left, a sidebar lists 'User Preferences' and 'Hash Keys'. The main area contains two tables: 'Shared Hash Key' and 'Personal Hash Key'. The 'Shared Hash Key' table lists entries like '#ACLM1', '#LM1chaperone', and '#LM1Dorecautions' with their descriptions. The 'Personal Hash Key' table lists entries like '##LM1note' with its detailed description. There are 'Clear', 'Search', and 'Add' buttons at the top right of the table areas.

Create a Personal Hash Key:

1. Select Hash Keys on the far-left side.

This screenshot shows the same Ubiquity interface as the previous one, but with a different focus. The sidebar on the left has 'Hash Keys' selected. The main area shows a search interface for 'Search Hash Key' with fields for 'Hash Key' and 'Description'. Below the search is a table for 'Shared Hash Key' which includes columns for 'Hash Key' and 'Description'. It lists entries such as '#A1cdoc', '#AARepair', '#abstraction', '#ACExplain', and '#ACLM1' with their respective descriptions. The 'Dynamic Hash Key' and 'Static Hash Key' tabs are also visible above the table.

2. Select “ADD” on the right side:



3. Create your hash key title (this will always automatically begin with “##”)

Add Hash Key

Hash Key	<input type="text" value="## Example"/>
Description	<input type="text" value=" "/>

Save

4. Enter the text as it should be displayed when using the hash key. Click Save when finished:

Add Hash Key

Hash Key	<input type="text" value="## Example"/>
Description	<input type="text" value="Patient Name:
Patient Preferred Name:
Contact Check:
HIPAA Verified: "/>

Save

To use a hash key in a note, begin typing “#” to view a list of Static / Dynamic hash keys and “##” to view a list of personal hash keys:

The screenshot shows the 'Case Note' interface. In the top left, there are buttons for Bold (B), Italic (I), Underline (U), and other document controls. Below these, the text '#corona' is typed into the note area. A dropdown menu lists several hash keys: '#coronavirus' (highlighted with a yellow cursor), '#confirmed', and '#consents'. To the right, a sidebar titled 'Did any of the following apply to this note?' contains a section for 'Note Type' with five options: 'Call(s) completed' (unchecked), 'Call(s) completed - Patient' (checked), 'Call(s) completed - Family/friend' (unchecked), 'Call(s) completed - Community Provider - PCP or Specialist' (unchecked), and 'Left VM' (unchecked).

Selecting the correct option will auto-fill the note with the desired content:

The screenshot shows the 'Case Note' interface after selecting the 'Call(s) completed - Patient' checkbox. The note area now displays: 'Coronavirus' followed by a numbered list: '1. Do you or anyone in your home have fever/chills, cough/sore throat, or SOB beyond what is typical?? {No/Yes}' and '2. Have you or any other persons in the home been Dx with COVID19 in the last 14 days {No/Yes}'. Below the list is the note: '{ } Patient answers No to BOTH Coronavirus Risk Screening Questions.' and '{ } Patient answers Yes to 1 or more questions. Escalated for clinical review'. At the bottom, it says 'Don't forget to wear a mask during your upcoming Landmark visit.' To the right, the sidebar shows the same 'Did any of the following apply to this note?' section with the 'Call(s) completed - Patient' checkbox checked.

Meaningful Touch

A meaningful touch is a successful and purposeful contact directly with a patient, family, or friend.

- Meaningful touches keep our patients actively engaged, which is the most effective way for us to influence their care.
- Meaningful touch documentation directly impacts patient retention and passive disengagement.
- When: Anytime s/w pt. or family member present with pt. that involved treatment, education, f/u communication.
- Why: Helps Markets keep track of how ALL team is actively engaging pt.



Link – Meaningful Touch Presentation

https://landmarkhealth.sharepoint.com/sites/LM1clinicalleadership/Shared%20Documents/onboarding_APP/DAY%202%20Part%20III%20APP%20ONBOARDING/meaningful%20touch%20training.pdf



Link – Patient Retention Annual Training

[Patient Retention Refresher Training.pdf](#)

Meaningful Touch Logic:

Meaningful touches are captured via completed notes:

- Users must select the following tags to properly document meaningful contacts.
- When completing a meaningful call with a patient, use the following:
 - Note Types:
 - Meaningful Touch (NEW)
 - Call(s) completed – Patient
- When completing a meaningful call with a patient's family member or friend, use the following:
 - Note Types:
 - Meaningful Touch (NEW)
 - Call(s) completed – Family / friend

- The “Meaningful Touch” tag must be checked for the note to be considered a meaningful touch.
- “Call(s) completed – Patient” or “Call(s) completed – Family/friend” tags alone will NOT count as a meaningful touch.
- Note Type : “Call(s) completed” or Contact Type: “Patient” or “Family/Friend” will NOT count as a meaningful touch.
- The Meaningful Touch tag should only be used in cases where there was a successful contact with a patient, family or friend.

Select Forms

Core

Case Note

Supplementary

<input type="checkbox"/> Advance Care Plan	<input type="checkbox"/> Behavioral Health Risk Assessment
<input type="checkbox"/> Call Landmark First Checklist	<input type="checkbox"/> Columbia-Suicide Severity Rating Scale (C-SSRS)
<input type="checkbox"/> Cornell Scale for Depression in Dementia	<input type="checkbox"/> Functional Status
<input type="checkbox"/> Health Risk Assessment NYC	<input type="checkbox"/> Historical Screenings
<input type="checkbox"/> Human Factor Assessment NCQA	<input type="checkbox"/> Human Factor Assessment Tool
<input type="checkbox"/> Human Factor Survey (Non-NCQA)	<input type="checkbox"/> Immunizations
<input type="checkbox"/> MAHC 10 - Fall Risk Assessment Tool	<input type="checkbox"/> Manic Episode
<input checked="" type="checkbox"/> Meaningful Touch	Opioid Risk Assessment

Successful Contacts Should Be:

- Meaningful in nature which would include completed conversations with a patient, family, or friend.
- Significant touch and more than a pure reminder call.
- Where we are giving or receiving information to determine course of care for the patient, providing health/wellness education and identifying patient needs.

Note Type

<input type="checkbox"/> Call(s) completed
<input checked="" type="checkbox"/> Call(s) completed - Patient
<input type="checkbox"/> Call(s) completed - Family/friend
<input type="checkbox"/> Call(s) completed - Community Provider - PCP or Specialist
<input type="checkbox"/> Left VM
<input type="checkbox"/> No Answer
<input type="checkbox"/> Wrong Number
<input type="checkbox"/> Meaningful Touch <small>?</small>

Contact Type

<input checked="" type="checkbox"/> Patient

Meaningful Touch FAQ:

1. Do I need to create multiple notes if I complete multiple contacts for the same patient in one day?

No, you should continue to combine all contacts associated with the same patient in a day into one note as long as you check the correct tags / note types.

2. If I complete multiple meaningful contacts with a patient in one day, do they count as multiple touches?

No, only one note per patient will count towards the touch logic per day (regardless of the number of tags).

3. Do contacts with community providers, PCP or specialist count as meaningful touches?

No. Although these external contacts are critical for taking care of our patients, they are considered a part of case management and do not count as meaningful patient touches.

4. Do reminder calls count as meaningful touches?

- A pure reminder call to a patient is not considered a meaningful touch.
- A pure reminder call should be documented using the “Reminder/confirmation call” tag (but not the “Meaningful Touch” tag).
- However, if you had a substantial and meaningful conversation with the patient or family/friend about care in addition to the upcoming visit reminder, this contact would count as a meaningful touch.
 - Please use the “Meaningful Touch” tag along with any other tags that reflect your contact (flu education, tuck in call, care plan updated, referral, etc.).

Offline Documentation

Documentation **MUST** be completed for every call regarding our patients. This means that any service or connectivity interruptions in Ubiquity **DOES NOT ABSOLVE** any LM1 employee from the responsibility of documenting.

To that end, there are offline documentation resources available to use if Ubiquity ever goes offline.

Where to Locate Offline Forms:

- Use the following link to download the Offline Triage Form Folder on the Knowledge Base:
 - A new copy of the tracker should be downloaded each time Ubiquity is offline.

The screenshot shows a SharePoint interface for a 'Knowledge Base' library. At the top, there is a blue header bar with a link icon and the text 'Link – Offline Triage Forms Folder'. Below this, a sub-header says 'Offline Documenting'. The main area is a SharePoint list view with the following columns: Name, Modified, and a More Actions button. There are two items listed:

Name	Modified	More Actions
LM1 clinical staff Offline Triage Form.docx	42 min	[More Actions]
Offline RN Triage Form.docx	A few	[More Actions]

The screenshot shows a SharePoint library interface. At the top, there's a search bar and a 'New' button. Below that, the library name 'Knowledge Base' is displayed. Underneath, there are buttons for 'Edit in grid view' and '...'. A message '1 selected' is shown. The main area lists two files: 'LM1 clinical staff Offline Triage Form' and 'Offline RN Triage Form'. A context menu is open over the first file, listing options: Open, Preview, Share, Copy link, Manage access, Delete, Automate, Favorite, Download (which is highlighted with a yellow arrow), and Rename.

- Right click on the appropriate file and download it to your desktop.

❖ By default, the file will appear in your system's "Downloads" folder.

