



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

User Manual

Version 1.1 Patch 13
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Preface

This manual provides information on the Electronic Health Record (EHR) p13 additions and changes.

Recommended Users:

This document addresses the needs of Clinical Application Coordinators (CAC), as well as end-users of the Indian Health Service (IHS) Imaging Viewer.

Related Manuals:

The VA also has multiple manuals for Computerized Patient Record System (CPRS). Refer to www.va.gov/vdl for additional information.

Required Configuration:

Configuration is required before utilization of the new functionality and components. Refer to the *Patch 13 MU Setup Guide* for configuration instructions before using this User Guide.

1.0 Introduction

This manual is designed to inform the CACs with the changes that have been implemented in the upgrade to EHR p13, as well as new items that have been added for IHS.

2.0 Overview

2.1 What's New

Note: Configuration is required for these components before use. Refer to the *Patch 13 MU Setup Guide* for details.

The following components are new for p13.

- Acute Myocardial Infarction (AMI) (Currently disabled)
- Consolidated Clinical Document Architecture (CCDA) Generation
- Clinical Information Reconciliation (CIR)
- Integrated Problem List (IPL)
- Stroke Tool (Currently disabled)

2.2 What's Changed

Note: Configuration may be required for these updates before utilization. Refer to the *Patch 13 MU Setup Guide* for details.

The following components have been updated with functionality for p13.

- Consults:

Note: A parameter must be defined for Consult Type that assigns a Systematized Nomenclature of Medicine-Clinical Terms (SNOMED® CT) value for the consult. Refer to the *Patch 13 MU Setup Guide*, “Defining a Consult Type SCT (SNOMED CT Consult Type) for a Consult Specialty/Service” topic for instructions.

- In the Consults Component, when Other is selected in the Clinical Indication field, a SNOMED CT term must be added when adding new consults.
- In the Orders Component, when Other is selected in the Clinical Indication field, a SNOMED CT term must be added when adding new consults.

Note: The new, optional Clinical Indication field replaces the Provisional Diagnosis field.

- Exams:
SNOMED CT and Logical Observation Identifiers Names and Codes (LOINC) codes store when completing the Document an Exam dialog.

- Family History:

- SNOMED CT code stores when adding a family history condition.

- Historical Diagnosis:

This component has been changed to view-only. Past diagnosis can no longer be edited or deleted, nor set as Today's POV.

- Immunizations:

- Lot number and manufacturer name can be added to active vaccines.
 - Administration Notes can be added to active vaccines.
 - Contraindications Reasons for specified vaccines display on the selected patient Official Immunization Record.
 - The Vac. Eligibility field drop-down list can be designated to present users with only codes relevant to their site.

- Infant Feeding:

- Infant Feeding Choices have been updated, including Secondary Fluids selections.
 - A right-click menu has been added to the component.
 - SNOMED CT codes associated with the feeding choices are stored.

- Lab POC Data Entry:

- SNOMED CT code is saved with associated the lab order when Other is selected in the Sign or Symptom field.

- Labs:

- Info button renamed to Education Information button and launches Medline Plus and the Add Patient Education Event dialog.
 - New Clinical Decision Support button automatically returns information from UpToDate about a highlighted lab order.

- Medications:

- When Other is selected in the Clinical Indication field, a SNOMED CT term must be added when ordering Simple Dose Outpatient medications.
 - Inpatient's Last Weight is displayed in the Medication Order dialog.
 - Outpatient's Last Weight is displayed in the Medication Order dialog.
 - A new Discharge Medications field has been added. The field defaults to selected if the patient is currently admitted or if the ordering location has clinic stop code of 30.
 - Order Checks show the source of drug interaction information.

- Info button renamed to Education Information button and launches Medline Plus and the Add Patient Education Event dialog.
- New Clinical Decision Support button automatically returns information from UpToDate about a highlighted medication order.
- Orders:
 - When Other is selected in the Clinical Indication field, a SNOMED CT term must be added when ordering Lab Tests.
 - When Other is selected in the Clinical Indication field, a SNOMED CT term must be added when using Quick Orders.
 - Order Details dialog lists patient height and weight at last measurement, whether the medication is a discharge medication, and any comments.
 - Order Checks show the source of drug interaction information.
- Patient Education:

SNOMED CT term must be added when adding patient education using the Disease/Illness button in the Disease & Topic Entry topic.
- Personal Health:

SNOMED CT term must be added when entering Service Not Provided/Refusal information in the Personal Health component.
- Visit Diagnosis:

This component has been changed to view-only. Past visits can no longer be added, edited, or deleted, nor can a previously selected POV be added as Today's POV.

