All the speakers and planning committee members have listed no financial interest/arrangement that would be considered a conflict of interest.
# Table of Contents

**INTRODUCTION TO ENTERPRISE EHR – CLINICAL INQUIRY**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logging in to Enterprise EHR</td>
<td>7</td>
</tr>
<tr>
<td>Navigating within Enterprise EHR</td>
<td>9</td>
</tr>
<tr>
<td>Toolplace Buttons</td>
<td>10</td>
</tr>
<tr>
<td>Locking and Unlocking Enterprise EHR</td>
<td>10</td>
</tr>
<tr>
<td>Logging out of Enterprise EHR</td>
<td>11</td>
</tr>
<tr>
<td>Personalizing Pages</td>
<td>12</td>
</tr>
<tr>
<td>Changing Print Sites in Enterprise EHR</td>
<td>13</td>
</tr>
<tr>
<td>Accessing Help</td>
<td>14</td>
</tr>
<tr>
<td>Accessing the Daily Schedule</td>
<td>16</td>
</tr>
<tr>
<td>Navigating the Daily Schedule</td>
<td>17</td>
</tr>
<tr>
<td>Searching for a Patient</td>
<td>19</td>
</tr>
<tr>
<td>Personalizing the Select Patient Page</td>
<td>20</td>
</tr>
<tr>
<td>View banner</td>
<td>21</td>
</tr>
<tr>
<td>PatientBanner Options</td>
<td>22</td>
</tr>
<tr>
<td>Break Glass Security</td>
<td>23</td>
</tr>
<tr>
<td>Accessing a Patient Profile</td>
<td>24</td>
</tr>
<tr>
<td>Adding FYI Information</td>
<td>25</td>
</tr>
<tr>
<td>Adding Chart Alerts</td>
<td>28</td>
</tr>
<tr>
<td>Adding Pharmacy Information</td>
<td>28</td>
</tr>
<tr>
<td>Using the Clinical Toolbar</td>
<td>29</td>
</tr>
<tr>
<td>Clinical Toolbar Icons</td>
<td>30</td>
</tr>
<tr>
<td>Show/Hide Clinical Toolbar</td>
<td>31</td>
</tr>
<tr>
<td>Working with the Clinical Desktop</td>
<td>32</td>
</tr>
<tr>
<td>Clinical Desktop Icons</td>
<td>33</td>
</tr>
<tr>
<td>Working within Components</td>
<td>34</td>
</tr>
<tr>
<td>Component Actions</td>
<td>35</td>
</tr>
<tr>
<td>Component Buttons</td>
<td>36</td>
</tr>
<tr>
<td>Viewing the Problems List</td>
<td>37</td>
</tr>
<tr>
<td>Viewing Past Medical History (PMH)</td>
<td>38</td>
</tr>
<tr>
<td>Viewing Past Surgical History (PSH)</td>
<td>39</td>
</tr>
<tr>
<td>Viewing Family History (Fam Hx)</td>
<td>40</td>
</tr>
<tr>
<td>Viewing Social History (Social Hx)</td>
<td>41</td>
</tr>
<tr>
<td>Viewing Allergies</td>
<td>42</td>
</tr>
<tr>
<td>Viewing the Medications List</td>
<td>43</td>
</tr>
<tr>
<td>Formulary Status Indicators</td>
<td>44</td>
</tr>
<tr>
<td>Viewing the Medication History List (Med Hx)</td>
<td>45</td>
</tr>
<tr>
<td>Viewing Immunization History</td>
<td>46</td>
</tr>
<tr>
<td>Discontinuing an Rx</td>
<td>47</td>
</tr>
<tr>
<td>Editing Item Entries and Adding Annotations</td>
<td>48</td>
</tr>
<tr>
<td>Accessing Chart Viewer</td>
<td>49</td>
</tr>
<tr>
<td>Print Options</td>
<td>50</td>
</tr>
<tr>
<td>Chart Viewer Views</td>
<td>51</td>
</tr>
<tr>
<td>Filtering within Chart Viewer</td>
<td>52</td>
</tr>
<tr>
<td>Chart Viewer Print Options</td>
<td>53</td>
</tr>
<tr>
<td>Viewing Results</td>
<td>54</td>
</tr>
<tr>
<td>Result Icons</td>
<td>55</td>
</tr>
</tbody>
</table>

**PATIENT VISIT OVERVIEW**
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENTERING VITALS</td>
<td>56</td>
</tr>
<tr>
<td>Entering Vitals Information</td>
<td>56</td>
</tr>
<tr>
<td>Correcting Vitals Information</td>
<td>58</td>
</tr>
<tr>
<td>CLINICAL INTAKE</td>
<td>61</td>
</tr>
<tr>
<td>Introduction to the ACI</td>
<td>61</td>
</tr>
<tr>
<td>Using Favorites to Search</td>
<td>62</td>
</tr>
<tr>
<td>Search Options</td>
<td>62</td>
</tr>
<tr>
<td>Searching the ACI</td>
<td>63</td>
</tr>
<tr>
<td>Search Tools</td>
<td>63</td>
</tr>
<tr>
<td>Creating a Favorites List</td>
<td>64</td>
</tr>
<tr>
<td>Introduction to the History Builder</td>
<td>64</td>
</tr>
<tr>
<td>Selecting an Encounter</td>
<td>65</td>
</tr>
<tr>
<td>Adding a New Problem</td>
<td>66</td>
</tr>
<tr>
<td>Adding Past Medical History (PMH)</td>
<td>68</td>
</tr>
<tr>
<td>Adding Past Surgical History (PSH)</td>
<td>70</td>
</tr>
<tr>
<td>Adding Family History (Fam Hx)</td>
<td>72</td>
</tr>
<tr>
<td>Adding Social History (Social Hx)</td>
<td>74</td>
</tr>
<tr>
<td>Adding Allergies</td>
<td>76</td>
</tr>
<tr>
<td>Printing Allergies</td>
<td>79</td>
</tr>
<tr>
<td>Adding Medication History (Med Hx)</td>
<td>81</td>
</tr>
<tr>
<td>Adding Unverified Prescriptions from SureScripts</td>
<td>83</td>
</tr>
<tr>
<td>Printing Medication History (Med Hx)</td>
<td>85</td>
</tr>
<tr>
<td>Adding Immunization History</td>
<td>86</td>
</tr>
<tr>
<td>Printing Immunization History</td>
<td>88</td>
</tr>
<tr>
<td>Viewing the Encounter Summary</td>
<td>90</td>
</tr>
<tr>
<td>Encounter Summary Toolbar</td>
<td>91</td>
</tr>
<tr>
<td>Committing Information to the Encounter Summary</td>
<td>91</td>
</tr>
<tr>
<td>Encounter Summary Actions</td>
<td>91</td>
</tr>
<tr>
<td>Editing Item Entries and Adding Annotations</td>
<td>92</td>
</tr>
<tr>
<td>Suppressing and Unsuppressing a Problem</td>
<td>93</td>
</tr>
<tr>
<td>MEDICATIONS</td>
<td>96</td>
</tr>
<tr>
<td>Creating a New Rx</td>
<td>96</td>
</tr>
<tr>
<td>Rx Actions</td>
<td>100</td>
</tr>
<tr>
<td>Using the Dosage Calculator</td>
<td>101</td>
</tr>
<tr>
<td>Replacing a Medication</td>
<td>103</td>
</tr>
<tr>
<td>Dispensing a Sample Medication</td>
<td>108</td>
</tr>
<tr>
<td>Rx Tasks</td>
<td>111</td>
</tr>
<tr>
<td>DUR Warnings</td>
<td>111</td>
</tr>
<tr>
<td>Rx Renewal with No Changes</td>
<td>112</td>
</tr>
<tr>
<td>Rx Renewal with Changes</td>
<td>113</td>
</tr>
<tr>
<td>Deferring a Medication</td>
<td>116</td>
</tr>
<tr>
<td>Reactivating a Deferred Medication</td>
<td>119</td>
</tr>
<tr>
<td>Reconciling the Medication List</td>
<td>121</td>
</tr>
<tr>
<td>Editing an Existing Medication</td>
<td>122</td>
</tr>
<tr>
<td>Discontinuing a Medication</td>
<td>123</td>
</tr>
<tr>
<td>Completing a Medication</td>
<td>124</td>
</tr>
<tr>
<td>Entering a Medication in Error</td>
<td>125</td>
</tr>
<tr>
<td>Printing a Medication Profile</td>
<td>126</td>
</tr>
<tr>
<td>SureScripts</td>
<td>127</td>
</tr>
</tbody>
</table>
Allscripts Enterprise EHR™

Processing Electronic Refill Requests ......................................................... 127
Entering an Administered Med ................................................................. 130
Entering a Scheduled Administered Med .................................................... 133

ORDERS ........................................................................................................ 137

Entering Lab Orders as Part of an Office Visit .......................................... 137
Entering Diagnostic Orders as Part of an Office Visit ................................ 139
Entering Imaging Orders as Part of an Office Visit .................................... 143
Entering Scheduled Orders as Part of an Office Visit .................................. 146
Entering Referral Orders ............................................................................. 150
Entering Follow-up Orders .......................................................................... 153
Ordering Instructions .................................................................................. 156
Editing Orders ............................................................................................. 160
Reprinting a Requisition ............................................................................ 160
Resulting Orders ......................................................................................... 162
Resulting Previously Entered Orders .......................................................... 165
Order Workflows ......................................................................................... 166
  Working with Scheduled Orders ............................................................... 166
  Marking an Order with a Complete Status ............................................... 166
  Changing the Status of an Order ............................................................. 166
  Viewing a Discontinued, Entered in Error, Canceled, or Completed Order .................................................. 167
  Discontinuing an Order Reminder ............................................................ 167
  Creating an Order Instance from an Existing Reminder .......................... 168
  Starting and Stopping an Order/Reminder Deferral ................................. 168

IMMUNIZATIONS ......................................................................................... 169

Entering Administered Immunizations ....................................................... 169
Entering an Immunization in Error ............................................................ 173
Immunization Workflows .......................................................................... 174
  Documenting a Single Immunization from a Scheduled Order .............. 174
  Deferring an Immunization .................................................................... 174
  Reactivating a Deferred Immunization .................................................. 175
  Printing the Immunization List ............................................................... 175
  Documenting the Reading of a PPD Administration ............................... 175

PROBLEM-BASED ORDERS ....................................................................... 176

Using CareGuides ....................................................................................... 176
Entering Orders via QuickSets ................................................................... 179
Modifying QuickSets ................................................................................ 181

