Allscripts v11.1.7
Clinical Staff Guide
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Logging in to Enterprise EHR

For secure access to the Enterprise EHR system, it is important to log in with a user name and password that are not shared with any other system users. It is also important to log off the system when work is complete.

1. From the desktop, double-click the Enterprise EHR icon. The Allscripts Enterprise EHR Login page displays.

2. Enter the Login ID and Password.
   - Some users have access to more than one organization.
   - Instead of clicking the New Session button to log in, these users should click the Options button to display the Login Options dialog box.
   - From the System field, select the appropriate organization and click the Login button.

3. Click the New Session button.
The user’s default page displays with the floating **Clinical Toolbar**.
Navigating within Enterprise EHR

Enterprise EHR is a series of modules accessed within a role-based workplace. The system utilizes simple point-and-click navigation. This makes it easy to lock the Enterprise EHR session when stepping away from the workstation and then unlock it upon return.

- The **Role** is the user’s role within the organization (according to security privileges). In the following example, the **Role** is **Provider**.
- The **Vertical Toolbar (VTB)** is **Role** dependent and is a menu of options corresponding to specific functional areas within Enterprise EHR.
- The **Horizontal Toolbar (HTB)** displays the tabs (or functional areas) available from the option selected on the **VTB**.
- Refer to the following table for descriptions of the buttons on the Enterprise EHR **Toolplace**, which can be used at anytime from anywhere in the system.
- The **Patient Banner** provides a way to search for and select a patient. When a patient is selected, the **Patient Banner** displays the patient’s demographic information.

To hide the **VTB**, click the **Hide VTB** button. The **VTB** is hidden, and the **Hide VTB** button toggles to the **Show VTB** button.

To show the **VTB**, click the **Show VTB** button. The **VTB** displays and the **Show VTB** button toggles to the **Hide VTB** button.
The following table describes the buttons displayed on the Enterprise EHR Toolplace.

<table>
<thead>
<tr>
<th>Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools</td>
<td>Displays a drop-down menu, including the Show/Hide Clinical Toolbar option for displaying or hiding the Clinical Toolbar.</td>
</tr>
<tr>
<td>Help</td>
<td>Accesses Enterprise EHR system help.</td>
</tr>
<tr>
<td>Lock</td>
<td>Locks the Enterprise EHR session.</td>
</tr>
<tr>
<td>Logoff</td>
<td>Logs off Enterprise EHR.</td>
</tr>
</tbody>
</table>

**Locking and Unlocking Enterprise EHR**

To ensure patient confidentiality, the Enterprise EHR session should be locked when stepping away from the workstation.

- From any page, click the Lock button. The Session Locked page displays.
- Enter the Password and click the Resume button to log back in to Enterprise EHR.

**Logging out of Enterprise EHR**

1. From any page in Enterprise EHR, click the Logoff button. The Windows Internet Explorer dialog box displays.
2. Click the OK button. The Allscripts Enterprise EHR Login page displays.
3. Close the browser window.
1. From any page where available, click the **Personalize** link. The **Personalize** page displays.

2. Select the desired default settings.

3. Click the **OK** button.
Changing Print Sites in Enterprise EHR

1. From the **Vertical** toolbar, select **User Options**. The **Site** page displays.

![Site page screenshot]

2. Click the **Select Site** button. The **Site Selector** page displays.

![Site Selector dialog]

3. **Double-click** the appropriate site location. The new location displays on the **Site** page.
Accessing Help

From the Toolplace in the upper-right of any page, click the Help button. The Help page displays.

The Help page only lists generic Enterprise EHR help topics.
Accessing the Daily Schedule

A schedule of appointments may be viewed for one or more providers. Information such as patient demographics, appointment details or patient appointment history is accessible from the schedule.

The appointments displayed on the **Daily Schedule** are determined by the group of appointment statuses selected. Appointment status originates from the practice management system. The following groups of appointment statuses display: All Appointments; or Arrived, Pending and Rescheduled; or Arrived, Pending, Rescheduled, or No Show; or Canceled, No Show and Bumped.

- The registration and scheduling information is sent via interface to Enterprise EHR. This allows users to monitor their schedules directly from Enterprise EHR without having to switch into the Practice Management System (PMS).
- It is important to understand what demographic data is interfaced with Enterprise EHR from the PMS.
1. From the **Vertical** toolbar, select **Chart**. The **Daily Schedule** page displays.

2. From the **Daily Schedule** page, select the **Provider** from the drop-down menu.

   ![Click the All button to search for a provider not listed in the drop-down menu.](image)

- The **Pt Loc** and **Pt Status** columns are populated using the associated fields on the **Clinical Toolbar**.
- The **Daily Schedule** and **Note** pages are integrated allowing the user to launch the **Note** page for an appointment from the **Daily Schedule**.
- Click the **Note** icon in the **N** column for the desired appointment to display the **Note**.
Navigating the Daily Schedule

The Last Updated field displays the last date and time the data on the Daily Schedule was refreshed. To display the most current schedule information, click the Refresh icon.

To display the Daily Schedule for a particular day of the week, select that day on the Day of the Week toolbar.

Click the Go To Today icon to display the Daily Schedule for the current date.

Click the Previous Week icon to display the Daily Schedule for the same day of the previous week.

Click the Next Week icon to display the Daily Schedule for the same day of the next week.

To the right of the Provider field, notice the AM, PM and Total fields.

- The AM field displays the number of appointments on the schedule for the morning.
- The PM field displays the number of appointments on the schedule for the afternoon.
- The Total field displays the total number of appointments on the schedule for the day.

- Select an appointment on the Daily Schedule to display the associated patient demographics on the Patient Banner.
- Double-click an appointment on the Daily Schedule to display the associated Clinical Desktop of current patient information, such as active problems and medications, allergies and encounters.
## Viewing Multiple Provider Schedules

It is possible to view the schedule of appointments for up to four providers at one time. Information such as patient demographics, appointment details or patient appointment history is visible for any of the provider schedules displayed.

1. From the **Vertical** toolbar, select Chart.
2. From the **Horizontal** toolbar, select Provider Schedules. The Provider Schedules page displays with four providers’ schedules displayed simultaneously.

| Provider Schedules | Personalize | Provider: Alexander | Provider: Bart | | Provider: Constance | Provider: Kelsy |
|--------------------|-------------|---------------------|----------------|---------------------|---------------------|
| **Date:** 12 Jul 2019 | **Last Updated:** 07/03/2019 2:00 PM | **Provider:** Alexander | **Provider:** Bart | | **Provider:** Constance | **Provider:** Kelsy |
| **Patient:** PATA,ALLISON | **Time:** 09:00 AM | **Time:** 06:00 AM | **Patient:** PATS,ALLISON | **Time:** 09:00 AM | **Time:** 09:00 AM | **Patient:** PATS,ALLISON |
| **Patient:**PAT,CJILL | **Time:** 10:00 AM | **Time:** 09:00 AM | **Patient:** PAT,CJILL | **Time:** 11:00 AM | **Time:** 11:00 AM | **Patient:** PAT,CJILL |
| **Patient:**PAT,CONNIE | **Time:** 11:00 AM | **Time:** 10:00 AM | **Patient:** PAT,CONNIE | **Time:** 01:00 PM | **Time:** 01:00 PM | **Patient:** PAT,CONNIE |
| **Patient:**PATA,DYLAN | **Time:** 01:00 PM | **Time:** 11:00 AM | **Patient:** PATA,DYLAN | | | **Patient:** PATA,DYLAN |
| **Patient:**PATA,ELIZABETH | **Time:** 02:00 PM | | **Patient:** PATA,ELIZABETH | | | **Patient:** PATA,ELIZABETH |

- Users can specify up to four default providers for simultaneous viewing. On the Provider Schedules page, click the Personalize link to display the Personalize page.
- Select a default value from the Default Providers 1, 2, 3, and 4 drop-down menus.
- Only available when logged in as a member of the Clinical Staff.
Using the All Provider View

Provider scheduling can be enhanced to accommodate a larger number of providers that can be viewed using the All Providers view. Up to 20 providers can be viewed at one time, giving a bigger picture of the day’s scheduling.

1. From the Vertical toolbar, select Chart. The Daily Schedule page displays.

2. Click the Personalize link. The Personalize page displays.

In the Daily section, the following personalization can be set:

- **Default Provider** – Defines the provider whose schedule displays when the Daily Schedule is accessed.
- **Automatic Refresh** – Defines how often the Daily Schedule is refreshed by the system.
- **Double-Click Action** – Defines the page that the system navigates to when an item on the schedule is double-clicked.
- **Schedule Contents** – Defines the appointments that will display on the Daily Schedule.

3. Click the New button.
4. In the **Provider** field, enter the search criteria to search for specific providers.

5. Click the **Search** button.
6. Select the checkbox next to the provider(s) to be added to the All Provider view. The selected provider(s) displays in the Provider(s) Selected accumulator table.
7. Click the **OK** button to return to the **Personalize** page.
8. Click the **OK** button to return to the **Daily Schedule**.
9. On the **Daily Schedule**, select the **All Providers** view from the drop-down menu.

The page now displays a **Provider** column.

When viewing appointments with the **All Providers** option, only appointments scheduled within 30 minutes of the actual time of the visit are visible.
1. From the **Patient Banner**, click the **Select Patient** drop-down arrow.
2. Select **Search** from the drop-down menu. The **Select Patient** page displays.

3. In the **Patient** field, enter at least three letters of the patient’s last name and at least three letters of the first name.
4. Click the **Search** button.
The search results display below the **Patient** field.

5. *Double-click* the desired patient. The patient’s information displays in the **Patient Banner**.
Personalizing the Select Patient Page

When searching for a patient on the Select Patient page, the system defaults to search by the patient name. Users can personalize this page so that the default search criterion better suits his or her process.

1. From the Select Patient page, click the Personalize link. The Personalize page displays.

2. In the Default Field for Patient Search field, select the desired default search criterion from the drop-down menu.

3. Click the OK button.
Viewing the Patient Banner

The **Patient Banner** displays demographic information pertaining to the selected patient below the **Horizontal toolbar (HTB)**. The following table describes available information that displays on the **Patient Banner**.

Not all of the demographic information contained in the PMS is interfaced into Enterprise EHR.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td></td>
<td>The Information icon is used to display and print demographic information for</td>
</tr>
<tr>
<td>MRN</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Age</td>
<td>Patient Age</td>
</tr>
<tr>
<td>Sex</td>
<td>Patient Gender</td>
</tr>
<tr>
<td>PCP</td>
<td>Patient Primary Care Provider</td>
</tr>
<tr>
<td>H Phone</td>
<td>Home Telephone Number</td>
</tr>
<tr>
<td>Allergies</td>
<td>Allergy Status (<strong>Yes</strong>, <strong>No</strong>, or <strong>Unknown</strong>)</td>
</tr>
<tr>
<td>FYI</td>
<td>For your information; informal, non-medical, patient information indicator</td>
</tr>
<tr>
<td>Security</td>
<td>Indicates if the patient information is restricted</td>
</tr>
<tr>
<td>Pri Ins</td>
<td>Patient Primary Insurance</td>
</tr>
<tr>
<td>Note</td>
<td>The <strong>Select</strong> button opens the <strong>Note Selector</strong> so that a new note can be</td>
</tr>
<tr>
<td></td>
<td>created. The <strong>Go To</strong> button navigates the user to the current note for the</td>
</tr>
<tr>
<td></td>
<td>patient. The <strong>Close</strong> button closes the current note for the patient.</td>
</tr>
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Break Glass Security

Whenever secured data is present in the patient chart, users who belong to a classification that contains the Break Glass security code will see a Break Glass button on the Patient Banner.

The Break Glass button indicates that a patient’s chart contains confidential information.

Multiple levels of Break Glass may exist in certain situations. In these cases, users are required to enter their ID and Password more than once in order to access certain charts.

To access restricted information, click the Break Glass button. The Patient Security Confirmation page displays a message that requires the user to enter his/her password. This is necessary in order to track and audit the user’s action.

Although it is not a required field, all users must enter a Reason for Access (such as “Participating in care of patient”, “Need to review claim”, “Need to review Denial”, etc.).
Accessing a Patient Profile

From the **Patient Banner**, click the **Information** icon. The **Patient Profile** displays with the selected patient’s profile information.

- **FVI:**
  - Patient lost her mother July 20, 2010. JLL:21808 7/20/10

- **Chart Alerts**
  - Hearing Impaired
  - Interpreter Needed
  - Latex Allergy

- **Clinical Information**
  - **Directives:**
  - **Instructions:**
  - **Medication Hi Coonset:** Unknown

- **Demographics**
  - **Address:** 1102 MILLER ST
  - **City:** OMAHA
  - **State:** NE
  - **Zip Code:** 68107-2334

**Information displayed includes:**
- Patient name
- Date of birth
- FYI information
- Chart Alerts
- Demographics
- Employer and contact information
- Insurance information (primary, secondary, and tertiary)
- Pharmacy Benefit
- Retail Pharmacy list (maximum of four)
- Mail Order Pharmacy list (maximum of four)
- Associated Providers
- The **Directives** field contains the patient response to HIPAA or Advanced Directives information
Adding FYI Information

FYI information is equivalent to a memo and not part of the patient’s medical record. The FYI feature is used to document important non-clinical information. Users can create an FYI that appears on the Patient Banner when a patient is in context.

1. From the Patient Banner, click the Information icon. The Patient Profile displays.
2. Click in the FYI section and add comments. The FYI button on the Patient Banner turns yellow.

OR

From the Patient Banner, click the FYI button.

- When adding FYI information, continue to follow the process of adding your Blue ID and date after the comment.
- For example: Pt is hard of hearing/db1234 06/1/2009
Adding Chart Alerts

Users can create **Chart Alerts** that appear in red on the **Clinical Toolbar** when a patient is in context in the **Patient Banner**. **Chart Alerts** are visible by any user who has the security to view the patient’s clinical record. **Chart Alerts** are the equivalent of a red underlined note on the front of a paper chart and contain clinically relevant information.

1. From the **Patient Banner**, click the **Information** icon. The **Patient Profile** displays.

    ![Patient Profile Dialog](image)

    **Patient Profile Dialog**

    **PATA, ALLISON 32 YO F DOB: 01 Jan 1978**

    **FYI**
    - **Interpreter Needed**
    - **Latex Allergy**

2. In the **Chart Alerts** section, click the **Add Alert** button.
The **Add/Edit Patient Chart Alerts** page displays.

3. Select the checkbox to the left of the desired item in the **Available Items** list.
4. Click the **OK** button. The selected chart alert(s) display in red text on the **Patient Profile**.

- **Chart Alerts** are not to be entered using the **Adhoc Alert** field. If the desired **Chart Alert** is not in the provided checklist, an additional one may be requested.
- **Chart Alerts** also display in red text on the **Clinical Toolbar**.
- A maximum of three chart alerts may be added to a patient.
- To remove a **Chart Alert**, click the **Delete** link to the right of the alert.
Adding Pharmacy Information

Pharmacies can be added during the Abstraction process.

1. From the **Patient Banner**, click the **Information** icon. The **Patient Profile** displays.
2. Scroll to the **Pharmacy** section.

3. Click the **Search** icon to search for **Retail Pharmacy/Mail Order**.
The **Detail** page displays.

4. Enter the search criteria and click the **Search** button. The results of the search display.
5. Select the pharmacy and click the **OK** button. The pharmacy information displays in the **Pharmacy** section of the patient’s profile.
**Using the Clinical Toolbar**

The **Clinical Toolbar** provides users access to a patient’s chart information from any page within **Enterprise EHR**. It displays as a “floating” toolbar until the **Clinical Desktop** is accessed; it is then docked at the top of the page.

<table>
<thead>
<tr>
<th>Icon/Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="qChart" /></td>
<td><strong>qChart</strong> – Opens the <strong>Clinical Desktop</strong> in a separate page.</td>
</tr>
<tr>
<td><img src="image" alt="Encounter Summary" /></td>
<td><strong>Encounter Summary</strong> – Displays the <strong>Encounter Summary</strong> page enabling the user to preview what has been documented during the current encounter.</td>
</tr>
<tr>
<td><img src="image" alt="Vitals" /></td>
<td><strong>Vitals</strong> – Displays the <strong>Order Details</strong> page with the <strong>Vitals</strong> tab active, enabling the user to enter vital signs for a patient.</td>
</tr>
<tr>
<td><img src="image" alt="Add New Problem" /></td>
<td><strong>Add New Problem</strong> – Displays the <strong>Add Clinical Items (ACI)</strong> window. The <strong>History Builder</strong> tab is automatically selected enabling the user to add and update the patient’s problems and historical information.</td>
</tr>
<tr>
<td><img src="image" alt="Add New Medication" /></td>
<td><strong>Add New Medication</strong> – Displays the <strong>Add Clinical Items (ACI)</strong> window. The <strong>Rx/Orders</strong> tab is automatically selected enabling the user to order medications.</td>
</tr>
<tr>
<td><img src="image" alt="Add New Order" /></td>
<td><strong>Add New Order</strong> – Displays the <strong>Add Clinical Items (ACI)</strong> window. The <strong>Problem-Based Orders</strong> tab is automatically selected enabling the user to search for and select from all available orderable items.</td>
</tr>
<tr>
<td><img src="image" alt="Note" /></td>
<td><strong>Note</strong> – Enables the user to create a new note, navigate to the current note in context, or close the current note.</td>
</tr>
<tr>
<td><img src="image" alt="Post to Encounter" /></td>
<td><strong>Post to Encounter</strong> – Ensures all problems assessed are automatically added to the <strong>Encounter Form</strong> for the current encounter and display within the <strong>Assessment</strong> section in the structured note.</td>
</tr>
<tr>
<td><img src="image" alt="Commit" /></td>
<td><strong>Commit</strong> – Submits and saves information (via the <strong>Encounter Summary</strong>) that has been entered and/or documented from within the <strong>Clinical Desktop</strong>. The <strong>Commit</strong> button turns yellow when the <strong>Encounter Summary</strong> contains unsaved information.</td>
</tr>
<tr>
<td><img src="image" alt="Pat Loc" /></td>
<td><strong>Patient Location</strong> – Enables users to track the patient’s current location throughout the course of the visit. This also displays on the <strong>Daily Schedule</strong>.</td>
</tr>
<tr>
<td><img src="image" alt="Status" /></td>
<td><strong>Status</strong> – Enables users to label and track the patient’s current status (e.g. “Roomed,” “Provider-Ready,” etc.) throughout the course of the visit.</td>
</tr>
</tbody>
</table>
1. To hide the **Clinical Toolbar**, click the **Close** button (red X) in the *upper*-right corner of the toolbar.

2. To show the **Clinical Toolbar**, click the **Tools** button located on the **Toolplace**.

3. From the **Tools** menu, select **Show/Hide Clinical Toolbar**. The “floating” **Clinical Toolbar** displays.
Working with the Clinical Desktop

Quickly review a patient’s condition prior to an appointment by viewing an overview of current information for the patient, including active problems and medications, allergies and encounters.

The staff has access to all areas of a patient’s record from the Clinical Desktop. The Clinical Desktop is comprised of the following elements:

- **Clinical Desktop View** – Indicates the configuration of the Clinical Desktop (that is, which components are visible, how the components are laid out on the screen, and so on).
- **Clinical Toolbar** – Icons that allow users to add clinical items, review data, and track patient location and status.
- **Components** – Configurable workspaces, including Problem, Encounter, Meds, Orders, Allergies, Chart Viewer, Patient Worklist, Vitals, and Health Management Plan; these components are described individually in the following sections.
- **Component Groups** – Indicates multiple tabs grouped together on a single component.

1. From the Horizontal toolbar, select the Clinical Desktop tab. The Clinical Desktop displays with patient information organized within components.
2. Select the desired tab within a component. The associated items display.
The Clinical Desktop view may be changed using the drop-down menu in the upper-left corner. Component views may be changed using the associated drop-down menus within each. Right-click an item within a component to display a menu of actions associated with the component.

The following table describes additional functionality within the Clinical Desktop.

<table>
<thead>
<tr>
<th>Icon</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Refresh View" /></td>
<td>Refresh View</td>
<td>Refreshes the information within the associated component.</td>
</tr>
<tr>
<td><img src="image" alt="Edit View" /></td>
<td>Edit View</td>
<td>Provides the user with the ability to edit a component or Chart Viewer view.</td>
</tr>
<tr>
<td><img src="image" alt="Tile/Full Screen" /></td>
<td>Tile/Full Screen</td>
<td>Toggles the Clinical Desktop between a tiled component view and a full-screen component view.</td>
</tr>
<tr>
<td><img src="image" alt="Expand" /></td>
<td>Expand</td>
<td>Expands/Collapses the items and associated information within a component.</td>
</tr>
<tr>
<td><img src="image" alt="New Task" /></td>
<td>New Task</td>
<td>Displays the Task Details page enabling the user to create a new task from the associated component.</td>
</tr>
<tr>
<td><img src="image" alt="FlowSheet" /></td>
<td>FlowSheet</td>
<td>Enables the user to view a graph or “flow” of vitals findings over a period of time.</td>
</tr>
<tr>
<td><img src="image" alt="Graph" /></td>
<td>Graph</td>
<td>Produces a visual graphic of selected vital signs with two or more dated entries. Select the checkbox next to the item(s) in the Graph column and then click the Graph icon.</td>
</tr>
</tbody>
</table>
Working within Components

Patient information within a component may be added, edited, or viewed using multiple techniques. The following table describes the methods for accessing information within a component on the Clinical Desktop.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single-click</td>
<td>Highlights an item and activates associated actions at the bottom of the component that may be used with the selected item.</td>
</tr>
<tr>
<td>Double-click</td>
<td>Displays the details of the selected item in a separate window.</td>
</tr>
<tr>
<td>Right-click</td>
<td>Displays a menu of actions that may be used with the selected item.</td>
</tr>
</tbody>
</table>
The buttons on the bottom of a component are used to perform specific actions for the items in the component. The buttons differ depending on the component. The following table defines the buttons found on the bottom of the different components.