3.0 New Components

The following components are new for p13.

3.1 Acute Myocardial Infarction Events

The AMI tool captures specific SNOMED CT terms in the evaluation and treatment of AMI. The user can easily capture onset of symptoms, date/time implement protocols and/or standing orders, time EKG done, and EKG findings.

This component is delivered *disabled* with the EHR p13 release. This component will be enabled in the EHR p14 release.

3.2 Consolidated Clinical Document Architecture Generation

The CCDA Generation component employs stylesheet templates that are declared at the document, section, and entry level of CCDA documents.

These templates (Clinical Summary and Transition of Care) are utilized to generate documents that are used to transition care and provide other external provider access to needed patient longitudinal data.

The clinical content of the templates is limited to the most relevant patient data captured during one or more encounters to ensure continuity of patient care.

The templates contain both human-readable and machine-readable data and provide a Summary of Care record for each transition of care or referral.



Figure 3-1: CCDA Button

The following options are available, depending on whether the encounter is a visit or a referral. Click the link for additional information about these topics.

- Clinical Summary (visits only)
- Transitions of Care (TOC) (visits and referrals)

Note: TOC is also used for Inpatient Discharges to other facilities.

The EHR displays the full .xml or .pdf file, whether a Clinical Summary or TOC, as a single document. When the Generate CCDA for Visits/Referrals option is used and multiple visits are selected; one document per selected visit is generated.

Transitions of Care documents, or documents that were customized (either Clinical Summary or TOC) are stored on an individual document basis in VistA Imaging, associated to the patient using an assigned HRN, and can be retrieved at a later time, as needed.

3.2.1 Clinical Summary

The CCDA component enables a user to electronically create a Clinical Summary or Transition of Care/Referral Summary from the Resource and Patient Management System (RPMS)-EHR in CCDA format. That summary is distributed to the patient and/or provider by the following methods:

- Printing
- Fax
- E-mail

For both ambulatory and inpatient settings, the Summary uses the Common MU Data Set data with named standards as appropriate:

- Patient name
- Sex
- Date of birth
- Race
- Ethnicity
- Preferred language
- Smoking status
- Problems
- Medications
- Medication allergies
- Laboratory tests
- Laboratory values/results
- Vital signs – height, weight, blood pressure, Body Mass Index, infant head circumference
- Care plan fields – including goals and instructions
- Procedures
- Care team members

If the patient refuses or declines the Clinical Summary, the SNOMED CT refusal type, 422735006- reason Refused, is stored.

The following tasks apply to the Clinical Summary:

- Generate Clinical Summary for Current Selected Visit
- Generate Clinical Summary for Current Date of Service Visits
- Generate CCDA for Visits/Referrals

3.2.2 Transitions of Care

The Transitions of Care (TOC) supports the electronic exchange of core clinical information for referrals among providers, patients, and other authorized entities electronically to improve the quality of care.

The TOC Submit button sends all referrals for the selected visit electronically to the external provider(s) in the vendor file. If a vendor does not have electronic-referral capability, the referral may be sent to print or fax.

The following tasks apply to the TOC:

- Generate Transition of Care for Current Selected Visit
- Generate Transition of Care for Current Date of Service Visits
- Generate CCDA for Visits/Referrals

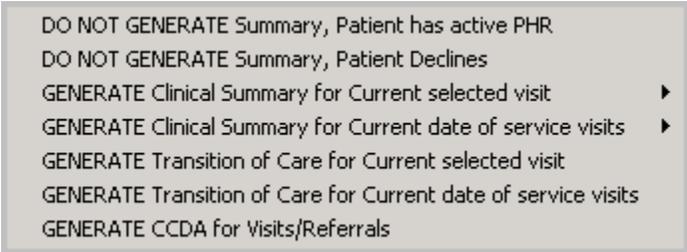
3.2.3 Completing CCDA Tasks

Follow these steps to complete various CCDA tasks, such as printing Clinical Summaries or submitting Transitions of Care.