- Use template each time a call is received whenever Ubiquity is down.
- Manage similarly to Urgent care / ER model.
(You know nothing about the patient and must obtain all of their pertinent information)
- No medical history or medical records to review.
- When Ubiquity is back online you will:
 - Place yourself in documenting status.
 - Copy and paste notes in charts.

The screenshot shows a Windows File Explorer window with the 'Downloads' folder selected. The left sidebar shows quick access links like Desktop, Documents, Downloads, Pictures, Diagrams, InContact Email Triage T, and Manual Prototype. The right pane shows a list of files under 'Today (10)'. Two Word document files are visible: 'Offline RN Triage Form' and 'LM1 clinical staff Offline Triage Form'.

APC Ordering Labs and Diagnostics

Considerations:

- Landmark cannot draw or complete orders that were given by community providers (ex: specialist or PCP).
- It is appropriate to order labs IF they are pertinent to that UEUV but need to keep in mind:
 - Will ordering the labs / imaging or results change the outcome for the patient?
 - Keep in mind that even if ordered STAT, results often take more than 24 hours to be received by Landmark.
- LM1 APCs do not order routine labs.

Attention – Assessing Patient Need

If you feel that an order needs to be completed STAT, the patient likely needs to be seen in urgent care or ER.

Diagnostics:

- In-home diagnostics are very poor quality.
- In-home imaging may not be available due to geography and / or the number of steps into the patient's home (cannot be more than 3 or 4 depending on the company).
- If not emergent and the patient is able to ambulate, consider sending an order to the local imaging center.
- If diagnostics indicated:
 - Coordination with the market is necessary. You will need to provide them with the following: Indication / ICD10, Provider NPI#, specify mobile v. imaging center.
 - ***During Business Hours:***
The request should be placed in the appropriate UEUV thread (where the visit was initially requested/scheduled)
 - ***After Business Hours:***
collaborate with on call provider

Using the Quest Lab Portal

Links & Resources:

 Link – Quest Portal

<https://www.questdiagnostics.com/>

 Link – Quest Portal Training Video

[LM1 Quest Training complete.mp4](#)

 Link – Quest Portal Training Attestation

<https://forms.office.com/Pages/ResponsePage.aspx?id=AeMqzqu1Qkm-ZInpHCG1XT0L6Vew3GROkxMc7uxzdRUNThWS0hLUVNPTzdTQ0M1WDZOV1FJRjVYVS4u>

 Link – Specimen Collection Policy

[Lab Specimen Collection FINAL 6-16-2023.pdf](#)

 Link – Specimen Handling

[lab specimen handling policy FINAL 6-16-2023.pdf](#)

 Link – Critical Results Review

[Critical Lab Results FINAL 6-16-2023.pdf](#)

Portal Navigation & Operations:

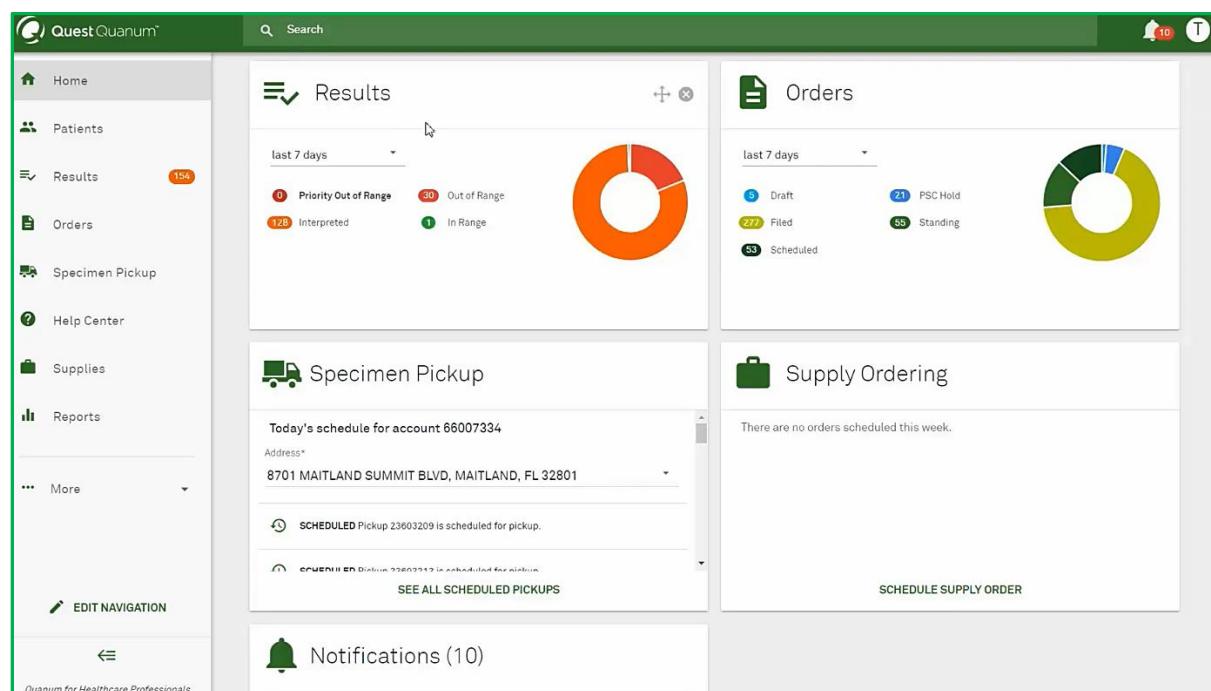
Use the Quest Lab Portal if Quest is a resource available in the patient's market:

- If the Quest Lab Portal is **NOT** available, then follow the process below:

During Business Hours, After Hours, Holidays, and Weekends:

- Collaborate with the UE to determine if there are lab drop off locations outside of normal business hours prior to collecting the specimen.
- Provide information to the UE for requisition form:
 - Provider Name and Title
 - ICD10 Code
 - Test Name

Dashboard:



Use the dashboard to view metrics of recent orders.

- Use the quick links to view result details.
- View scheduled specimen pickups and orders.
- View recent lab notifications.

Find a Patient:

1. Use the search bar at the top of the window, or the “Patients” option from the menu on the left.

The screenshot shows the Quest Quanum software interface. The sidebar on the left includes links for Home, Patients (which is selected and highlighted in orange), Results (with a red badge showing 154), Orders, and Specimen Pickup. The main content area is titled "Results" and displays a summary of recent activity over the last 7 days. It shows counts for different status categories: Priority Out of Range (0), Out of Range (30), Interpreted (128), and In Range (1). There is also a large orange circular graphic on the right side of the main panel.

2. Locate the patient from the search results provided:
 - a. You can also add new patients by clicking the “Add New Patient” button to the right.
 - b. Click the three (3) vertical dots to the far right of the patient’s name to start a new order.
 - c. Click the patient’s name to view a patient details screen,

The screenshot shows the Quest Quanum software interface with the "Patients" option selected in the sidebar. The main area displays a search bar and a grid of "Recently Viewed Patients". Below this is a table of search results. Annotations are present: 'a' points to the "ADD NEW PATIENT" button in the top right corner; 'b' points to the three vertical dots next to a patient's name in the results table; and 'c' points to a patient's name in the results table.

Result	Details	DOB	Sex	Tel
Patient, Tracking 4321 Main St., Wallingford, CT 06495	06/06/1966	F	(777) 7	
Patient, History 1234 Main St., Wallingford, CT 06495	01/01/1977	F	(555) 555-1212	
Test, Patient 123 Test Lane, Detroit, MI 48221	12/16/1980	F	(555) 555-5555	
Test, Patients 123 Nowhere Lane, TN 37202	01/01/1970	M	(555) 555-1212	

Patient Details:

Contact and demographic information can be found in the details pane.

- If a patient's demographic / contact information changes, it can be edited by clicking the pencil icon to the right.

By scrolling down this window, you can view the patient's:

- Billing
- Specific Diagnosis
- Patient Comments
- Lab Orders
- Results
- Patient Tracking

The screenshot displays two windows of a medical charting application.

Top Window (Patient, Tracking):

- Patient Information:**
 - CONTACT & REFERENCE INFORMATION:**
 - Contact Information: Primary Phone (777) 777-1212 (Mobile), Secondary Phone (777) 777-1212 (Home).
 - Address: 4321 Main St., Wallingford, CT 06495
 - Reference Information:** Health ID: 8573018831152311
- BILLING INFORMATION:**
 - Bill Type: Patient Bill
 - Guarantor Information: Name: Patient, Tracking, Sex: F, Relationship to Patient: Self

Bottom Window (Patient, Tracking):

- Requisition Number:** 0000406 **Tests Ordered:** 31789 - Homocysteine
- Order Status:** A timeline shows the status of the lab order: Pending, Received, Processing, and Reported (02/07/2018 14:25:00). A yellow circle with the letter 'a' and a pencil icon is positioned above the timeline.
- Show Details:** A button at the bottom left of the window.

PRACTICE RESULTS EXTENDED RESULTS

Start Date: 02/04/2018 End Date: 02/08/2018 1-2 of 2

HOMOCYSTEINE FINAL 02/07/2018 02:25PM OUT OF RANGE

HOMOCYSTEINE FINAL 02/05/2018 12:16PM OUT OF RANGE

Don't see the results you're looking for? Try extending your search across your region.