<table>
<thead>
<tr>
<th>Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Opens the ACI to allow for creation of a new item.</td>
</tr>
<tr>
<td>Edit</td>
<td>Opens the Details page for the selected item for modification.</td>
</tr>
<tr>
<td>View</td>
<td>Opens the selected item in a viewer for review.</td>
</tr>
<tr>
<td>Order D/C</td>
<td>Allows the selected medication to be discontinued or continued.</td>
</tr>
<tr>
<td>Reprint Rx/Resend Rx</td>
<td>Allows the user to either reprint the prescription, or resend it to the pharmacy or mail order, depending on the action originally selected when the medication was ordered.</td>
</tr>
<tr>
<td>Continue</td>
<td>Shows the medication is being continued as a current therapy.</td>
</tr>
</tbody>
</table>
Viewing the Problems List

From the **Clinical Desktop**, select the **Medical Problems** tab. The **Medical Problems** component displays a list of the patient’s problems organized by the default view.

- A problem with an asterisk to the left of the name indicates the presence of an **Annotation**.
- **Double-click** the item to display the details including any annotations.
Viewing Past Medical History (PMH)

1. From the Clinical Desktop, select the Problem tab.

   - Chronic
     - Abdominal Pain 709.00
     - Diabetes Mellitus 250.00
   - Health Maintenance/Risks
     - Health Maintenance

   New  Edit  CareGuide  Resolve

2. From the view drop-down list, select Past Medical History.

   The Problem component displays with a list of the patient’s medical history organized by the default view.

   - A Past Medical History item with an asterisk to the left of the name indicates the presence of an Annotation.
   - Double-click the item to display the details including any annotations.
Viewing Past Surgical History (PSH)

1. From the **Clinical Desktop**, select the **Problem** tab.

2. From the **view** drop-down list, select **Past Surgical History**.
   The **Problem** component displays with a list of the patient’s surgical history organized by the default view.

- A Past Surgical History item with an asterisk to the left of the name indicates the presence of an **Annotation**.
- **Double-click** the item to display the details including any annotations.
Viewing Family History (Fam Hx)

1. From the Clinical Desktop, select the Problems tab.

2. From view drop-down list, select Family History. The Problems component displays with a list of the patient’s family history organized by the default view.

- A Family History item with an asterisk to the left of the name indicates the presence of an Annotation.
- Double-click the item to display the details including any annotations.
Viewing Social History (Social Hx)

1. From the Clinical Desktop, select the Problems tab.

2. From the view drop-down list, select Social History. The Social History Problems component displays with a list of the patient’s social history organized by the default view.

- A Social History item with an asterisk to the left of the name indicates the presence of an Annotation.
- Double-click the item to display the details including any annotations.
Viewing Allergies

1. From the **Clinical Desktop**, select the **Allergies** tab. The **Allergies** component displays with a list of the patient’s allergies organized by the default view.

![Allergies tab in Clinical Desktop](image)

2. If desired, from the **view** drop-down menu, choose to view the patient’s allergies by **Medications** or **Non-Medications**.
   - An allergy item with an asterisk to the left of the name indicates the presence of an **Annotation**.
   - *Double*-click the item to display the details including any annotations.
**Viewing the Medications List**

The **Medications List** is used to view a list of medications for a selected patient, including instructions for use, the number of refills, the dates between which the patient is to take the medication, and other medication-related information.

From the **Clinical Desktop**, select the **Meds** tab. The **Medications** component displays with a list of the patient’s medications organized by the default view.

The following table describes the formulary status indicators on the **Meds** and **Orders** tab:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>🌻</td>
<td>Preferred formulary status (lowest co-pay)</td>
</tr>
<tr>
<td>🌼</td>
<td>Approved formulary status (higher co-pay)</td>
</tr>
<tr>
<td>🙁</td>
<td>Non-approved formulary status (full price)</td>
</tr>
<tr>
<td>💯</td>
<td>Prior Authorization is required</td>
</tr>
<tr>
<td>🌿</td>
<td>Over-the-Counter medication</td>
</tr>
<tr>
<td>&lt;no indicator&gt;</td>
<td>No formulary information available for the selected medication</td>
</tr>
</tbody>
</table>
Viewing the Medication History List (Med Hx)

1. From the **Clinical Desktop**, select the **Meds** tab.

2. From **view** drop-down list, select **Past Medications**. The **Meds** component displays a list of the patient’s past medication history organized by the default view.

- A medication item with an asterisk to the left of the name indicates the presence of an **Annotation**.
- **Double-click** the item to display the details including any annotations.
Viewing Immunization History

1. From the **Clinical Desktop**, select the **Immunizations** tab.

2. From the **view** drop-down menu, select **Immunization series**. The patient’s immunization history displays.
1. From the **Clinical Desktop**, select an item within a **Component** tab.
2. Right-click the desired entry and select **Annotate** from the displayed menu. The **Problem Details** page displays.

3. In the **New Annotation** textbox, enter a free-text annotation.

4. Click the **OK** button. The **Details** page closes and the selected item(s) display in magenta.

5. To save the changes, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.

6. On the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.
Accessing Chart Viewer

Use **Chart Viewer** to view and print any clinical documentation from a patient chart, including notes, referrals, test results, scanned images and consent forms. Chart items can be searched grouped and filtered by various criteria in order to find specific documents quickly and easily.

1. From the **Vertical** toolbar, select **Chart**.
2. From the **Horizontal** toolbar, select the **Clinical Desktop** tab. The **Clinical Desktop** displays.
3. Select the **Chart Viewer** tab. The patient’s chart items display.
4. Select the appropriate **View** from the drop-down menu. The recommended view is **All by Section by Sub-Section**.
5. To print a document, highlight and **right-click**.

6. Select **Print** from the menu and choose a print option.

![Print Menu]

Click the **Print** button at the bottom of the component to view the print menu:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selected</strong></td>
<td>Prints only the selected document.</td>
</tr>
<tr>
<td><strong>SnapShot</strong></td>
<td>Prints the patient’s active problem, medication and allergy lists, HMP items, as well as a list of encounters.</td>
</tr>
<tr>
<td><strong>Worksheet</strong></td>
<td>Prints the patient’s active problem, medication and allergy lists, along with a list of the patient’s results.</td>
</tr>
<tr>
<td><strong>Chart</strong></td>
<td>Prints the entire chart. <strong>Only a select group of users</strong>, such as Medical Records, is able to print an entire chart.</td>
</tr>
</tbody>
</table>
7. To view a document, double-click the appropriate document to view it in a separate page.
The following table describes the available views when using Chart Viewer:

<table>
<thead>
<tr>
<th>Selected View</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter</td>
<td>Shows any associated documents to a specific visit date.</td>
</tr>
<tr>
<td>Owner</td>
<td>Shows documents created by a specific staff member.</td>
</tr>
<tr>
<td>Problem</td>
<td>Shows all documents associated with a particular diagnosis/problem.</td>
</tr>
<tr>
<td>Provider</td>
<td>Shows all documents by provider with which they were associated.</td>
</tr>
<tr>
<td>Section</td>
<td>Shows documents separated by the main category under which they fall (e.g., labs, notes, etc.).</td>
</tr>
<tr>
<td>Specialty</td>
<td>Separates documents by specialty type (e.g., Family Practice, Internal Med, OB/GYN, etc.).</td>
</tr>
<tr>
<td>Visit</td>
<td>Shows all items in one list.</td>
</tr>
<tr>
<td>All Items (default view)</td>
<td>Shows all items in one list.</td>
</tr>
<tr>
<td>All by Encounter</td>
<td>Shows any associated documents to a specific visit date.</td>
</tr>
<tr>
<td>All by Owner</td>
<td>Shows documents created by a specific staff member.</td>
</tr>
<tr>
<td>All by Owner by Encounter</td>
<td>Shows documents created by a specific staff member, but further broken down by date of encounter.</td>
</tr>
<tr>
<td>All by Problem</td>
<td>Shows documents associated with a certain problem/diagnosis.</td>
</tr>
<tr>
<td>All by Problem by Encounter</td>
<td>Shows documents associated with a certain problem/diagnosis, but is further broken down by date.</td>
</tr>
<tr>
<td>All by Section</td>
<td>Shows documents separated by the main category under which they fall (e.g., labs, notes, etc.).</td>
</tr>
<tr>
<td>All by Section by Sub-Section</td>
<td>Shows the main document categories and is further broken down by individual sub-folders (e.g., types of labs, types of patient information, etc.).</td>
</tr>
<tr>
<td>All by Specialty</td>
<td>Separates documents by specialty type (e.g., Family Practice, Internal Med, OB/GYN, etc.).</td>
</tr>
<tr>
<td>All Notes</td>
<td>Shows a list of all notes, any type.</td>
</tr>
<tr>
<td>All Results</td>
<td>Shows a list of all results, any type.</td>
</tr>
</tbody>
</table>
Filtering within Chart Viewer

1. After accessing the **Chart Viewer**, select the appropriate **View** from the drop-down menu.

2. Click the **Quick Filter** icon to filter a list of desired records. A **Search** field displays with a list of filtering options.

   ![Quick Filter Icon]

   Clicking the **Quick Filter** icon a second time hides the **Search** field.

3. In the **Quick Filters** section, select from one or more categories to narrow the list of chart items further.
Viewing Results

1. From the **Clinical Desktop**, select the **Chart Viewer** component.
2. **Double-click** the desired result or resulted order. The **Order Viewer** displays with the details of the selected item.

   **OR**

   From the **Clinical Desktop**, select the **Meds** or **Orders** component.

---

**Urine Dip** Resulted: Requires Verification

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Flag</th>
<th>Reference</th>
<th>Last Verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color</td>
<td>Brown</td>
<td>A</td>
<td>REQUIRED</td>
<td></td>
</tr>
<tr>
<td>Clarity</td>
<td>Bloody</td>
<td>A</td>
<td>REQUIRED</td>
<td></td>
</tr>
</tbody>
</table>

Ordered by: **NOLAN, KELLY**  Collected/Examined: 18Aug2009 04:12PM
Verification Required: Stage: Final

---

**Results History**

18Aug2009 01Jun2009 4:12 PM 11:54 PM

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Flag</th>
<th>Reference</th>
<th>Last Verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color</td>
<td>Brown</td>
<td>A</td>
<td>REQUIRED</td>
<td></td>
</tr>
<tr>
<td>Clarity</td>
<td>Bloody</td>
<td>A</td>
<td>REQUIRED</td>
<td></td>
</tr>
<tr>
<td>Leukocytes</td>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitrite</td>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* indicates comments or annotations. Hover * or Report to view full result. Right click on result to view in new window.

---

**Order Details**

Status: Resulted: Requires Verification  Recorded as History: 18Aug2009 05:12PM
Requested Performing Location: In Office  Priority: Routine  Order #: T163671  Requisition #: 475  Overdue after: 26Aug2009
Ordered by: **NOLAN, KELLY**  Supervised by: **NOLAN, KELLY**  Authorization: Not Required
Order Instructions: Clean Catch Method Used

---

**Results** can be printed, faxed, or copied, among other actions, from this page.
The following table describes the various icons associated with results.

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Icon" /></td>
<td>Indicates normal results that are unverified.</td>
</tr>
<tr>
<td><img src="image2" alt="Icon" /></td>
<td>Indicates unverified results containing at least one abnormal value.</td>
</tr>
<tr>
<td><img src="image3" alt="Icon" /></td>
<td>Indicates normal results that are verified.</td>
</tr>
<tr>
<td><img src="image4" alt="Icon" /></td>
<td>Indicates verified results containing at least one abnormal value.</td>
</tr>
<tr>
<td><img src="image5" alt="Icon" /></td>
<td>Viewed in Chart Viewer, this icon indicates results that have been scanned into Enterprise EHR.</td>
</tr>
</tbody>
</table>
**Appointment Scheduling**

The purpose of this workflow is to schedule a patient for an appointment.

1. The Clinic staff/Call Center determines if patient is new or established by performing a **thorough** search in IDX.

2. If the patient is **New**, the Front Desk needs to obtain and enter the following information: Billing Party, Patient Full Name, Address, Phone Number, Date of Birth, and Social Security Number.

3. If the patient is **Established**, the current demographic information should be **reviewed** for accuracy.

4. Once demographic information is obtained, an appointment, including **Reason for Visit**, is scheduled via IDX.

5. If the appointment is a **Referred Appointment**, enter the Referring Physician on the appointment detail screen.

6. The registration and scheduling information is sent via an interface to Allscripts.

**Appointment Preparation**

The purpose of this workflow is to prepare the appointment based on whether the patient is **New** or **Established**.

For **New Patients**:

1. No paper chart currently exists and will not be created.

2. Determine at this time if the patient's appointment requires paperwork to be prepared prior to the patient's appointment and proceed accordingly.

3. It is recommended that all necessary documents are scanned at the time the patient arrives for their appointment.

For **Established Patients**:

1. If applicable, check the patient's appointments for any arrived office visits with other providers. Example: Referrals/consults

2. To check patient's medical record for referral/consult notes, from the **VTB**, click **Chart**.

3. From the **HTB**, click the **Clinical Desktop** tab.

4. Click the **Chart Viewer** component and review for any notes associated with referral/consult appointment(s).
Appointment Check-In

The purpose of this workflow is to check-in the patient via IDX.
1. Verify that the PCP (Primary Care Provider) is loaded into IDX.
2. If necessary, add Referring Provider to the correct field in IDX.
3. Scan any necessary documents such as signed demographic form, HIPAA, and Insurance cards.

Appointment Check-In with Front Desk Adding Medical History

The purpose of this workflow is to check-in the patient via IDX and then add Medical History.
1. Verify that the PCP (Primary Care Provider) is loaded into IDX.
2. If necessary, add Referring Provider to the correct field in IDX.
3. Scan any necessary documents such as signed demographic form, HIPAA, and Insurance cards.
4. From the appropriate Daily Schedule in Allscripts, double-click the patient. The Clinical Desktop displays.
5. Per the clinic protocol, only clinical staff or physician will add medical history using the patient intake process.
PATIENT VISIT OVERVIEW

The Patient Visit, at its basic level, is comprised of a “collection” of workflows. For example, during an office visit, there are many variables that could make up this collection, such as:

- The provider writing a prescription
- Placing a laboratory order, a radiology order, or a referral order
- Using different note definitions and templates to document the encounter, etc.

This workflow is used to achieve a basic understanding of the steps your organization follows to efficiently transport the patient through an office visit.
ENTERING VITALS

Entering Vitals Information

The Vitals icon on the Clinical Toolbar allows quick and convenient access to enter and edit vitals for a selected patient. Additionally, FlowSheets are available to track trends over time by graphing or flowing vitals. Once Vitals have been entered, it is a simple matter to update the values and apply them again to the same patient.

1. From the Clinical Toolbar, click the Add New Vitals button. The Order Details page displays.

   - A default Vital Sign panel displays for patient based on sex and age. To change panel view, click drop-down menu, and click appropriate Vital Signs panel: Child <3, Female, Male, and Orthostatic Blood Pressure.

2. From the Link to drop-down menu in the upper-right corner of the page, verify that a problem is NOT linked to the vitals entry.

3. Enter the patient’s vital signs.
Enter vital information **Temperature, Pulse, Respiration, and Blood Pressure**, by typing information in the provided field, and pressing the **Tab** key on the keyboard to advance to the next entry space.

When available, you can click a number pad icon next to a selected field.

Add additional information to the vitals by clicking the appropriate information from the drop-down menu, or tap the **Space Bar** and then use **Up or Down Arrows** on the keyboard to make a selection. It is also possible to type the first letter of the selection to open the drop-down menu, and allow you to make your correct choice.

Enter **Height** and **Weight** by typing in appropriate fields.

Add additional information to the vitals by clicking the appropriate information from the drop-down menu, or tap the **Space Bar** and then use **Up or Down Arrows** on the keyboard to make a selection. It is also possible to type the first letter of the selection to open the drop-down menu, and allow you to make your correct choice.

Enter **Height** and **Weight** by typing in appropriate fields.

4. Click the **OK button**. The **Order Details** page closes and the selected vital(s) displays in magenta.

5. To save, access the **Encounter Summary** by clicking the **Commit** button on the **Clinical Toolbar**.

6. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.

- **BMI** and **BSA** calculate if height and weight are entered.
- **Orthostatic Blood Pressures** can be entered as part of initial vitals, or separately if done later in the office visit.
- If a value is entered outside of the normal parameters, a prompt displays giving the appropriate range.
Correcting Vitals Information

It is possible to make corrections to Vital sign entries from the Vitals, Flowsheets and HMP components on the Clinical Desktop.

1. From the HMP component of the Clinical Desktop, right-click the incorrect vital entry.

2. Select Edit from the right-click menu.

   Or select Edit from the component Action bar.
The **Order Details** page displays.

3. Locate the incorrect vital entry and type or use the number pad to enter the correct information.

4. Click the **OK** button.
The **Order Details** page closes and the corrected vital(s) displays in magenta.

5. To save, access the **Encounter Summary** by clicking the **Commit** button on the **Clinical Toolbar**.

6. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.

   - If a vital was **Entered in Error** (EIE), right-click the entry and select **Enter in Error** from the menu.
   - **Enter in Error** removes the entire vital entry for that specific date and time.
Introduction to the ACI

The Add Clinical Item (ACI) window allows the entry of the patient’s clinical information in a single location.

- The History Builder tab contains secondary tabs for entering or updating Medical History (PMH, PSH, Fam Hx, and Social Hx) as well as Allergies, Med Hx, and Immun Hx.
- The Rx/Orders tab contains secondary tabs for ordering and administering medications, ordering labs, tests, follow-up appointments, requesting referrals, or immunizations.
- The Problem-based Orders tab contains secondary tabs that organize medication and non-medication orders linked to a specific problem. The two options for problem-based ordering include CareGuides and QuickSets. CareGuides are pre-delivered problem-based order sets, whereas QuickSets are automatically developed as the user links orderable items to specific problems. Both options provide efficiency when placing orders.
- After entering or updating all relevant information, click the OK button. Clicking the OK button does not commit the information to the database; instead, it places the entries in a “Work In Progress (WIP)” status. Placing items in a WIP status allows the user to continue the designated workflow without having to pause and save after every step. The added items can then be reviewed simultaneously after completing the workflow and Committed to the clinical record. Another advantage to the WIP status is allowing for corrections prior to committing entries to the record. This avoids having to Enter in Error anything that was added incorrectly. The information is saved to the Encounter Summary and is available to the provider to review at the start of the patient encounter.
- The WIP is also valuable if a computer freezes or during a power failure. If the same user logs in to the same terminal and selects the same patient, they get a WIP message to allow them to Commit the information for that patient. Information such as free text or dictation does not save to the WIP.
Using Favorites to Search

When adding new clinical items such as allergies or problems to a patient’s record, it is necessary to perform an item search.

- Searching using the **My Favorites List** or **QuickList** is significantly more efficient than searching through a master list of items.
- If a **My Favorites List** has not been created, **Enterprise EHR** automatically searches through the **Specialty Favorites**.
- **Enterprise EHR** automatically conducts incremental searches.
- If the search produces no matching results, click the **Search** icon to utilize the master search capabilities of **Enterprise EHR** or search from the alpha tabs located on the right side of the **ACI**.
- Searches utilizing the alpha tabs are far more efficient for tablet users as there is no need to scroll through lists of items.

<table>
<thead>
<tr>
<th>Search Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Master List</strong></td>
<td><strong>Enterprise EHR</strong> dictionary containing all diagnoses and codes.</td>
</tr>
<tr>
<td><strong>My Favorites</strong></td>
<td>Enables the user to save his/her most frequently used dictionary entries in a user-specific custom list.</td>
</tr>
<tr>
<td><strong>Specialty Favorites</strong></td>
<td>A pre-defined list of items that is relevant to the selected department or specialty. Enables a user to move quickly through a list of items in place of searching through an extensive master list.</td>
</tr>
<tr>
<td><strong>QuickList</strong></td>
<td>Functions as a subset of the <strong>My Favorites</strong> list that contains the most frequently used orderable items. This is a personalized specialty favorites listing per user.</td>
</tr>
</tbody>
</table>
# Searching the ACI

When adding new clinical items such as allergies or problems to a patient’s record, it is necessary to perform an **item search**.