1. In RPMS-EHR, select a patient and a visit.

Note: If a visit is not selected, you are presented with only the Generate CCDA for Visits/Referrals option, where you must select a visit or referral. Refer to the Generate CCDA for Visits/Referrals topic for details.

2. Briefly rest your mouse pointer over the CCDA button. Alternatively, you can right-click to view the menu. The CCDA menu appears with the following options.



DO NOT GENERATE Summary, Patient has active PHR
 DO NOT GENERATE Summary, Patient Declines
 GENERATE Clinical Summary for Current selected visit ▶
 GENERATE Clinical Summary for Current date of service visits ▶
 GENERATE Transition of Care for Current selected visit
 GENERATE Transition of Care for Current date of service visits
 GENERATE CCDA for Visits/Referrals

Figure 3-2: CCDA Menu

3. Click a link:

- DO NOT GENERATE Summary, Patient has active Personal Health Record (PHR):
 - This option is only visible if the patient has active PHR data captured in RPMS and stores a patient education.
- DO NOT GENERATE Summary, Patient Declines:
 - The SNOMED CT refusal type 422735006 is stored in the background.
- GENERATE Clinical Summary for Current selected visit:
 - Print
 - Review/Customize
- GENERATE Clinical Summary for Current date of service visits:
 - Print
 - Review/Customize
- GENERATE Transition of Care for Current selected visit:
- GENERATE Transition of Care for Current date of service visits:
- GENERATE CCDA for Visits/Referrals

3.2.3.1 Generating Clinical Summary for Current Selected Visit

To generate a Clinical Summary for the current selected visit, select Generate Clinical Summary for Current selected visit. Then select one of the following actions.

Note: To select an additional action, you must re-enter the CCDA component.

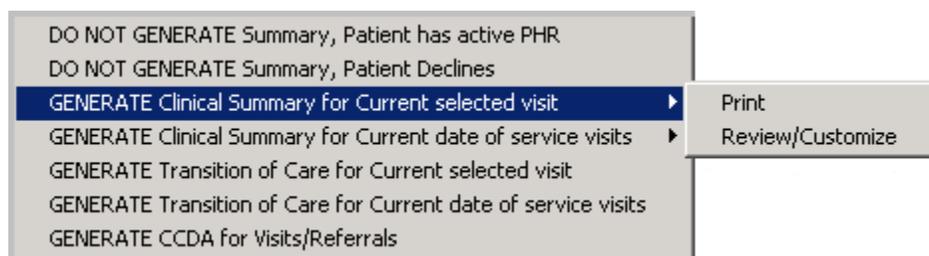


Figure 3-3: Clinical Summary for Current Selected Visit

3.2.3.1.1 Print

To print a Clinical Summary for the current selected visit, follow these steps:

1. Click the Print option. The Print dialog opens.
2. In Select Printer, select a printer.

3. Click Print.

3.2.3.1.2 Review/Customize

To review or customize a Clinical Summary for the current selected visit, follow these steps:

1. Click the Review/Customize option. The CCDA Clinical Summary dialog opens.

Note: The Clinical Document list is fully expanded and all of the check boxes are pre-selected as the default.