EXTENDED SEARCH

Lab Orders

Starting a New Order:

Click the “Start New Order” button.

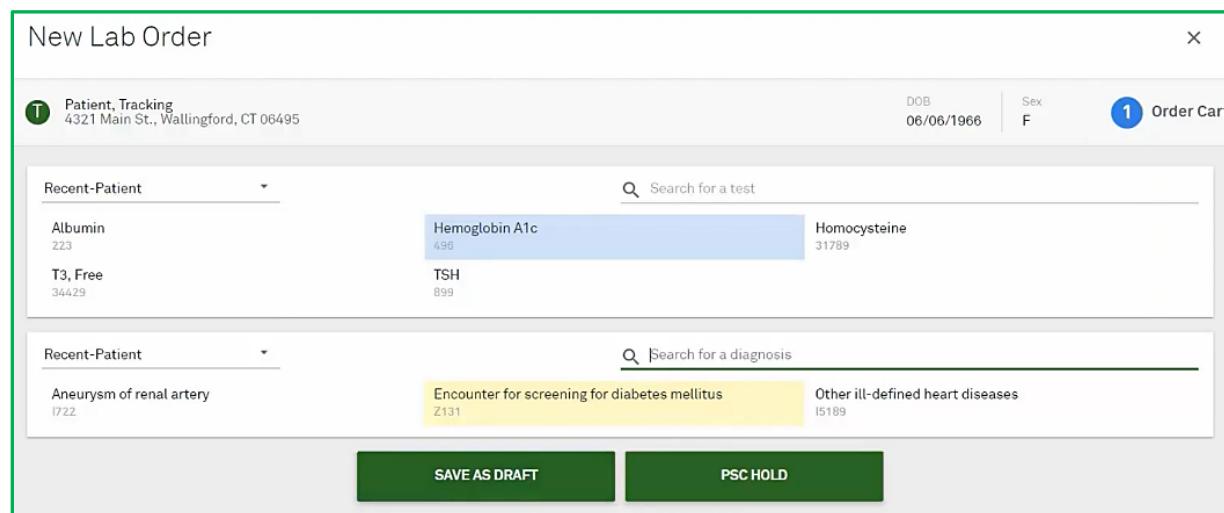
+ START NEW ORDER

DOB: 06/06/1966 Sex: Female

Secondary Phone: (777) 777-1212 Type: Home

Fill out the information on the provided form:

- You can select a test or diagnosis from a list of recent options or use the search bar in each category to locate the desired listings.
- If you need to step away from the order, click the “SAVE AS DRAFT” button located at the bottom of the form.
- If the patient is visiting a Quest facility, select the “PSC HOLD” button.
- The selected items will be added to the patient’s cart.



New Lab Order

Patient Tracking
4321 Main St., Wallingford, CT 06495

DOB: 06/06/1966 | Sex: F | Order Cart (1)

Recent-Patient

Albumin 223	Hemoglobin A1c 496	Homocysteine 31789
T3, Free 34429	TSH 899	

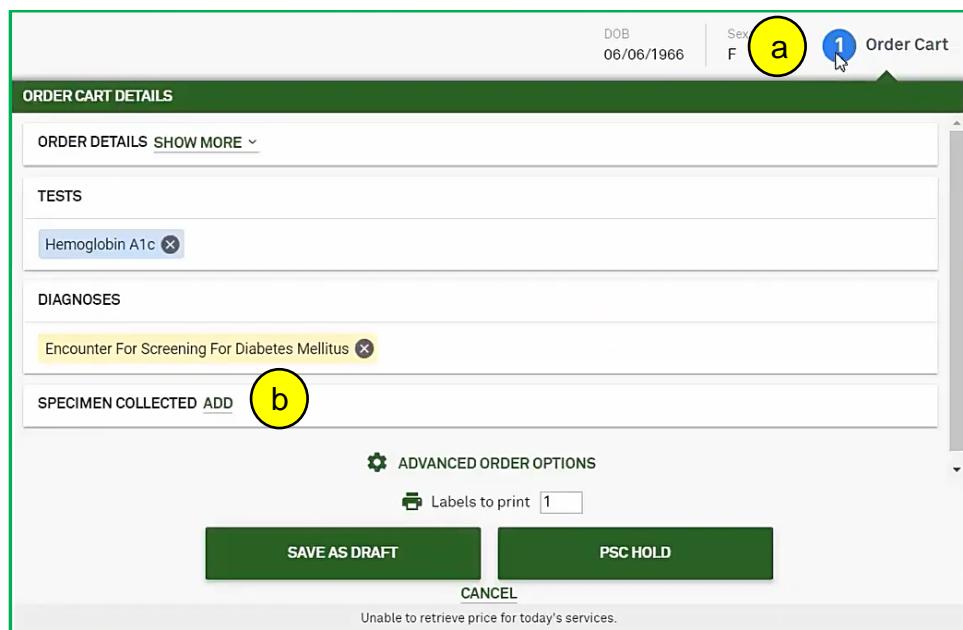
Recent-Patient

Aneurysm of renal artery I722	Encounter for screening for diabetes mellitus Z131	Other ill-defined heart diseases I5189
----------------------------------	---	---

Buttons: SAVE AS DRAFT | PSC HOLD

If the sample is being collected in the patient’s home:

- Select the patient’s cart.
- Choose the “SPECIMEN COLLECTED ADD” option.



Order Cart Details

ORDER DETAILS SHOW MORE ▾

TESTS

- Hemoglobin A1c

DIAGNOSES

- Encounter For Screening For Diabetes Mellitus

SPECIMEN COLLECTED ADD **b**

a Order Cart (1)

ADVANCED ORDER OPTIONS

Labels to print: 1

Buttons: SAVE AS DRAFT | PSC HOLD | CANCEL

Unable to retrieve price for today's services.

- c. You will be prompted to select specific dates for specimen collection. When finished, click the “DONE” button to return to the patient’s cart.

The screenshot shows a mobile application interface for entering specimen collection details. At the top, it displays the patient's information: DOB 06/06/1966, Sex F, and a cart icon showing 1 item. Below this is a header "Specimen Collected Details". A "CLEAR FIELDS" button is located in the top right corner. The form contains fields for "Collected Date*" (2/12/2018), "Time" (with a dropdown for AM/PM), "Total Volume (ml)", "Duration (hrs)", and a dropdown for "Fasting". At the bottom is a large green "DONE" button with a cursor icon pointing to it.

- d. If you are finished with the order, click the “SUBMIT” button.

The screenshot shows the "Order Cart Details" screen. At the top, it displays the patient's information: DOB 06/06/1966, Sex F, and a cart icon showing 1 item. The screen is divided into sections: "TESTS" (listing "Hemoglobin A1c"), "DIAGNOSES" (listing "Encounter For Screening For Diabetes Mellitus"), and "SPECIMEN COLLECTED EDIT" (listing "Collected 2/12/2018"). At the bottom, there are buttons for "SAVE AS DRAFT", "SUBMIT ORDER" (which has a cursor icon pointing to it), and "CANCEL". There is also a label "Labels to print 1" with a printer icon.

- e. You can keep track of submitted orders via the patient details pane or from the "Orders" tab on the left.

The screenshot shows the Quest Quanum software interface. The top navigation bar includes the Quest Quanum logo and a search bar. The left sidebar contains links for Home, Patients, Results (with a red notification badge '6'), Orders (selected), Feedback, Specimen Pickup, Help Center, and More. The main content area is titled 'Lab Orders' and displays two tabs: 'PRACTICE ORDERS (64)' and 'EXTENDED ORDERS'. Below these tabs is a 'Filter By' section with 'Patient Name' dropdowns. A specific order card is highlighted for requisition number 0000443, which has been 'Tested' (status) and 'Reported' (status). The order card includes fields for Requisition Number, Tests Ordered (496 - Hemoglobin A1c), Order Status, and a timeline showing the progression from Pending to Received, Processing, and Reported. A 'SHOW DETAILS' link is also present. A context menu is open over the 'Reported' status, listing options: EDIT REQ (with a pencil icon), PRINT REQ (with a printer icon), REPRINT LABELS (with a printer icon), and CANCEL REQ (with a cancel icon).

Edit or Cancel a Lab Order:

To edit or cancel a lab order, locate the order listing and click the three (3) vertical dots located to the far right of the order name. This will open the appropriate options menu.

This screenshot shows a detailed view of a lab order within the Quest Quanum software. The top header shows 'Patient, History' and includes fields for DOB (01/01/1977) and Sex (F). The order card displays the following information: Requisition Number 0000442, Tests Ordered (483 - Glucose; 496 - Hemoglobin A1c; 334 - Cholesterol, Total; 608 - HDL Cholesterol; 896 - Triglycerides; 829), and Order Status (Pending, Received, Processing, Reported). The status timeline shows the order was pending until 02/12/2018 at 03:58:19, received at 02/11/2018 at 15:34:00, and processed at 02/11/2018 at 15:34:00. A 'SHOW DETAILS' link is available. A context menu is open over the 'Reported' status, listing options: EDIT REQ (pencil icon), PRINT REQ (printer icon), REPRINT LABELS (printer icon), and CANCEL REQ (cancel icon).