<table>
<thead>
<tr>
<th>Search Tools</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Search</strong> field</td>
<td>The search field allows for the entry of free text.</td>
</tr>
<tr>
<td><strong>Green Arrow</strong> icon</td>
<td>The Green Arrow icon erases the text in the search field.</td>
</tr>
<tr>
<td><strong>Refresh</strong> icon</td>
<td>If a search produces no matching results, click the Search icon to utilize the master search capabilities of Enterprise EHR or search from the alpha tabs located on the right side of the ACI.</td>
</tr>
<tr>
<td><strong>Refresh</strong> icon</td>
<td>The Refresh icon clears the text in the search field and refreshes the item list.</td>
</tr>
<tr>
<td><strong>ICD9</strong> button</td>
<td>When the ICD9 button displays a green light, the search will only return results associated with ICD9 codes. When the button displays a gray light, all results will display.</td>
</tr>
<tr>
<td><strong>My Favorites List</strong></td>
<td>If a My Favorites List has not been created, Enterprise EHR automatically searches through the Specialty Favorites (such as Family Medicine).</td>
</tr>
<tr>
<td><strong>Alpha Tabs</strong></td>
<td>Searches using the My Favorites List or QuickList. This is much more efficient than hunting through a master list of items.</td>
</tr>
<tr>
<td><strong>Alpha Tabs</strong></td>
<td>Searches utilizing the Alpha Tabs are far more efficient for tablet users as they do not require scrolling through lists of items.</td>
</tr>
</tbody>
</table>
Creating a Favorites List

1. On the **ACI**, highlight the “favorite” item from the **Specialty List**.

2. **Right-click** the highlighted item. A menu displays.

   - **Favorite Item**
   - **Quick List Item**
   - **Edit**
   - **Deny**
   - **Alpha Tab**
   - **List Mode**

3. Select **Favorite Item** to add the highlighted item to the **My Favorites List**. The favorite items display when **My Favorites** is selected as the search list.

Introduction to the History Builder

The **History Builder** tab is used to quickly add or edit new historical items to the patient’s record. These items are verified at the beginning of the encounter or recorded during the patient intake process.
The information on the left pane of the **History Builder** tab displays the patient’s chart. In this image, the user is able to view quickly the patient’s Active Problems, Current Meds/Orders, and Allergies. Click the drop-down arrow in each section to view other historical items for the patient.

The tabs on the right pane of the **History Builder** tab are used to add historical items.

### Selecting an Encounter

The **Encounter Selector** allows you to manage the current encounter for the selected patient. The Encounter selector displays when data is added to a patient that was **not** selected off the Daily Schedule.

1. From the **Encounter Selector**, select the **Appointment** under **Existing Encounters** that the data you are adding is related to. **Do not use** the **New Encounter** option.

2. To continue, Click the **OK** button.

![Encounter Selector -- Webpage Dialog](image)

- The Encounter Selector will display anytime that you attempt to add data to a non-scheduled patient’s chart.
Adding a New Problem

The ACI provides a tool for effective documentation, tracking and management of patient problems. Problems are used to describe the condition of a selected patient, and include diagnoses, complaints, problematic conditions and social issues such as exposure to smoke or a family history of terminal illness.

**NOTE:** Only symptoms should be added to the chart (such as “Cough”). Any problems which are diagnoses (such as “Hypertension”) may only be added by a provider.

3. From the Clinical Toolbar, click the Add New Problem icon. The ACI displays with the History Builder and Active tabs selected.

4. Enter the problem in the search field. The selected list filters as text is entered to create a string of search results.
   - The selected list may be changed by choosing another option from the drop-down menu.
   - Click the Search icon to search the master dictionary.
   - Chronic diseases that could be associated with Medicare patients are identified in the ACI with an HCC label.
   - It is possible for a problem to display on more than one view of the Problems page. For example, a problem can display on both the Active and PMH view.

5. Once identified, select the checkbox to the left of the problem(s). The selected problem(s) displays in magenta in the upper-left section of the ACI.
6. If necessary, double-click the problem in the master list to display the **Problem Details** page.

   The **Problem Details** page displays.

   ![Problem Details Page]

7. Enter any necessary problem details.

8. Click the **Save and Return to ACI** button to save the details and return to the **ACI**.

   **OR**

   Click the **Save and Close ACI** button to save the details and return to the **Clinical Desktop**.

9. If returned to the **ACI**, click the **OK** button to return to the **Clinical Desktop**.

10. To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.

11. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.

   - To save time, users can remain on the **ACI** to continue entering a patient’s clinical information by selecting the desired tab, such as **PSH** or **Med Hx**.
   - When all entries are completed, click the **OK** button to return to the **Clinical Desktop**.
   - **Commit** To save all entries, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.
   - To maintain accurate patient records, the status of a problem that has been added to the patient chart in error can be changed to **Entered in Error**. If a patient no longer has a problem recorded on the chart, simply change the problem status to **Resolved**.
Adding Past Medical History (PMH)

1. From the **ACI**, select the **PMH** tab.
2. Enter the medical history item in the **search** field. The selected list filters as text is entered to create a string of search results.

3. Once identified, select the checkbox to the left of the item(s). The selected item(s) displays in magenta in the **upper**-left section of the **ACI**.
4. If necessary, **double-click** the item in the master list to display the **Problem Details** page.
5. Enter any necessary problem details.
6. Click the **Save and Return to ACI** button to save the details and return to the **ACI**. OR
   Click the **Save and Close ACI** button to save the details and return to the **Clinical Desktop**.
7. If returned to the **ACI**, click the **OK** button to return to the **Clinical Desktop**.
8. **Commit**
   To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.
9. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.
Adding Past Surgical History (PSH)

1. From the ACI, select the PSH tab.
2. Enter the surgical item in the search field. The selected list filters as text is entered to create a string of search results.
3. Once identified, select the checkbox to the left of the item(s). The selected item(s) displays in magenta in the upper-left section of the ACI.
4. If necessary, double-click the item in the master list to display the Problem Details page.
The **Problem Details** page displays.

5. Enter any necessary problem details.
6. Click the **Save and Return to ACI** button to save the details and return to the **ACI**.

   OR

   Click the **Save and Close ACI** button to save the details and return to the **Clinical Desktop**.

7. If returned to the **ACI**, click the **OK** button to return to the **Clinical Desktop**.

8. To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.

9. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.
Adding Family History (Fam Hx)

1. From the ACI, select the Fam Hx tab.
2. Enter the family history item in the search field. The selected list filters as text is entered to create a string of search results.
3. Once identified, select the checkbox to the left of the item(s). The selected item(s) displays in magenta in the upper-left section of the ACI.
4. Indicate the relationship of the problem owner to the patient. If unsure of the relationship, click the Fam Hx button (not the tab).
5. If necessary, double-click the item in the master list to display the Problem Details page.
The Problem Details page displays.

6. Enter any necessary problem details.
7. Click the **Save and Return to ACI** button to save the details and return to the ACI. OR
   - Click the **Save and Close ACI** button to save the details and return to the Clinical Desktop.
8. If returned to the ACI, click the **OK** button to return to the Clinical Desktop.
9. To save, click the **Commit** button on the Clinical Toolbar to access the Encounter Summary.
10. From the Encounter Summary, click the **Save and continue** button. The magenta text changes to black.
Adding Social History (Social Hx)

1. From the ACI, select the Social Hx tab.
2. Enter the social history item in the search field. The selected list filters as text is entered to create a string of search results.

3. Once identified, select the checkbox to the left of the item(s). The selected item(s) displays in magenta in the upper-left section of the ACI.
4. If documenting that a patient denied a Social Hx such as smoking, highlight the item and right-click.
5. From the menu, select Deny.
   - The Deny option can be applied to other sections, such as denying that a patient is allergic to latex.
6. If necessary, double-click the item in the master list to display the Problem Details page.
The **Problem Details** page displays.

7. Enter any necessary problem details.
8. Click the **Save and Return to ACI** button to save the details and return to the **ACI**.

   OR

   Click the **Save and Close ACI** button to save the details and return to the **Clinical Desktop**.

9. If returned to the **ACI**, click the **OK** button to return to the **Clinical Desktop**.

10. To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.
11. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.
Adding Allergies

Two types of allergies may be entered: Medication allergies and Non-Medication allergies (pollen, bee stings, etc.). Users have the option to include reaction information with each allergy added to a patient’s chart.

1. From the ACI, select the Allergies tab.

2. Select the associated radio button for the allergen being recorded: Medication or Non-Medication.

3. Enter the allergen in the search field. The selected list filters as text is entered to create a string of search results.
   - The selected list may be changed by choosing another option from the drop-down menu.
   - Click the Search icon to search the master dictionary.
   - The Allergies page can also be accessed from the Clinical Toolbar. Click the Add New Problem icon and select the Allergies tab.

4. Once identified, select the checkbox to the left of the allergen(s). The selected allergen(s) display in magenta in the lower-left section of the ACI.

5. Details for the selected item may be viewed or modified by double-clicking the allergen.
The **Allergy Details** page displays.

6. In the **Reactions** field, click the **Search** icon to enter a reaction.
   - If the patient has no allergies OR no drug allergies, it is required to select either **No Known Allergies** or **No Known Drug Allergies** as appropriate.
The **Allergy Reaction** page displays.

7. Select the checkbox for the appropriate allergy reaction(s).
8. Click the **OK** button to return to the **Allergy Details** page.
9. Enter other allergy details as needed.
10. Click the **OK** button to return to the **Clinical Desktop**.
11. **Commit** To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.
12. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.

⚠️ Allergens associated with a lethal reaction (e.g., anaphylaxis) display with a red triangle icon within the **Allergies** component of the **Clinical Desktop**.

- If the desired reaction is not in the list, **Other** can be selected and the needed reaction typed in the **Describe Other** field.
There are times when either the provider or the clinical staff will need to print the allergy list.

1. Select the **Allergies** tab.

2. Select **Print Allergy List** from the menu at the bottom of the component.

3. In the **Print Dialog** box, select the appropriate server and printer from the provided drop-down lists.

4. Click **OK** to print the list.
Adding Medication History (Med Hx)

Med Hx is most often used to document paper chart histories or to record a patient’s medication history into Enterprise EHR.

1. Right-click anywhere within the Meds or Orders component. A menu displays.
2. From the ACI, select the Med Hx tab.

3. Enter the medication in the search field. The selected list filters as text is entered to create a string of search results.
   - The selected list may be changed by choosing another option from the drop-down menu.
   - Click the Search icon to search the master dictionary.
   - The Med Hx page can also be accessed from the Clinical Toolbar. Click the Add New Problem icon and select the Med Hx tab.

4. Once identified, select the checkbox to the left of the medication(s). The selected medication(s) displays in magenta in the middle of the left pane of the ACI.

5. If necessary, double-click the item in the master list to display the Medication Details page.
6. Enter any necessary medication details.
7. Click the **Save and Return to ACI** button to save the details and return to the **ACI**.
   OR
   Click the **Save and Close ACI** button to save the details and return to the **Clinical Desktop**.
8. If returned to the **ACI**, click the **OK** button to return to the **Clinical Desktop**.
9. To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.
10. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.
    - If the patient is not currently taking any medications, it is required to select **No reported medications** from the **ACI**.
Adding Unverified Prescriptions from SureScripts

1. Double click on patient from Daily Schedule.
2. Go to the MEDS tab on the clinical desktop.
3. Right click on the Medication name. Highlight the “Verify and Add” to display a second menu.
4. Click on the appropriate action from the second Menu.
   a. **Active** - Patient states they are currently taking the medication.
   b. **D/C** - The provider determines the medicine needs to be discontinued for specific reasons like an adverse reaction or it is ineffective for the problem.
   c. **Complete** - The patient was taking it, but the medication is all gone.
      i. Example - an Antibiotic.
   d. **Temporary Deferral** - the patient states they stopped taking it for a short period of time for a specific reason. (example - Coumadin before teeth extraction)
   e. **Permanent Deferral** - Patient refuses to take the medication for whatever reason.

5. If the Patient states they were never taking the medication - Right click on the medication and select “**Remove**” from the menu.
Printing Medication History (Med Hx)

There are times when the need arises to print the Medication History, such as the patient requesting a list of medications.

1. Right-click anywhere in the **Meds** component to display the menu.

2. Scroll to the bottom of the menu. Select **Print Medication List**.

3. In the **Print Dialog** box, select the appropriate server and printer from the provided dropdown lists.

4. Click **OK** to print.

- Only the displayed list will be printed (e.g. Current Medications or Past Medications). To print both Current and Past Medications, the process will need to be executed twice, changing between Current Medications and Past Medications in between.
Adding Immunization History

Patient immunization information can be documented and managed within Enterprise EHR. Enter both current and historical immunization information in order to maintain complete, up-to-date and accurate patient records.

1. From the ACI, select the Immun Hx tab.

2. Enter the immunization in the search field. The selected list filters as text is entered to create a string of search results.
   - Click the Search icon to search the master dictionary.
   - The selected list may be changed by choosing another option from the drop-down menu.
   - To avoid opening the Immunization Details page, click the Calendar icon to enter a date in the Done field.

3. Once identified, select the checkbox to the left of the immunization(s).
The Immunization Details page displays.

4. Click the Calendar icon to enter the Date/Time that the immunization was given.
5. Click the OK button to return to the Clinical Desktop.
6. To save, click the Commit button on the Clinical Toolbar to access the Encounter Summary.
7. From the Encounter Summary, click the Save and continue button. The magenta text changes to black.
   - In order to avoid the need to Commit between entries in the immunization record, right-click on the selected immunization in the ACI and select Duplicate. Follow steps 5 – 7 above after all immunizations are entered.
   - It is required to select Immunization History Unknown if no history is available.
Printing Immunization History

There are times when the need arises to print the Immunization History, such as the patient requesting a list of immunizations.

1. Select the Immunization component of the Clinical Desktop or the Immunizations Series view in the HMP component.

2. From the drop-down menu, select Immunizations Series.
3. Click **Print** on the toolbar at the bottom of the **Immunizations** component.

4. In the **Print Dialog** box, select the appropriate server and printer from the provided drop-down lists.

5. Click **OK** to print.
Adding a Chief Complaint

To add a Chief Complaint, determine what type of visit the patient is coming in for. There are 3 types of visits – an Acute Visit, Problem Based Visit, and a Health Maintenance Visit.

1. **Acute Visit** - Select the reason the patient is coming in from the list of Chief Complaints.

2. **Problem Based Visit** - When a patient comes in for an established problem select the problem from their problem list.
When the note is started the HPI form related to that problem will populate.

3. Free text the reason for the visit in the **Chief Complaint Comments** box. This box is also used for **Health Maintenance Visits** and to provide additional details about the chief complaint.

4. **Health Maintenance Visit** – Start the **Health Maintenance Note** and use the **Chief Complaint Comments** box to note the reason for the visit.
Viewing the Encounter Summary

The **Encounter Summary** is used to review and edit the information entered during the encounter. It provides users a final opportunity to modify data before saving to the patient’s chart.

- On the **Clinical Toolbar**, click the **Encounter Summary** icon.
  OR
- On the **Clinical Toolbar**, click the **Commit** button.

The **Encounter Summary** displays.

- To remove an item, select the checkbox to the left of the desired item in magenta. The checkmark is removed from the associated checkbox.
- To modify an item, right-click the desired item and select the appropriate action from the displayed menu.
The following table describes the items on the **Encounter Summary** toolbar.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>View By: Problem</td>
<td>Filters the <strong>Encounter Summary</strong> by problem or type.</td>
</tr>
<tr>
<td></td>
<td><strong>Expands all of the folders on the</strong> <strong>Encounter Summary</strong>.</td>
</tr>
<tr>
<td>Pat Loc: 04 Exam Room</td>
<td>Displays the patient’s location and allows it to be changed.</td>
</tr>
<tr>
<td>Status: Departed</td>
<td>Displays the patient’s status and allows it to be changed.</td>
</tr>
<tr>
<td></td>
<td>Creates a new task.</td>
</tr>
<tr>
<td></td>
<td>Displays a menu to allow the user to add additional items to the patient’s chart or create a new task.</td>
</tr>
</tbody>
</table>

**Committing Information to the Encounter Summary**

On the bottom of the **Encounter Summary**, click one of the following buttons to perform the appropriate action.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Print Pt.Ed</strong></td>
<td>Prints a copy of all actions taken during the encounter for the patient including ordered medications, labs, imaging, follow-ups, referrals, supplies, or patient instructions as appropriate.</td>
</tr>
<tr>
<td><strong>Continue</strong></td>
<td>Returns the user to the <strong>Clinical Desktop</strong> without saving the patient information.</td>
</tr>
<tr>
<td><strong>Save and continue</strong></td>
<td>Commits/Saves the patient information and returns the user to the <strong>Clinical Desktop</strong>.</td>
</tr>
<tr>
<td><strong>Save</strong></td>
<td>Commits/Saves the patient information without closing the <strong>Encounter Summary</strong>.</td>
</tr>
<tr>
<td><strong>Delete Unsaved</strong></td>
<td>Deletes all items in magenta text displayed on the <strong>Encounter Summary</strong>.</td>
</tr>
</tbody>
</table>
7. From the Clinical Desktop, select an item within a Component.

8. Right-click the desired entry and select Edit from the displayed menu. The Details page displays.

9. If necessary, scroll down to the Annotations section.

10. Make necessary changes to the item (medication, order, problem, allergy, immunization, etc) details.

11. In the New Annotation text box, enter a free-text annotation.

12. Click the OK button. The Details page closes and the selected item(s) displays in magenta.

13. To save, access the Encounter Summary by clicking Commit on the Clinical Toolbar.

14. From the Encounter Summary, click the Save and continue button. The magenta text changes to black.

This process may be used to add an annotation to any item in the patient’s chart.
MEDICATIONS

Dispensing a Sample Medication

Sample medications given to patients during a visit can be recorded in Allscripts.

1. From the Clinical Toolbar, click the Add New Medication drop-down.
2. Select Rx from the menu. The Add Clinical Item (ACI) displays with the Rx/Orders and Rx tabs selected.

3. From the ACI, select method of Communication. Send to Retail should be the default.
4. Select Dispense Sample.
5. From View Pane #1, select the associated problem.
   - If the problem is not entered, select the History Builder tab, enter the problem, and then continue to enter the order.
   - For Providers: Ensure the box to the left of the problem in View Pane #1 is checked to also Assess it.
6. Enter the medication in the search field. The selected list filters as text is entered to create a string of search results.
   - The selected list may be changed by choosing another option from the drop-down menu.
   - Click the Search (binoculars) icon to search the master dictionary.
7. Once identified, click the checkbox to the left of the medication(s). The Medication Details page displays. The selected problem displays in the Link to field.

- If an Alternative Medications page displays, prescribe as appropriate.
- Based on the patient’s Rx Benefit Plan, the Co-Pay and Coverage Detail section may contain pertinent information. This section displays any retail and mail order co-pay data and provides a link to additional coverage details. The link navigates the user to the coverage details panel within that dialog where data such as age/gender/quantity limits are displayed. The Co-Pay field displays the co-pay detail for the medication in context. The Coverage field displays the coverage limit detail for the medication in context.

8. From the Medication Details page, select the appropriate SIG and instructions.

- Personal – Displays list of all available sigs or those that the user has previously used for the selected medication.
- New Structured – Enables the user to create a new sig for the selected medication using pre-defined entry fields; the sig is available under Personal the next time the user selects the medication.
- New Free Text – Enables the user to create a new sig for the selected medication using free text entry; the sig is available under Personal the next time the user selects the medication.

9. In the Days field, enter the number of days supply.

10. In the Qty field, enter the appropriate quantity based on the days and SIG.

11. In the next two immediate fields, select the appropriate follow-up action from the drop-down menus – Complete, Evaluate, or Renew and the desired date for the action.

- Complete – complete the therapy at this date: the medication no longer displays on the active meds list. It displays in Past Meds, keeping the meds list clean.
- Evaluate – evaluate the therapy at this date: the patient must be evaluated again prior to refilling the medication.
- Renew – renew the therapy at this date.
12. Click the **Record Sample** tab in the *upper*-left corner of the screen.

13. In the **Qty** field, enter the appropriate quantity based on the days and **SIG**.

14. In the **Lot #** field, enter the manufacturer’s lot number.

15. In the **Exp** field, enter the expiration date on the medication packaging.

16. Select the appropriate manufacturer from the **Manufacturer** drop-down field.

17. Enter the **Dispense Date** as today.

18. Click **Save and Close ACI**. The **Medication Details** page closes. The selected medication(s) displays in magenta in the middle of the left pane of the **ACI**.

19. If additional orders need to be entered, click **Save and Return to ACI**.

20. To save, access the **Encounter Summary** by clicking **Commit** on the **Clinical Toolbar**.

21. From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.
A Task is a request for action assigned to an individual or team of individuals responsible for completing the task. The following tasks are used from the Allscripts Rx+ module:

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to Med</td>
<td>A Go to Med task is created when a user creates a new task from the Medications page with a medication selected. The new task’s action is Process Med.</td>
</tr>
<tr>
<td>Med Renewal</td>
<td>A Med Renewal task is created when a user creates a new task from the Medications page with a medication selected. The new task’s action is Process Med.</td>
</tr>
<tr>
<td>Med Admin</td>
<td>A Med Admin task is created by the system when a prescription is written with an action of Administer and any of the following fields on the Administration tab of the Medication Detail page are blank: Admin by Admin date</td>
</tr>
</tbody>
</table>

**DUR Warnings**

Drug Utilization Review is an important component and indicator when ePrescribing. These are system-prompted warnings that display during the prescribing process. These warnings are just that; they do not tell providers how to prescribe, but they do caution that what is being prescribed may not be appropriate for this patient based on past medications, interactions, established industry standards, or allergy history. Depending on what medication with associated information is being prescribed at the time, the user may or may not receive a warning.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-Drug</td>
<td>Identifies potentially dangerous drug combinations and assists in assessing the risk of administering the prescribed drugs concurrently. Rx+ considers a past prescription to be current up to 30 days past duration of therapy, including refills.</td>
</tr>
<tr>
<td>Drug Dosing</td>
<td>Identifies prescriptions where daily dosage or duration of therapy is outside the recommended ranges.</td>
</tr>
<tr>
<td>Duplicate Therapy</td>
<td>Identifies prescribed drugs that have the same therapeutic effects as medications the patient is currently taking. Warnings provide the names of potentially duplicate drugs and their therapeutic class. Rx+ considers a past prescription to be current up to 30 days past duration of therapy, including refills.</td>
</tr>
<tr>
<td>Drug-Health State Interactions</td>
<td>Identifies drugs that may be contraindicated based on the patient’s known health state. In addition to specific disease-state contraindications, broader conditions such as pregnancy, lactation, and patient age are considered.</td>
</tr>
<tr>
<td>Prior Adverse Reactions (PAR)</td>
<td>Identifies drugs that, based on the patient’s history of a previous allergy or other adverse experience, include drugs or ingredients to which the patient may react similarly.</td>
</tr>
<tr>
<td>Formulary Alternatives</td>
<td>Identifies and displays alternative drug therapies to the drug being selected for prescribing which may be more cost-effective to the patient. It provides detailed information about co-pay and coverage by the patient’s Rx Benefit Plan.</td>
</tr>
</tbody>
</table>
Rx Renewal with No Changes

1. From the Clinical Desktop, select the Meds tab. The Medications component displays with a list of the patient’s medications organized by the default view.