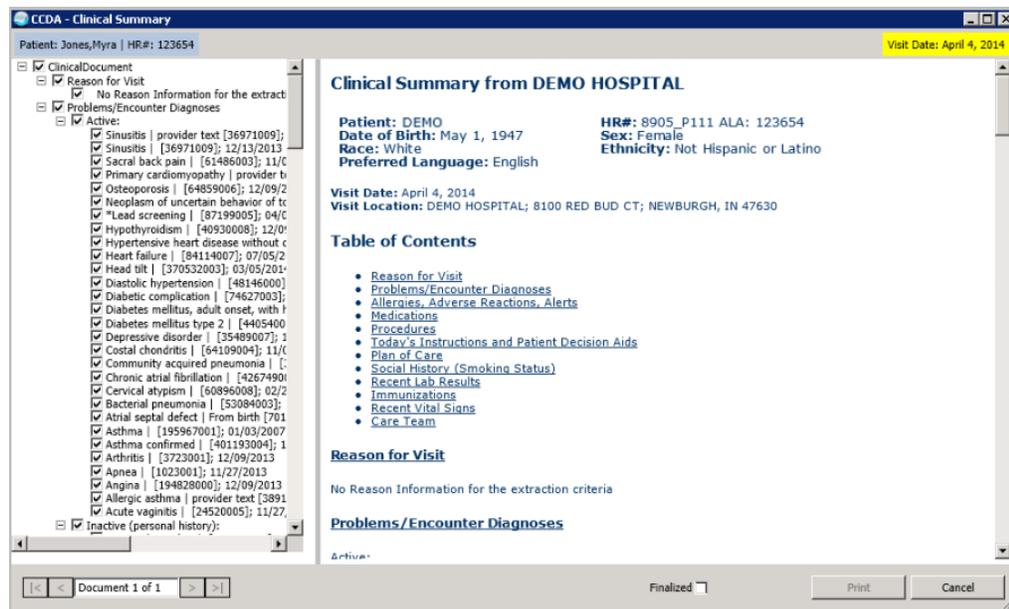


Figure 3-4: CCDA Clinical Summary dialog

Note: Briefly rest the mouse pointer in the Clinical Document pane of the Clinical Summary dialog to view a message that instructs to press F1 to view Online Help about the topic.

2. Clear the check boxes next to any items you want to remove from the Clinical Summary. Clearing a check box also clears any check boxes below it. For example, clearing the Allergies check box also clears all allergy items listed individually below it. Select any check boxes for individual sub-topics, as needed.

The following occurs in the Clinical Summary preview when a check box is cleared:

- The topic data is cleared when the check box is cleared but the heading remains and the word Redacted appears below the heading of the section that was cleared.

- When a subheading check box is cleared, the subheading remains and the word Redacted appears below it.
- The following note appears at the top of the Clinical Summary, "Some information may have been redacted at patient's request or legal requirement."

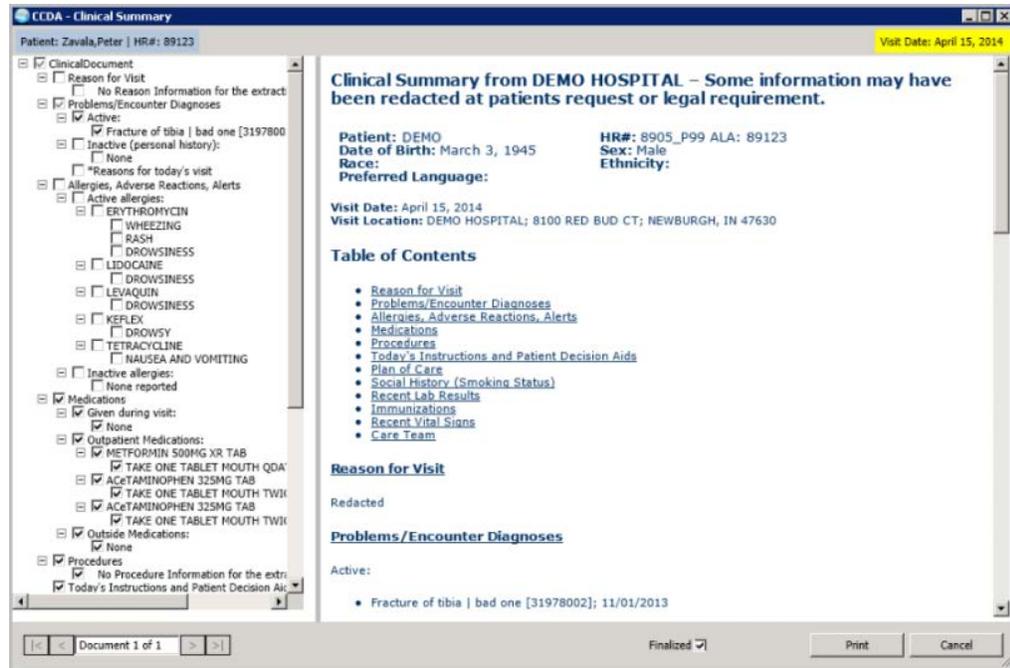


Figure 3-5: Redacted Clinical Summary dialog

If no data is available for a specific item, the text below the heading indicates None or No information for the report-generation criteria.

3. Click the Collapse button ([-]) to collapse Subheadings, as needed.

Note: The arrows in the bottom-left of the dialog are only active to view multiple pages if the Generate CCD for Visits/Referrals option is used and multiple visits are selected.

4. When you have completed your selections, select the Finalized check box at the bottom of the CCD Clinical Summary dialog. The Print button becomes active.
5. Click Print. The Print dialog opens.
 - a. In Select Printer, select a printer.
 - b. Click Print.
6. Close the CCD Clinical Summary dialog.