View Lab Results:

Selecting the “Results” tab on the menu to the left will show the most recent seven (7) results obtained that you ordered. You can also search for specific results if they are not found in this list.

Click on any result to view it:

The screenshot shows the Quest Quanum software interface. The left sidebar includes links for Home, Patients, Results (which is currently selected), Orders, Feedback, Specimen Pickup, Help Center, and More. The main area is titled 'Results' and has tabs for 'PRACTICE RESULTS (24)' and 'EXTENDED RESULTS'. Below these tabs, there is a search bar labeled 'Patient Name' and a 'ADVANCED OPTIONS' dropdown. The results list shows two entries: 'TEST, PATIENTZ' and 'PATIENT, HISTORY'. Each entry includes a patient icon, the test name, a status indicator (e.g., 'OUT OF RANGE'), and a detailed view button. At the bottom right of each entry, there is a 'DOB' field (01/01/1970 or 02/11/1977), a 'Sex' field (M or F), and a timestamp (04:06PM or 03:34PM).

The Extended Results tab can be used to find lab results that were requested by providers who are not employed by Landmark:

The screenshot shows the Quest Quanum software interface with the 'EXTENDED RESULTS' tab selected. The top navigation bar includes a search bar and a bell icon. The main area is titled 'Results' and has tabs for 'PRACTICE RESULTS (24)' and 'EXTENDED RESULTS'. Below these tabs, there is a search bar with the placeholder 'Search results across all ordering physicians within your regions.' and fields for 'Patient Date of Birth*' (set to 010119) and 'Last Name*'. To the right, there are fields for 'Approximate Collection Date*' (set to 'Last 90 Days (Default)') and a large green 'SEARCH' button. Below the search bar, a date picker calendar shows the month of February 2018.

Out of range results will appear at the top of this section.

PATIENT,HISTORY

CHOLESTEROL, TOTAL Lab: NL1

Analyte	Value	Reference Range
CHOLESTEROL, TOTAL (206)	206 H	<200 mg/dL

DIRECT LDL Lab: NL1

Analyte	Value	Reference Range
DIRECT LDL (108)	108 H	<100 mg/dL

Cardiovascular Disease – A Comprehensive Approach to Manage the Risks of Cardiac Events

Dr. Cesar Molina, Heart and Vascular Associates, Mountain View, California discusses the significance of residual risk and outlines how a more comprehensive approach to patient management, beyond a single focus on reducing LDL-C, can reduce clinical events in at-risk populations.

[View More](#)

Results may be viewed in a range to allow comparisons between the current results with previous recorded data:

PATIENT,HISTORY

CHOLESTEROL, TOTAL Lab: NL1

Note: Data displayed only for results that meet strict identification matching. Historical result view may vary based on corrected or updated patient demographics. The reference range displayed may vary due to potential changes in laboratory testing methods. Please refer to the published reference range on each lab report.

CHOLESTEROL, TOTAL Lab: NL1

From 02/05/2018 To 02/12/2018 APPLY TO ALL

1w 1m 6m 1y Reset

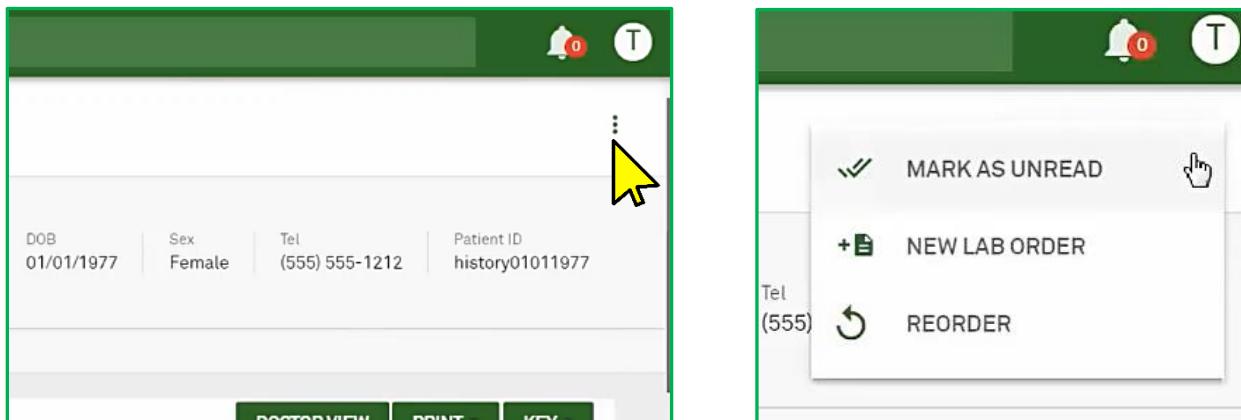
5. Feb 6. Feb 7. Feb 8. Feb 9. Feb 10. Feb 11. Feb 12. Feb

104 208

Jul '16 Jan '17 Jul '17 Jan '18

DIRECT LDL Lab: NL1

If additional testing is necessary, click on the three (3) vertical dots at the top-right of the results page to submit an order.



Trident Care Referral Response

Links & Resources:

 Link – Trident Portal

<https://connectonline.tridentcare.com/>

 Link – Trident Portal Tutorial Video

[Tridentcare video-20220317_215549-Meeting Recording.mp4](#)

 Link – APC Trident Referral Response

[LM1 APP Process for responding to Trident Care referrals.pdf](#)

 Link – APC Trident Referral Response

[Triage RN Process for responding to Trident Care referrals.pdf](#)

Those with accounts will need to log in once weekly to Tridentconnect to keep their account active.

Referral Response Procedure & Portal Navigation:

Trident referral notifications may be received through the Interactions pane in Genesys. Like triage emails, they will first ring as an incoming notification which must be answered within 15 seconds.

The screenshot shows the Genesys Interactions pane. On the left, under 'Conversations', there is a blue-highlighted message from 'as@ceas.us' in the 'LM1 PCC Queue'. The message subject is 'New Message From Elation Answer' and it was sent 4 minutes ago. On the right, the message content is displayed: 'TridentCare Result Notification' from 'noreply@tridentcare.com' dated Tuesday, March 15, 2022, at 22:48:02 GMT-0700 (Pacific Daylight Time). The message body states: 'A Report has been faxed to your facility that may need your immediate attention, LANDMARK HEALTH - LOS ANGELES unit/wing/floor: ALL, for Claim Number 36650572. Please check your fax machine or go online to review the report. If your facility is not set up for online access, please reach out to your Account Manager for assistance.' It includes a link: <https://connectonline.tridentcare.com>.

During Business Hours (8:30 AM – 5:00 PM Local Time)

Complete a note in Ubiquity with the following:

- “Imaging Results Received – Uploaded to Ubiquity”
- “Will defer to Market Team to follow-up”

The patient's Market Team will then be notified by the Notes Report data and follow up with the patient.

After Business Hours (5:00 PM – 8:30 AM Local Time)

Locate and copy the Claim Number noted in the referral:

TridentCare Result Notification

From: noreply@tridentcare.com
 Sent: Tue Mar 15 2022 22:48:02 GMT-0700
 (Pacific Daylight Time)
 To: inlandempiretriage@incontactemail.com
 Subject: TridentCare Result Notification
 A Report has been faxed to your facility that may
 need your immediate attention, LANDMARK
 HEALTH - LOS ANGELES unit/wing/floor: ALL, for
 Claim Number **36650572**. Please check your fax
 machine or go online to [review the report](#). If your

Open the Trident Portal and select the correct market from the drop-down “Customer” menu:

Customer: LANDMARK HEALTH - LOS ANGELES, CERRITOS, CA (ACCT: 49723)

- Facility
- HILLIARD, OH (ACCT: 49159)
- BLUE ASH, OH (ACCT: 49143)
- CERRITOS, CA (ACCT: 49723)
- SOUTHFIELD, MI (ACCT: 56077)
- SOUTH SAN FRANCISCO, CA (ACCT: 54325)
- TIGARD, OR (ACCT: 47554)
- WESTBOROUGH, MA (ACCT: 45877)

Paste the Claim Number into the Order Number search field and click the “Search Orders” button:

Order No: **36650572**

Search Orders

From the result that displays below the search fields, you can view imaging results, the type of labs requested, and the order's current status.

- Note the patient's name and DOB
 - Ensure that you can locate the patient in Ubiquity.
 - Review recent Notes and information.

The screenshot shows the TridentConnect software interface. At the top, there is a navigation bar with links for 'Results/Orders', 'Customer Support', 'Management Reports', 'Sign Out', and 'User Settings'. Below the navigation bar, there is a search bar with the placeholder 'Place an Order' and a dropdown menu set to 'Customer: LANDMARK HEALTH - LOS ANGELES, CERRITOS, CA (ACCT: 49723)'. To the right of the search bar is a 'Contact Account Manager' link. The main area is titled 'Search for Orders/Results by...' and contains several search filters: 'Patient Name: ENTER PATIENT I', 'DOB:', 'MRN:', 'Order No: 36650572', 'Exam Type:', 'Start DOS:', 'End DOS:', 'DOS Period:', and 'Extended Search' and 'Clear Search' buttons. Below the filters, a table titled 'Search results for Order No. 36650572' is displayed. The table has columns for Order No., Patient Name, DOB, DOS, Priority, Status, Exam Type, Exam Description, Image, Result, Delivery, and Document. A single row is shown for the order: Order No. 36650572, Patient Name GEMELLI, MYRNA, DOB 01/01/1941, DOS 03/15/2022, Priority ROUTINE, Status COMPLETED, Exam Type RADIOLOGY, Exam Description XRAY CHEST 2 VIEW, and icons for Image, Result, Delivery, and Document. The 'Result' icon is highlighted with a yellow box.