2. Highlight the medication to be renewed.

   Multiple medications can be renewed at the same time by using the Shift or Ctrl keys on the keyboard to select medications.

3. Right-click within the component and select Renew from the menu.

4. To save, click Commit on the Clinical Toolbar.

   This option should be used only if you are certain that no changes are necessary. This includes changes to the days, supply, qty, and refills.
Rx Renewal with Changes

1. From the **Clinical Desktop**, select the **Meds** tab. The **Medications** component displays with a list of the patient’s medications organized by the default view.

   ![Medications Component](image)

   - **Amoxicillin 250 MG Oral Capsule; TAKE 1 CAPSULE ORAL ACTIVE - Retrospective Authorization**
   - **Aspirin 81 MG Oral Tablet; TAKE 1 TABLET 1 TIME A DAY**
   - **Cefclor 500 MG Oral Capsule; TAKE 1 CAPSULE ORAL**
   - **Citalopram Hydrobromide 10 MG Oral Tablet; ACTIVE - Retrospective Authorization**
   - **Cyanocobalamin 1000 MCG/ML Injection Solution; TO BE DONE: 20Aug2010; Status: IN PENDING**
   - **Cyanocobalamin 1000 MCG/ML Injection Solution; ONCE A MONTH; Recurring Schedule 7/2010:**
   - **Meds Component with Renew with Changes option highlighted**

2. Highlight the medication to be renewed.

   - **Multiple medications can be renewed at the same time by using the Shift or the Ctrl keys on the keyboard to select medications.**

3. **Right-click** within the component and select **Renew with Changes** from the menu.
The **Medication Details** page displays.

4. If necessary, modify the **dosage** using the drop-down menu in the upper-left corner of the page.
5. From the **Medication Details** page, select the appropriate **SIG** and instructions.
6. In the **Days** field, enter the amount of days supply. Based on the **SIG** and instructions, the **Qty** field may populate with the correct amount.
7. In the **Refill** field, enter the number of refills for this medication.
8. In the next two immediate fields, select the appropriate follow-up action from the drop-down menus – **Complete**, **Evaluate**, or **Renew**, and the **desired date** for the action.
9. Select the desired action for the prescription delivery method from the corresponding **Action** drop-down menu.
10. If sending to a pharmacy or calling the prescription in to a pharmacy, select the appropriate location from the Pharmacy drop-down menu.

   ![Search (binoculars)](image)

   Click the **Search (binoculars)** to search the master dictionary.

11. If appropriate, select the **Split Rx** checkbox and complete the secondary set of fields.

12. In the **Ordered by** field, select the authorizing provider for the medication.

13. If appropriate, in the **Therapy** area, select the **End date** for this medication.

14. Click **Save and Close ACI**. The **Medication Details** page closes. The selected medication(s) displays in magenta in the middle of the left pane of the **ACI**.

   ![Save and Close ACI](image)

   If additional orders need to be entered, click **Save and Return to ACI**.

15. To save, access the **Encounter Summary** by clicking **Commit** on the **Clinical Toolbar**.

16. From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.
Deferring a Medication

1. **From the Clinical Desktop**, select the **Meds** tab. The **Medications** component displays with a list of the patient’s medications organized by the default view.

2. Highlight the medication to be deferred.

3. From the bottom of the component, click **Edit**.
The **Medication Details** page displays.

4. Click the **Status** button. The **Change Status** page displays.
5. Click the **Status** drop-down arrow.
6. From the menu, select **Temporary** or **Permanent Deferral**.
7. Select the reason and the date for the deferral and click **OK**.
8. **Commit**

To save, click **Commit** on the **Clinical Toolbar**.

9. The medication displays as **Deferred** in the **HMP**.

Permanent Deferrals do not display on the **HMP**.
Reactivating a Deferred Medication

1. From the Clinical Desktop, select the Meds tab. The Medications component displays with a list of the patient’s medications organized by the default view.

   ![Medications Component](image)

2. Sort by Status.

3. Locate and select the medication with a status of Temporary Deferral.

4. Right-click within the component and select Renew with Changes from the menu.

   The medication component on the qChart can also be used to renew a medication.
5. From the Medication Details page, in the upper-right corner, check Record w/o Ordering checkbox.

6. Click OK. The medication displays on the Clinical Desktop with an Active status.

7. To save, click Commit on the Clinical Toolbar.
Reconciling the Medication List

1. From the **Clinical Desktop**, select the **Meds** tab.

2. **Right-click** the medication.

3. Select **Reconciliation Hx** or **List Reconciled** from the menu. The **Reconciliation History** window displays with the medication, date, and user.
Editing an Existing Medication

During **Clinical Intake**, it is necessary to update the Medications of a patient. **Editing** a medication updates the information so that when the patient’s note for this appointment is opened, the Current Medications accurately cite into the note.

8. From the **Schedule**, **double-click** the appropriate patient. The **Clinical Desktop** displays with the appropriate patient in the **Patient Banner**.

9. From the **Meds** component, **right-click** the medication to be edited.

10. Select **Edit**. The **Medication Details** page displays.

11. Update the appropriate SIG, dosage, Ordering Provider, etc.

   - The **Action** (Record, Print Rx, Send to Retail, etc) cannot be changed in edit mode. That must be done in **Renew with Changes**.
   - Do not select a **SIG** that contains Days or Quantity.

12. If necessary, complete any other fields.

13. Click **OK**.

14. To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.

15. From the **Encounter Summary**, click **Save and continue**. The magenta text changes to black.
Entering a Medication in Error

For Clinical intake to update the current medication, it is possible that a medication was entered incorrectly and needs to be removed. Entering in Error removes a medication completely from a patient’s medication list. To **Complete** or **D/C** a medication places it into **Past Medications** for that patient.

1. From the **Schedule**, **double**-click the appropriate patient. The **Clinical Desktop** displays with the appropriate patient in the **Patient Banner**.
2. From the **Meds** component, click the medication to be entered in error. If more than one medication is to be entered in error, press the **Ctrl** key to highlight each medication.
3. **Right**-click the medication and select **Enter in Error**.
4. To save, click **Commit** on the **Clinical Toolbar**.
Printing a Medication Profile

A patient-centric Medication Profile can be printed to display the patient’s active medications, instructions, and reason for the medication, as part of the patient education materials.

1. Click the Encounter Summary button on the Clinical Toolbar. The Encounter Summary displays.

2. Check the Medication Profile checkbox.

3. Click Print Pt. Ed at the bottom of the Encounter Summary.

4. If necessary, select the correct print server and printer from the drop-down menus of the Print Dialog window.

5. Click OK. The Medication Profile prints to the selected printer. An example is shown below.
SureScripts

SureScripts is a vendor who provides online connectivity to retail pharmacies (vs. paper faxes). Best practice use of Rx+ is to enroll with this program as it further eliminates paper and requires less technical resources on the fax server.

If SureScripts is active, the system automatically detects if the pharmacy and the provider are enrolled. If either the selected pharmacy or the provider who created the prescription is not enrolled with SureScripts, the system automatically sends the prescription via traditional fax method.

Automatic transmission of the prescription is sent via SureScripts only if both the pharmacy selected, and the provider who created the prescription, are enrolled. Schedule II prescriptions are never sent or received electronically via SureScripts. They always need to be printed.

Processing Electronic Renew Requests

The Rx Renew Request displays on the Task List.

1. Highlight the task to display its details in the Comments section.
2. Double-click an Rx Renew Request task.

- **Schedule III-V** prescriptions are sent electronically and drop to hardcopy via fax at the pharmacy.
- **Schedule I-II** prescriptions are **NOT** to be sent or received via SureScripts.
The **Refill Details** page displays.

![Refill Details Page](image)

Allscripts has added an additional field, highlighted above:

- A new problem cannot be added from the **Rx Renew Task** workspace.
- Navigate to the ACI to enter a new problem, save and close.
- Go back to the **Rx Renew Request** task and complete the workflow.
- The new problem is available in the **Link To** field.
- When filling in the **Refill** field, notice that the **Total Fill** field automatically increases the refill number by one.
- The **Total Fills** is the total number of fills that the pharmacy can dispense.
  - Example above would be to dispense the 30 day supply with zero (0) refills.
  - The total number of fills that the pharmacy receives is one (1).
  - Information about the refill(s) updates the medication fill history appropriately.

3. Complete the required fields, and click **Grant**.

The following **Mail Order** pharmacies also accept **ePrescriptions** via **SureScripts**:

- CVS Caremark Mail Order
- Express Scripts Home Delivery (ESI)
- Medco Health Services Mail Order
- Prescriptions Solutions Mail Order
- Prime Mail
- Walgreens Mail Service Pharmacy
- WellPoint, NextRx
OR

If the medication is not to be renewed, click Refuse.

- If your medication is not linked to a problem, when you click Grant, the Medication Details page displays.
- The link in the upper right-hand corner displays in Yellow indicating that it is required for a medication to be linked to a problem before the Rx Renewal can be completed.
- Select the problem from the drop-down list of problems.
- If you do not have the problem in the patient’s chart, cancel out of the Medication Details window, select cancel in the lower right hand corner of the Script Message Webpage Dialog (task).
- Navigate to the Add New Problem icon on the clinical toolbar, update the patient’s problem list, and return to your task.

OR

If you need to verify information, click Cancel from the Refill Details page.

- Return the ACI.
- Verify that the problem exists or add the problem.
- When a problem is not linked to the medication N/A displays.

- Go back to the Refill task and proceed as normal.
Ordering and Entering an Administered Med

1. From the Clinical Toolbar, click the Add New Medication drop-down.

2. Select Medication Administration from the menu. The Add Clinical Item (ACI) displays with the Med Admin tab selected.

3. From View Pane #1, select the associated problem.
   - If the problem is not entered, select the History Builder tab, enter the problem, and then continue to enter the order.
   - For Providers: Ensure the box to the left of the problem in View Pane #1 is checked to also assess it.

4. Enter the medication in the search field. The selected list filters as text is entered to create a string of search results.
   - The selected list may be changed by choosing another option from the drop-down menu.
   - Click the Search (binoculars) icon to search the master dictionary.
The **Medication Details** page displays. The selected problem displays in the **Link to** field.

5. Select the appropriate **Sig** and instructions.
6. In the **To Be Done** section, select the desired date for the order to be completed.
7. In the **Ordered By** field, select the authorizing provider for the medication.
8. If appropriate, in the **Therapy** area, select the **End date** for this medication.
9. From the top of the page, select the Record Administration tab.

10. Complete all fields in the Administration Details section on the Record Administration tab.

11. Click Save and Return to ACI. The Medication Details page closes, returning to the ACI. The selected medication(s) displays in magenta in the middle of the left pane of the ACI.

12. Click OK to return to the Clinical Desktop.

13. To save, access the Encounter Summary by clicking Commit on the Clinical Toolbar.

14. From the Encounter Summary, click Save and continue. Magenta text changes to black.
Entering a Scheduled Administered Med

1. From the Clinical Toolbar, click the Add New Medication drop-down.

2. Select Medication Administration from the menu. The Add Clinical Item (ACI) displays with the Rx/Orders and Med Admin tabs selected.

3. From View Pane #1, select the associated problem.
   - If the problem is not entered, select the History Builder tab, enter the problem, and then continue to enter the order.
   - For Providers: Ensure the box adjacent to the problem is checked to also assess it.

4. To enter a series of dates, click Schedule.
5. The **Schedule Dialog** page displays. Select the **Recurring** radio button.

6. Select a **Recurrence Type** (*Dates*, Recurring, or *As Needed*).

7. Create a **Recurrence Pattern** (*Daily*, *Weekly*, *Monthly*, or *Yearly*).

8. Verify a date or **Range Of Recurrence** pattern.

9. Click the **Generate** button. The dates display in the **Selected Date:** field.

10. Click **OK** to exit the **Schedule Dialog** page. The **ACI** page displays.

11. Enter the medication in the **search** field. The selected list filters as text is entered to create a string of search results.

   - The selected list may be changed by choosing another option from the drop-down menu.

   - Click the **Search (binoculars)** icon to search the master dictionary.

12. After selecting the date or the schedule for the administration, if needed, complete the **Ordered By** field, selecting the authorizing provider for the medication.

13. If appropriate, in the **Therapy** area, select the **End** date for this medication.

14. Click **Save and Close ACI**. The Medication Details page closes. The selected medication(s) displays in magenta in the middle of the left pane of the ACI.

   - If additional orders need to be entered, click **Save and Return to ACI**.
15. **Commit**: To save, access the **Encounter Summary** by clicking **Commit** on the **Clinical Toolbar**.

16. **Save and continue**: From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.

17. From the **Clinical Desktop**, navigate to the **HMP** tab.

18. **Right-click** the medication, and select **Record As Admin** from the menu.
The **Record Administration** page displays.

19. Complete all fields in the **Administration Details** section on the **Record Administration** tab.

20. Click **OK**. The **Medication Details** page closes. The selected medication(s) displays in magenta on the **HMP** and the **Meds** component.

21. To save, access the **Encounter Summary** by clicking **Commit** on the **Clinical Toolbar**.

22. From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.
ORDERS

Entering Lab Orders as Part of an Office Visit

Allscripts enables users to generate and manage patient orders. Orders may include lab procedures, diagnostic imaging, and other orderable items. These may then be grouped or added to a favorites list.

1. From the Daily schedule, click the Note icon next to the patient name to bring the patient into context and open the visit note.

2. From the Clinical Toolbar, click the Add New Order drop-down arrow.

3. Select Lab/Procedures from the menu. The Add Clinical Item (ACI) displays with the Rx/Orders and Lab/Procedures tabs selected.

If not searching for a Lab/Procedures order, select the tab of the desired type of order: Imaging, FU/Ref, Instructions, Immun, Supplies, or Med Admin.

4. From View Pane #1, highlight the associated problem.
   - If the problem is not entered, select the History Builder tab, enter the problem, and then continue to enter the order.
   - For Providers: Check the box to the left of the problem in View Pane #1 to also assess it.
5. Select the **Specialty Group** or **My Favorites**.
   - The selected list may be changed by choosing another option from the drop-down menu.

6. In the **To Be Done** field, verify the current date or click the **Calendar** icon to enter the date.
   - To record an order without ordering it, select the **Record w/o Ordering** checkbox to the right of the **Specialty Group**. This is useful for recording tests or immunizations that have been reported by the patient or have otherwise come the attention of the clinical staff.

7. Enter the order in the **search** field. The selected list filters as text is entered to create a string of search results.
   - The selected **Specialty Group** list may be changed by choosing another option from the drop-down menu.
   - **Medical Necessity Checking** should occur outside of the Allscripts order entry process following the clinic-defined process.

8. Once identified, click the checkbox to the left of the orderable item(s).
   - The order displays in **Viewing Pane #2** of the **ACI**.

9. If the order is complete, click **OK**.
   - **OR**
   - If the order requires additional details, right-click and select **Edit** from the menu. Complete order details as needed.

10. Collection dates and times need to be entered manually from the **Clinical Questions** section of the **Order Details** page for applicable orders.

    Click **Commit** from the **Clinical Toolbar**.
Editing Orders

1. From the Clinical Desktop, select the Orders tab. The Current Orders component displays with a list of the patient’s orders organized by the default view.

2. Right-click the order.
3. Click the Edit button.

   The Order Details page displays.

   To record the specimen collection and send the lab order electronically to the lab:

   a. Select Additional Details to open the section on the screen.

   b. Click Specimen Collection. The window to record collection opens.
c. Click **Now** at the top of the window to record the collection of the specimen. The current date and time is automatically recorded.

d. Click **OK** to save the information to the order.

e. Click **OK** in the bottom right-hand corner to save the order.

4. If there are multiple orders for the same patient, the previous steps will enter the collection date and time for all orders with the **same specimen type** (such as blood, stool, or urine). Repeat step 3 above for lab orders with **different** specimen types. **For example**, if you have an order for a CBC and a Urine Culture, you will need to repeat step 3 above for each order due to the difference in specimen type (blood vs. urine).

5. Click **Commit** to send the requisition(s) electronically to CML. Fold the printed requisition and insert it in the outer sleeve of the bio-bag with the specimen.

6. For the specimen label, the **minimum** requirements are: **Name, Date of Birth, Requisition Number, Gender, Date and Time the specimen was drawn**, and **Initials of who drew the specimen**.
Reprinting a Requisition

1. From the **Clinical Desktop**, select the **Orders** tab. The **Current Orders** component displays with a list of the patient’s orders organized by the default view.

2. Highlight the order.
3. **Right-click** the order.
4. Select **Print Requisition** from the menu.
The **Print Dialog** page displays.

5. If not already defaulted, select a printer.

6. Click **OK**. All orders related to the selected encounter and for the same performing location reprint.

7. Add or edit the order details including the collection date/time for lab orders or the linked problem and click **OK**.

8. **Commit**. To save, click **Commit** on the **Clinical Toolbar**.
Resulting Orders

Once a new In-office Order is added from the ACI, Results can be entered.

1. From the Order Details page, select the Results tab.
2. Verify that the result is linked to the correct problem.
3. Next to the Collected/Examined box, click Now to indicate that you are currently recording.
4. Specify the Performing Location as In Office.
5. Select the appropriate person for the Performed By field using the drop-down menu.
6. In the Results Item(s) section, enter the specific results.

7. If the provider should receive a task to verify the result, check the Verification Required checkbox.
   - It is recommended to send the provider a task for electronic verification of in-house labs instead of signing and scanning the paper result. This applies to specific lab tests only, and to those in which an automated report is not available from the instrumentation.
   - If you fail to check the verification box, it is necessary to error the entry after it is saved and begin the process again.
8. Click the OK button to return to the Clinical Desktop.
9. To save, click the Commit button on the Clinical Toolbar.
Resulting Previously Entered Orders

1. From the Daily schedule, double-click the patient to bring the patient into context in the patient banner.

2. Navigate to the Orders component tab of the Clinical Desktop view.

3. Validate that the display view is Current Orders.

4. Right-click the order and select Enter Result from the menu.

5. Enter the collected/examined date and time.

6. If the provider should receive a task to verify the result, select the Verification Required checkbox.

7. Specify the Performing Location and Performed By from the drop-down menus.

8. In the Results Item(s) section, enter the specific results.

9. Click the OK button to return to the Clinical Desktop.

10. To save, click the Commit button on the Clinical Toolbar to access the Encounter Summary.

11. From the Encounter Summary, click the Save and Continue button. The magenta text changes to black.
Entering Results from Outside Sources

1. From the Daily schedule, double-click the patient to bring into context in the patient banner.
2. Click the Add New Order icon on the Clinical Toolbar. The ACI displays.
3. Highlight the problem in the Problem viewing pane.
   - If the problem is new, select the History Builder tab and add the problem.
4. Return to the Rx/Orders primary tab and the Lab/Procedures secondary tab.
5. Locate the order.
6. Right-click the order and select Enter Result.
7. Enter the collected/examined date and time.
8. Enter the patient’s PCP in the Ordered By field.
9. Specify the Performing Location and Performed By from the drop-down menus.
10. In the Results Item(s) section, enter the specific results.

11. Click the Orders tab, and in the Order Annotation section enter the specifics of where this lab was drawn/resulted.
12. Click the OK button to return to the Clinical Desktop.
13. To save, click the Commit button on the Clinical Toolbar to access the Encounter Summary.
Order Workflows

Working with Scheduled Orders

1. **Double-click** the patient to activate from the appropriate schedule OR search to activate and navigate to the clinical desktop.
2. Navigate to the **Orders** component tab of the **Clinical Desktop** view.
3. Validate that the display view is **Current Orders**.
4. Note that the parent order is displayed in italics. Each child order associated to the scheduled parent order displays individually.
5. The children orders activate/generate on the date that they are to be done.
6. The orders may also be viewed by navigating to the **HMP** tab of the **Clinical Desktop** view.
7. To create the next instance of an order, **right-click** the date in the **Incomplete** column from the **HMP** and select **Generate Next Instance**.
8. Click **Commit**.
9. Click **Save and Continue** from the **Encounter Summary**.
10. If the order is being performed prior to the originally scheduled date, **right-click** the date in the **Incomplete** column of the **HMP**.
11. Click **Edit**.
12. Update the date as needed from the order detail screen and click **OK**.
13. Click the **Commit** button on the **Clinical Toolbar**. The **Encounter Summary** page displays.
14. From the **Encounter Summary** page, click **Save and Continue**.