CLINICAL NOTE ......................................................................................... 182

Clinical Note Workflow ............................................................................. 182
Adding Structured v11 Notes ..................................................................... 182
Adding/Removing Forms from a Note ....................................................... 185
Documenting within Note Forms ............................................................... 187
  Note Authoring Controls ....................................................................... 187
Using Degree Indicators .......................................................................... 188
Citing Relevant Lab Results ..................................................................... 190
  Citing Lab Results using Cite Selected ................................................ 190
  Citing Lab Results using Advanced Result Citation .............................. 191
Working with Clinical Item Lists within a Note ........................................ 192
Assessing a Problem .................................................................................. 193
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completing the Plan</td>
<td>194</td>
</tr>
<tr>
<td>Adding the Attestation</td>
<td>197</td>
</tr>
<tr>
<td>Note Output Documents</td>
<td>198</td>
</tr>
<tr>
<td>E/M Coder Defined</td>
<td>200</td>
</tr>
<tr>
<td>Using the E/M Coder</td>
<td>200</td>
</tr>
<tr>
<td>Entering Medical Decision Making Information in the Note</td>
<td>203</td>
</tr>
<tr>
<td>DICTATE</td>
<td>205</td>
</tr>
<tr>
<td>Recording a Structured Dictation Marker</td>
<td>205</td>
</tr>
<tr>
<td>Recording an Unstructured Dictation</td>
<td>207</td>
</tr>
<tr>
<td>Marking a Dictation as Hold or Stat</td>
<td>207</td>
</tr>
<tr>
<td>Setting Dictation Toolbar Preferences</td>
<td>208</td>
</tr>
<tr>
<td>DRAGON NATURALLYSPEAKING®</td>
<td>209</td>
</tr>
<tr>
<td>Using Dragon NaturallySpeaking® in an Enterprise EHR Structured Note</td>
<td>209</td>
</tr>
<tr>
<td>NON-PATIENT VISIT OVERVIEW</td>
<td>210</td>
</tr>
<tr>
<td>Viewing the Task List</td>
<td>211</td>
</tr>
<tr>
<td>Task Columns</td>
<td>212</td>
</tr>
<tr>
<td>Task Views</td>
<td>213</td>
</tr>
<tr>
<td>Managing Tasks</td>
<td>214</td>
</tr>
<tr>
<td>Task List Actions</td>
<td>214</td>
</tr>
<tr>
<td>Working the Task List</td>
<td>215</td>
</tr>
<tr>
<td>Task List Buttons</td>
<td>217</td>
</tr>
<tr>
<td>Medication Refill – Call Processing Tasks</td>
<td>218</td>
</tr>
<tr>
<td>Copying a Task to a Note</td>
<td>219</td>
</tr>
<tr>
<td>Removing a Task</td>
<td>222</td>
</tr>
<tr>
<td>Personalizing the Task List Page</td>
<td>224</td>
</tr>
<tr>
<td>Creating a New Task</td>
<td>225</td>
</tr>
<tr>
<td>WORKLISTS AND RESULTS VERIFICATION</td>
<td>227</td>
</tr>
<tr>
<td>Viewing a Worklist</td>
<td>227</td>
</tr>
<tr>
<td>Patient –Centric Worklist</td>
<td>227</td>
</tr>
<tr>
<td>Cross-Patient Worklist</td>
<td>228</td>
</tr>
<tr>
<td>Scheduling Referral or Follow-Up Appointments from the Worklist</td>
<td>229</td>
</tr>
<tr>
<td>Authorizing Orders</td>
<td>230</td>
</tr>
<tr>
<td>Authorize Order Options</td>
<td>231</td>
</tr>
<tr>
<td>Verifying Results</td>
<td>232</td>
</tr>
<tr>
<td>Verifying Result Options</td>
<td>234</td>
</tr>
<tr>
<td>Using the Worklist Quick Filter</td>
<td>237</td>
</tr>
<tr>
<td>Worklist Filter Options</td>
<td>238</td>
</tr>
<tr>
<td>Invalidating Results During the Verification Process</td>
<td>239</td>
</tr>
<tr>
<td>Establishing Results Verification Preferences</td>
<td>240</td>
</tr>
<tr>
<td>Results Verification Preferences</td>
<td>243</td>
</tr>
<tr>
<td>HEALTH MANAGEMENT PLANS</td>
<td>246</td>
</tr>
<tr>
<td>Viewing a Health Management Plan</td>
<td>246</td>
</tr>
<tr>
<td>HMP Views</td>
<td>248</td>
</tr>
<tr>
<td>HMP Buttons</td>
<td>249</td>
</tr>
<tr>
<td>HMP Columns</td>
<td>250</td>
</tr>
<tr>
<td>Normative Growth Charts</td>
<td>251</td>
</tr>
<tr>
<td>Graphing Information</td>
<td>252</td>
</tr>
<tr>
<td>VIEWING MULTIPLE SCREENS</td>
<td>253</td>
</tr>
</tbody>
</table>
qChart ........................................................................................................................................... 253

DOCUMENT MANAGEMENT ........................................................................................................ 254

Signing Structured Notes ............................................................................................................ 255
Editing Structured Notes ............................................................................................................ 257
Amending Finalized Structured Notes ......................................................................................... 260
Invalidating Structured Notes .................................................................................................... 263
Creating Carbon Copies ............................................................................................................. 269
Tracking Document History for Structured Notes ....................................................................... 272
Monitoring the Print/Fax Queue .................................................................................................. 274

Job Queue Status ....................................................................................................................... 275

ENTERING CHARGES .................................................................................................................. 279

Selecting a Patient From the Daily Schedule ............................................................................. 279
Selecting the Charge Option from the Horizontal Toolbar (HTB) ............................................. 280
Entering a Diagnosis for a Charge ............................................................................................... 281
Entering Visit Charges ................................................................................................................ 284
Entering Procedure Charges ....................................................................................................... 286
The Encounter Form and Submitting Charges .......................................................................... 290
Charge Edits .................................................................................................................................. 294

Status Indicators .......................................................................................................................... 294

Entering a Charge for a Patient on a Generic Schedule ............................................................ 298
Charge Views ............................................................................................................................... 303

Creating and Working with Favorites ....................................................................................... 303
Working with Modifiers ............................................................................................................... 305
The Audit Log ................................................................................................................................ 308
Diagnosis Codes from the Problem List and Charge ................................................................. 309
Personalizing Charge Entry ........................................................................................................ 311
Accessing Encounter Forms ........................................................................................................ 315

CHARGE TASKS ............................................................................................................................ 319

Charge Related Tasks ................................................................................................................ 319

Charge Task Types ....................................................................................................................... 320
Completing Tasks ......................................................................................................................... 321

GLOSSARY .................................................................................................................................. 322
INTRODUCTION TO ENTERPRISE EHR – CLINICAL INQUIRY

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.

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

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.

   - 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.
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.
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>
<tbody>
<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 (Yes, No, or Unknown)</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 Select button opens the Note Selector so that a new note can be created. The Go To button navigates the user to the current note for the patient. The Close button closes the current note for the patient.</td>
</tr>
</tbody>
</table>
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.

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.

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**.
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>
Show/Hide Clinical Toolbar

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>Renew</td>
<td>Renews the selected medication without any changes to the prescription.</td>
</tr>
<tr>
<td>Renew w/Changes</td>
<td>Opens the Medication Details page to allow for the renewal of a prescription with changes.</td>
</tr>
<tr>
<td>Order D/C</td>
<td>Allows the selected medication to be discontinued or continued.</td>
</tr>
<tr>
<td>Verify/Add</td>
<td>Allows the Provider to validate the medication is correct for the patient, and adds the medication to the patient’s Current Medications list. The medication can then be renewed.</td>
</tr>
<tr>
<td>Annotate</td>
<td>Opens the Details page so that an annotation can be added to the selected item.</td>
</tr>
<tr>
<td>Resolve</td>
<td>Marks the selected problem as resolved.</td>
</tr>
<tr>
<td>Resolve/Assess</td>
<td>Marks the selected problem as assessed and resolved.</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.

   - **Problem**
   - **Vitals**
   - **HMP**
   - **Chart Viewer**
   - **Encounter**

   - **Active Problems**
   - **Type**

   - **Chronic**
     - Asthma 493.90
     - Basal Cell Carcinoma Of The Skin Of The Face 173.3
     - Chronic Obstructive Pulmonary Disease 496
     - Diabetes Mellitus 250.00
     - External Hemorrhoids 453.3
     - Vitamin B Deficiency 266.9

   - **Acute**
     - Abdominal Pain 789.00
     - Acute Bronchitis 466.0
     - Acute Sore Throat 462

   - **Health Maintenance/Risks**
     - Health Maintenance

   ![Problem Component](image)

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.

   - **Past Medical Hist**
   - **Type**

   - **Chronic**
     - History of Asthma With Acute Exacerbation 493.92
     - History of Laryngitis 464.00
     - History of Lightheadedness 780.4
     - History of Osteoarthritis Of The Ankle/Foot (Multiple Joints) 715.97
     - History of Sore Throat 462
     - History of Tendonitis 726.90
     - History of Wrist Sprain 842.00

   - **Acute**
     - History of Acute Gastritis 536.00
     - History of Acute Tonsillitis 483
     - History of Ankle Joint Pain 719.47

   ![Past Medical History Component](image)

   - 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.

   - **Problem** component displays with a list of the patient’s surgical history organized by the default view.

   - **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.

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.
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.

   ![Problems Table](image)

   - **Chronic**
     - Asthma 493.90
     - Basal Cell Carcinoma Of The Skin Of The Face 173.3
     - Chronic Obstructive Pulmonary Disease 496
     - Diabetes Mellitus 250.00
     - External Hemorrhoids 458.3
     - Vitamin B Deficiency 268.9
   - **Acute**
     - Abdominal Pain 789.00
     - Acute Bronchitis 466.0
     - Acute Sore Throat 462
   - **Health Maintenance/Risks**
     - Health Maintenance

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.

   ![Social History Problems](image)

- 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.

   - 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.

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>PA</td>
<td>Prior Authorization is required</td>
</tr>
<tr>
<td>OTC</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.

![Medication History List Image]

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.

![Past Medications List Image]

- 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.
Discontinuing an Rx

Sometimes it is necessary to discontinue a medication therapy before it is complete. A specific reason is required to complete this process.

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. Select the medication to be discontinued.
3. **Right-Click**, choose **Order D/C** or **Record D/C** from menu. The selected medication displays in magenta text and displays on the **Past Medications** list.

4. To save, click the **Commit** button on the **Clinical Toolbar** to access the **Encounter Summary**.
   - **Order D/C** displays as **DISCONTINUED**. **Order D/C** is used when the Provider discontinues the medication.
   - **Record D/C** displays as **RECORD D/C**. **Record D/C** is used when either another Provider or the patient has discontinued the medication.

5. From the **Encounter Summary**, click the **Save and continue** button. The magenta text changes to black.
   - It is also possible to continue a medication therapy. Only active prescriptions may be continued.
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) displays 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.

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</td>
</tr>
<tr>
<td></td>
<td>(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</td>
</tr>
<tr>
<td></td>
<td>(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.

   ![Chart Viewer with Quick Filter icon highlighted](image)

   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.

   ![Quick Filters section](image)
Chart Viewer Print Options

Grouping and filtering may also be applied to printing from Chart Viewer. The view created when using grouping and quick filter(s) is also the default when the Print Chart button is clicked. An asterisk indicates a modified Chart View.

Only certain groups, such as Medical Records, will have access to this functionality.
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></td>
<td>REQUIRED</td>
</tr>
<tr>
<td>Clarity</td>
<td>Bloody</td>
<td>A</td>
<td></td>
<td>REQUIRED</td>
</tr>
</tbody>
</table>

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

Results History

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Color</th>
<th>Clarity</th>
<th>Leukocytes</th>
<th>Nitrates</th>
</tr>
</thead>
<tbody>
<tr>
<td>18Aug2009</td>
<td>04:12PM</td>
<td>Brown</td>
<td>Transparent</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>01Jun2009</td>
<td>11:54PM</td>
<td>Yellow</td>
<td>Bloody</td>
<td>Negative</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 #: TW6373  Requisition #: 475  Overdue after: 26Aug2009
Ordered by: NOLAN, KELLY  Supervised by: HUNTLEY, HHANK  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.png" alt="Icon" /></td>
<td>Indicates normal results that are unverified.</td>
</tr>
<tr>
<td><img src="image2.png" alt="Icon" /></td>
<td>Indicates unverified results containing at least one abnormal value.</td>
</tr>
<tr>
<td><img src="image3.png" alt="Icon" /></td>
<td>Indicates normal results that are verified.</td>
</tr>
<tr>
<td><img src="image4.png" alt="Icon" /></td>
<td>Indicates verified results containing at least one abnormal value.</td>
</tr>
<tr>
<td><img src="image5.png" alt="Icon" /></td>
<td>Viewed in <strong>Chart Viewer</strong>, this icon indicates results that have been scanned into <strong>Enterprise EHR</strong>.</td>
</tr>
</tbody>
</table>
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.