You will now need to download the result to your computer and upload it to Ubiquity's "Documents" section.

Click the option to view the result. It will then open in a new tab.

This screenshot shows a close-up of the search results table from the previous screenshot. The 'Result' column is highlighted with a yellow box. The table row for Order No. 36650572 is visible, showing the 'Result' icon highlighted.

Save the result to your computer:

- Please save this document to a folder you will remember and have easy access to as it will need to be referenced in the next step.

If Opened in Chrome:

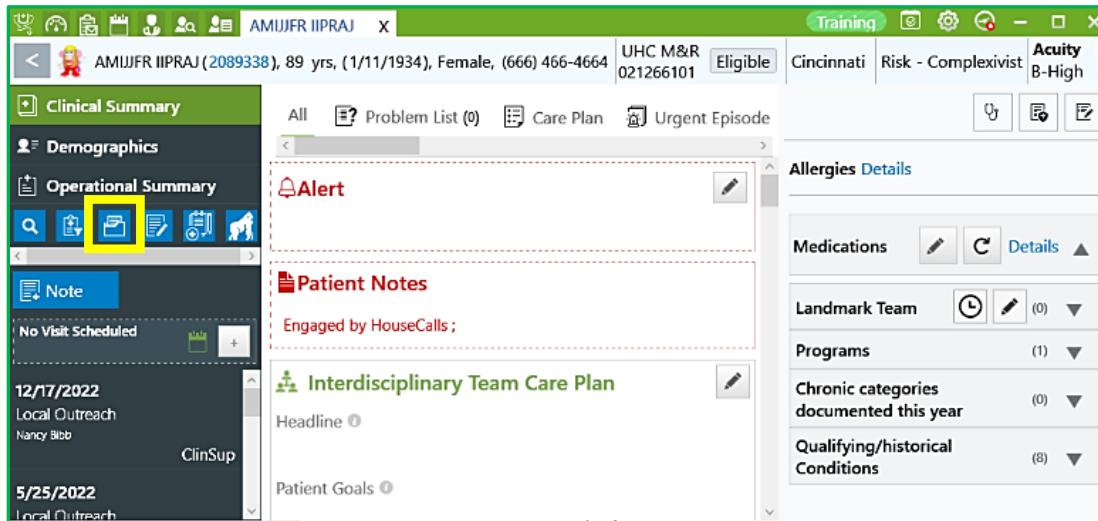


If Opened in Microsoft Edge (default on Optum devices):

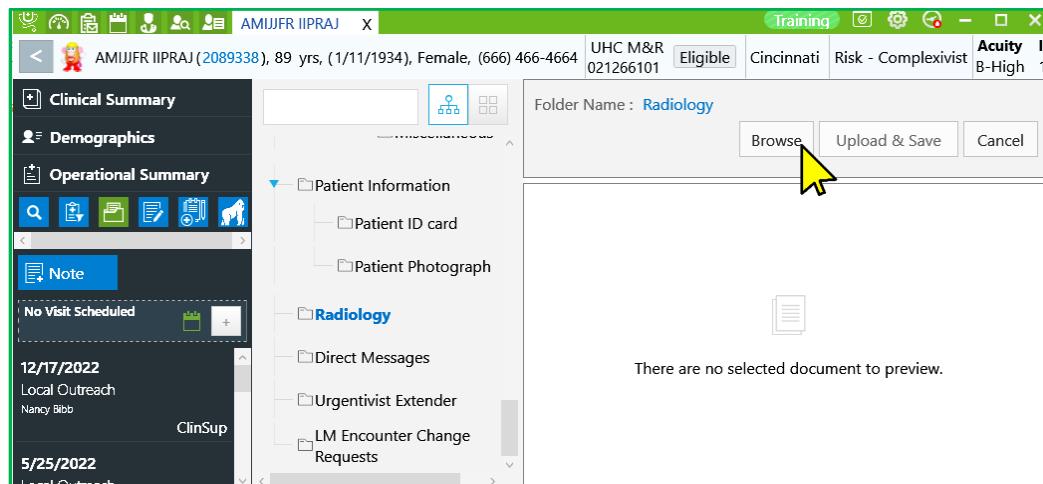


Once saved, upload the results to the “Documents” section.

- Once the patient’s chart is opened, click the “All Documents” icon above the Notes and Encounter Listings.



- Navigate to the “Radiology” folder and upload the saved lab results to Ubiquity.
 - Click “Browse” and locate the results file stored on your computer.
 - Once uploaded, a preview will appear in the Radiology folder.
 - If you are satisfied with your upload, click “Upload & Save.”



Next Steps:

Once the results are uploaded to Ubiquity, call the patient to reassess symptoms and make a plan of care:

- Follow the Receiving Triage Emails Through Genesys guidelines for accepting the email, setting the appropriate statuses, contacting the patient, and follow-up documentation.

Health Gorilla

Links & Resources:

 Link – Health Gorilla Provider Portal

<https://www.healthgorilla.com/login>

 Link – Health Gorilla Login Instructions (Attestation)

<https://forms.office.com/Pages/ResponsePage.aspx?id=AeMqzqu1Qkm-ZInpHCG1XT0L6Vew3GROkxMc7uxzdzRUNFpRTkZEWkdLR1FSSIZVVVRIOVhPSjNEMy4u>

Overview:

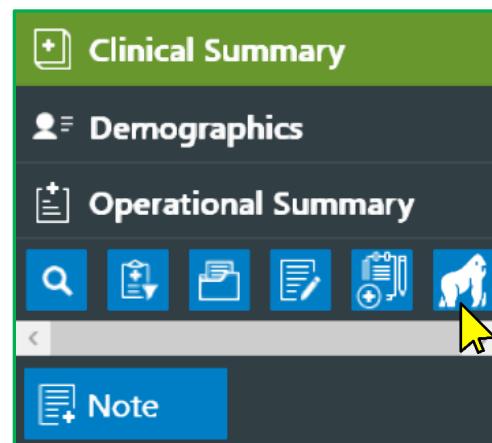
Landmark has partnered with a software company, Health Gorilla, to improve our access to patient records. Health Gorilla takes information from Health Data Exchanges set up in many states to coordinate medical records between institutions and aggregates it into one common portal.

The system is very intuitive. This integration will significantly streamline your workflow and enhance patient care by allowing you to seamlessly access patient charts in Health Gorilla directly from the Ubiquity platform.

We believe that this Health Gorilla integration will significantly improve your efficiency, enhance care coordination, and ultimately lead to better patient outcomes. We encourage you to explore the integrated features and provide us with your valuable feedback and suggestions.

Access In Ubiquity:

1. Open a patient's chart in Ubiquity.
2. Find the Health Gorilla microtabs on the left-side notes and documents panel.
3. Clicking the Health Gorilla button will open a popup window for you to quickly navigate the Health Gorilla portal information.
 - o First time users must agree to Health Gorilla's terms and conditions before proceeding.



A screenshot of a web-based patient portal for "Evelyn Flowers, 01/11/1933...". The portal has a green header with the "Health Gorilla" logo. On the left, a vertical sidebar lists microtabs: Demographics (selected), HumanGraph™, Messages, Tel Encounters, Orders, Future Orders, Labs/Imaging, Documents, Progress Notes, and History and Physical. The main content area displays patient details: First Name Evelyn, Last Name Flowers, DOB 1/11/1933, Gender Female. Below this are sections for ID (patient's ID displayed here), Global ID (patient's global ID displayed here), Home Phone (518) 353-2112, Email Aflowers55@gmail.com, Address (patient's address displayed here), Need Translator No, Race, and Ethnicity. A timestamp indicates the data was retrieved on 08/31/2022.

- Access to Health Gorilla will now be seamless and automatic, eliminating the need for access forms or manual sign-up requests.
- This integration eliminates the need for manual navigation between different platforms, saving you time and effort.
- You can efficiently review patient information, access medical records, and manage care coordination tasks all within one integrated system.

Browser Login Instructions:

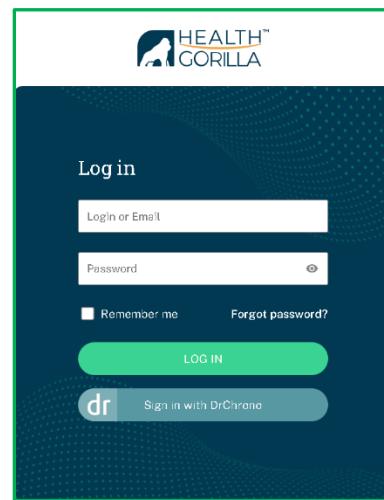
1. Open your web browser and visit <https://www.healthgorilla.com/login>.
2. Enter your login credentials (email and password) to access your account.