Marking an Order with a Complete Status

1. **Double-click** the patient to activate from the appropriate schedule OR search to activate and navigate to the clinical desktop.
2. Navigate to the **Orders** component tab of the **Clinical Desktop** view.
3. Validate that the display view is **Current Orders**.
4. **Right-click** the order name and select **Completed Today**. (May also hold the **Ctrl** key and highlight numerous orders at the same time.)
5. Click the **Commit** button on the **Clinical Toolbar**. The **Encounter Summary** page displays.
6. From the **Encounter Summary** page, click **Save and Continue**.
Changing the Status of an Order

1. *Double*-click the patient to activate from the appropriate schedule OR search to activate and navigate to the clinical desktop.
2. Navigate to the Orders component tab of the Clinical Desktop view.
3. Validate that the display view is Current Orders.
4. *Right*-click the order name.
5. Select **Edit**.
6. Click the **Status** button.
7. Update the status to Canceled (single order), Discontinued (series order), Entered in Error, or Temporary Deferral.
   - It is not recommended to use Permanent Deferral as these entries do not display on the HMP and display in the overdue orders list.
8. If using the deferral status, enter the length of time for the deferral.
9. Select a reason for the status change.
10. Click **OK**.
11. Click the **Commit** button on the Clinical Toolbar. The Encounter Summary page displays.
12. From the Encounter Summary page, click **Save and Continue**.

Viewing a Discontinued, Entered in Error, Canceled, or Completed Order:

1. From the Orders tab on the Clinical Desktop, change to the All Meds/Orders view.
2. Scroll to the section for Entered in Error, Completed, Canceled, or Discontinued.

Discontinuing an Order Reminder

The reminder displays on the HMP tab on the Clinical Desktop. Once an Order Instance is generated, it displays in the Incomplete column. Until that time, the Reminder date displays in the To Do column.

1. *Double*-click the patient to activate from the appropriate schedule OR search to activate and navigate to the clinical desktop.
2. Navigate to the HMP tab of the Clinical Desktop view.
3. *Right*-click the date in the To Do column next to the order reminder.
4. Select Order D/C.
5. Click **OK**.
6. Click the Commit button on the Clinical Toolbar. The Encounter Summary page displays.
7. From the Encounter Summary page, click **Save and Continue**.
Creating an Order Instance from an Existing Reminder

1. *Double-*click the patient to activate from the appropriate schedule OR search to activate and navigate to the clinical desktop.
2. Navigate to the **HMP** tab of the **Clinical Desktop** view.
3. *Right-*click the date in the **To Do** column next to the reminder.
4. Select **Order**.
5. Complete the required fields on the order detail screen, if needed.
6. To edit an order in which the detail screen did not automatically display, *right-*click the date in the incomplete column and select **Edit**.
7. Complete the required fields on the order detail screen, if available.
8. Click **OK**.
9. Click the **Commit** button on the **Clinical Toolbar**. The **Encounter Summary** page displays.
10. From the **Encounter Summary** page, click **Save and Continue**.

Starting and Stopping an Order/Reminder Deferral

1. *Double-*click the patient to activate from the appropriate schedule OR search to activate and navigate to the clinical desktop.
2. Navigate to the **HMP** tab of the **Clinical Desktop** view.
3. *Right-*click the date in the **To Do** column next to the order/reminder.
4. Select **Defer or Stop Deferral**.
5. If **Defe**r is chosen, select a **Deferral Reason** and **Deferral Time Frame** on the detail screen.
6. Click **OK**.
7. Click the **Commit** button on the **Clinical Toolbar**. The **Encounter Summary** page displays.
8. From the **Encounter Summary** page, click **Save and Continue**.
IMMUNIZATIONS

Ordering and Entering Administered Immunizations

The physician or provider notifies the clinical staff of the need for an Immunization via order, and changes the patient’s status to Orders Pending. The clinical staff cites the information into the note created by the provider during the visit.

1. From the Daily schedule, click the Note icon next to the patient name to bring the patient into context and open the visit note.
2. From the Plan section of the Note, click the New button.

3. The Add Clinical Item (ACI) displays. Select Immunizations from the menu.
4. From **View Pane #1**, highlight **Health Maintenance**.

If not being ordered for a specific problem, immunizations can generally be linked to **Health Maintenance**.

5. Select the **Specialty Group** or **My Favorites**.

6. In the **To Be Done** field, verify the current date or click the **Calendar** icon to enter the date.

**Immunizations** and **Medication Administrations** can also be ordered on a recurring basis.

7. Enter the order in the **search** field. The selected list filters as text is entered to create a string of search results.

   - The selected list may be changed by choosing another option from the drop-down menu.
   - Click the **Search (binoculars)** icon to search the master dictionary.

8. Once identified, select the checkbox to the left of the orderable item(s). The **Immunization Details** page displays. The selected problem displays in the **Link to** field.

9. Select the appropriate **SIG** and instructions.

   - To create a new **Sig**, select the **New Structured** radio button.
   - Once a new **Sig** is created, it displays on the **Personal** list for future orders.
10. In the **Ordered By** field, verify or select the ordering, managing, or supervising provider for the medication.

11. If appropriate, in the **Therapy** area, select the **End** date for this medication.

12. From the top of the page, select the **Record Administration** tab.

13. In the **Series** field, enter the number of the immunization within the immunization series, if applicable.

14. In the **Dose** field, enter the dose administered and select the appropriate method and location from the **Route** and **Site** drop-down menus.

15. Select the appropriate user from the **Admin By** drop-down menu.

16. Verify the date and time already entered in the **Date/Time** field or change the date and time in the corresponding field using the **Date/Time** button.

17. Select the manufacturer of the vaccine from the **Manufacturer** drop-down menu.

18. In the **NDC** field, enter the National Drug Code (NDC).

19. In the **Lot** field, enter the number of the lot in which the vaccine was manufactured.

20. In the **Exp** field, enter the expiration date of the vaccine.

   The last day of the month should be entered for vials containing only a month and year of expiration.
21. Select the checkbox for **Consent Obtained**, if applicable.
22. Complete the **Vaccine Information Statement** section in the lower section of the page.
   - To enter **Annotations**, return to the **Order Entry** tab.
   - **Annotations** may be used when multiple staff members are administering the vaccines and their names need to be recorded.

23. Click **Save and Close ACI**. The **Note** page displays.

If additional orders need to be entered, click **Save and Return to ACI**.

24. From the **Note** page, click **Save** or **Sign** or click **Commit** from the **Clinical Toolbar**. The **Encounter Summary** page displays.

25. From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.
Entering an Immunization in Error

1. From the Schedule, double-click the appropriate patient. The Clinical Desktop displays with the appropriate patient in the Patient Banner.
2. From the HMP component, select Immunizations Series from the drop-down menu.
3. Right-click the date of the appropriate Immunization.
4. Click Enter in Error. The date disappears from the flowsheet.
5. To save, access the Encounter Summary by clicking Commit on the Clinical Toolbar.
6. From the Encounter Summary, click Save and Continue. Magenta text changes to black.
Immunization Workflows

Documenting a Single Immunization from a Scheduled Order

1. Navigate to HMP component on the Clinical Desktop.
2. Locate the immunization.
3. Right-click the date.
4. Select Record as Admin from the menu. The Medication Details page displays.
5. From the Record Administration tab, complete the administration, VIS, and Consent fields as required in the medication dialog box.
6. From the Order Entry tab, enter any annotations.
7. Click OK.
8. Click the Commit button on the Clinical Toolbar. The Encounter Summary page displays.
9. From the Encounter Summary page, click Save and Continue.

Deferring an Immunization

1. The provider notifies the clinical staff at end of the visit of the need for an immunization deferral or the clinical staff gathers the information during the history collection.
2. From the Daily schedule, double-click the patient to bring the patient into context in the patient banner.
3. Click the Add New Order drop-down from the Clinical Toolbar.
4. Select Immunizations from the menu. The ACI displays.
5. From the Viewing pane, select Health Maintenance as the associated problem.
6. Begin typing the immunization name in the search field to search from the My Favorites list. Press Enter to search the Master List.
7. Click the checkbox to the left of the desired immunization.
8. In the Immunization Details screen, click the Status box.
9. From the Change Status dialog box, from the Status drop-down menu, select Permanent or Temporary Deferral. (Not recommended to post these entries to a note.)
10. Click the box to select an appropriate deferral option, such as had illness or out of supplies and click OK.
11. Enter the Sig, as this is required.
12. It may be necessary to select the New Structured radio button and create a new sig if an appropriate choice is not already available in the Personal sig listing.
13. Verify or update the ordering, managing, and supervising provider(s).
14. Click Save and Close ACI.
15. From the Clinical Toolbar, click Commit.
16. From the Encounter Summary, click Save and Continue.
17. Navigate to the HMP tab of the clinical desktop view.
18. Select Immunizations Series from the drop-down menu.
19. The immunization is listed as Permanently Deferred in the immunization flowsheet/grid.
Reactivating a Deferred Immunization
1. With the patient in context, navigate to the HMP tab of the Clinical Desktop view.
2. Right-click the status of Deferred and select Stop Deferral.
3. Click the Commit button on the Clinical Toolbar. The Encounter Summary page displays.
4. From the Encounter Summary page, click Save and Continue.
5. Right-click the date next to the immunization in the HMP tab and select Record as Admin.
6. On the administration screen, complete the required fields. (See administration workflow for details.)
7. Click the Commit button on the Clinical Toolbar. The Encounter Summary page displays.
8. From the Encounter Summary page, click Save and Continue.

Printing the Immunization List
1. With the patient in context, navigate to the Immunizations Series flowsheet of the HMP on the Clinical Desktop view.
2. From the Action bar, click Print.
3. If not already defaulted, select the printer.
4. Click OK.

Documenting the Reading of a PPD Administration
1. With the patient in context, navigate to the Immunizations Series flowsheet of the HMP on the Clinical Desktop view.
2. Right-click the immunization in the flowsheet grid.
3. Select Annotate.
4. Enter annotations regarding the reading of the PPD.
5. Click OK to return to the Clinical Desktop.
6. Click the Commit button on the Clinical Toolbar. The Encounter Summary page displays.
7. From the Encounter Summary page, click Save and Continue.
PROBLEM-BASED ORDERS

Entering Orders via QuickSets

QuickSets are groups of previously ordered medications and non-medications. They provide the user with an efficient way of entering problem-related orders. Unlike CareGuides, QuickSets are “learned” over time for each user. As orderable items are linked to specific problems, a QuickSet is developed for the associated diagnosis (problem).

1. From the Clinical toolbar, click the Problem-Based Order button. The Add Clinical Item (ACI) displays.

Quicksets automatically populate as problem-based orders for medications, labs and tests, and other orderable items are ordered.
2. From **Viewing Pane #1**, select the checkbox to the left of the desired problem. A list of previously ordered items (orderable items and medications) for the selected problem displays.

3. Click the checkbox to the left of the desired orderable item(s).

4. Click **OK** to return to the **Clinical Desktop**.

5. To save, access the **Encounter Summary** by clicking **Commit** on the **Clinical Toolbar**.

6. From the **Encounter Summary**, click **Save and continue**.
Modifying QuickSets

1. From **Viewing Pane #1** of the **ACI**, select the checkbox to the left of the desired problem. A list of previously ordered items (orderable items and medications) for the selected problem displays.

2. Right-click the **QuickSet** item.

3. Select **Edit**, **Reminder**, **Administer**, **Remove** or **Save as Personal QSet Defaults**.

4. Click **OK**.
CLINICAL NOTE

Clinical Note Workflow

Clinical Notes provide an electronic record of a patient’s encounter.
- Clinical staff will start the Note for the provider.
- Text is entered into a note using Note Forms, Custom Text Templates or free-text.
- Patient data can be automatically or manually cited into a note from other pages within Allscripts, such as the Medications or Problems List.
- Dictations and anatomical markups can be included in a note as well.

The Clinical Note includes problem management, ordering medications, labs, tests, and other orderable items, creating dictations, and capturing patient visit charges.

Adding Structured v11 Notes

Notes provide an electronic record of a patient’s encounter. Text is entered into a note using custom templates or free text. Patient data can be automatically or manually cited into a note from other areas within Allscripts, such as the Medications or Problems List. Anatomical markups can be included in a note as well.

Notes are displayed and managed from the Note Authoring workspace (NAW). To access the NAW, perform one of the following:

- Click the Note icon on the Clinical Toolbar.
- Click the Note icon to the left of a patient’s name on the Daily Schedule. This icon displays once a note has been created for the selected encounter.
- From the Chart Viewer component of the Clinical Desktop, double-click the appropriate note title. The Note Viewer displays the selected note. Click the Edit button at the bottom of the Note Viewer.
- From the Task List page, select a note-related task. Review the task comments, if necessary, and click the Go To button.
1. On the **Clinical Toolbar**, click the **Note** icon and select **Start New Note** from the drop-down menu. The **Note Selector** page displays.

2. In the **Style** field, select the **Note** radio button.
3. Select the **Specialty** from the drop-down menu.
4. Select the appropriate **Visit Type**. The current note is used to document.
5. From the **Owner** drop-down menu, select the user who finalizes the note. If the appropriate user is not displayed in the drop-down, click the **search** (binoculars) icon to search. Users with insufficient ownership authority are not options for selected visit types.

6. To add a chief complaint, expand the **Chief Complaint** section.
7. Click the **Add/Remove Chief Complaints** link and refer to the *Adding a Chief Complaint* section in this Reference Guide. The **Chief Complaint(s)** displays in the lower portion of the **Note Selector** page.
8. Click the **OK** button. The **NAW** displays.
Structured Note templates may be designed to auto-cite the patient’s active Allergies, Problems, Vitals, and Medications depending on the **Visit Type** selected when starting the note.

- The left-hand panel displays the **Table of Contents** with the available forms listed within each note section. It is recommended that staff use the table of contents when working the note.
- The **Visit Type**, **Owner**, and associated **Encounter Date** may be changed at any time until the note has been finalized.

If additional chief complaints are added, click the **Recompile** button at the bottom of the **NAW**. This automatically inserts any associated note forms in the **Table of Contents** in the **History of Present Illness** section.

- The **NAW** uses a separate Internet Explorer browser page, not part of the **Clinical Desktop**. This makes it possible to toggle between the **Clinical Desktop** and the **NAW**. If the **NAW** is minimized, it is located in the taskbar at the bottom of the screen.
Documenting within Note Forms

1. Select a form in the Table of Contents.

2. Document the selected note form using the associated controls. Refer to the following table for control descriptions.

<table>
<thead>
<tr>
<th>Control</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checkbox</td>
<td>When selected, indicates symptoms exist.</td>
</tr>
<tr>
<td>Degree Indicator</td>
<td>Displays to the right of clinical items within a form indicating additional details may be linked. When selected, the Detail page displays. Once completed the degree indicator displays as filled or “colored” in. Detail forms may be linked to any finding on a form, including symptoms.</td>
</tr>
<tr>
<td>Radio button</td>
<td>Indicates one of many possible symptoms exist. When a group of radio buttons is present, only one may be selected.</td>
</tr>
<tr>
<td>Text box</td>
<td>Used for entry of free text or dictation into a note section. Text templates may also be used to expedite this process.</td>
</tr>
<tr>
<td>Y/N Box</td>
<td>Indicates the presence or lack of a symptom.</td>
</tr>
</tbody>
</table>

3. At the bottom of the NAW, click the Save button when finished.
   OR
   Click the Save & Close button to save the current note and exit out of the NAW.
   OR
   Continue documenting note sections in the Table of Contents.
1. From the displayed form, click the **Degree Indicator** to the right of the appropriate clinical item.

The **Details** page displays.
2. Complete the pertinent information displayed on the **Details** page using the available controls.

3. When finished, click the **OK** button to exit and return to the **NAW**.
   - The Degree indicator under HPI will “tally” the points received and drop them to E/M Coder.
   - The **NAW** displays.

- Review the information rendered into the **Accumulator** (lower pane) of the note.
- If edits are necessary, click the **Degree Indicator** to access the **Details**.
NON-PATIENT VISIT OVERVIEW

The term “Non-Patient Visit Workflow” actually refers to a collection of process flows that may directly or indirectly pertain to a patient’s encounter. These process flows also relate to the day-to-day functions within the organization including internal and external communication, record keeping, etc.

The Non-Patient Visit Workflow includes the following areas of Allscripts:

- Call Processing
- Tasking
- Worklist Management
- Health Management Plans (HMPs)
- Document Management
- Scan
MANAGING PATIENT INFORMATION

Processing a Call

The Call Processing functionality in Allscripts is designed to allow staff to efficiently gather, route, communicate, and document patient phone calls. The primary mechanism used to route calls is via tasking. The Call Processing page contains patient demographic information as well as information pertaining to the call in process.

1. From the Vertical toolbar select Call Process, and from the Horizontal toolbar, select Call Process. The Call Processing page displays.

2. Click the Select Pt button.

3. Enter the patient’s last name, at least three letters of the first name, and press the Enter key.

4. Double-click the desired patient. The patient information displays in the Patient Banner.

5. Select the Patient is Caller checkbox, if applicable. The patient’s information populates the Call Processing page.

6. If the patient is not the caller:
   - Enter the caller’s relationship to the patient.
   - Enter up to two phone numbers and select the type from the drop-down.

7. Verify and, if necessary, add or edit the patient’s phone number.

   - Review the patient’s most recent previous and next appointments.
   - Review and discuss any Alerts as defined by protocol.
7. Select the appropriate User or Team from the Route To drop-down menu.
8. Select the appropriate reason for the call from the Reason for Call drop-down menu.
9. Enter the appropriate detail information in the Comments field.

Refer to the Using a Text Template procedure for more information about entering Comments with a template.

10. Click Copy to Task.
The **Task Detail** page displays.

11. Select the desired task type from the **Task** drop-down menu.
12. Select the desired priority for the task from the **Priority** drop-down menu.
   - **Routine** - overdue at 7 days
   - **ASAP** - overdue at 2 days
   - **Urgent** - overdue at 1 hour and must be accompanied by a phone call.
14. Enter additional text, if desired, in the **Comments** field.
15. If applicable, select the desired **Create Notify Task When** checkbox for this task.
16. Click **OK**.

   **AND / OR**

17. Click **Copy to Note**. The **Note Selector** page displays.

Refer to the **Copying a Task to Note** section for more information about using the **Copy to Note** function.

- Although the call information still displays on the page, the information has been sent to the appropriate user/team. Click the **Clear Form** button.
  
  **OR**

- Set the personalize page to automatically clear.
Personalizing the Call Processing Page

1. Click the **Personalize** link in the upper-right corner of the **Call Processing** page. The **Personalize** page displays.

2. Select the **General** options to default on the **Call Processing** page by selecting the appropriate checkbox(es).
   - Select the first three options.
   - The most popular option is **Clear Call Processing screen when click Copy to Task button**.
   - This option clears the **Call Processing** page when the **Copy To Task** button is clicked so that a visual confirmation is received that the task was copied successfully.

3. In the **Route to Default** section, select a **User** or a **Team** only if you send every call to the same person or team.

4. Select the appropriate user from the drop-down menu or click the **All** button to search for the user.

5. Select the **Default sort for My Calls** from the drop-down menu.

6. Click the **OK** button.
Accessing Unfinished Calls

1. From the **Vertical** toolbar, select **Call Process**.
2. Select **Unfinished Calls** from the **Horizontal** tabs. The **Unfinished Calls** page displays.
3. Select the appropriate call.
4. Finish entering call information as described above and **Copy to Task**.
   - **Unfinished calls** may be edited, deleted, and copied to a note or task from this page by the user who placed them in Unfinished status.
   - A new call can be started from the **Unfinished Calls** page by clicking the **Start New** button.
**Using a Text Template**

**Text Templates** contain standard content and are used to facilitate complete and consistent entry of information in the **Comments** field. Multiple text templates can be combined and if additional information is needed, free text can be entered directly into the **Free Text** page.

1. **Text Templates**... Click the **Text Templates** button to access the list of **Text Templates**. The **Free Text** page displays.
2. From the **Text Templates** section, select the appropriate template from the scrolling list. The selected text template displays on the left-hand side of the page.

3. Enter the required data into the template. Use the **Tab** key to advance to the next text field indicated within the brackets.
The following table describes the placeholders available for text entry within a template.

<table>
<thead>
<tr>
<th>Placeholder</th>
<th>Name</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>Text Entry</td>
<td>Onset: [ ] days ago. Enter text between the brackets.</td>
</tr>
<tr>
<td>[text]</td>
<td>Multiple-Choice</td>
<td>Progression: Pain is [increasing] [decreasing] [unchanged]. Click the appropriate option(s).</td>
</tr>
<tr>
<td>Text [ ]</td>
<td>Optional Text</td>
<td>Triggers: [None] [Exertion] [Stress] Other: [ ]. Enter text between the italicized brackets. If no text is entered between the italicized brackets, then the optional text does not display in the note.</td>
</tr>
</tbody>
</table>

4. Click the **Spell Check** button, if desired.

5. Click **OK**. The **Call Processing** page displays with the completed text template in the **Comments** section.
6. **Copy To Task...** Click **Copy to Task.** The **Task Detail** page displays with all of the information from the call.