![Order Details Screen]

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.
   - Enter Pain scale and if appropriate, enter FiO2 and O2 Saturation information.
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.
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.

<table>
<thead>
<tr>
<th>Weight</th>
<th>150 lb</th>
</tr>
</thead>
</table>

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**.

## Search Tools

<table>
<thead>
<tr>
<th>Search Tools</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdom</strong></td>
<td>The <em>search</em> field allows for the entry of free text.</td>
</tr>
<tr>
<td>[Green Arrow]</td>
<td>The <em>Green Arrow</em> icon erases the text in the <em>search</em> field.</td>
</tr>
<tr>
<td>If a search produces no matching results, click the <em>Search</em> 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>
<td></td>
</tr>
<tr>
<td>[Refresh]</td>
<td>The <em>Refresh</em> icon clears the text in the <em>search</em> field and refreshes the item list.</td>
</tr>
<tr>
<td>[ICD9]</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>Family Medicine</td>
<td>If a <em>My Favorites List</em> has not been created, Enterprise EHR automatically searches through the <em>Specialty Favorites</em> (such as Family Medicine).</td>
</tr>
<tr>
<td>[Alpha Tabs]</td>
<td>Searches using the <em>My Favorites List</em> or <em>QuickList</em>. This is much more efficient than hunting through a master list of items.</td>
</tr>
<tr>
<td></td>
<td>Searches utilizing the <em>Alpha Tabs</em> 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.

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.

- 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.

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](image)

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. **Commit**. 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**.

   ![Encounter Summary](image)
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.
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 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.
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.
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. 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.
Printing Allergies

There are times when either the provider or the clinical staff will need to print the allergy list.

1. Select the **Allergies** tab.
2. **Right-click** and select **Print Allergy List**.
3. Select **Print Allergy List**.
The Print Dialog box displays.

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

5. 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. **Commit**
   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 drop-down 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.
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></td>
</tr>
<tr>
<td></td>
<td>Expands all of the folders on the <strong>Encounter Summary</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Displays the patient’s location and allows it to be changed.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Displays the patient’s status and allows is to be changed.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creates a new task.</td>
</tr>
<tr>
<td></td>
<td></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>Print Pt.Ed</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>Continue</td>
<td>Returns the user to the <strong>Clinical Desktop</strong> without saving the patient information.</td>
</tr>
<tr>
<td>Save and continue</td>
<td>Commits/Saves the patient information and returns the user to the <strong>Clinical Desktop</strong>.</td>
</tr>
<tr>
<td>Save</td>
<td>Commits/Saves the patient information without closing the <strong>Encounter Summary</strong>.</td>
</tr>
<tr>
<td>Delete Unsaved</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.
Suppressing and Unsuppressing a Problem

When a problem is entered as a symptom for the purpose of entering and linking an order, it is often moved to a suppressed status after an assessment/diagnosis is made by the provider. For example, if a patient presents with a sore throat, the sore throat is entered into the History Builder as an active problem and linked to a strep test, it can be suppressed once the diagnosis is made.

Active and Past problems can be suppressed. Suppressed problems remain part of the patient’s medical record and can be viewed on the Clinical Desktop by selecting the Problems tab and the All view.

1. From the **Clinical Desktop**, select the **Problem** tab.
2. To suppress an **Active** problem, highlight the item and *right*-click.
3. From the menu, select **Resolve and Suppress**.
4. To suppress a **Past** problem, highlight the item and *right*-click.
5. From the menu, select **Suppress**.

6. The problems no longer display as **Active** or **Past**, they display as **Suppressed** in the **All** view.
   
   - When sorted by **Type**, the **Suppressed** problems do not display.
   - Your right-click only displays **Hide Suppressed Problems**.
   - When changed to **Problem List** view, you can show and view the **Suppressed** problems or **Hide the Suppressed** problems.
7. To hide the **Suppressed** problems, *right-click* the problem and selected **Hide Suppressed Problems** from the menu. The **Suppressed** section of the **All** view no longer displays.

8. To unhide the **Suppressed** problems, *right-click* in the problem component of the Clinical Desktop and select **Unsuppress** from the menu. The **Suppressed** section of the **All** view displays.

   - If you did not want the problem suppressed, *right-click* and select **Unsuppress**.
MEDICATIONS

Creating a New Rx

Allscripts enables clinicians to prescribe and manage medications for patients. Activities in the ePrescribe module include prescribing medications, managing pending prescriptions, and removing medications and SIGs from My Favorites list.

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. If sending to retail, confirm that the patient’s preferred Pharmacy displays; if not, search for and add a pharmacy.
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.

Allscripts displays icons to the left of medications in the search area based on insurance and Rx Benefit information from the patient in context. The following table describes these icons and their meaning:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Green Smiley Face" /> <img src="image" alt="Number" /></td>
<td>A green smiley face with a number displaying to the right of the face indicates the medication is preferred by the insurance company. The higher the number, the more preferred the medication is on the formulary.</td>
</tr>
<tr>
<td><img src="image" alt="Green Smiley Face" /></td>
<td>A green smiley face indicates the medication is preferred by the insurance company.</td>
</tr>
<tr>
<td><img src="image" alt="Yellow Straight Face" /></td>
<td>A yellow straight face indicates the medication is approved by the insurance company; however, a higher co-pay may be required.</td>
</tr>
<tr>
<td><img src="image" alt="Red Frowny Face" /></td>
<td>A red frowny or sad face indicates the medication is not approved by the insurance company or is at an even higher co-pay.</td>
</tr>
<tr>
<td><img src="image" alt="PA Icon" /></td>
<td>PA indicates proper authorization for the medication is required by the insurance company. &lt;br&gt;<strong>Note:</strong> PA is really a Coverage condition, not a formulary status, but some formulary sources continue to include PA as part of their formulary.</td>
</tr>
<tr>
<td><img src="image" alt="OTC Icon" /></td>
<td>OTC indicates an over-the-counter medication, which is not covered by insurance.</td>
</tr>
<tr>
<td><img src="image" alt="No Indicator" /></td>
<td>No indicator indicates no formulary information is available.</td>
</tr>
</tbody>
</table>

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 a **Formulary Alternatives** 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 a 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.
11. In the **Refill** field, enter the number of refills for this medication.
12. 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.
13. Select the desired **Action** for the prescription delivery method from the corresponding drop-down menu.
14. If sending to a pharmacy or calling the prescription in to a pharmacy, select the appropriate location from the **Pharmacy** drop-down menu.
   - If a pharmacy is not entered or requires updating, click the **Search (binoculars)** icon to search the master dictionary.
15. If appropriate, select the **Split Rx** checkbox and complete the secondary set of fields.

Two separate entries for the **Split Rx** medication display in the Meds component on the Clinical Desktop and in the **Encounter Summary**.
16. In the **Ordered by** field, select the authorizing provider for the medication. For **Residents Ordered By** should be the **Resident**. **Managed By** and **Supervised By** should be the **Attending Provider**.

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

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

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Send to Retail</td>
<td>Sends a transmission to a pharmacy; pharmacies are defined in the Pharmacy dictionary.</td>
</tr>
<tr>
<td>Send to Mail Order</td>
<td>Sends a transmission to a mail order company.</td>
</tr>
<tr>
<td>Print Rx</td>
<td>Prints the prescription for the patient.</td>
</tr>
<tr>
<td>Record</td>
<td>This is used to merely record the prescription in the patient’s medical record. It does not print a prescription or send it to a pharmacy or mail order company for fulfillment.</td>
</tr>
<tr>
<td>Dispense Sample</td>
<td>Indicates one or more samples of the medication were provided to the patient during the office visit.</td>
</tr>
<tr>
<td>Call Rx</td>
<td>Generates a <strong>Call in Rx</strong> task for follow-up.</td>
</tr>
</tbody>
</table>

**Recording vs. Recording without Ordering**

- **Choosing Record** from the drop-down menu indicates the medication is being recorded as ordered. This means this medication is going to participate in authorization and other Rx workflows if necessary. In addition, it displays in a note as a medication order.
- **Checking the Record without Ordering checkbox in the upper-right corner of the Medication Details screen means this medication is NOT being ordered. It is just being reported that the medication was ordered at some time in the past for the patient. It may be patient reported. It may be from information received from another provider. This means this medication is NOT going to participate in authorization and other Rx workflows. It displays in a note as a current medication but does not display as a medication order.**
Using the Dosage Calculator

The Dosage Calculator is a tool used to calculate the target dosage and dosage frequency rounded to the nearest dosage units using the patient’s vitals. It includes a function for performing a dosing calculation based on Body Surface Area (BSA). It is optimized for many dose forms.

1. After searching for and selecting the appropriate medication, click the **Dosage Calculator** button. The **Dosage Calculator** displays.

2. To use the Body Surface Area (BSA) calculator, enter the appropriate **Weight** and **Height**.

3. Click **Update**. The calculated **BSA** displays.

4. Enter the appropriate **Target Dose**, selecting the correct units from the drop-down menu to the right of the **Target Dose** field.

5. Select the desired **Frequency** from the drop-down menu.

6. Click **Calculate**. The **Calculated SIG** displays based on the other entries.

7. If the dosage displayed does not calculate to a whole number, it is possible to click **Round** to have Allscripts do the rounding.
8. If the calculated SIG is not acceptable, it is possible to select a SIG from the list displayed to the right of SIG Favorites.

9. To transfer the calculated dosage to the Medication Details screen, click OK.

- When information from the Dosage Calculator is saved, it is entered in the Free Text control for the New Free Text option button of the SIG section in the Medication Details page.

- If there is recent height and weight data already recorded for the patient, then this data automatically displays in the page. If this data is not available, then those controls of the calculator are blank.

- The data used to calculate the SIG is automatically entered in the Pharmacy Instructions field in the Medication Details page.
Replacing a Medication

Medications can be ordered as a replacement for a previously ordered medication.

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. If sending to retail, confirm that the patient’s preferred **Pharmacy** displays; if not, search for and add a pharmacy.
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**: Check the box to the left of the problem in **View Pane #1** 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 **Refill** field, enter the number of refills for this medication.
12. 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.

13. Select the desired **Action** for the prescription delivery method from the corresponding drop-down menu.
14. If sending to a pharmacy or calling the prescription in to a pharmacy, select the appropriate location from the **Pharmacy** drop-down menu.

   ![Tip] If a pharmacy is not entered or requires updating, click the **Search (binoculars)** icon to search the master dictionary.

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

   Two separate entries for the **Split Rx** medication display in the Meds component on the Clinical Desktop and in the **Encounter Summary**.

16. In the **Ordered by** field, select the authorizing provider for the medication.
17. If appropriate, in the **Therapy** area, select the **End** date for this medication.
18. Since this medication is being prescribed to replace an existing medication, click the **Replaced** drop-down arrow. A list of the patient’s current and past medications displays.

19. Select the medication that is being replaced.

20. 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**.

21. To save, click **Commit** from the **Clinical Toolbar**.
22. From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.

23. In the **Meds** component on the **Clinical Desktop**, the replaced medication is listed in the **Past Medications** view with a status of **DISCONTINUED-Replaced**.
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 <em>Go to Med</em> task is created when a user creates a new task from the <em>Medications</em> page with a medication selected. The new task’s action is <em>Process Med</em>.</td>
</tr>
<tr>
<td>Med Renewal</td>
<td>A <em>Med Renewal</em> task is created when a user creates a new task from the <em>Medications</em> page with a medication selected. The new task’s action is <em>Process Med</em>.</td>
</tr>
<tr>
<td>Med Admin</td>
<td>A <em>Med Admin</em> task is created by the system when a prescription is written with an action of <em>Administer</em> and any of the following fields on the <em>Administration</em> tab of the <em>Medication Detail</em> page are blank:</td>
</tr>
<tr>
<td></td>
<td>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. <em>Rx+</em> 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. <em>Rx+</em> 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. Select Renew from the action menu at the bottom of the Meds component. The selected medication displays in magenta text.