Attention – Health Gorilla User Names

The username format **firstname.lastname** no longer works.

- Instead, use your email address in its place.

3. Once logged in, you will have full access to all the features and functionalities of Health Gorilla.



Portal Navigation:

Upon logging into the Health Gorilla Provider Portal, you will be directed to the portal's dashboard.

Frequently Asked Questions (FAQ):

Will this access be available to all team members outside of New York?

Yes, all team members (providers, care coordinators, ambassadors, etc.) outside of New York, who have access to view charts in Ubiquity will be able to utilize this integration.

What if I have access issues?

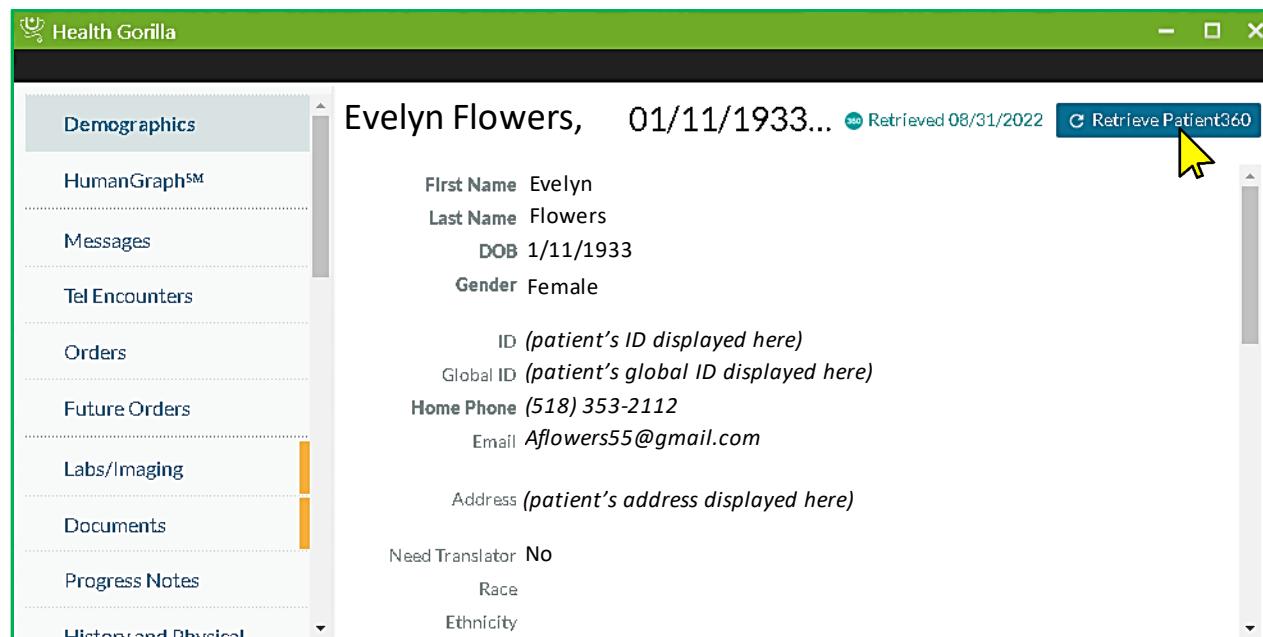
Users will be set up automatically. If you need additional IT support, you will be able to submit a ticket to the [Optum Service Desk](#) who will then route you to the appropriate team to troubleshoot access issues.

Where can I get training materials?

Job aids and video instruction will be available on [Landmark Way](#)

Do we still need to refresh the chart with the retrieve button?

Yes, in the Health Gorilla popup, you will need to continue refreshing the chart using the “Add to Patient360” button to ensure it stays updated.



LabCorp

Links & Resources:

 Link – LM1 APC Management of Labs and Imaging Results

[LM1 APP Process for managing lab and imaging results.pdf](#)

 Link – LM1 Triage RN Management of Labs and Imaging Results

[Triage RN Process for lab and imaging results triage requests.pdf](#)

Labs and Imaging Results Management:

LM1 APCs and RNs may receive calls / emails from patients or their caregivers requesting their lab / imaging results.

- These calls / emails can sometimes come from labs or imaging centers to give results.
- "Change in condition" is abbreviated using the acronym CIC.

Overview of Lab Diagnostics / Results Review Workflow:

1. Complete a brief triage:
 - Use Health Gorilla to access results.
 - Assess any change in condition (CIC) after the Urgent Visit and any emergent symptoms present.
 - ❖ If emergent, follow the emergent call flow.
1. Determine next steps:
 - LM1 Triage RNs determine need next steps such as Tele-UV, UEUV, or UV.
 - ❖ If a critical value is present, transfer immediately to a LM1 APC.
 - LM1 APCs will manage the patient.

If No CIC or New Information Listed in Health Gorilla:

During Business Hours:

Attempt a warm transfer to the market NCM listed in the patient's chart.

- If there is no response from the Market NCM, send an email to the patient's Care Team requesting follow-up.
 - CC the Longitudinal APC and Market Call Center in the email.

After Business Hours (Next Day is a Business Day):

Send an email to the patient's Care Team requesting next-day follow-up.

- CC the Longitudinal APC and Market Call Center in the email.

After Business Hours (Next Day is NOT a Business Day):

Send an email to lm1followup@optum.com requesting LM1 APC follow-up.

- CC the Longitudinal APC and Market Call Center in the email.
- Tag the APC in the "LM1 Full" Teams group.

NewCrop

NewCrop is the application used to be able to view and edit a patient's medication list, allergies, identify drug interactions, and to electronically prescribe medications.

Links & Resources:

Link – How to Document NKDA

<https://support.newcroprx.com/hc/en-us/articles/5858561242132-Document-No-Known-Drug-Allergies-NKDA->

Link – How to Add / Edit Allergies

<https://support.newcroprx.com/hc/en-us/articles/360056496272-Record-and-Manage-Patient-Allergies>

Link – How to Add Medications

<https://support.newcroprx.com/hc/en-us/articles/360058174471-Record-a-Medication>

Link – How to Free-Text Allergies & Medications

<https://support.newcroprx.com/hc/en-us/articles/5051156939412-Map-Free-Text-Allergies-and-Medications>

Link – How to Edit a Prescription

<https://support.newcroprx.com/hc/en-us/articles/360056815331-Edit-a-Prescription>

Link – Create a New Prescription

<https://support.newcroprx.com/hc/en-us/articles/360056804891-Create-a-New-Prescription>

🔗 Link – How to Discontinue a Prescription

<https://support.newcroprx.com/hc/en-us/articles/360057413912-Discontinue-a-Prescription>

🔗 Link – How to Assign a Patient Pharmacy

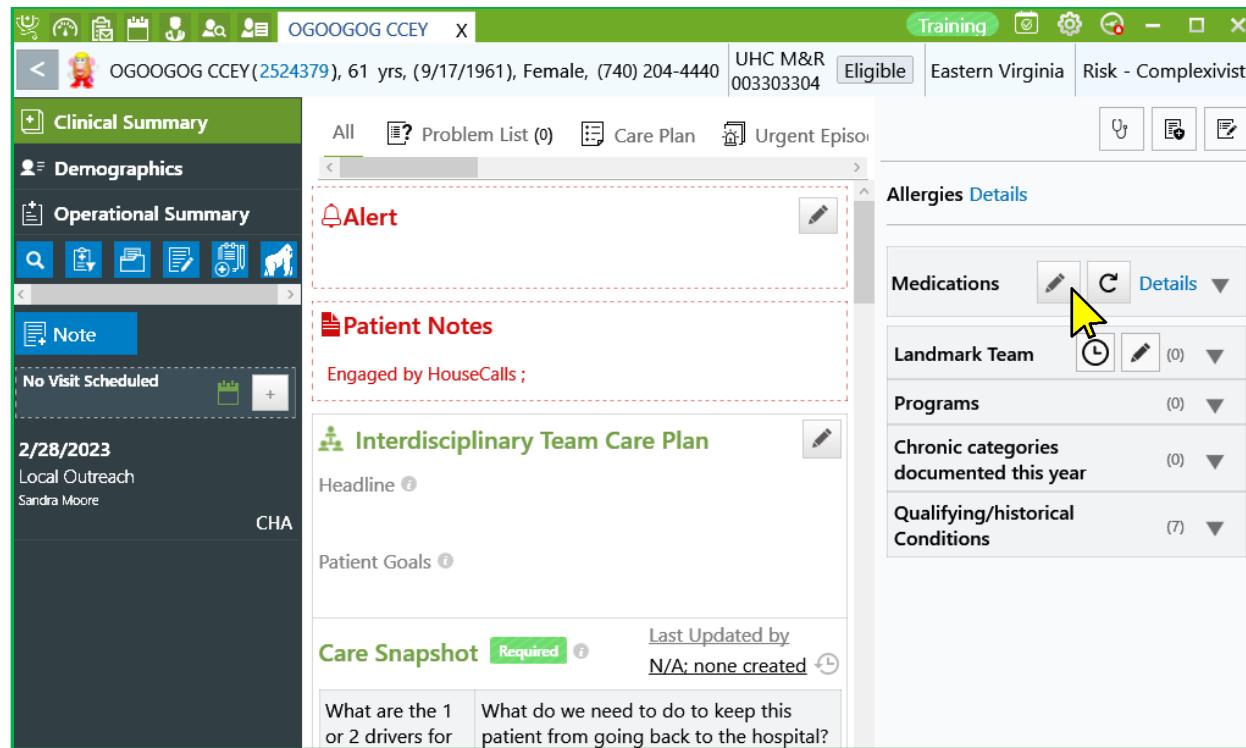
<https://support.newcroprx.com/hc/en-us/articles/360056407172-Assign-Patient-Pharmacies>

🔗 Link – Surescripts Tutorial

<https://support.newcroprx.com/hc/en-us/articles/5739568847124-Surescripts-Drug-History>

Accessing NewCrop Medication Lists:

Open a patient's chart in Ubiquity. The NewCrop platform may be accessed in a note or from the Clinical Summary window. Click the "edit" button above the list of medications on the right side of the window to view the NewCrop dashboard.