![Task Detail](image)

7. From the **Task** drop-down field, select the **desired task type.**
8. Select the appropriate **User** or **Team** from the **Route To** drop-down menu.
9. Select the desired priority for this task from the **Priority** field.
   - **Routine**—overdue at 7 days
   - **ASAP**—overdue at 2 days
   - **Urgent**—overdue at 1 hour
10. Enter additional text, if desired, in the **Comments** field.
11. If applicable, select the desired **Create Notify Task When** checkbox for this task.
12. **OK** Click **OK** to activate the new task.
Viewing the Task List

An Allscripts task is defined as a request to either supply information or perform an action. **Tasks** are both created and completed in the system either manually or automatically (that is, triggered by the system because of specific activities). Utilizing tasks promotes effective communication and maximizes efficiency.

1. From the **Vertical** toolbar, select **Chart**. From the **Horizontal** toolbar, select **Task List**. The **Task List** page displays.

- The **Task List** page may be sorted in ascending or descending order using any of the column headings displayed by clicking the arrows to the right of the column name.
- The table below describes each column displayed on the **Task List** page.
<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
</table>
| P      | Indicates the **Priority** (level of urgency) for the selected task. The three priorities are:  
- Urgent  
- ASAP  
No indicator displayed indicates a task that should be completed on a Routine basis. |
| D      | **Delegated** indicates whether responsibility for the task has been assigned to another person. |
| Task   | Describes the particular information or action required by the task. |
| Patient| Patient with whom the task is associated. If blank, the task is not associated with a specific patient. |
| Assigned To | Person or team to whom “ownership” of the task is assigned. |
| Created By | Indicates whether the task was manually created (name of the person who created the task) or system-generated. |
| Created On | Date and time the task was created. |
| Status | Task status. Statuses may include:  
- **Active** — Indicates a task for which the activate date has been reached, but has not yet been completed.  
- **In Progress** — Indicates a task that is currently being performed.  
- **Complete** — Indicates a task that has been performed or completed.  
- **Inactive** — Indicates a task for which the activate date has not yet been reached.  
- **Removed** — Indicates a task that has been removed rather than completed. |
| Due    | Task due status.  
- Indicates a task for which the due date has been reached, but has not yet been completed.  
- No indicator displayed indicates a task for which the due date has not yet been reached. |
| MRN    | (Medical Record Number) MRN of the patient with whom the task is associated. |

Once a **Task** is completed, it can always be accessed in the **Current Patient – All** View.
2. Select the appropriate view from the **View** drop-down menu. The table below describes the three default task views available on the **Task List** page.

- **Tasks can be created from many pages in Allscripts by clicking the New Task button.**
- The **New Task** button displays differently on the **Clinical Desktop**.

<table>
<thead>
<tr>
<th>Task View</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Active Tasks</td>
<td>Displays active tasks for the person currently logged into the system.</td>
</tr>
<tr>
<td>Current Patient – Active</td>
<td>Displays only active tasks associated with the patient currently displayed in the <strong>Patient Banner</strong>.</td>
</tr>
<tr>
<td>Current Patient – All</td>
<td>Displays all tasks associated with the patient currently displayed in the <strong>Patient Banner</strong>.</td>
</tr>
</tbody>
</table>
Managing Tasks

After selecting the **Task List** page and sorting the information, the task list is ready to be “worked.”

When the action required by a task is performed within Allscripts, the associated task is automatically completed by the system. For example, the act of signing a note within Allscripts automatically completes the task requiring signature of the note.

However, a task that cannot be performed (or verified) within Allscripts must be manually completed in the system. For example, a telephone call cannot be made within Allscripts; therefore, after a telephone call has been made, the associated task must be manually completed in the system.

Working a task list includes the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viewing more information about a task</td>
<td>Select the task then click <strong>Details</strong>. The system displays the <strong>Task Details</strong> page for that task.</td>
</tr>
<tr>
<td>Marking the status of a task as In Progress</td>
<td>Select the task then click <strong>In Progress</strong>. The name of the user who performed this action displays in the <strong>Comments</strong> box.</td>
</tr>
<tr>
<td>Performing or Completing a task</td>
<td>Select the task then click <strong>Go To</strong>. The system displays the workspace from which a task’s action must be performed. For example, if working a Sign Note task, click <strong>Go To</strong> to display the <strong>Note Authoring Workspace</strong> and sign the note.</td>
</tr>
<tr>
<td>Reassigning a task</td>
<td>Select the task and then click <strong>Reassign</strong>. Indicate the new owner’s name; select an Allscripts user or a team.</td>
</tr>
<tr>
<td>Removing a task</td>
<td>Select the task and then click <strong>Remove</strong>. The system requires a reason why the task is being removed to be indicated. Enter additional details as appropriate.</td>
</tr>
<tr>
<td>Replying to a task</td>
<td>Select the task then click <strong>Reply</strong>. Indicate who should receive the reply, and then enter an appropriate comment. You can also edit the task’s priority if appropriate.</td>
</tr>
<tr>
<td>Copying a task to a note</td>
<td>Select the task then click <strong>Copy to Note</strong>. If a note is not in context, then the system displays the <strong>Note Selector</strong>; select the appropriate note.</td>
</tr>
</tbody>
</table>
Working the Task List

1. Highlight the task from the Task List.

2. Click In Progress from the Task List page. This alerts other team members that the task is being addressed.

3. From the Comments section, review the task information.
4. Click the **Details** button to open the task details page.

![Task Details](image)

5. In the **Comments** section type any additional information or possible follow-up actions.

   ![Text Templates](image)

   **Text Templates** can also be used for additional comments.

6. If the task requires additional follow-up by a user or team, select the appropriate **Assign To** radio button.

   ![Select User or Team](image)

   Select the **User** or **Team** from the drop-down list.

7. Verify that the **Priority** (ASAP, Routine, or Urgent) is correct based on the urgency of the task.

8. Click **OK**, the task is sent to the designated user or team for additional follow-up. The **Task** page displays.

   - If the task was assigned to a user or team, it is no longer on the user’s task List.
   - If the task was not assigned to a user or team, it remains as an active task on the user’s task list. Click the **Done** button to complete the task.
   - If a task is completed, additional information can no longer be added to the comments section.
The following buttons are available as options to aid in working the Task List:

<table>
<thead>
<tr>
<th>Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details</td>
<td>Displays the Task Details page for the task in context.</td>
</tr>
<tr>
<td>In Progress</td>
<td>Changes the status of the task to alert clinic personnel that the task is being addressed. The Comments box displays that performed this action.</td>
</tr>
<tr>
<td>Go To</td>
<td>Displays the workspace from which a task’s action must be performed. For example, clicking Go To for a Sign Note task displays the NAW to</td>
</tr>
<tr>
<td></td>
<td>allow editing, signing, and finalizing the note.</td>
</tr>
<tr>
<td>Reassign</td>
<td>Allows the user to send the task to a specific user or team for action.</td>
</tr>
<tr>
<td>Remove</td>
<td>Allows the user to remove the task from the system. The system requires a reason to be indicated for why the task is removed. Additional</td>
</tr>
<tr>
<td></td>
<td>comments can be entered as appropriate.</td>
</tr>
<tr>
<td>Reply</td>
<td>Allows the user to send a reply back to the sender of the task. The task’s priority can also be edited.</td>
</tr>
<tr>
<td>Copy to Note</td>
<td>Copies the task to a note. If a note is not in context, the system displays the Note Selector; select the appropriate note.</td>
</tr>
<tr>
<td>Undelegate</td>
<td>Sends the task back to the Assigned To user or provider.</td>
</tr>
<tr>
<td>Print List</td>
<td>Prints the entire task list for the selected view.</td>
</tr>
<tr>
<td>Print Task</td>
<td>Prints the selected task.</td>
</tr>
<tr>
<td>Original</td>
<td>When a notification that a task was completed is received, clicking on Original displays the original task sent previously.</td>
</tr>
<tr>
<td>Done</td>
<td>Completes the selected task and removes it from the list. Note: The system displays the Done button instead of Go To if a task</td>
</tr>
<tr>
<td></td>
<td>must be performed manually outside of Allscripts. In this case, click Done to complete the task.</td>
</tr>
</tbody>
</table>
Medication Refill – Call Processing Tasks

A call is received that a patient would like a medication renewed.

1. Click the Task List tab on the Horizontal Toolbar.
2. Highlight the appropriate Med Renewal Request task.
3. Review the task details in the Comments
   OR
   • Double-click the task. The Task Detail Web Page Dialog display.
   • Review the task details.
   • Close the Task Detail Web Page Dialog
4. From the Horizontal toolbar, select the Clinical Desktop tab. The Clinical Desktop displays.
5. From the Meds component, click the plus sign (+) to the left of the appropriate medication.
6. Review the medication to determine if Renew or Renew with Changes is appropriate.
   • Review the dosage.
   • Review the SIG.
   • Review the diagnosis linked.
   • Review the refills.
   • Review the action.
   • If any of these are no longer valid, use Renew with Changes.
   • If all are valid, use Renew. This option should be used with caution.
7. Right-click the appropriate medication.
8. Click Renew/Renew with Changes. (See above).
9. If Renew, go to Step # 13
10. If Renew with Changes, the Medication Details displays
11. Change the diagnosis link, Dosage, SIG, Action (Record, Send to Retail, etc), Quantity, Refills and/or Provider as is appropriate.
12. Click OK.
13. To save, access the Encounter Summary by clicking Commit on the Clinical Toolbar.
14. From the Encounter Summary, click Save and Continue. Magenta text changes to black.
15. Return to the Task List.
16. With the task highlighted, click Done.
Copying a Task to a Note

The Copy to Note function provides a method for documenting task history into a note. The information captured during the life cycle of the task becomes part of the patient’s permanent record and can be viewed in Chart Viewer.

1. Highlight the task from the Task List.

2. From the Task List page, click Copy to Note. The Encounter Selector page displays.
   - All tasks that contain clinical information associated with treatment, advice, or orders should be copied to a note.
   - It is a best practice for the last person to complete a task should be the person to copy to note, depending on security rights of the user.

3. If the task is not associated with an encounter, the Encounter Selector page displays.

4. Select the existing encounter if an actual appointment exists in the schedule.
   
   OR

   From the Type drop-down menu, select Chart Update. The Date defaults to today.

5. Click OK.
6. Select **Note** as the appropriate **Style**.
7. From the **Visit Type** drop-down menu, select **Telephone Note**.
8. Validate that the **Owner** is you and click **OK**.
The **Note** page displays based on **Style** selection.

9. Add additional comments as necessary and click **Sign**.

10. Enter your **Password** and click **OK**.

   - The ability to finalize a document is based on security rights.
   - If the **Make Final** checkbox is available, select it to finalize the note.
Removing a Task

Tasks that have been created in error should be removed, such as a duplicate task or a task created for an incorrect patient. The reason the task is being removed must be documented.

1. Highlight the task from the Task List.

2. Click Remove from the Task List page. The Remove Task page displays.

3. From the Remove Reason drop-down menu, select the reason the task is being removed.

4. Click OK.

Ensure additional comments are added to the Comment section.

4. Click OK.
The task displays in the **Current Patient-All** view with a status of **Removed**.

To restore a Removed task, highlight the task and click **Unremove**.
Personalizing the Task List Page

1. Click the **Personalize** link in the upper-right corner of the Task List page. The Personalize page displays.

2. Depending on your workflow, set the **General** radio button to either **User** or **Team**.
3. If appropriate, in the **Default Assigned To** field select a specific user or team.
4. Unless you have a very specific duty, the **Default Task Type** should remain blank.
5. **Automatic Refresh** should remain at 5 minutes.
6. Select **Always Show Note Selector When Copy Task to Note**.
7. Click the **OK** button.
Creating a New Task

1. Click the **New Task** button on the **Clinical Desktop**. **OR**
   - Click the **New...** button on the **Task List**. The **Task Detail** page displays.

2. Verify that the **Concerning patient** radio button is selected.
3. Select the appropriate **User** or **Team** radio button in the **Assign To** area.
4. Select the desired **User** or **Team** name from the **Assign To** drop-down menu or click the **All** button and search for the appropriate recipient.
5. From the **Task** drop-down field, select the desired task type.
6. Select the desired priority for this task in the **Priority** field.

   - **Routine** - overdue at 7 days
   - **ASAP** - overdue at 2 days
   - **Urgent** - overdue at 1 hour

7. Enter the desired text for the person receiving this task to read in the **Comments** field.

8. If applicable, select the desired **Create Notify Task When** checkbox for this task.

9. Click **OK** to activate the new task.

   - Tasking is only to be used for patient-related messages.
   - Tasking is not to be used for personal messages between staff that are not patient-related.
   - Tasking is only to be handled during “non clinic” hours. The Worklist is to be used during the normal clinical workflow.
WORKLISTS

Viewing a Worklist

Readily accessible, up-to-date test results enhance clinical decision-making, and thus directly affect the quality of patient care. Allscripts quickly and conveniently displays current test results via a Worklist. A Worklist is a series of orders and resultable orders within a patient record that meet the criteria defined in the Worklist view. Worklists provide an organized and efficient way to authorize medication orders, verify lab and test results, and process follow-ups and referrals.

Worklist items and tasks are not the same thing. Tasks are assigned to an owner; Worklist items are linked to a specific patient. In some cases, a task is a reminder that a Worklist item exists, but the inverse is not true. A best practice is to check the Worklist first then follow up with any remaining Task List items.

Patient-Centric Worklist:

The Patient-Centric Worklist displays a list of order or result-related items for a specific patient from the Clinical Desktop. The provider has access to the patient’s complete chart at the same time they are reviewing, authorizing, or verifying orders.

1. With a patient in context, select Chart from the Vertical toolbar.
2. To view a patient-centric Worklist, from the Clinical Desktop, select the Patient Worklist tab. A list of items requiring attention displays for the current patient in context.
3. Select the appropriate view from the View drop-down menu.
Cross-Patient Worklist:

The Cross-Patient Worklist displays a list of order or result-related items for multiple patients. The Cross-Patient Worklist is useful when it is not necessary to view the patient’s chart. Clinical Staff has access to the Cross-Patient Worklist.

1. To view a Cross-Patient Worklist, select Chart from the Vertical toolbar.

2. From the Horizontal toolbar, select Worklist. A list of patients with items requiring attention displays.

3. Select the appropriate view from the View drop-down menu. A list of patients with items requiring attention displays.

4. Highlight the desired patient name. A list of items requiring attention displays.
Results Communications

Additional Provider Input Needed:

1. Navigate to the Task list for Result FU tasks.
2. Highlight the first Call Patient with Results task to be worked.

3. Click In Progress. Note the patient's phone number before advancing.
4. Click Go To or double-click the task.
The **Results View** displays

5. Click **Edit** at the bottom of the output window.
The **Note Authoring** page displays.

6. In the **Verified Results** note section, review the results and provider annotation.  
   With any of the results notes, if the note was previously finalized, it may be necessary to click the **Unlock/Amend** button to gain access to the verified results note section.

7. Call the patient.  
   If necessary, minimize the note window to return to the Task list. From here, you may locate the patient’s phone number in the task details or the patient profile.

8. Highlight the first **Order/Result** in the list.  
   To highlight all items, hold the **Shift** key and highlight the last **Order/Result** in the list.

9. With the order names highlighted, **right-click** and select **Annotate**.  
   If preferred, it is possible to **right-click** and annotate on the orders/results individually instead of as a group.

10. **Type** the annotations that apply to all results OR click **TT** to use a text template.  
11. Click **OK** until the template/annotations are saved and you are returned to the Worklist.  
    If you must enter a second annotation, it is necessary to **Commit** the first one prior to entering a second; if you do not, the second annotation overlays the first.
12. If the provider needs to review this again or make additional comments based on the conversation held with the patient, click **Save and Close**.

13. Click **Save and Continue** from the **Encounter Summary** screen. The **Task List** displays.

14. With the task highlighted, click **Undelegate**.

15. With the task highlighted, click **Details** and return the task to an **Active** status.

16. Add the comment **see annotations** so the provider realizes there is new activity on the task.

17. Click **OK**. The task displays in the provider’s **My Active Task** view.

18. The provider is now responsible for the task. **Double-click** or click the **Go To** button; the result displays.

19. The provider clicks **Edit** to open the **Results Note**.

20. Navigate to the **Verified Results** section of the note.

21. **Right-click** on the result and select **Annotate** from the menu.

22. Enter additional comments on the result as appropriate.

   If you must enter a second annotation, it is necessary to **Commit** the first one prior to entering a second; if you do not, the second annotation overlays the first.
23. Once all comments have been entered for all of the results, click **Sign**. The **Note Signature** window displays. Ensure **Make Final** is checked. The note closes and finalizes.

24. With the task highlighted on the **Task List**, click **Details**.

25. Add the comment **see annotations** so the staff realizes there is new activity on the task.

26. Change the task to go to the appropriate team or individual in the **Assign to** field.

27. Click **OK**. The task displays in either the team’s or individual’s **My Active Task** view.

28. This sequence repeats until all issues and questions have been resolved between the provider and the staff.
**Call Patient with Results:**

1. Navigate to the clinic specific task list for **Call Results** tasks.
2. Highlight the first **Call Patient with Results** task to be worked.
3. Click **In Progress**.
4. Note the patient's phone number before advancing.
5. Click **Go To** or double-click the task. The **Result Communication** displays.
6. Click **Edit** at the bottom of the output window.
7. Review the results and provider annotation in the **Verified Results** note section.

8. Call the patient.
   - If necessary, minimize the note window to return to the Task list. From here, you may locate the patient’s phone number in the Task Details or the Patient Profile.

9. If the patient does not answer or a message is left to return the call, click **Cancel** in the lower right-hand corner to close the note and enter a comment in the Task Details.

10. Highlight the first **Order/Result** in the list.
    - To highlight all items, hold the **Shift** key and click the last **Order/Result** in the list.

11. With the order names highlighted, **right-click** and select **Annotate**.
    - If preferred, it is possible to **right-click** and annotate on the orders/results individually instead of as a group.

12. Type the annotations that are to be applied to all results **OR** click **TT** to use a text template.

13. Click **OK** until the template/annotations are saved and you are returned to the Worklist
    - If you must enter a second annotation, it is necessary to **Commit** the first one prior to entering a second; if you do not, the second annotation overlays the first.
14. If the patient requests a copy to be mailed, right-click the **Results Document** in the lower-left corner (output) and select **Print**.

- If necessary, select a printer and an appropriate document header.
- Click **OK**.
- Only the initial provider annotations display on the output.

15. Click **Save and Close**.

16. Mark the task as **Done**.
**Printing/Mailing Patient Results:**

1. Navigate to the **Printing Tasks** tab on the HTB.
2. Change the Task view to the clinic specific **Mail/Print** task view.

3. Check the boxes next to those to be printed OR check the top 'P' box to print all listed documents.

4. The **Print Dialogue** window displays.
   - If necessary, select a printer and an appropriate document header.
   - Click **OK**.
   - The tasks are automatically marked as **Done**.

5. It is recommended that the key pieces of information for the patient to review be highlighted prior to mailing.

6. To document that the results were mailed, navigate to the **Chart Viewer** component on the **Clinical Desktop**.

7. Locate the **Results Note**.
   - The date of the document should be the date the results were reviewed.

8. **Right**-click and select **Edit**.

9. Navigate to the **Verified Results** note section.

10. Highlight the first **Order/Result** in the list
    - To highlight all items, hold the **Shift** key and highlight the last **Order/Result** in the list.
11. With the order names highlighted, right-click and select **Annotate**.

   If preferred, it is possible to right-click and annotate on the orders/results individually instead of as a group.

12. Type the annotations that are to be applied to all results **OR** click **TT** to use a text template.

13. Click **OK** until the template/annotations are saved and you are returned to the Worklist.

   If you must enter a second annotation, it is necessary to **Commit** the first one prior to entering a second; if you do not, the second annotation overlays the first.

14. Click **Save and Continue**.

15. Repeat the above documentation steps for each printed result to be mailed.
HEALTH MANAGEMENT PLANS

Viewing a Health Management Plan

Allscripts Health Management Plan (HMP) provides a tool to prescribe and monitor periodic events related to patients’ health maintenance and disease management. Although neither tasks nor orders are generated from an HMP, alerts are created when an HMP item is near due or overdue. These may be viewed on the Clinical Desktop.

Physicians are able to view health management alerts from the Clinical Desktop. Health Management Alerts are visual indicators that a patient has an orderable item, with a status of either Overdue or Near Due. Health Management alerts occur because of Health Management Plans (HMP), which are defined as the creation and review of scheduled periodic orderable events related to patient disease and health management issues. An orderable event can be any of the following:

- Medication
- Follow-up or Referral
- Immunization
- Diagnostic test or Imaging study

An important point to keep in mind is that the HMP component consists of only the following three items:

- Orders or Results linked to a Problem
- Medications linked to a Problem
- Order Reminders
1. From the **Clinical Desktop**, select a view containing the patient’s **Health Management Plan (HMP)**.

2. Select the **Health Management Plan** component. The patient’s **HMP** displays.

3. Select the desired view from the drop-down menu in the upper-left corner of the component.
   - Items listed in a patient’s **HMP** may be viewed by *double*-clicking the desired item.
   - If modifications to the selected item are desired, click the **Edit** button within the item viewer.
   - Clicking the **New** button launches the **ACI** with the **Rx/Order** tab selected, allowing the user to add a new orderable item for the selected patient.
   - To invalidate a result, *right*-click and select **Enter in Error**.
The table below describes the available HMP views.