   OR

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

5. 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.

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. From the bottom of the component, click **Renew w/Changes**.

   **OR**

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

5. If necessary, modify the dosage using the drop-down menu in the upper-left corner of the page.
6. From the Medication Details page, select the appropriate SIG and instructions.
7. 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.
8. In the Refill field, enter the number of refills for this medication.
9. 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.
10. Select the desired action for the prescription delivery method from the corresponding Action drop-down menu.
11. If sending to a pharmacy or calling the prescription in to a pharmacy, select the appropriate location from the Pharmacy drop-down menu.

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

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

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

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

15. 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**.

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

17. 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.

   ![Medications Component]

   - Aspirin 81 MG Oral Tablet; Status: ACTIVE
   - Cefadroxil 500 MG Oral Capsule; TAKE 1 CAPSULE TWICE DAILY; Status: ACTIVE - Retrospective Authorization
   - GlyBURIDE 5 MG Oral Tablet; TAKE 1 TABLET DAILY; Status: ACTIVE
   - Hydrochlorothiazide 25 MG Oral Tablet; TAKE 1 TABLET ORALLY EVERY DAY; Status: ACTIVE
   - Hydrocodone-Acetaminophen 10-500 MG Oral Tablet; TAKE 1 TABLET 4 TIMES DAILY; Status: UNAUTHORIZED - Requires Signature
   - Januvia 100 MG Oral Tablet; TAKE 1 TABLET DAILY; Status: ACTIVE
   - Lipitor 10 MG Oral Tablet; TAKE 1 TABLET DAILY; Status: ACTIVE
   - Lovastatin 20 MG Oral Tablet; TAKE 1 TABLET ORALLY AT BEDTIME; Status: ACTIVE

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. 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**.
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. Sort by **Status**.

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

4. From the bottom of the component, click **Renew w/Changes**.

5. **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.
6. From the **Medication Details** page, in the upper-right corner, check **Record w/o Ordering** checkbox.

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

8. 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.

   - Clicking the **Edit** button on the component Action bar also displays the **Medication Details** page.

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.
Discontinuing a Medication

During Clinical Intake, it is necessary to update the Medications of a patient. Discontinuing a medication places the medication into the Past Medication view. When the patient’s note for this appointment is opened, the Current Medications accurately cite into the note.

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 discontinued. If more than one medication is to be discontinued, press the Ctrl key to highlight each medication.

3. Right-click the medication, select Order D/C from the menu or click the Order D/C button.

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

5. From the Encounter Summary, click Save and Continue. Magenta text changes to black.
Completing a Medication

In Clinical Intake, it is necessary to update the Medications of a patient. **Completing** a medication places the medication into the Past Medication view. Completing indicates that a patient completed a therapy as opposed to merely stopping a therapy. When the patient’s note for this appointment is opened, the **Current Medications** cite into the note.

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, highlight the medication to be completed. If more than one medication is to be completed, use the **Ctrl** key + left-mouse click to highlight each medication.

3. **Right-click** the medication and select **Completed Today**.

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

17. From the **Clinical Desktop**, navigate to the **HMP** tab.
18. **Right-click** the medication, and select **Record As Admin** from the menu.
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.
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.

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

10. Click **Commit** from the **Clinical Toolbar**.
Entering Diagnostic Orders as Part of an Office 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)** window displays. Select **Lab/Procedures** from the menu.

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**: Ensure the box to the left of the problem in **View Pane #1** is checked 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.
   - Click the **Search (binoculars)** icon to search the master dictionary.

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 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**

10. If **Prior Authorization** and/or **Appointments** are necessary for the diagnostic order, right-click the order in the **ACI**.
    In some cases, the **Order Details** page displays by default.

11. Click **Edit** from the menu.
12. From the **Order Details** section, select the appropriate performing location and communication method in the **To Be Performed** and **Communicated By** fields.  
- **Record** does not generate any output.  
- **Print Requisition** prints to the default printer.  
- **Send to Performing Location** is used to send labs electronically.  

13. In the **To Be Done** section, verify or change the date for the order to be completed.
14. From the **Additional Details** section, verify the appropriate ordering, managing, and supervising providers. For **Residents** all 3 fields should be the **Attending Provider**.

15. Enter **Comments to Performing Location** as needed to give additional instructions to the laboratory performing the test.

16. Enter **Prior Authorization** numbers in the **Fin Auth #** field.

17. Enter **Annotations** in the **Order Annotations** section if needed.

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

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

20. From the **Encounter Summary**, click **Save and Continue**. Magenta text changes to black.
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 Imaging from the menu.

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: Ensure the box to the left of the problem in View Pane #1 is checked to also Assess it.
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.

   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 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 adjacent to the order and **right-click** the orderable item.

   The order displays in **Viewing Pane #2** of the **ACI**.

9. Select **Edit** from the menu. The **Order Details** displays. The selected problem displays in the **Link to** field.

10. From the **Order Details** section, update the appropriate performing location and communication method in the **To Be Performed** and **Communicated By** fields.

    - **Record** does not generate any output.
    - **Print Requisition** prints to the default printer.
    - **Send to Performing Location** is used for transmitting the order electronically.

11. In the **To Be Done** section, verify or select the desired date for the order to be completed.
12. From the **Additional Details** section, verify the appropriate ordering, managing, and supervising providers. For **Residents** all 3 fields should be the **Attending Provider**.

13. Enter **Comments to Performing Location** as needed to give additional instructions to the laboratory performing the test.

14. Enter **Prior Authorization** numbers in the **Fin Auth #** field.

15. From the **Order Annotations** section, enter **Annotations** as needed.

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

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

18. From the **Encounter Summary**, click **Save and Continue**. Magenta text changes to black.
Entering Scheduled Orders as Part of an Office 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 **Lab/Procedures** from the menu.

   If not searching for a **Lab/Procedures** order, select the tab of the desired type of order: **Imaging**, **FU/Ref**, **Instructions**, **Immun**, 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:** Ensure the box to the left of the problem in **View Pane #1** is checked to also **Assess** it.

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

6. To enter a series of dates, click **Schedule**.
   The **Schedule Dialog** page displays.
7. Select a **Recurrence Type**.

**Recurrence types:**

- **Dates:** when a certain pattern is not necessary for recurring orders (random selection). Select the necessary dates and verify those dates display in the **Selected Dates** list box to the right of the screen.
- **Recurring:** if a pattern of recurrence is apparent for the selected order. Select a pattern of **Daily**, **Weekly**, **Monthly**, or **Yearly** before establishing the date range.
- **As Needed:** this option is for providers who want to establish a pattern of recurrence for orders that can be taken on an as-needed basis (PRN).
- **Age-Based:** orders may be established on a 5-year recurring schedule based on the patient’s date of birth and current age.

8. Create a **Recurrence Pattern**.

9. Verify a date or **Range Of Recurrence Pattern**.

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

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

12. 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.

- The selected 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.
13. Once identified, check the checkbox adjacent to the order or right-click and select **Edit** from the menu. 

The order displays in **Viewing Pane #2** of the **ACI**.

The **Order Details** displays. The selected problem displays in the **Link to** field and the recurring dates display next to the **Schedule** button.

14. From the **Order Details** section, update the appropriate performing location and communication method in the **To Be Performed** and **Communicated By** fields.

- **Record** does not generate any output.
- **Print Requisition** prints to the default printer.
- **Send to Performing Location** is used to transmit the requisition electronically.

15. In the **To Be Done** section, verify the dates for the recurring order.

16. From the **Additional Details** section, verify the appropriate ordering, managing, and supervising providers.

17. Enter **Comments to Performing Location** as needed to give additional instructions to the laboratory performing the test.

18. Enter **Prior Authorization** numbers in the **Fin Auth #** field.

19. From the **Order Annotations** section, enter **Annotations** as needed.

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

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

When the physician or provider notifies the clinical staff of the need for Follow-up or Referral, the clinical staff enters the order and 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 FU/Ref from the menu.
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**.

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

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, click the checkbox adjacent to the order and **right-click** the orderable item.
   - The order displays in **Viewing Pane #2** of the **ACI**.

9. Select **Edit** from the menu. The **Order Details** displays. The selected problem displays in the **Link to** field.

10. Enter the details for the **Consult/Referral** order.
- Enter the required information on the **Order Details** screen, including the selection of a provider from the external provider field.
- Do not select the **Internal** radio button.
- Enter the **To Be Done** date to reflect the date of the patient appointment. Adjust the **Overdue In** date if necessary.
- Complete the **Type** and **Referral Reason** fields.
- **Additional Details** section: Complete the Ordering, Managing, and Supervising Providers fields. Complete Fin Auth # (Prior Authorization) field if necessary. If previous orders have been entered, that provider’s name is the default.
- Enter additional order information, including the specifics of the appointment and the patient notification in the **Order Annotations** section.

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

```plaintext
Save and Close ACI
```

If additional orders need to be entered, click **Save and Return to ACI**.
- **Consult, Follow-up or Referral** orders generate an entry on the **Worklist**.
- If an appointment was made, the order remains in **Active** status and does not generate a **Worklist** entry.
Entering Follow-up Orders

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 **FU/Ref** from the menu.

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:** Ensure the box to the left of the problem in **View Pane #1** is checked to also **Assess** it.
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.

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, check the checkbox adjacent to the order and **right**-click the orderable item.
   - The order displays in **Viewing Pane #2** of the **ACI**.

9. Select **Edit** from the menu. The **Order Details** displays. The selected problem displays in the **Link to field**.

10. Enter the details for the **Follow-up** order.
    - Enter the required information on the **Order Details** screen, including the selection of a provider from the external provider field.
    - The **Follow-up Reason** field should default to **Follow-up**.
    - If a printed requisition is not needed, the **Communicated by** field should be left set to **Record**.
    - **Additional Details** section: Complete the Ordering, Managing, Supervising Providers, and Fin Auth # (Prior Authorization) fields. Complete the Fin Auth # field only if needed.
    - Enter additional order information including specifics of the follow-up in the **Order Annotations** section.
11. Click **Save and Close ACI**. The **Note** page displays.

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

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

13. From the **Encounter Summary**, click **Save and continue**. Magenta text changes to black.
Ordering Instructions

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 Instructions on the menu.

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: Ensure the box to the left of the problem in View Pane #1 is checked to also Assess it.
5. Select the **Specialty Group** or **My Favorites**.

6. 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.

7. You can select multiple instructions or right-click and select **View Patient Instructions** in order to review the narrative prior to making the selection.

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

   The **Order Details** page does not display for instructions that do not contain an editable field.
9. Enter any additional details for the instructions order. For **Residents Ordered By**, **Managed By**, and **Supervised By** should be the **Attending Provider**.

Click the **View Instructions** button to review the narrative associated with the order.

10. If needed, **click Show on Orders List**.

11. To review the narrative associated with the order, **click View Instructions**.

   If additional orders need to be entered, **click Save and Return to ACI**.
12. Click **Save and Close ACI**. The **Note** page displays.

13. Click **Commit** from the **Clinical Toolbar**. The **Encounter Summary** page displays.

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

   To print instructions, click **Print Pt Ed**. The **Patient Education Preferences** dialog page displays.

   ![Patient Education Preferences](image)

   Click **Yes**, **No** or **Cancel**. If printing, choose or verify a printer.