NewCrop Dashboard:

PT: SAMPLE PATIENT
DOB: 3/5/1977 Gender: Female Height: Weight:
[Surescripts Drug History](#)
[PDMP](#)
[Request Genetic Test](#)

Doctor: NewCrop Doctor
Health Plan:
Pharmacy: Shollenberger Pharmacy

⚠ Pharmacy Message(s) need attention for this Patient!
Review Renewal and Change Requests on Tasks page

Pending Rx

Date	Drug	Sig	Dispense	Refills	Source
3/16/22	Sominex 25 mg tablet [diphenhydramine HCl]	Take 1 tablet by mouth four times a day ergargwgwg	36 Tablet	4	M. MD Edit
3/11/22	Tylenol Sinus Headache 5 mg-325 mg tablet [phenylephrine-acetaminophen]	Incomplete Directions	Tablet	0	M. MD Edit

Allergies NKDA

Active Medications [Drug Review](#)

Date	Drug	Sig	Dispense	Refills	Source
3/17/22	Tylenol 325 mg capsule [acetaminophen]	Take 1-3 capsules by mouth twice a day	20 Capsule	2	M. MD Edit
3/11/22	Lipitor 10 mg tablet [atorvastatin]	Take 1 tablet by mouth twice a day	60 Tablet	1	M. MD Edit
3/3/22	Isinopril 5 mg tablet	1 Select Frequency Take 1/2 tablet by mouth daily	30 Tablet	1	M. MD Edit
3/3/22	omeprazole 10 mg capsule, delayed release	Take 1 capsule by mouth daily Take as needed for heartburn	90 Capsule	0	M. MD Edit
3/3/22	quinapril 5 mg tablet	Take 1 tablet by mouth daily	30 Tablet	2	M. MD Edit
3/3/22	Crestor 5 mg tablet [rosuvastatin]	Take 1 tablet by mouth twice a day	60 Tablet	1	M. MD Edit
3/3/22	simvastatin 5 mg tablet	Take 1 tablet by mouth daily	30 Tablet	1	M. MD Edit

Attention – Closing NewCrop

You must close the NewCrop window before closing your note for the note to reflect any updates.

Drug Review:

The Drug Review option indicates how a patient's active medications will interact with one another:

Active Medications

	Effective Date	Stop Date	Drug	Sig	Dispense	Refills	Source
<input type="checkbox"/>	8/15/23		doxycycline monohydrate 100 mg capsule	Take 1 capsule by mouth twice a day	14 Capsule	0	O. Kim-Hodgkins
<input type="checkbox"/>	8/15/23		amlodipine 2.5 mg tablet	Take 1 tablet by mouth daily	30 Tablet	0	O. Kim-Hodgkins

Drug Review

Drug-Drug Interactions

Severity	Drug(s)	Summary
Moderate	gabapentin 400 mg capsule tramadol 50 mg tablet	Monograph
Moderate	tramadol 50 mg tablet warfarin 5 mg tablet	Monograph
Moderate	doxycycline monohydrate 100 mg capsule warfarin 5 mg tablet	Monograph

Drug-Allergy Interactions

- No Interactions Found -

Diagnosis Interactions

- No Interactions Found -

Geriatric Alerts

Severity	Drug(s)	Summary
Precaution	gabapentin 400 mg capsule	Renal; Neuro/Psych; Pulmonary
Precaution	hydrochlorothiazide 25 mg tablet	Cardiovascular; Metabolic; Endocrine; Renal
Precaution	tramadol 50 mg tablet	Hepatic; Neuro/Psych; Endocrine; Pulmonary; Renal; General
Precaution	warfarin 5 mg tablet	General

Potential Genomic Alerts

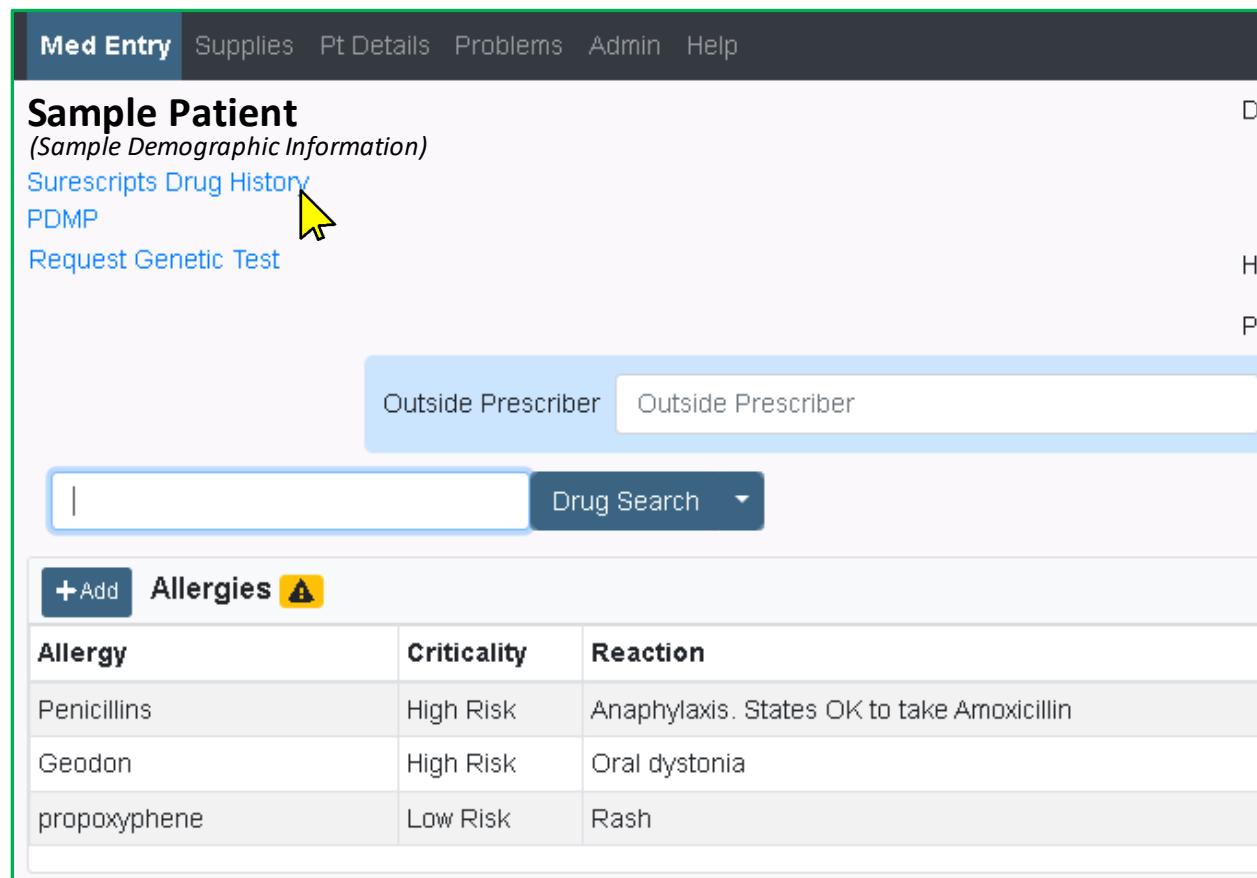
Severity	Drug(s)	Summary
Potential	warfarin 5 mg tablet	CYP2C9 and VKORC1 variants are associated with an increased risk of bleeding with the use of warfarin.
Potential	tramadol 50 mg tablet	Ion channel variants are associated with an increased risk of QT prolongation with numerous drugs.
Potential	hydrochlorothiazide 25 mg tablet	Ion channel variants are associated with an increased risk of QT prolongation with numerous drugs.

Food-Drug Warnings

Severity	Drug(s)	Summary
More Significant	tramadol 50 mg tablet	Alcohol may increase CNS depressant effects.