<table>
<thead>
<tr>
<th>View</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Management</td>
<td>Displays an overview of what is being treated for the patient. By default, these items are organized by Problem. The HMP can also be grouped by Specialty Problem or Problem Type.</td>
</tr>
<tr>
<td>Reminders/Alerts</td>
<td>Displays the active order reminders for the patient’s problems; can be grouped by Problem or Alert Type.</td>
</tr>
<tr>
<td>Immunizations Series</td>
<td>Displays the immunizations that are recorded for the selected patient.</td>
</tr>
<tr>
<td>Flowsheets</td>
<td>Displays a list of flowsheets defined for the organization and created by the system administrator.</td>
</tr>
<tr>
<td>Vital Signs/Findings</td>
<td>Displays a flowsheet of the selected patient’s vitals data.</td>
</tr>
<tr>
<td>Normative Growth</td>
<td>Enables selection of normative growth charts, defaulting to the appropriate chart for the patient based on age and sex. Two grouping options are available: <strong>0-36 Months Graph</strong> and <strong>2-20 Years Graph</strong>.</td>
</tr>
</tbody>
</table>
There are several buttons located at the top of the HMP component.

The following table describes their use:

<table>
<thead>
<tr>
<th>Name</th>
<th>Button</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refresh</td>
<td>🔄️</td>
<td>Refreshes the data within the component.</td>
</tr>
<tr>
<td>Flowsheet</td>
<td>📊</td>
<td>Displays a flowsheet view with data from the items checked on the previous view. If the user has not checked items with enough data to graph, the system displays the message, “There needs to be at least one item with more than one value to display a graph.”</td>
</tr>
<tr>
<td>Graph</td>
<td>📊</td>
<td>Generates a graph with data from the items checked from the previous view. If the user has not checked items with enough data to graph, the system displays the message, “There needs to be at least one item with more than one value to display a graph.”</td>
</tr>
<tr>
<td>Expand/Restore</td>
<td>📊</td>
<td>Expands or contracts the data within the component. By clicking the Expand/Restore button, it is possible to expand or contract all data items within the component simultaneously. <strong>Tip:</strong> For a complex patient with many problems displaying in the HMP component, it is a best practice to expand just one problem at a time to focus on the details for that single problem, rather than having the details for all problems expanded.</td>
</tr>
<tr>
<td>New Task</td>
<td>📊</td>
<td>Displays the Task Detail page to create a new task. Allscripts populates the Task Detail page with the selected patient’s name in the Concerning Patient box. It also sets the Assign To value to User and sets the User box to the current user. This occurs whether or not an item is selected in the HMP component.</td>
</tr>
</tbody>
</table>
The system displays the following values in the columns to the right of the problem and/or medication and order:

<table>
<thead>
<tr>
<th>HMP Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item Name</strong></td>
<td>Displays the item(s) actively associated to the patient’s HMP.</td>
</tr>
<tr>
<td><strong>Schedule</strong></td>
<td>If the provider has scheduled another instance of the order, then the system displays an abbreviation for that schedule. For example, Q 1 Year indicates the item is a recurring order, due once per year. If there is a value in this column, it is possible to double-click the value to edit the schedule in the Health Management Reminder Details page.</td>
</tr>
<tr>
<td><strong>Graph</strong></td>
<td>Select the checkboxes to graph the selected items by clicking the Graph button. <strong>Note:</strong> For the system to graph the selected items there has to be at least two data points for each item. If the user has not checked items with enough data to graph, the system displays the message, “There needs to be at least one item with more than one value to display a graph.”</td>
</tr>
<tr>
<td><strong>Most Recent</strong></td>
<td>Displays the most recent result for an orderable item or the Sig for a medication. Double-click this cell to display the Order Details page. The Most Recent and Date columns are outlined in blue for easy recognition.</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>If the item is an orderable item (for example, medication, lab order, and so on), the system displays the date on which the order was executed.</td>
</tr>
<tr>
<td><strong>Trend</strong></td>
<td>If the item is an orderable item that has occurred multiple times, the system displays a “spark graph.” The spark graph is a small image that enables the provider to see trends in measurements.</td>
</tr>
<tr>
<td><strong>To Do</strong></td>
<td>If the item is an orderable item, then the system indicates the date on which the next instance of the order is due. The To Do column is outlined in red for easy recognition.</td>
</tr>
<tr>
<td><strong>Incomplete</strong></td>
<td>If the item is an orderable item and the To Do date is in the past, then the system indicates the date on which the order was due. <strong>Note:</strong> An item can be incomplete because the results have not returned yet for a test. As soon as the results come back either electronically or by manual entry, the system automatically completes and deletes the item from the Incomplete column. (For example, a dietician referral could be listed as incomplete because it has a task associated with it to set it up.)</td>
</tr>
</tbody>
</table>

A best practice when using the HMP is to move right-to-left:
- If there is an entry in the Incomplete column, right-click in the cell to display a context menu.
- If there is no entry in the Incomplete column, but there is an entry in the To Do column, right-click in the cell to display a context menu.
- If there are no entries in the Incomplete or To Do columns, right-click in the Most Recent column to display a context menu.
- If action needs to be taken on an order reminder and there are no entries in the Incomplete or To Do columns, right-click in the Schedule column to display a context menu.
Normative Growth Charts:

- Access the **Normative Growth** tab from the **Pediatric Clinical Desktop OR change** the view from the **Health Management Plan** tab of the **Adult Desktop**.
- **Right-click** any area within the chart to select **Graph Labels** or to **Print**.
Graphing Information

1. From the Clinical Desktop, select the Vitals tab. The results display within the component.

2. Select the appropriate checkbox(es) and click the Graph button.

Click Refresh to return to the regular view.
Viewing Multiple Screens

qChart

1. From any screen with a floating Clinical Toolbar, click the qChart icon.

2. The Clinical Desktop page opens in a separate window with the Current Patient in context. The mouse can be used to toggle between the two screens.

3. Resize or move the screens to display the data needed by selecting the gray border around the window with the mouse.

   - Both screens are fully active and may be changed while using this feature (i.e., Select a different task from the Task window or right-click and renew an Rx from the Clinical Desktop).
   - This tool is helpful when completing tasks in order to view the details of the task, while working in the patient chart (i.e., renewing an Rx) or while documenting a note while working or viewing the patient chart.
DOCUMENT MANAGEMENT

- Maintaining complete and accurate patient charts is essential to quality care.
- Document Flow within Allscripts streamlines the process of documenting patient care, resulting in greater efficiency, and reduced potential for error.
- When a document enters the Allscripts system, a user may view and modify the document if he or she has appropriate security privileges. Adding an electronic signature documents the act of reviewing and confirming the information within a document.
- All users may sign a document, but only those with sufficient signature authority or level of access, may finalize the document with their signature.
- To finalize a document, the user must have signature authority equal to or greater than the signature authority required by the document.

Monitoring the Print/Fax Queue

The Print/Fax Queue is used to monitor the status of printed and/or faxed documents and prescriptions.

1. From the Vertical toolbar, select User Options.
2. From the Horizontal toolbar, select Print Queue. The Job Queue lists all print and fax jobs.

The Job Queue can be filtered using the following View options:
- Current Queue
- Archived Yesterday
- Archived 5 Days Ago
- Archived 10 Days Ago
- The default selection is Current Queue
The **Job Queue Status Filter** tabs can be clicked on to show only those print and fax jobs that meet the criteria of the filter.

### Job Queue (All) - 11 Items

<table>
<thead>
<tr>
<th>Queued</th>
<th>Time</th>
<th>Type</th>
<th>Destination</th>
<th>Patient</th>
<th>SSSN</th>
<th>MRN</th>
<th>User</th>
<th>Status</th>
<th>Progress</th>
<th>#’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/22 02:14 PM</td>
<td>PRINT</td>
<td>CROTCMA16 (EHR)</td>
<td>PATA, BILL</td>
<td>111223333</td>
<td>08000329</td>
<td>provider</td>
<td>Complete</td>
<td>Job Completed Successfully</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7/22 02:14 PM</td>
<td>SCRIPT</td>
<td>AHS Report</td>
<td>PATA, BILL</td>
<td>111223333</td>
<td>08000329</td>
<td>provider</td>
<td>Complete</td>
<td>Job Completed Successfully</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7/22 02:14 PM</td>
<td>PRINT</td>
<td>CROTCMA16 (EHR)</td>
<td>PATA, BILL</td>
<td>111223333</td>
<td>08000329</td>
<td>provider</td>
<td>Failed</td>
<td>Error in file C:\DOCS\1-5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7/22 11:31 AM</td>
<td>PRINT</td>
<td>CROTCMA16 (EHR)</td>
<td>PATA, BILL</td>
<td>111223333</td>
<td>08000329</td>
<td>provider</td>
<td>Complete</td>
<td>Job Completed Successfully</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7/22 11:31 AM</td>
<td>PRINT</td>
<td>CROTCMA16 (EHR)</td>
<td>PATA, BILL</td>
<td>111223333</td>
<td>08000329</td>
<td>provider</td>
<td>Complete</td>
<td>Job Completed Successfully</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7/20 04:21 PM</td>
<td>FAX</td>
<td>99999999-99999</td>
<td>Allscripts, Allison T</td>
<td>000000001</td>
<td>ZZITW01</td>
<td>provider</td>
<td>Failed</td>
<td>Error in file C:\DOCS\1-5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7/19 02:57 PM</td>
<td>FAX</td>
<td>99999999-99999</td>
<td>Allscripts, Allison T</td>
<td>000000001</td>
<td>ZZITW01</td>
<td>provider</td>
<td>Failed</td>
<td>Error in file C:\DOCS\1-5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7/15 04:46 PM</td>
<td>FAX</td>
<td>4000451-7434</td>
<td>PATA, BILL</td>
<td>111223333</td>
<td>08000329</td>
<td>provider</td>
<td>Failed</td>
<td>Error in file C:\DOCS\1-5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7/15 04:09 PM</td>
<td>FAX</td>
<td>800825-0005</td>
<td>PATA, ALLISON</td>
<td>34578456</td>
<td>08000316</td>
<td>provider</td>
<td>Failed</td>
<td>Error in file C:\DOCS\1-5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7/15 04:09 PM</td>
<td>FAX</td>
<td>4000451-7434</td>
<td>PATA, ALLISON</td>
<td>34578456</td>
<td>08000316</td>
<td>provider</td>
<td>Failed</td>
<td>Error in file C:\DOCS\1-5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

The **All** filter is displayed by default.

<table>
<thead>
<tr>
<th>Job Queue Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td>All job requests based on User privilege. User /Admin</td>
</tr>
<tr>
<td><strong>Failed</strong></td>
<td>The job request was picked up for processing and failed. These are shown in red.</td>
</tr>
<tr>
<td><strong>Canceled</strong></td>
<td>User or Administrator canceled the request.</td>
</tr>
<tr>
<td><strong>Idle</strong></td>
<td>Unprocessed job request; waiting for spooler to pick it up.</td>
</tr>
<tr>
<td><strong>On-Hold</strong></td>
<td>Unprocessed job is in a pending state.</td>
</tr>
<tr>
<td><strong>Active</strong></td>
<td>Currently in a processing state.</td>
</tr>
<tr>
<td><strong>Posted</strong></td>
<td>Crystal Report which has been pre-processed by a Print Center.</td>
</tr>
<tr>
<td><strong>Complete</strong></td>
<td>Successfully processed to completion.</td>
</tr>
</tbody>
</table>
Specific information listed for each print and fax job includes the following:

- Queued (Date/Time job was received)
- Type (Filter type - Print or Fax)
- Destination
- Patient
- MRN
- User
- Status
- Progress

<table>
<thead>
<tr>
<th>Time</th>
<th>Type</th>
<th>Destination</th>
<th>Patient</th>
<th>Status</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/22 12:14 PM</td>
<td>PRINT</td>
<td>CR27CM16</td>
<td>PATA, BILL</td>
<td>Complete</td>
<td>Job Completed Successfully</td>
</tr>
<tr>
<td>7/22 12:14 PM</td>
<td>PRINT</td>
<td>CR27CM16</td>
<td>PATA, BILL</td>
<td>Failed</td>
<td>Error in File C\DOCUME~1 5</td>
</tr>
<tr>
<td>7/19 02:57 PM</td>
<td>PRINT</td>
<td>CR27CM16</td>
<td>PATA, BILL</td>
<td>Failed</td>
<td>Error in File C\DOCUME~1 5</td>
</tr>
<tr>
<td>7/15 04:59 PM</td>
<td>PRINT</td>
<td>CR27CM16</td>
<td>PATA, BILL</td>
<td>Failed</td>
<td>Error in File C\DOCUME~1 5</td>
</tr>
<tr>
<td>7/15 04:59 PM</td>
<td>PRINT</td>
<td>CR27CM16</td>
<td>PATA, BILL</td>
<td>Failed</td>
<td>Error in File C\DOCUME~1 5</td>
</tr>
</tbody>
</table>
3. **Personalize** By default, the Job Queue lists all jobs for all sites. To filter or personalize the list by site, click the Personalize link. The Personalize page displays.

4. Select the **Site** and **Job Type** filters.
5. To view details of a job, highlight and click **Details**.
The **Print Request** page displays.

Information accessed in the **Details** button include:

- Org and Site info
- User
- Patient Name and Job Date and Time
- Priority
- Printer Server, Printer Name and Spooler Name
- Job Items and Audit tabs

6. **Resubmit** To reprint or refax a job, highlight and click **Resubmit**.

7. **Cancel** To cancel a job, highlight and click **Cancel**.
ENTERING CHARGES

The Charge module in Allscripts provides the capability of viewing and entering specific diagnoses and charges for patient encounters.

Providers are responsible for entering and submitting charges by selecting the patient from the Daily Schedule, then selecting the charge option and completing the appropriate charges. This creates a Review Encounter task, which displays in the Biller/Coders Task List. Billing personnel are responsible for opening the Review Encounter task to review and submit the charge. Once billing submits the charge, it is transferred to IDX. The following procedures detail these steps.

Selecting a Patient from the Daily Schedule

The patient must be selected from your daily schedule and the appointment must be arrived to start charges. Please do not enter charges on a patient who has a pending status.

- It is important for providers who travel to various locations to select the correct site before proceeding.
- To choose the correct Site, select the User Options option from the Vertical Toolbar (VTB), click the Select Site button and select the appropriate location. The site will display at the bottom of the screen next to Site:

1. Select the patient from the Daily Schedule by clicking on the patient once. **Do not double-click.**

Selecting the Charge Option from the Horizontal Toolbar (HTB)

- Once selected, the patient is associated with this encounter and tied to an appointment.
- Once charges have been entered and submitted, they are indicated by a $ on the Daily Schedule.
1. From the **Vertical** toolbar, select **Charges**.
2. From the **Horizontal** toolbar, select **Encounter Form**.

The **Encounter Form** page displays.
Entering a Diagnosis for a Charge

A primary diagnosis is required and must be linked to at least one visit or procedure charge, or both, in order to submit an Encounter Form to billing.

From the **Diagnosis Selector** in the **Charge** module, the user enters the diagnosis codes related to the patient visit.

1. From the **Horizontal Toobar**, select the **Diagnosis** tab.
2. If the **Diagnosis Selector** page does not defaults to the a specialty view, select **Master**.

2. **To manually search for a diagnosis**, type the full or partial name or **ICD9** code for the item and click **Go** (or press the **Enter** key). A list of diagnoses displays.
3. You can use the **view** drop-down arrow to change the view if necessary. (For example, you may want to search for **Favorites** created or **Patient Past Diagnoses** views).
4. Add all appropriate diagnosis codes. (The first diagnosis code selected is set as the primary diagnosis.)

5. To change a diagnosis code to the primary diagnosis, highlight the code and single-click the **Set Primary Dx** button.

6. Removing diagnoses can be done from the encounter form or the diagnosis screen. Select the diagnosis and click **Remove**.
To search the Master dictionary, type the full or partial name or ICD9 code in the search field and then click the Go button.

When searching, matches above the dashed lines begin with the characters the user entered or typed, which is the ICD9 Starts With category.

Matches below the dashed lines contain characters the user entered or typed, which is the ICD9 Contains category.

For further information on Views, see the Views section in this manual.

7. Click the Next button or select the Visit Charges tab on the HTB. The Visit Charge Selector displays.
Entering Visit Charges

A visit charge must be linked to at least one valid diagnosis code in order to submit the Encounter Form for billing.

From the Visit Charge Selector, the user specifies the visit charge(s) for an encounter.

1. If the Visit Charge Selector page does not default to the specialty view, select Master.

2. You can use the View drop-down arrow to change the view if necessary. (For example, you may want to search for Favorites created or the Master List.)

3. The diagnosis codes previously entered on the Diagnosis tab automatically link to the Visit Charges.

   - To search the Master dictionary, type the full or partial name or CPT code in the search field and then click the Go button.
   - The codes display in the Visit Charge section and must be linked to at least one diagnosis code.
   - To unlink a diagnosis code that is not associated with the visit charge, click the Visit Charge and uncheck the appropriate diagnosis code(s).
4. To add a modifier, select the **Visit Charge**. In the **Modifier Group** section, click the drop-down arrow to select your specialty view or Linked Modifiers to see the appropriate modifiers. Select the checkbox(es) of the desired modifiers, if needed.

If a provider performs an office visit and some type of procedure (i.e. an immunization, lesion removal, chemotherapy, ear lavage, flexible sigmoidoscopy, or colonoscopy), then the provider records a visit charge and a procedure charge for that encounter.

- In this case, the provider or biller/coder must also add the 25 modifier to the visit charge.
- This situation occurs frequently, particularly in primary care specialties.

5. Click the **Next** button or the **Procedure Charges** tab on the **HTB**. The **Procedure Charges Selector** page displays.
Entering Procedure Charges

A procedure charge must be linked to at least one valid diagnosis code in order to submit the Encounter Form to billing.

From the Procedure Charge Selector, the user specifies the procedure charge(s) for an encounter. Multiple diagnoses may be selected for each procedure if appropriate. If the procedure should not be linked to the primary diagnosis but to a different diagnosis, the user may modify the link.

1. If the Procedure Charge Selector page does not default to the specialty view, select Master.
2. From the specialty view on the left hand side of the screen, select the procedure charges category.
3. Once the category is selected, associated procedure charges display on the right hand side. Select the appropriate Procedure charge(s).
4. You can use the View drop-down arrow to change the view if necessary. (For example, you may want to search for Favorites created or the Master List).
5. The diagnosis codes previously entered on the Diagnosis tab automatically link to the Procedure Charges.
   - The codes display in the Procedure Charge section and must be linked to at least one diagnosis code.
   - To unlink a diagnosis code that is not associated with the procedure charge, click the Procedure Charge and uncheck the appropriate diagnosis code(s).
   - To search the Master dictionary, type the full or partial name or CPT code in the search field and then click the Go button.
6. **Exploding Sets for Immunizations.** Under **Procedure Charge Selector**, using the list on the left side of the page, *single-click* on the name of the Vaccine that was administered. This automatically populates the **Diagnosis**, **Medication** given, and the **Administration codes**.

7. To add a modifier, select the **Procedure Charge**.
8. In the **Modifier Group** section, click the drop-down arrow to select your specialty view or **Linked Modifiers** to see the appropriate modifiers. Select the checkbox (es) of the desired modifiers, if needed.

- If a provider performs an office visit and some type of procedure (i.e. an immunization, lesion removal, chemotherapy, ear lavage, flexible sigmoidoscopy, or colonoscopy), then the provider records a visit charge and a procedure charge for that encounter.
- In this case, the provider or biller/coder must also add the 25 modifier to the visit charge.
- This situation occurs frequently, particularly in primary care specialties.

- Users have the ability to modify a linked diagnosis and a charge from the **Encounter Form** on either the **Visit Charge Selector** or the **Procedure Charge Selector**.
- Click the **Remove** button to remove a selected charge.
- Click the **Charge Details** button to enable also **Charge Modifiers** and linked diagnoses to be added and/or modified as necessary.
- After selecting a procedure code, users have the ability to add a modifier, link, or unlink a diagnosis.
When recording a procedure it is sometimes necessary to record units given. Other details available are Comments, Discount Type, Percent, Procedure Fee, and Units.

9. To add additional information about the procedure, click the Charge Details button.

10. From the Charge Details screen, select the Other tab. Enter additional details per protocol on this screen.

11. Click OK to return to the Procedure Charge Selector page.

12. Click the Next button or the Encounter Form tab. The Encounter Form page displays.
The Encounter Form and Submitting Charges

Prior to submitting charges to billing, it is required to verify the information on the Encounter Form. Review and modify as required.

1. From the Billing Provider field, review, select or search for the billing provider.

   - **Billing Provider** – This may be the same as the performing provider or it can be used for Supervising Provider when the provider’s specialty requires a supervising provider (such as a Physician’s Assistant).

2. From the Performing Provider field, review, select or search for the performing provider.

   - **Performing Provider** – This provider is performing the services. In some cases, the performing provider may default to a billing department (example: Allergy Lab). In those cases, you need to change this to the provider on call or the provider who performed services as long as they are defined as a billable provider.

3. From the Billing Area field, review, select or search for the billing area if applicable.

4. From the Location and Division fields, select or search for the appropriate location and division.

5. The Compliance Code is a mandatory entry. Choose from the following entries:
6. Review the **Diagnosis** and **Visit Charges** for accuracy.

7. To remove a **Visit** or **Procedure Charge**, select the charge then click **Remove Charge**.

8. To modify a visit or procedure charge, select the **Visit Charges** or **Procedure Charges** tab and the make necessary changes. (See Entering Visit Charges or Entering Procedure Charges section).