   From the **Encounter Summary**, click **Save and Continue**.
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.

<table>
<thead>
<tr>
<th>Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count (CBC) Status: Active Requested for: 19May2010</td>
</tr>
<tr>
<td>Complete Blood Count (CBC) Status: Active Requested for: 21Apr2010</td>
</tr>
<tr>
<td>Hemoglobin A1C Status: Active Requested for: 22Jun2010</td>
</tr>
<tr>
<td>Mammogram Status: Active Requested for: 17Jun2010</td>
</tr>
<tr>
<td>POS-Hgb A1C (QW) Status: Active Requested for: 17Jun2010</td>
</tr>
<tr>
<td>RAD Exam Chest 2 Views Status: Active Requested for: 09Jul2010</td>
</tr>
<tr>
<td>RAD Exam Chest 2 Views Status: Active Requested for: 17Jun2010</td>
</tr>
<tr>
<td>Walker Standard Status: Active Requested for: 12May2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hold For - Call Center, Scheduling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up visit 4 weeks Outpatient Follow-up Status: Hold For - Scheduling Call Center Requested for: 08Jun2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hold For - Scheduling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up visit in 1 week Physical Therapy Follow-up Status: Hold For - Scheduling Requested for: 12May2010</td>
</tr>
<tr>
<td>RAD Exam Foot 2 Views Status: Hold For - Scheduling Requested for: 28May2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hold For - Specimen/Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC With Platelet and Differential Status: Hold For - Specimen/Data Collection Requested for: 09Jul2010</td>
</tr>
<tr>
<td>Hemoglobin A1C Status: Hold For - Specimen/Data Collection Requested for: 01Jul2010</td>
</tr>
<tr>
<td>Insulin Status: Hold For - Specimen/Data Collection Requested for: 01Jul2010</td>
</tr>
<tr>
<td>Lipid 2 Panel Status: Hold For - Specimen/Data Collection Requested for: 01Jul2010</td>
</tr>
</tbody>
</table>

| Unauthorized - Requires Signature |

2. Right-click the order.
3. Click the Edit button.
The **Order Details** page displays.

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

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.
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.
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. 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.
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 Defer 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. For **Residents Ordered By** is the **Resident**. **Managed By**, and **Supervised By** should be the **Attending Provider**.

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.

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

Using CareGuides

CareGuides are pre-defined, problem-based order sets. They provide additional efficiency for providers and can include medication and non-medication orders, patient instructions, and follow-up and referral information.

The process of order selection also creates a customized patient education document that reflects the selected orders, and a fixed-text monograph about the condition or health maintenance topic that the CareGuide template addresses.

Orderable items and order reminders selected from CareGuides are reflected in the Health Management Plan component on the Clinical Desktop.

1. With the patient in context in the Patient Banner, the provider should open the appropriate note.

   OR

2. Once the note is open, click New at the bottom of the Plan section of the note. The ACI displays.

3. Search for and select a new problem from the ACI. The problem displays in magenta in Viewing Pane #1.

   OR

   From Viewing Pane #1, highlight the appropriate problem.
Providers can check the box associated to the problem to also assess it.

4. Click the CareGuide button. A list of associated CareGuides displays on the Problem-based Order primary tab and the CareGuide secondary tab.

The CareGuide button only activates if a template is available for the selected problem.

5. Select the appropriate CareGuide from the list. The contents of the template display within the CareGuide secondary tab of the ACI.

6. Select the checkbox to the left of the desired items to be ordered.

7. Select the radio buttons All, Rx, Instructions, or FU/Referral, to navigate to the various sections of the CareGuide.

8. Select the checkbox to the left of the desired items to be ordered.

   - To change details, right-click and select Edit. The appropriate Order Details page displays.
   - Note: It is NOT recommended to save the CareGuide as a personal template. If this is done, the user runs the risk of not receiving changes to the enterprise care guides in the future.

9. Click OK from the ACI or Save and Close ACI from the Order Details page.
10. Click **Commit** on the **Clinical Toolbar**. The **Encounter Summary** displays.

11. To print instructions, select the **CareGuide Patient Instructions** checkbox, the **CareGuide Patient Monographs** checkbox, or both.

   If the patient’s primary language is designated as **Spanish** in the patient demographics, it is possible to print the monographs in Spanish by checking the **Print Monographs in Spanish** checkbox.

12. Click **Print Pt Ed**. The **Patient Education Preferences** dialog page displays.

13. Click **Yes**, **No** or **Cancel**. If printing, choose or verify a printer.

14. From the **Encounter Summary**, click **Save and Continue**.
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.

![Add Clinical Item](image)

**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.
- 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.
Adding/Removing Forms from a Note

Note forms are pre-defined templates containing discreet data that may be selected using various controls. Note forms are linked to specific sections within the note and are generally symptom or problem-based.

1. Right-click the desired form to be removed from or added to the **Table of Contents**. A menu of actions displays.

2. Select **Add Form Above** or **Add Form Below** to insert a new form in the desired location.

   OR

   Select **Delete Form** to remove the selected form from the current note.

   OR

   Select **Clear Form** to clear the contents of the form.
If adding a form, the **Form Selector** displays.

3. ![Form Selector](image.png)

   Enter the desired form in the **search** field and click the **Search (binoculars)** icon to search the master dictionary. The search results display.

   ![Tip](image.png)

   If no appropriate note forms are available, search for and use the **Text Templates** form instead.

4. Once identified, select the checkbox to the left of the form, and then click the **OK** button. The selected form displays within the designated section of the note.
Documenting within Note Forms

1. Select a form in the **Table of Contents**.

![Image of Allscripts Enterprise EHR interface]

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 <strong>Detail</strong> 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**.
Citing Relevant Lab Results

The default setting for citing lab results in a Note is to automatically cite results recorded within the last seven days. This can be changed by the system administrator.

It is possible to cite other lab results in a note from the ChartViewer component.

Citing Lab Results using “Cite Selected”:

1. Open the desired Progress Note where the lab results are to be cited.
2. Navigate to the ChartViewer component.
3. Right-click the lab result to be cited in the Progress Note.
4. Click Cite selected from the menu.
5. The selected result is cited into the Results/Data section of the note.

- Unverified results can be cited using this method.
- This option applies to results only; it is not available when an item other than a result is selected.
Citing Lab Results using “Advanced Result Citation”:

1. Open the desired Progress Note where the lab results are to be cited.
2. Navigate to the ChartViewer component of the Clinical Desktop.
3. Right-click the first lab result to be cited in the Progress Note.

4. Click Advanced Result Citation from the menu. The Results Citation Selection window displays with the results listed in reverse-chronological order.

5. Select the result(s) to be cited in the Progress Note by choosing the checkbox to the left of each result.

6. Click OK.

7. The selected result(s) is/are cited into the Results/Data section of the note.

- Unverified results can be cited using this method.
- This option applies to results only; it is not available when an item other than a result is selected.
Working with Clinical Item Lists within a Note

Certain note sections may have an associated list of clinical items that can be modified from the NAW and incorporated into an output document. These note sections include:

- Active Problems
- Past Medical History
- Surgical History
- Family History
- Social History
- Immunizations
- Current Meds
- Allergies
- Vitals
- Results
- Assessment

1. From the NAW, select a section in the Table of Contents that offers a list of clinical items as an input option.

2. Modify the list as needed using the available actions.

   Each section with cited information can be shown or hidden in the Note Outputs, depending on whether Show All or Hide All is selected. In addition, individual items in each section can be shown or hidden by selecting the item and choosing either Show or Hide.
Assessing a Problem

The assessment or diagnosis of a patient’s problem can be managed from the NAW using the patient’s active problem list cited from the Clinical Desktop. New problems may also be added.

1. Select Assessment from the Table of Contents. The patient’s active problem list and any associated diagnosis forms display.

2. Select the checkbox to the left of the assessed problems. The problems display in magenta in the Assessed list.

3. If the problem is unavailable, search for and select a new problem using the Clinical Toolbar or the New button on the action menu below the active problem list.

   - The assessment becomes final when committed to the Encounter Summary.
   - Right-click a problem to re-order diagnoses so they display in the correct order in the Encounter Form.

   ![Assessment Diagram]

Make Primary
Make Secondary
Make Tertiary
Completing the Plan

Providers are able to create orders during the patient encounter from the NAW.

1. From the **Table of Contents**, select **Plan**.
2. Click the **New** button.
3. Select the tab of the desired type of order: Rx, Lab/Procedures, Imaging, FU/Ref, Instructions, Immun, Supplies, or Med Admin.

4. Enter the order. Refer to the Orders and Plan section in this Reference Guide.

5. Click the OK button.
6. Verify that the order(s) is/are linked to the appropriate assessed problem.
Adding the Attestation

When working with residents, **AND/OR**

when reviewing clinical staff documentation, providers are required to complete the **Attestation** section of the note.

1. From the **Table of Contents**, select **Attestation**.

2. From the **Table of Contents**, select the **CMA Attestations** form.

3. Complete as needed by selecting the appropriate statement from the displayed list.

4. If applicable, select and complete the **Procedure Attestation**.
Note Output Documents

The NAW displays note output documents in the lower-left pane. Note Output Documents are defined for input documents or templates.

1. To view and sign an output document(s), select the appropriate document(s) and click the **View** button.
The document(s) displays.

2. Click the **Sign** button. The **Note Signature** box displays.

3. Enter the logon password in the **Password** field.

4. Select the **Make Final** checkbox if available.
   - Any future edits to the document after the note is final changes the status from **Final** to **Amended**.
   - If there are more edits to be made before finalizing or if there are outstanding dictations, it is possible to sign the note without finalizing. Uncheck the **Make Final** checkbox before signing and then click **OK**.

5. Click **OK**.
E/M Coder Defined

The E/M Coder utility helps users select the appropriate level of service coding for documenting a clinical encounter. It suggests the calculated E/M code that is based on the patient’s documented encounter data.

- Free text and text templates are not taken into consideration in the E/M Code recommendation. For this reason, Allscripts allows the user to override the suggested levels by manually selecting a documentation level.

Available documentation levels are displayed in four colors:

- **White** – Indicates an unselected, but available level.
- **Blue** – Indicates an unselected, but unavailable level due to its value being based on prior levels. For example, a level for **Overall History** cannot be selected because that level is selected by the system based on what is selected for **HPI**, **ROS**, and **PFSH**.
- **Green** – Indicates a level derived by the system.
- **Fuchsia** – Indicates a level overridden by the user.

Using the E/M Coder

1. Click the E/M button located at the bottom of the NAW.
The E/M Coder page displays a suggested code derived from data already documented in the Note.

2. From the **E/M Code Recommendations** section, review the **Calculated from Abstracted Levels** field to view the suggested code.
   - The **Tests Risk** and **Mgt Risk** sections on the E/M Coder must be manually updated.
   - Hovering the mouse pointer over entries in the **Documentation Levels** box gives more detailed descriptions of the fields.
The **Medical Decision Making** tab of the **E/M Coder** is used to enter additional information that affects the level of service as appropriate. For example, calculating the number of diagnoses or treatment options, amount and/or complexity of data reviewed, and the level of risk.

3. As appropriate, select sections of the patient’s history that were reviewed in the **History Reviewed** section by clicking the pertinent checkboxes.

4. Click **Apply** in the bottom right-corner of the **Medical Decision Making** page to update the Abstracted Level of the PFSH on the **Summary** page.

5. Select any pertinent topics of the patient’s chart in the **Complexity of Data to be Obtained/Reviewed/Analyzed** section that were reviewed and/or ordered by clicking the appropriate checkboxes.