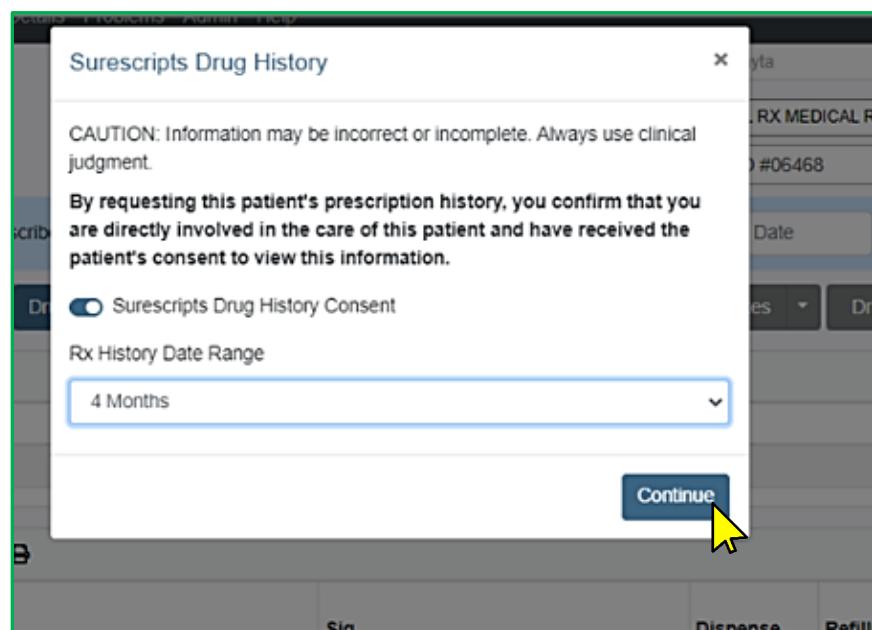
Surescripts:

Surescripts is the medication fill history database used by participating pharmacies that lists medications filled for patients within past 4, 6, or 12 months.



The screenshot shows the Med Entry software interface. At the top, there is a navigation bar with tabs: Med Entry (which is selected), Supplies, Pt Details, Problems, Admin, and Help. Below the navigation bar, the title "Sample Patient" and subtitle "(Sample Demographic Information)" are displayed. Underneath this, there are several links: "Surescripts Drug History" (with a yellow arrow pointing to it), "PDMP", and "Request Genetic Test". A search bar with the placeholder "Outside Prescriber" and a dropdown menu labeled "Drug Search" are also visible. Below the search bar, there is a table titled "Allergies" with a yellow warning icon. The table has columns: Allergy, Criticality, and Reaction. The data in the table is as follows:

Allergy	Criticality	Reaction
Penicillins	High Risk	Anaphylaxis. States OK to take Amoxicillin
Geodon	High Risk	Oral dystonia
propoxyphene	Low Risk	Rash



This screenshot shows a consent form for viewing a patient's prescription history. The title is "Surescripts Drug History". It includes a caution message: "CAUTION: Information may be incorrect or incomplete. Always use clinical judgment." Below this, it states: "By requesting this patient's prescription history, you confirm that you are directly involved in the care of this patient and have received the patient's consent to view this information." There is a checked checkbox for "Surescripts Drug History Consent". A dropdown menu for "Rx History Date Range" is set to "4 Months". At the bottom right, there is a blue "Continue" button with a yellow arrow pointing to it.

Select the timeframe you wish to view and click "Continue".

Charting, Labs, Imaging, & Medication Data

Last Updated: 5/3/2024

Proprietary & Confidential

Published by LM1 Training

Active Medications					Pharmacy:	RITE AID #06468	
Date	Drug	Prescriber	Dx		Confirm	Cancel	Reset
7/13/18	Oyster Shell Calcium 500 500 mg calcium (1,250 mg) tablet [calcium carbonate] 30 Not Specified, 0 Refills	S. Degomez					
9/5/18	ProAir HFA 90 mcg/actuation aerosol inhaler [albuterol sulfate] 8.5 Not Specified, 0 Refills	S. Degomez					
1/30/19	alendronate 70 mg tablet 4 Not Specified, 6 Refills	Walgreens #06094 Phone: 6192210634 3005 MIDWAY DR SAN DIEGO, CA 921104502	E. Zavala				
1/30/19	aspirin 81 mg tablet,delayed release 30 Not Specified, 6 Refills	Walgreens #06094 Phone: 6192210834 3005 MIDWAY DR SAN DIEGO, CA 921104502	E. Zavala				
1/30/19	Singular 10 mg tablet, [montelukast] 30 Not Specified, 6 Refills	Walgreens #06094 Phone: 6192210834 3005 MIDWAY DR SAN DIEGO, CA 921104502	E. Zavala				
10/22/20	Combivent Respirat 20 mcg-100 mcg/actuation solution for inhalation [ipratropium-albuterol] Not Specified, 6 Refills		C. Monahan				
10/22/20	meclizine 12.5 mg tablet Not Specified, 6 Refills		C. Monahan				
4/5/21	nystatin-triamcinolone 100,000 unit/g-0.1 % topical cream 60 Not Specified, 6 Refills	RITE AID #05544 Phone: 8183484650 6410 PLATT AVENUE WFST HILL S. CA	M. Ruiz				

Importance of reconciliation

Reconciled Medications	
Drug	
Oyster Shell Calcium 500 500 mg calcium (1,250 mg) tablet	
ProAir HFA 90 mcg/actuation aerosol inhaler	
alendronate 70 mg tablet	
aspirin 81 mg tablet,delayed release	
Singular 10 mg tablet	
Combivent Respirat 20 mcg-100 mcg/actuation solution for inhalation	
meclizine 12.5 mg tablet	
nystatin-triamcinolone 100,000 unit/g-0.1 % topical cream	
Wixela Inhub 250 mcg-50 mcg/dose powder for inhalation	
montelukast 10 mg tablet	
Symbicort 160 mcg-4.5 mcg/actuation HFA aerosol inhaler	
dextromethorphan HBr 15 mg tablet	
doxycycline hydrate 100 mg capsule	
guafenesin 400 mg tablet	
prednisone 50 mg tablet	
albuterol sulfate HFA 90 mcg/actuation aerosol inhaler	

RightFax

Request Access to RightFax:

1. Navigate to: [UHG IT Provisioning Portal](#)
2. Click on “Enterprise Fax”

The screenshot shows the UHG IT Provisioning Portal homepage. The top navigation bar has tabs for Welcome, Outlook Requests, Mobile, Instant Messaging, Distribution Lists, WebEx, HUP, Enterprise Fax (highlighted with a yellow arrow), SharePoint, and Help. The date is Thursday, May 02, 2024. A large yellow icon on the left represents account provisioning services. The main content area is titled "ACCOUNT PROVISIONING SERVICES" and contains a message about migrating to a new ServiceNow portal.

3. On the left side of the screen, click “New / Create” (or other option if applicable):

The screenshot shows the Enterprise Fax page within the UHG IT Provisioning Portal. The left sidebar shows a menu with 'Requests' selected, and 'New/Create' is highlighted with a yellow arrow. The main content area is titled "ENTERPRISE FAX PROVISIONING REQUESTS" and contains information about Enterprise Fax Requests, a note about manager approval, and an important note about fax volume requirements.

4. As you fill out the form.
5. Note the section named **Enterprise Fax Information:**
 - If you are NOT to receive inbound FAX messages, make sure to select the **No** radio button.

Important! An inbound fax number is not required for you to have the ability to send electronic faxes.

 - Make sure that the **Fax Delivery File Format** you request is compatible with your Business Units needs.
6. Submit your request.

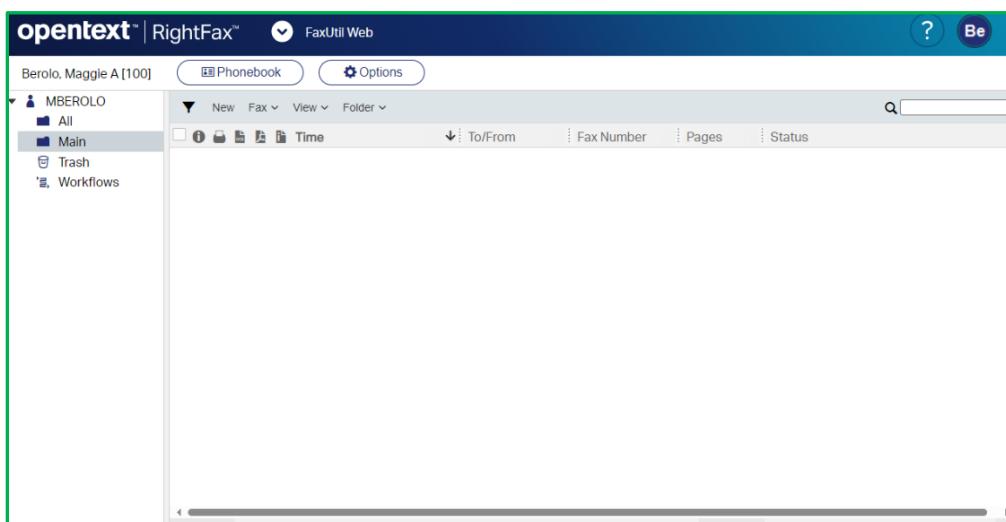
Enterprise Fax information:

Are you required to receive inbound Faxes? Yes No

Fax delivery file format: PDF TFF

With Approved Access to RightFax:

1. Login using the following page: <https://efxprodc.uhc.com/rightfax/user/>
 - Save this page to your favorites / bookmarks for future use.
2. You will be directed to the main page once logged in:



To Fax:

1. Click "New"
2. Destination = Fax number
3. Name = named individual / facility name
4. Type cover sheet notes and add files/attachments as needed
5. Click Send