9. To modify or add a diagnosis, select the **Diagnosis** tab and make the necessary changes. (See Entering a Diagnosis for a Charge section for more details)

10. **Nurse Practitioners, Physician’s Assistants and Nurses** must review and modify the **Billing** and **Performing** Providers as appropriate (Make sure to review the Billing and Performing Provider).

11. When all required fields are completed on the **Encounter Form**, the **Submit** button activates.

12. To submit charges, click **Submit**.
13. When **Submit** is selected, the **Submit Encounter** dialog box displays reminding the user of the necessary supporting documentation.

14. Click **OK** to continue.

The **Submit Encounter Dialog** should not be suppressed by choosing the checkbox to the left of **Don’t show this message in the future** prior to clicking **OK**. The displayed notification will serve as a reminder to ensure proper documentation is supplied to support submitted charges.
15. After completing and submitting the charge, the user is returned to the **Daily Schedule**. A $ displays next to the patient of the charges submitted.
The following table describes the **Status** icons on the **Encounter Form**.

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Red Status" /></td>
<td>Items displaying a <strong>Red Status</strong> icon require attention. Click the <strong>Red Status</strong> icon or the <strong>Needs Info</strong> link and follow the instructions to correct the issue.</td>
</tr>
<tr>
<td><img src="image" alt="Yellow Status" /></td>
<td>Items displaying a <strong>Yellow Status</strong> icon indicate the charge failed medical necessity checking or the charge or linked diagnosis is inappropriate based on the patient’s age or gender.</td>
</tr>
<tr>
<td><img src="image" alt="Green Status" /></td>
<td>Upon correction, the icon changes to a <strong>Green Status</strong> icon.</td>
</tr>
</tbody>
</table>

1. To review the Red Status icon and make appropriate changes, click the **Red Status** icon. The **Charge Edits** page displays a list of missing information or warnings related to the selected charge.

2. Click the link at which point the **Charge Entry Detail** page displays.
The **Charge Entry Detail** page displays. Make the necessary changes from the **Charge Entry Details** page.

**OR**

Close the page and edit the diagnosis or the charge code.
3. Click the **Submit** button when finished. The status changes to **Review**.

- Once charges have been submitted in Allscripts by the provider they display in the Biller/Coders task list. After the Biller/Coders review the charge they submit them, which then transfers them to IDX.

4. After the charge is submitted a $ displays on the Daily Schedule next to the patients name, which indicates charges have been posted.

A record of the charge is electronically filed in the patient’s chart under the **Chart Viewer** option.
5. To view the charges from Chart Viewer double-click $ under Encounter Forms in Chart Viewer.

The record of charges displays.
Entering a Charge for a Patient on a Generic Schedule

When patients are scheduled on a **Generic** schedule such as a Nurses or Infusion schedule, the billing information defaults to the generic schedule.

Prior to submitting charges to billing, it is required to verify the information on the **Encounter Form**. Review and modify as required.

1. From the schedule, highlight the patient’s name and click **Encounter Form** from the HTB.
2. Enter the diagnosis, visit, and procedure charges.
3. Once all information is entered, display the **Encounter Form**. All of the billing information defaults to the generic clinic.
4. From the **Billing Provider** field, review, select or search for the billing provider.
5. From the **Performing Provider** field, review, select or search for the performing provider.

6. From the **Billing Area** field, review, select or search for the billing area.

7. Verify and/or select the appropriate **Division** (hospital location) and **Location** for proper billing.

8. From the **Location** and **Division** fields, select or search for the appropriate location and division.

9. Review the **Diagnosis** and **Visit Charges** for accuracy.
10. **Remove Charge**  To remove a Visit or Procedure Charge, select the charge then click **Remove Charge**.

11. To modify a visit or procedure charge, select the Visit Charges or Procedure Charges tab and make the necessary changes. (See Entering Visit Charges or Entering Procedure Charges section.)

12. To modify or add a diagnosis, select the Diagnosis tab and make the necessary changes. (See Entering a Diagnosis for a Charge section for more details.)

13. Nurse Practitioners, Physician’s Assistants and Nurses must review and modify the Billing and Performing Providers as appropriate. (Make sure to review the Billing and Performing Provider.)

14. When all required fields are completed on the Encounter Form, the Submit button activates.
15. To submit charges, click **Submit**.

16. The **Submit Encounter** dialog box displays reminding the user of the necessary supporting documentation.

17. Click **OK** to continue.
18. After completing and submitting the charge, the user is returned to the **Daily Schedule**. A $ displays next to the patient of the charges submitted.
Charge Views

The following table explains the Views available when entering Diagnoses, Visit Charges, or Procedure Charges.

<table>
<thead>
<tr>
<th>View</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty (i.e., Family Medicine)</td>
<td>The default list contains the codes used most often by your practice. They are organized in sub-groups based on your paper super-bill.</td>
</tr>
<tr>
<td>My Favorites</td>
<td>The list of codes you prefer to use most often. To build your list of favorites, highlight the code and select the Add to Favorites icon. The selected codes display in the My Favorites list view. For further information, see the Working with Favorites section.</td>
</tr>
<tr>
<td>Master</td>
<td>Select this view to search the master ICD9 dictionary. To search the dictionary, type the full or partial name or code in the search field, then click the Go button.</td>
</tr>
<tr>
<td>Patient Past Diagnosis</td>
<td>The list of all diagnosis codes previously submitted for this patient through the Allscripts Charge Module. This list is patient specific and contains all codes submitted, regardless of provider.</td>
</tr>
</tbody>
</table>

Creating and Working with Favorites

To increase efficiency when searching for frequently used diagnoses, visits, or procedures, users are able to create a list of personal favorites. The user can then select the My Favorites view to retrieve the Favorites list.

1. Select the Diagnosis, Visit Charges, or Procedure Charges tab to build a My Favorites list for diagnoses, visits, or procedures.

2. Search for the item you wish to add to the My Favorites list by entering a few letters of the name or the ICD9 code and then click Go.

3. From the list, select the appropriate item.
4. Click the **Favorite** button. The diagnosis, visit, or procedure displays on the users **My Favorites** view.

5. To retrieve the **Favorites** list, click the **View** down arrow and select **My Favorites**.
The Audit Log

1. **Audit Log** To view a log of modifications made to the encounter, click the **Audit Log** link.

2. The **Audit Log** screen displays.

---

You cannot print the Audit Log.

---

**Personalizing Charge Entry**
Users can personalize the Charge Entry pages to fit their workflow by setting the following:

- General, Diagnosis, Visit, and Procedure settings (this may change the process flow outlined in this manual for entering charges).
- Number of columns that display in the selector boxes.
- Default linking of diagnoses to charges.

From the Encounter Form, Diagnosis Selector, Visit Charge Selector, or Procedure Charge Selector, click the Personalize link.
The **Personalize** page displays.

![Personalize dialog box](image)

Scroll down to personalize each of the **Charge Entry** tabs:

- **General Section**: Enables the user to personalize general charge options.
- **Diagnosis Selector Section**: Enables the user to personalize the **Diagnosis Selector**.
- **Visit Charge Selector Section**: Enables the user to personalize the **Visit Charge Selector**.
- **Procedure Charge Selector Section**: Enables the user to personalize the **Procedure Charge Selector**.
General Personalizations:

- **Default menu item for MD Charges**: Indicates the page that should display when the user first accesses an encounter that does not have previously entered charges or diagnoses.
- **Auto Link of Dx(s) to Charges**: Indicates how diagnoses should be linked to all charges by default. Links can always be removed manually on individual charges.
- **Warning Message on Submit**: Indicates whether Charge displays a confirmation message when a user submits an **Encounter Form** for billing.
- **Display When Submit Button is Activated**: Indicates the page that the system displays when the user clicks the **Submit** button on the **Encounter Form**.

Diagnosis Selector Personalizations:

- **Default Selection Method**: Indicates the default selection method for the **Diagnosis Selector**.
- **Display Patient Past Diagnoses if Present**: Indicates whether to override the user’s default group and display the **Patient Past Diagnosis** list if the patient has past diagnoses.
- **Display ICD-9 Codes in selector box**: Indicates how diagnosis codes should display in the selector box on the **Diagnosis Selector**.
- **Default Sort Order**: Indicates whether diagnoses displayed on the **Diagnosis Selector** are sorted by **Display Name** or **Entry Code**.
- **Number of Columns in selector box**: Indicates the number of columns that display in the selector box on the **Diagnosis Selector**.
Visit Charge Selector Personalizations:

Display Charge Codes in selector box: Indicates how charge codes should display in the selector box on the Visit Charge Selector.

Procedure Charge Selector Personalizations:

Display Charge Codes in selector box: Indicates how charge codes should display in the selector box on the Procedure Charge Selector.
Accessing Encounter Forms from the Chart Viewer

After charges are recorded and submitted the Patient Encounter forms are available for review in Chart Viewer.

1. Bring the patient into context in the Patient Banner by selecting the patient from the Daily Schedule or by searching for the patient.

2. To search for the patient, from the Patient Banner click the Select Patient drop-down arrow.

3. From the Select Patient drop-down menu, select Search. The Select Patient page displays.
4. In the **Patient** field, enter the patient’s last name, at least 3 letters of the first name, and press the **Enter** key.

5. **Double-click** the desired patient. The patient’s information displays in the **Patient Banner**.

6. From the **Horizontal toolbar (HTB)**, select **Clinical Desktop**.
7. From the Clinical Desktop, select the Chart Viewer component.

8. From Chart Viewer, double-click the encounter form to view.

A blue check next to the encounter indicates that it has been submitted into IDX.
The **Encounter Viewer** displays.

Click **Print** and select the printer.
CHARGE TASKS

**Charge Related Tasks**

A task is a request for action assigned to an individual or team who is responsible for completing the task. Tasks can be automatically created by a particular system event or can be manually generated on demand. After charges are submitted, different tasks are generated that display in the biller/coder task lists. The following table contains a list of **Billing-related** tasks:

<table>
<thead>
<tr>
<th>Charge Task Types</th>
<th>Description</th>
</tr>
</thead>
</table>
| Review Encounter Form | These task types are created for coders or attending physicians requesting a review of the encounter forms before charges are submitted for billing into PMA.  
- Navigates to the associated Encounter Form  
- Assigned to: Enc Review Team  
- Created by: Billing Provider automatically when charges are submitted  
- Target User: Primarily a coding/billing representative; however, could also be physician  |
| Adjust Charges | These are system-generated when a user changes or removes a charge previously submitted for billing, which displays in the appropriate billing/coding tasklist.  
- Review the encounter form in IDX and make adjustments  
- This task is manually completed when charges are edited in IDX  
- Navigates to the associated Encounter Form  
- Assigned to: Billing Provider  
- Target User: Coding/billing representative  |
| Manage Charge Edits | These are system-generated if there are one or more charges on an encounter with status of **Needs Info**.  
- If the billing team is not able to provide the needed information, reassign the task back to the provider or contact the provider directly.  
- These tasks are auto-completed when there are no charges on the encounter with status of **Needs Info**.  
- Navigates to the associated Encounter Form.  
- Assigned to: Charge Edits Team  
- Created by: Billing Provider  
- Target User: Primarily a coding/billing representative; however, could also be physician.  |
### Charge Task Types

<table>
<thead>
<tr>
<th>Task Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to Encounter Form</td>
<td>This is a user created task, which is generated when the New Task button is selected from the Encounter Form.</td>
</tr>
<tr>
<td></td>
<td>• This task is manually completed by clicking <strong>Done</strong>.</td>
</tr>
<tr>
<td></td>
<td>• Navigates to the associated Encounter Form</td>
</tr>
<tr>
<td></td>
<td>• Assigned to: selected user or team</td>
</tr>
<tr>
<td></td>
<td>• Target User: Front Desk or Coding/billing representative</td>
</tr>
<tr>
<td>Submit Encounter Form</td>
<td>This is a System task, which is generated when an appointment is arrived in IDX.</td>
</tr>
<tr>
<td></td>
<td>• The Submit Encounter Form task is assigned to the Billing Provider.</td>
</tr>
<tr>
<td></td>
<td>• These tasks auto-complete under these conditions:</td>
</tr>
<tr>
<td></td>
<td>• Whenever the user clicks <strong>Submit</strong> regardless of the status of any charge on that encounter.</td>
</tr>
<tr>
<td></td>
<td>• When the user ** Cancels** a charge and there are no charges with a status of Needs Info, Saved, or Ready.</td>
</tr>
<tr>
<td></td>
<td>• Navigates to the associated Encounter Form</td>
</tr>
<tr>
<td></td>
<td>• Assigned to: Billing Provider</td>
</tr>
<tr>
<td></td>
<td>• Target User: Physician</td>
</tr>
<tr>
<td>Billing Follow Up</td>
<td>A <strong>Follow Up</strong> task is sent by a provider to the billing team about charges with missing information and provides a method for navigating to the corresponding encounter form.</td>
</tr>
<tr>
<td>B-Order Clarification</td>
<td>• <strong>DOS _____</strong> Lab selected not available in clinic.</td>
</tr>
<tr>
<td></td>
<td>• <strong>DOS _____</strong> Immunization age range is not appropriate.</td>
</tr>
<tr>
<td></td>
<td>• <strong>DOS _____</strong> Invalidate duplicate note.</td>
</tr>
<tr>
<td></td>
<td>Review and update encounter form.</td>
</tr>
<tr>
<td></td>
<td>*DOS stands for Date of Service.</td>
</tr>
<tr>
<td>B-Miss Doc</td>
<td>• <strong>DOS _____</strong> Procedure CPT#_____ selected on encounter but not documented.</td>
</tr>
<tr>
<td></td>
<td>• <strong>DOS _____</strong> E&amp;M Service CPT#_____ selected on encounter but not documented.</td>
</tr>
<tr>
<td></td>
<td>• <strong>DOS _____</strong> Clarify exam documentation complete</td>
</tr>
<tr>
<td></td>
<td>• <strong>DOS _____</strong> Document time on the note under medical decision making CMA; Counseling/Coordination of Care</td>
</tr>
<tr>
<td></td>
<td>• Time Spent: ____ minutes.</td>
</tr>
<tr>
<td></td>
<td>Review and update encounter form.</td>
</tr>
<tr>
<td></td>
<td>*DOS stands for Date of Service.</td>
</tr>
<tr>
<td>B- Review Doc</td>
<td>• <strong>DOS _____</strong> Review exam based on chief complaint or age of patient; confirm ________ was a done.</td>
</tr>
<tr>
<td></td>
<td>Review and update encounter form.</td>
</tr>
<tr>
<td></td>
<td>*DOS stands for Date of Service.</td>
</tr>
</tbody>
</table>
Completing Tasks
Some tasks are created automatically. These tasks are referred to as “auto-generated” or “system-generated” tasks. In the task list, the Created by column for system-generated tasks shows System. Other tasks are manually generated and the name of the user who created the task displays in the Created by column.

There are two ways for a task to be completed – manually and through use of the system.

1. Manual completion is required when the task is requesting something that cannot be tracked and verified by the system. For tasks that must be manually completed, the Done button is typically enabled. The Go To… button is normally not enabled.
   - For example, if a physician has a Follow Up task, Allscripts cannot verify that the follow up action was made.
   - To complete those tasks, the user performs the requested action and then marks the task as complete selecting it from the task list and pressing Done.

2. Some tasks can be completed by use of the system. This process is referred to as “auto-completion”. For tasks that can be auto-completed, the GoTo… button is enabled. The Done button is normally not enabled.
   - For example, a Sign Note task that can be auto-generated can be completed by reviewing and signing the progress note in question.
   - Allscripts does not require the user to manually indicate that the task is complete – it is auto-completed by the action of submitting.
   - The user typically auto-completes tasks by selecting the task and pressing GoTo…, then performing the requested action.

3. However, some tasks allow for use of both buttons.
   - A primary example is the Go to Enc Form task. Pushing the GoTo… button from the task list (with a Go to Enc Form task selected) takes the user to the Encounter Form in question.
   - Because Allscripts cannot verify that the document was actually reviewed, the user is required to return to the task list and manually mark the task as complete by pressing the Done button.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABN</td>
<td>Advance Beneficiary Notice.</td>
</tr>
<tr>
<td>AKA</td>
<td>Also-known-as, or alias.</td>
</tr>
<tr>
<td>Appointment Status</td>
<td>Indicates whether a patient has arrived (Arr), rescheduled (Rsc) or canceled (Can); is pending (Pen) or a no show (NSH); or has been bumped (BMP).</td>
</tr>
<tr>
<td>CareGuide</td>
<td>Allows the association of a template with an active problem or defaulted Active Problem List entry of Health Maintenance (which corresponds to patient characteristics of age and sex). The CareGuide template then becomes available for ordering and creation of customized patient education documents.</td>
</tr>
<tr>
<td>Chart Alert</td>
<td>An alert within the Clinical Toolbar pertaining to the selected patient. This alert is the equivalent of a red underlined note on the front of a paper chart.</td>
</tr>
<tr>
<td>Chart Viewer</td>
<td>Located within the Clinical Desktop of Allscripts; displays clinical documentation from a patient chart, including notes, referrals, test results, scanned images and consent forms.</td>
</tr>
<tr>
<td>Clinical Desktop</td>
<td>Indicates the configuration of the Clinical Desktop. Users can personalize views for different types of patients, such as pediatric, Adult, Cardiology, etc.</td>
</tr>
<tr>
<td>Clinical Toolbar</td>
<td>Icons that allow users to add clinical items, review data, and track patient location and status.</td>
</tr>
<tr>
<td>Daily Schedule</td>
<td>Located in Schedule on the VTB of Allscripts; displays the schedule of appointments for a provider.</td>
</tr>
<tr>
<td>Dictation Marker</td>
<td>A place holder enabling users to add a dictation within a clinical note. Dictation markers may be pre-defined within note templates.</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of birth.</td>
</tr>
<tr>
<td>ECP</td>
<td>Encounter Care Provider.</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record.</td>
</tr>
<tr>
<td>Encounter Form</td>
<td>The paper form that enables physicians to designate diagnoses, visit charges, and procedure charges for a patient encounter.</td>
</tr>
<tr>
<td>Favorite List</td>
<td>Allows user to save most frequent used dictionary entries in a separate list.</td>
</tr>
<tr>
<td>FYI</td>
<td>For your information - informal patient information indicator.</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act.</td>
</tr>
<tr>
<td>HMP</td>
<td>Health Management Plan.</td>
</tr>
<tr>
<td>HPI</td>
<td>History of Present Illness.</td>
</tr>
<tr>
<td>HTB</td>
<td>Horizontal Toolbar - displays the tabs (or functionality) available within the sections selected on the VTB.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hx</td>
<td>History.</td>
</tr>
<tr>
<td>ID</td>
<td>Identification.</td>
</tr>
<tr>
<td>Master List</td>
<td>Allows the user to search from all values within a given dictionary.</td>
</tr>
<tr>
<td>MRN</td>
<td>Medical Record Number.</td>
</tr>
<tr>
<td>NKA</td>
<td>No Known Allergies.</td>
</tr>
<tr>
<td>NKDA</td>
<td>No Known Drug Allergies.</td>
</tr>
<tr>
<td>Note Authoring Workspace (NAW)</td>
<td>A separate dialog enabling users to document clinical notes using a table of contents, note forms, section entry, rendered note viewer, and output documents.</td>
</tr>
<tr>
<td>Note Forms</td>
<td>Serve as the building blocks of a note. These contain various controls enabling users to document the associated note section. Note forms may be pre-defined for individual note sections.</td>
</tr>
<tr>
<td>Note Selector</td>
<td>A dialog used to specify style, specialty, visit type, and owner when creating a new note.</td>
</tr>
<tr>
<td>Output Documents</td>
<td>Defined documents based on the note input template. A viewer is provided to preview the selected document.</td>
</tr>
<tr>
<td>Patient Banner</td>
<td>Located below the HTB; displays demographic information pertaining to a selected patient.</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary care provider.</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information.</td>
</tr>
<tr>
<td>PMH</td>
<td>Past Medical History.</td>
</tr>
<tr>
<td>PMS</td>
<td>Practice Management System.</td>
</tr>
<tr>
<td>Pri Ins</td>
<td>Displays the selected patient’s primary insurance within the Patient Banner.</td>
</tr>
<tr>
<td>PSH</td>
<td>Past Surgical History.</td>
</tr>
<tr>
<td>Quick List</td>
<td>Subset of the favorites list that includes just the items the users selects most often.</td>
</tr>
<tr>
<td>QuickSet</td>
<td>Groups of previously ordered medications and non-medications. They provide the user with an efficient way of entering problem-related orders.</td>
</tr>
<tr>
<td>RFP</td>
<td>Referring Provider.</td>
</tr>
<tr>
<td>ROS</td>
<td>Review of Systems.</td>
</tr>
<tr>
<td>SnapShot</td>
<td>Located in Chart Viewer as a Print option; displays current information for a selected patient, including active problems and medications, allergies and encounters.</td>
</tr>
<tr>
<td>Specialty</td>
<td>A list of specialty, or department, items commonly used.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Favorites List</td>
<td></td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number.</td>
</tr>
<tr>
<td>Allscripts Toolplace</td>
<td>Located in the <em>upper</em>-right corner of the page; change the password, lock the Allscripts session or logoff the system.</td>
</tr>
<tr>
<td>Workplace</td>
<td>Located in the <em>upper</em>-left corner of the page; defined by the user role within the organization (according to security privileges).这本书的中文名******</td>
</tr>
<tr>
<td>VTB</td>
<td>Vertical Toolbar; displays links to Allscripts available functionality, which are dependent upon the Workplace.</td>
</tr>
</tbody>
</table>