6. Click the **OK** button to accept the suggested code.

   **OR**

   Override the general encounter information or documentation levels by making changes to the levels calculated in the **Setting**, **Service**, **Exam Type**, **Total Time Spent w/Patient**, and **Documentation Levels** fields. When finished, click the **Re-calculate** button. The new suggested code displays in the **With user Override Levels** field.

   **OR**

   Click the **Cancel** button to enter codes manually.

   - Select the **Post Charge to Current Encounter** checkbox to insert the derived CPT4 code in the **Visit Charges** section of the **Encounter Form**.
   - If values are added to the **Medical Decision Making** page, those selections are required to be documented in the **Level of Service** section of the **NAW** (see next section below).
Entering Medical Decision Making Information in the Note

If values are added to the Medical Decision Making page of the E/M Coder, those selections are required to be documented in the Level of Service section of the NAW.

1. From the Table of Contents, select Level of Service.
2. Enter the information added to the **Medical Decision Making** page of the **E/M Coder**.

3. In the **Risk** subsection of the **Medical Decision Making** form of the **Note**, enter the levels of risk from the **Prob Risk**, **Tests Risk**, and **Mgt Risk** sections of the **Summary** page of the **E/M Coder**.
DICTATE

Recording a Structured Dictation Marker

- Dictation can be used to record the information obtained during an encounter. The Dictate module offers providers a quick way to dictate, review, and submit these dictations in an electronic format.
- Dictations may be marked as Stat or placed on hold pending further information.

1. From the Note page, select the desired Note Section in the Table of Contents that contains the dictation marker.

2. Click the dictation marker before beginning a dictation. A Dictation Marker displays in the Accumulator with specific details. When a microphone icon displays to the left of the dictation marker, this indicates that the Dictation Toolbar may be used.
The dictation marker includes your provider initials, the date, and a sequence number. For example, the following dictation marker: MDG-072110-1

- User’s initials: MDG
- Current Date: July 21, 2010
- Number of dictation for the current date

3. To launch the **Dictation Toolbar**, right-click anywhere on the **Clinical Toolbar** and check the **Dictation Toolbar** option.

The **Dictation Toolbar** displays beneath the **Clinical Toolbar**.

The following table describes the different controls on the **Dictation Toolbar**.
Recording an Unstructured Dictation

1. Bring a patient into context on the **Patient Banner**.
2. From the **Dictation Toolbar**, click the drop-down menu and select the type of desired dictation.

3. Click the **Record** button and speak into the microphone to record a dictation.

4. Click the **Pause** button when done dictating.

5. Click the **Play** button to review the dictation.

6. Click the **Cancel** button to delete the dictation.
   
   **OR**

   Click the **Done** button to send the dictation.

Marking a Dictation as Hold or Stat

1. Record a dictation.

2. Click the **Dictation** button on the left side of the **Dictation Toolbar** and select **Mark as Stat** from the drop-down menu.

   **OR**

   Click the **Hold Dictation** button on the **Dictation Toolbar**.
   - **Mark as Stat** – submits immediately
   - **Hold Dictation** – enables dictation to be finished later
Setting Dictation Toolbar Preferences

1. Right-click from anywhere on the Clinical Toolbar.

2. Put a check mark in the box next to Dictation Toolbar.

3. Click the Dictation button on the left side of the Dictation Toolbar and select User Preferences from the drop-down menu. The Dictation User Preference page displays.

4. From the Dictation User Preference page, deselect the dictation types you do not wish to display in the Worktypes drop-down menu.

5. To ensure the Dictation Toolbar is always visible, select the check box to the right of Enable Dictation Toolbar.

6. Click the OK button.
DRAGON NATURALLYSPEAKING

Using Dragon NaturallySpeaking® in an Allscripts Structured Note

1. Double-click the Dragon icon located on the desktop. The DragonBar displays and remains accessible.
2. In Allscripts, create a Structured Note for a patient.

3. From the NAW, place the cursor adjacent to the text field in the appropriate section of the accumulator.

4. Click the Microphone button to begin recording. The microphone displays vertically, when recording.
5. Speak into the microphone.
6. Navigate and correct any errors as encountered.
7. To accept the dictation, click the Save & Close button at the bottom of the NAW.
8. To turn the Microphone off, say "Microphone Off."

   OR

Click the Microphone icon.

- Open Dragon, and then open Allscripts.
- To avoid outside noise and the need to make corrections, pause the microphone.
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

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.
### Column Description

<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><strong>My Active Tasks</strong></td>
<td>Displays active tasks for the person currently logged into the system.</td>
</tr>
<tr>
<td><strong>Current Patient – Active</strong></td>
<td>Displays only active tasks associated with the patient currently displayed in the <strong>Patient Banner</strong>.</td>
</tr>
<tr>
<td><strong>Current Patient – All</strong></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</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>about a task</td>
<td></td>
</tr>
<tr>
<td>Marking the status of a task</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>as In Progress</td>
<td></td>
</tr>
<tr>
<td>Performing or Completing a</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>task</td>
<td></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>task</td>
<td></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>
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.

5. In the **Comments** section type any additional information or possible follow-up actions. **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 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 <strong>Task Details</strong> 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 <strong>Comments</strong> 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 <strong>Go To</strong> for a <strong>Sign Note</strong> task displays the <strong>NAW</strong> to 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 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 <strong>Note Selector</strong>; select the appropriate note.</td>
</tr>
<tr>
<td>Undelegate</td>
<td>Sends the task back to the <strong>Assigned To</strong> 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 <strong>Original</strong> displays the original task sent previously.</td>
</tr>
<tr>
<td>Done</td>
<td>Completes the selected task and removes it from the list. <strong>Note:</strong> The system displays the <strong>Done</strong> button instead of <strong>Go To</strong> if a task must be performed manually outside of Allscripts. In this case, click <strong>Done</strong> 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**
   - *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**.
The **Note Selector** page displays.

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.
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.

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.

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

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 AND RESULTS VERIFICATION

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.
Follow-Up requests generate an order with a Hold-for Scheduling status on the Orders Clinical Staff Worklist. Referral requests generate an order with an Active status on the Referrals Worklist. The clinical staff is responsible for scheduling the appointment and changing the appointment status of the order.

1. From the Horizontal toolbar, select Worklist.

   The Worklist is also accessible on the Clinical Desktop.

2. From the left pane, highlight a patient.

3. From the right pane, locate the order in the Hold for-Scheduling or Active section, depending on the order type.

4. Highlight the order, click Edit or right-click and select Edit from the menu.

   To view detailed information for the selected order, double-click the item to display the Order Viewer.

5. Enter the required information on the order detail screen; including the selection of a provider from the External Provider field (Do not select the Internal radio button).

   The location should default to Other.

6. Update the To Be Done date to reflect the date of the patient appointment.

7. If necessary, adjust the Overdue date.

8. Change the Communicated by field to Record if a copy of the requisition is not needed.

9. Open the Additional Details section. Verify the ordering, managing, and supervising provider(s).

10. Update the Appointment Status field.

    Once the status is changed to Scheduled and the data is Committed, the option to change providers is no longer available.

11. Enter the prior authorization number in the Fin Auth # field if needed.

12. To enter annotations, open the Order Annotations section and document specifics of the appointment and patient notification as needed.

13. Click OK. The Worklist displays.

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

15. From the Encounter Summary, click Save and Continue. Magenta text changes to black.
Orders require provider authorization when they are entered into the system by someone other than the ordering provider.

1. From the **Vertical** toolbar, select **Chart**.
2. From the **Horizontal** toolbar, select **Worklist**.
3. Select **Provider Authorizations** from the view pull-down.

4. Select a patient by clicking on a name in the **Patient Name** column.
5. Items to be authorized display in the section to the right.

   When covering for other physicians, change the view from the **view** drop-down menu to **Order – Result Group Coverage**.

6. Expand view if necessary and review the information.

   To view detailed information for the selected order, double-click the item to display the **Order Viewer**.

7. Highlight the medication(s) or order(s) and click the **Authorize** button.
OR

Right-click the desired order and highlight the appropriate menu action for the selected result(s). The selected order(s) is/are removed from the displayed Worklist.

The Ctrl key can be used to highlight multiple medications or orders and use the option to authorize all.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorize</td>
<td>Authorizes the selected orderable item. Once authorized, any associated action is fulfilled (e.g., Send to Pharmacy, Print, etc.).</td>
</tr>
<tr>
<td>Authorize All</td>
<td>Authorizes all orderable items displayed. Once authorized, any associated actions is fulfilled (e.g., Send to Pharmacy, Print, etc.).</td>
</tr>
<tr>
<td>Void</td>
<td>Changes the status of the selected item to “Void.” The user may re-order or take further action based on department and/or patient protocol.</td>
</tr>
</tbody>
</table>
Verifying Results

Results that need to be verified by the provider will appear on the Worklist in the Results Verification view. Results to be verified will be reviewed in the Worklist, but verified from the Clinical Desktop of the patient.

1. From the Horizontal toolbar, select Worklist.
2. Review results to be verified for each patient by selecting the patient from the list on the left. The results needing verification for the selected patient display in the viewing pane on the right.

- Patients with nothing in the column indicate normal results to be verified.
- Patients with an exclamation point on a yellow background indicate abnormal results to be verified.
- Patients with two exclamation points on a red background indicate a patient has multiple abnormal results.
  - To view the results to be verified, click on the “+” to the left of the result OR double-click the title of the test.
3. With a patient in context on the **Patient Banner**, select **Clinical Desktop** from the **Vertical** toolbar.

4. From the view pull-down just below the **Patient Banner**, select **Worklist Desktop View**.

5. From the view pull-down in the **Patient Worklist** component, select **Results Verification**.

6. Click **Verify** on the component menu at the bottom of the screen. A pop-up menu displays.
7. From the menu, select the appropriate action.

The provider can perform the following actions from the drop-down menu when right-clicking on a result:

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QVerify</td>
<td>This menu item is used to verify one or more selected results without making changes to default settings, or enter annotations and/or messages. When this item is clicked, the Results Verification page is not displayed.</td>
</tr>
<tr>
<td>Qverify All</td>
<td>This menu item is used to verify all results that are displayed for a patient without making changes to default settings, or enter annotations and/or messages. When this item is clicked, the Results Verification page is not displayed.</td>
</tr>
<tr>
<td>Verify...</td>
<td>This menu item is used to verify one or more selected results. The provider is able to make changes to the default settings and enter annotations and messages to staff or patients regarding the selected results. When this item is clicked, the Results Verification page is displayed (details described in the Establishing Results Verification Preferences section below).</td>
</tr>
<tr>
<td>Verify All...</td>
<td>This menu item is used to verify all results that are displayed for a patient. The provider is able to make changes to the default settings and enter annotations and messages to staff or patients regarding the selected results. When this item is clicked, the Results Verification page is displayed (details described in the Establishing Results Verification Preferences section below).</td>
</tr>
</tbody>
</table>
8. If needed, right-click and select Annotate from the menu. The Add Annotation dialog box displays with the order information in the header.

9. Type the annotation message or click TT to use a text template. The Free Text dialogue box displays.

10. Select and complete the appropriate template.
11. Click OK.
- To add the same annotation to multiple results, highlight the first result, hold the Ctrl key, and highlight additional orders.
- Right-click and select Annotate from the menu.
- The Add Annotation dialog box header indicates that the annotation is assigned to multiple items.
Using the Worklist Quick Filter

The Worklist Quick Filter button is available to show or hide results review items. It is possible to hide or show only reviewed items, show both reviewed and not reviewed items, and to restore the default view.

1. Navigate to the Patient Worklist component on the Clinical Desktop for the appropriate patient.
2. Click the Filter button on the menu bar at the top of the Patient Worklist component.
3. Select the appropriate filters from the menu.
The following table describes the filter choices available:

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Location</td>
<td>Filters results based on patient location in the clinic workflow.</td>
</tr>
<tr>
<td>Patient Status</td>
<td>Filters results based on patient status in the clinic workflow.</td>
</tr>
<tr>
<td>Ordering Provider</td>
<td>Filters by the provider who ordered the test.</td>
</tr>
<tr>
<td>Order Status</td>
<td>Filters by order status (for example, Resulted, Need information, Entered in Error, Hold For, etc.).</td>
</tr>
<tr>
<td>Order Status Reason</td>
<td>Filters by status reason (for example, Requires Authorization, Requires Verification, Requires Signature, etc.).</td>
</tr>
<tr>
<td>Hide Reviewed</td>
<td>Hides results that have already been reviewed.</td>
</tr>
<tr>
<td>Show Reviewed Only</td>
<td>Hides all results that have not been previously reviewed.</td>
</tr>
<tr>
<td>Show All</td>
<td>Shows all results review items.</td>
</tr>
<tr>
<td>Restore View Defaults</td>
<td>Restores the default view of the result review items.</td>
</tr>
</tbody>
</table>
Invalidating Results During the Verification Process

Results that need to be verified by the provider will appear on the Worklist in the Results Verification view.

1. Select a patient from the list on the left. The results for the selected patient display in the viewing pane on the right.

   - Patients with nothing in the column indicate normal results to be verified.
   - Patients with an exclamation point on a yellow background indicate abnormal results to be verified.
   - Patients with two exclamation points on a red background indicate a patient has multiple abnormal results to be verified.

2. Right-click the order/lab name and select Annotate. Document the reason the result is being invalidated.

3. Right-click the order/lab name and select Enter in Error.

   **CAUTION:** The option Enter in Error invalidates both the order and the result.

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

5. From the Encounter Summary, click Save and Continue. Magenta text changes to black.
Establishing Results Verification Preferences

1. From the Worklist, click the desired result and select Verify or Verify All from the Verify menu on the component toolbar at the bottom of the screen. The Results Verification Preferences page displays.

   ![Results Verification Preferences page](image)

   - **Patient Communications**
     - Call Pt with Results
     - Schedule Results F/U
     - Mail Results To Patient

   - **Assign delegated task to** Provider, Alexander

   - **Task Priority** Routine

   - **Result Document**
     - New: Results Document FoS; Family Medicine; Provider, Alexander

   - **Messages**
     - Message to Staff
     - Message to Patient

   - **Annotations to Apply to All Results Being Verified**

2. Verify the provider is listed in the Assign delegated task to section.
   - A note is required if using the Call Patient with Results or Mail Results To Patient options.
   - A system-generated task is sent to the designated support staff member when using the Call patient with results, Mail Results To Patient or Message to Patient, or Schedule Results F/U option.

3. Select the appropriate option from the Task Priority drop-down menu.
4. If necessary, document a message in the **Message to Staff** and **Message to Patient** sections.

- Text templates may also be used to document these sections.
- See table below for description of other actions that can be taken in the **Results Verification Dialog**.
5. To verify the current patient’s results and continue to the next patient in the Worklist, click **Verify & Next Patient**.

- If the **Encounter Selector** displays, enter a **New Encounter** with the current date and select **Results Review** as the Type.

OR

To return to the worklist, click **Verify**.
<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Patient with Results</td>
<td>Generates a <strong>Call Results to Patient</strong> delegated task and a Progress Note.</td>
</tr>
<tr>
<td>Schedule Results F/U</td>
<td>Sends a delegated task to schedule a follow up appointment for the patient.</td>
</tr>
<tr>
<td>Mail Results to Patient</td>
<td>Generates a <strong>Mail Patient with Results</strong> delegated task and a Progress Note.</td>
</tr>
<tr>
<td>Discussed results with patient</td>
<td>No action</td>
</tr>
<tr>
<td>No patient communication needed at this time</td>
<td>No action</td>
</tr>
<tr>
<td>Assign delegated task to</td>
<td>Defaults the provider and sends a delegated task to designated staff.</td>
</tr>
<tr>
<td>To/CC</td>
<td>Allows the user to send a carbon copy (CC) to another staff member. The staff member who receives this CC does not need to act on the results. The CC is for viewing only.</td>
</tr>
<tr>
<td>Message to Staff</td>
<td>Displays a message to the patient in the <strong>Message</strong> section of the Progress Note.</td>
</tr>
<tr>
<td>Message to Patient</td>
<td>Displays a message to the patient in the <strong>Discussion/Summary</strong> section of the Progress Note.</td>
</tr>
<tr>
<td>Append Staff Message to Task Comment</td>
<td>Displays the <strong>Message to Staff</strong> in both the Progress Note and the Comments section of the Task.</td>
</tr>
<tr>
<td>Annotations to Apply to All Results Being Verified</td>
<td>Text entered here displays after each selected result being verified.</td>
</tr>
<tr>
<td>Verify and Go To Note</td>
<td>Verifies the result(s) and displays the note for review and signature.</td>
</tr>
<tr>
<td>Verify and Next Patient</td>
<td>Verifies the result(s) and prompts the next patient needing verification.</td>
</tr>
<tr>
<td>Verify</td>
<td>Verifies the result(s) and returns the user back to the <strong>Clinical Desktop</strong>.</td>
</tr>
<tr>
<td>Cancel</td>
<td>Cancels the <strong>Results Verification Dialog</strong> page.</td>
</tr>
</tbody>
</table>
Adding Common Annotations for Multiple Results

1. Access the Worklist on the Horizontal Toolbar (HTB) with multiple unverified results for a patient.

2. Select multiple results by holding down the Ctrl key and highlighting the unverified results.

3. Right-click and select Annotate from the menu. The Add Annotation page displays.

4. Add desired text and click OK.
The common annotation is applied to all of the selected results and is marked with an asterisk. Unsaved results display in magenta text.

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.
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 <strong>Problem</strong>. The HMP can also be grouped by <strong>Specialty Problem</strong> or <strong>Problem Type</strong>.</td>
</tr>
<tr>
<td>Reminders/Alerts</td>
<td>Displays the active order reminders for the patient’s problems; can be grouped by <strong>Problem</strong> or <strong>Alert Type</strong>.</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 <strong>Expand/Restore</strong> 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 <strong>HMP</strong> 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 <strong>Task Detail</strong> page to create a new task. Allscripts populates the <strong>Task Detail</strong> page with the selected patient’s name in the <strong>Concerning Patient</strong> box. It also sets the <strong>Assign To</strong> value to <strong>User</strong> and sets the <strong>User</strong> box to the current user. This occurs whether or not an item is selected in the <strong>HMP</strong> 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>Item Name</td>
<td>Displays the item(s) actively associated to the patient’s HMP.</td>
</tr>
<tr>
<td>Schedule</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>Graph</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>Most Recent</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>Date</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>Trend</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>To Do</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>Incomplete</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**.

![Normative Growth Chart](image-url)
Graphing Information

1. From the Clinical Desktop, select the Flowsheet tab. From the FlowSheets menu, select the desired flowsheet to view. The flowsheet displays within the component.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Vitals</th>
<th>HMP</th>
<th>Chart Viewer</th>
<th>Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VitalSigns/Findings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Includes: All</strong></td>
<td><strong>Graph</strong></td>
<td><strong>13 Jul 2010</strong></td>
<td><strong>12 Jul 2010</strong></td>
<td></td>
</tr>
<tr>
<td>Item Name</td>
<td></td>
<td>1:56 PM</td>
<td>1:56 PM</td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td></td>
<td>120</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Diastolic</td>
<td></td>
<td>80</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td>98.3 F</td>
<td>98.6 F</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td>5 ft 6 in</td>
<td>5 ft 2 in</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td>115 lb</td>
<td>110 lb</td>
<td></td>
</tr>
<tr>
<td>Patient Declined Having Weight...</td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
<td>18.85 kg/m²</td>
<td>20.12 kg/m²</td>
<td></td>
</tr>
<tr>
<td>BSA</td>
<td></td>
<td>1.58 m²</td>
<td>1.48 m²</td>
<td></td>
</tr>
</tbody>
</table>

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.

The following table describes the document flows used within Allscripts. Every document in the system uses one of the described flows, which govern document status and how the document is routed within the system.

<table>
<thead>
<tr>
<th>Flow</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Signature</td>
<td>Used for documents in the system with a status of <strong>Unsigned</strong>. These documents automatically generate a task for the document owner to sign the document. All users may sign the document, but only those with sufficient authority can change the document status to <strong>Final</strong> with their signature.</td>
</tr>
<tr>
<td>Non-Electronic</td>
<td>Used for documents in the system with a status of <strong>Final-Receipt</strong>. These documents do not require electronic signature or verification.</td>
</tr>
<tr>
<td>Electronic Verification</td>
<td>Used for documents in the system with a status of <strong>Unverified</strong>. All users can verify the document.</td>
</tr>
</tbody>
</table>
Signing Structured Notes

Sign Note tasks are generated for the owner of a note at the time the note is started. They are also created when completed transcription is returned to Allscripts. Sign Note tasks can also be manually created by a user when a co-signature is required on a document.

Documents may be viewed and signed within Allscripts from either the Note or Chart Viewer page. In order to access chart information, a patient must be selected.

1. For Providers, from the Vertical toolbar, select Chart.
2. From the Horizontal toolbar, select Documents. The Document Completion Tasks page displays.
3. Select the view from the View drop-down menu.
   - The number of documents to be signed displays in the gray highlighted line above the document panel.
4. Select the Patient Name in the Patient column.
   - An efficient method for signing documents is using the batch signing functionality provided by Allscripts.
   - This task-related method enables users to review all documents requiring an electronic signature by entering the user’s password only once.
   - The Sign button is used for the remaining documents without entering the electronic signature.
The **Note Output** displays on the right.

5. Validate that the **Final** checkbox, located at the bottom of the screen, is checked.
   - Only providers can assign a secure status to a note. This must be done before signing the document.
   - Notes should not be finalized until they are completed and all transcription has been returned.
   - Notes can also be signed from the **Chart Viewer**, the **Note** workspace or the **Task List**; however, the password must be entered each time.
   - Dictations do not display in the **Chart Viewer** note until the dictation is signed.

6. **Click Sign** to officially enter the document’s text into the patient’s electronic chart. The **Signature** page displays.

7. In the **Password** text field, enter your password.

8. Select the appropriate entry from the **Sig Type** pull-down.

9. **Click OK** to return to the **Document Completion Tasks** page.
   - The next patient note should display automatically.
   - Review the note and click **Sign**.
   - It is not necessary to re-enter the password; however, if a note is opened or the screen is left, it is once again necessary to re-enter the password.
   - Continue signing.
Editing Structured Notes

1. From the Document Completion Tasks page, select the desired patient name in the Patient column. The Note Output displays.

2. Click Edit from the bottom menu bar. The Note page displays.

OR
3. From Chart Viewer, click View, or double-click the note to be edited. The Note Viewer page displays.

4. From the Note Output page or Note Viewer page, click Edit from the bottom menu bar. The NAW displays.
5. Select the **Note Section** in the **Table of Contents** that contains the entry to be edited.

6. Click **Sign** to officially enter the document’s text into the patient’s electronic chart.
Amending Finalized Structured Notes

Once the status of a structured **Note** is changed to “Final,” any change(s) made to the note is considered a “note amendment” by the system. Users can quickly view a note output that has been amended and determine what has changed in the note from the previous version and who made changes to the note.

1. **From Chart Viewer**, double-click the finalized note to be amended. The selected note displays in the Note Viewer.

2. Click the **Edit** button.
The **Note** page displays.

3. Select the section from the **Table of Contents** to be amended and add, remove, or change the finding or free text from within the form.

4. **Sign** to save all changes.
   - Click **Save & Close** to save the amended document without signing.
   - Some note sections are locked when the note is finalized. Click **Unlock/Amend** to access these sections for editing.
5. The status of the note is now displayed as **Amended, Final**.
6. The amended data is date/time stamped and displays the name of the user who made the changes.

The status of an amended document changes from **Final** to one of the following statuses, depending on whether or not the amended document is saved, signed or finalized.

- **Amended, Unsigned** – The document has been amended but not signed since the amendment.
- **Amended, Signed** – The amended document has been signed by someone with insufficient signature authority to finalize it, or by someone with authority who opted not to finalize it.
- **Amended, Final** – The amended document has been signed by someone with sufficient signature authority to finalize it.
Invalidating Structured Notes

- At times, it may be necessary for users to invalidate existing notes. For example, a note is initiated for the wrong patient, a wrong note type or date of service may have been used, or a duplicate note was created for a patient’s encounter.
- Invalidating a note invalidates the entire document and is only used by the owner or a user with sufficient authority to invalidate.
- Those users with sufficient signature authority to finalize a note may invalidate as well. Invalidated notes are not deleted from Allscripts.
- It is also important to know that invalidating a note does not invalidate instances of allergies, immunizations, medications, orders, problems, or vital signs that may have been cited in the Note.
- Any inaccuracies within these areas must be corrected in the associated areas of the patient’s medical record.

1. From the **Clinical Desktop**, select the **Chart Viewer** component.
2. **Double-click** the desired note requiring invalidation. The **Note Viewer** displays.
3. **Right-click** anywhere in the **Note Viewer**.
4. Select **Invalidate** from the menu.

5. Click **Yes** to invalidate the note. The note no longer displays in the **Chart Viewer** but has not been deleted.
It is also possible to **invalidate** a note when you open the note in **edit** mode.

1. Navigate to the patient’s Clinical Desktop. Select the Chart View tab, and find the two notes. (highlighted below)

2. Right Click on the first document, and select “View”
3. When viewing the note you decide it’s the incorrect note, select "Edit" from the bottom toolbar. This will open the Note Authoring Window (NAW). ***VERY IMPORTANT*** DO NOT click on anything until the note is FULLY loaded. The bottom toolbar of the NAW will be “ACTIVE/BOLD” when this process is complete.

4. ***VERY IMPORTANT*** DO NOT click on anything until the note is FULLY loaded. The bottom toolbar of the NAW will be “ACTIVE/BOLD” when this process is complete.
5. Next select the arrow in the top right window for the Note tab. (next to the status/task icon)

6. From the menu select “invalidate”
7. Select “YES”
Creating Carbon Copies

A carbon copy of a document can be printed, faxed, or sent as a task by Allscripts to designated recipients when the document is finalized. Therefore, this distribution occurs one time in the life of a document unless the document is amended and then finalized again, or additional carbon copy recipients are designated after a document has been finalized.

1. **Double-click** a note in **Chart Viewer** to view the note.

2. ![To/CC (Carbon Copy) button](image)

   **Click the To/CC (Carbon Copy) button in the upper-left corner.**
The **Carbon Copies** dialogue page displays. The document selected displays in the upper-left corner under the patient demographics.

3. On the **Role** tab, select the checkbox next to the desired recipient(s).

   OR

4. If the desired recipient(s) are not displayed on the **Role** tab, click the **Manual** tab to search the dictionary of providers.

   OR
5. Click **AdHoc** to manually enter the recipient’s name and method of communication (print or fax). Finish by typing in optional information of address, city, state, zip code, and fax number.

![Recipient window]

6. Click **OK**.

7. Click **OK** to apply the carbon copy recipients to the note. The recipient list displays in the upper left corner of the **Note** page.

   ![Recipient list]

   Allscripts, Cardiologist M.D.; Allscripts, Orthopedist M.D.; Dr. John Jones;
Tracking Document History for Structured Notes

Document information may be viewed from either the Chart Viewer or the Note page, including the following:

- The source of the document
- What action was taken on the document, when, and by whom
- Tasks associated with the document
- User-defined information

1. From the Clinical Desktop, select the Chart Viewer component.
2. Double-click the desired document requiring tracking. The Note Viewer displays.
3. Click the Document Hx button at the bottom of the page.
4. Review the document history.

5. Click the **Close** button to exit the **Document History** page.
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.

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

![Job Queue (All) - 11 Items](image)
3. 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.

- 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 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 Toolbar, select the Diagnosis tab.
2. The Diagnosis Selector page defaults to the providers specialty view.

3. To manually search for a diagnosis, type the full or partial name or IDC9 code for the item and click Go (or press the Enter key). A list of diagnoses displays.
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, the Master List or Patient Past Diagnoses views).
5. Add all appropriate diagnosis codes. (The first diagnosis code selected is set as the primary diagnosis.)

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

7. 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.

8. 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. The Visit Charge Selector page defaults to the providers specialty view.
2. From the specialty view on the left hand side of the screen, select the Visit Charges category.
3. Once the category is selected, associated visit charges display on the right hand side of the screen. Select the appropriate visit charge(s) from the right hand side of the screen.

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 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).
6. To add a modifier, select the **Visit Charge**. In the **Modifier Group** section, click the dropdown 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.

7. 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. The Procedure Charge Selector page defaults to the providers specialty view.
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.

![Charge Details Dialog]

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.

2. From the **Performing Provider** field, review, select or search for the performing 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).
   - **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:

   **Compliance Code:**
   - **Level 0** - Attending MD or mid-level provided care
   - **Level 1** - (GC) Resident involved. Teaching MD present during key portions of the visit and/or procedure.
   - **Level 2** - (GE) Resident performed w/o the presence of a teaching prov under the primary care exception.
   - **Level 3** - (GC) Resident provided care.
6. Review the **Diagnosis** and **Visit Charges** for accuracy.

7. **Remove Charge** 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. **Submit** 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>![Red Status icon]</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>![Yellow Status icon]</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>![Green Status icon]</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 patient’s 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.

- **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.
- **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.

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. **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**.
Working with Modifiers

Modifiers are codes used to report additional information used during the billing process. Some modifiers describe additional work or circumstances that affected the service provided. There are several ways to add a modifier. Modifiers can be used on the Visit or Procedure Charge tabs.

1. To add a modifier from the Visit/Procedure Charge tab, once the charge has been added, select the charge. The selected item(s) display in the lower section of the Visit/Procedure Charge Selector page.

2. Select the checkbox(es) of the desired modifiers in the Modifier Group section if needed.
3. To add a modifier from the **Encounter Form** tab, once the **Encounter Form** tab has been chosen, select the Visit or Procedure Charge.

4. Click the **Charge Details** button.
5. The **Charge Details** page displays, click the **Modifier Group** drop-down menu and select the appropriate modifiers.

![Charge Details](image)

- **Charge**: 99213  
  OFC/OUTPT VISIT E&M EST LOW-MOD SEVERITY 15 MIN

- **Modifiers**:
  - **Modifier Group**: Family Medicine
  - 24 UNRELATED E/M SERV SAME PHYS POST OP PERIOD
  - 25 SEPART E/M BY SAME PHYS ON DAY OF PROC
  - 32 MANDATED SERVICES
  - 52 REDUCED SERVICES
  - 55 POSTOPERATIVE MANAGEMENT ONLY
  - 56 PREOPERATIVE MANAGEMENT ONLY

- **Linked Dx**:
  - **Diagnosis Order**: 1
    - 1) 250.00 DIAB W/O COMP TYPE II/UNS NOT STA...
The Audit Log

1. 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.
Diagnosis Codes from the Problem List and Charge

The provider has the capability of adding diagnoses from the problem list on the Clinical Desktop.

1. After the problem is added to the patient’s problem list, click the problem checkbox to assess it.

2. Click **Commit** on the Clinical Toolbar to save the assessment/diagnosis.
3. From the **Horizontal Toolbar (HTB)**, select **Encounter Form**. The assessed problem is automatically listed as a diagnosis.
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.

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.

![Chart Viewer](image)

- A blue check next to the encounter indicates that it has been submitted into IDX.

8. From **Chart Viewer**, double-click the encounter form to view.
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>
<tbody>
<tr>
<td>Review Encounter Form</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Navigates to the associated Encounter Form</td>
</tr>
<tr>
<td></td>
<td>• Assigned to: Enc Review Team</td>
</tr>
<tr>
<td></td>
<td>• Created by: Billing Provider automatically when charges are submitted</td>
</tr>
<tr>
<td></td>
<td>• Target User: Primarily a coding/billing representative; however, could also be physician</td>
</tr>
<tr>
<td>Adjust Charges</td>
<td>These are system-generated when a user changes or removes a charge previously submitted for billing, which displays in the appropriate billing/coding tasklist.</td>
</tr>
<tr>
<td></td>
<td>• Review the encounter form in IDX and make adjustments</td>
</tr>
<tr>
<td></td>
<td>• This task is manually completed when charges are edited in IDX</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: Coding/billing representative</td>
</tr>
<tr>
<td>Manage Charge Edits</td>
<td>These are system-generated if there are one or more charges on an encounter with status of Needs Info.</td>
</tr>
<tr>
<td></td>
<td>• If the billing team is not able to provide the needed information, reassign the task back to the provider or contact the provider directly.</td>
</tr>
<tr>
<td></td>
<td>• These tasks are auto-completed when there are no charges on the encounter with status of Needs Info.</td>
</tr>
<tr>
<td></td>
<td>• Navigates to the associated Encounter Form.</td>
</tr>
<tr>
<td></td>
<td>• Assigned to: Charge Edits Team</td>
</tr>
<tr>
<td></td>
<td>• Created by: Billing Provider</td>
</tr>
<tr>
<td></td>
<td>• Target User: Primarily a coding/billing representative; however, could also be physician.</td>
</tr>
<tr>
<td>Charge Task Types</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Go to Encounter Form**   | This is a user created task, which is generated when the New Task button is selected from the Encounter Form.  
  - This task is manually completed by clicking **Done**.  
  - Navigates to the associated Encounter Form  
  - Assigned to: selected user or team  
  - Target User: Front Desk or Coding/billing representative |
| **Submit Encounter Form**  | This is a System task, which is generated when an appointment is arrived in IDX.  
  - The Submit Encounter Form task is assigned to the Billing Provider.  
  - These tasks auto-complete under these conditions:  
    - Whenever the user clicks **Submit** regardless of the status of any charge on that encounter.  
    - When the user **Cancels** a charge and there are no charges with a status of Needs Info, Saved, or Ready.  
  - Navigates to the associated Encounter Form  
  - Assigned to: Billing Provider  
  - Target User: Physician |
| **Billing Follow Up**      | A **Follow Up** 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. |
| **B-Order Clarification**  |  
  - DOS _____ Lab selected not available in clinic.  
  - DOS _____ Immunization age range is not appropriate.  
  - DOS _____ Invalidate duplicate note.  
  Review and update encounter form.  
  *DOS stands for Date of Service. |
| **B-Miss Doc**             |  
  - DOS _____ Procedure CPT#_____ selected on encounter but not documented.  
  - DOS _____ E&M Service CPT#_____ selected on encounter but not documented.  
  - DOS _____ Clarify exam documentation complete  
  - DOS _____ Document time on the note under medical decision making CMA; Counseling/Coordination of Care  
  - Time Spent: _____ minutes.  
  Review and update encounter form.  
  *DOS stands for Date of Service. |
| **B- Review Doc**          |  
  - DOS _____ Review exam based on chief complaint or age of patient; confirm ______ was a done.  
  Review and update encounter form.  
  *DOS stands for Date of Service. |
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 GoTo… 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.
## GLOSSARY

<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 <strong>Clinical Desktop</strong> 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 <strong>VTB</strong> 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).</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>