3.2.3.2 Generate Clinical Summary for Current Date of Service Visits

To generate a Clinical Summary for the current date of service visits (multiple visits for one date), from the CCDA menu, select Generate Clinical Summary for Current Date of service visits. Then select one of the following actions.

Note: To select an additional action, you must re-enter the CCDA component.

- Print
- Review/Customize

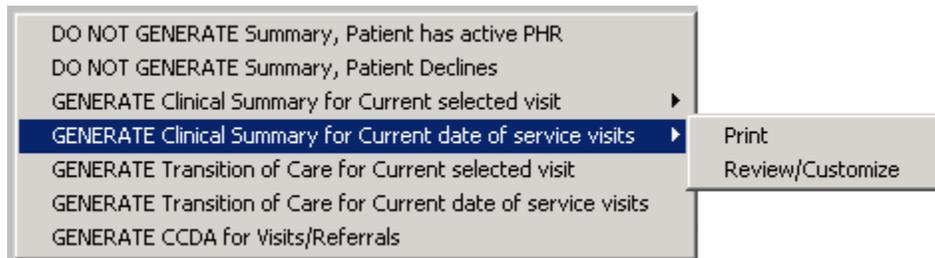


Figure 3-6: Clinical Summary for Current Date of Service Visits

3.2.3.2.1 Print

To print a Clinical Summary for the current date of service visits, follow these steps:

1. Click the Print option. The Print dialog opens.
2. In Select Printer, select a printer.
3. Click Print.

3.2.3.2.2 Review/Customize

To review or customize a Clinical Summary for the current date of service visits, follow these steps:

1. Click the Review/Customize option. The CCDA Clinical Summary dialog opens.

Note: The Clinical Document list is fully expanded and all of the check boxes are pre-selected as the default.

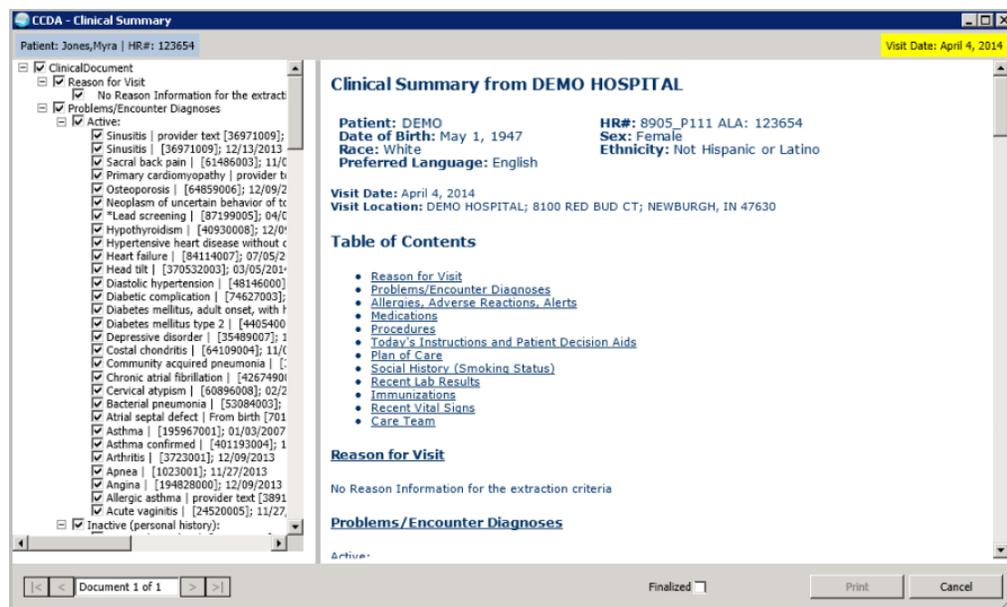


Figure 3-7: CCDA Clinical Summary dialog

Note: Briefly rest the mouse pointer in the Clinical Document pane of the Generate CCDA for Visit/Referrals dialog to view a message that instructs to press F1 to view Online Help about the topic.

2. Clear the check boxes next to any items you want to remove from the Clinical Summary. Clearing a check box also clears any check boxes below it. For example, clearing the Allergies check box also clears all allergy items listed individually below it. Select any check boxes for individual sub-topics, as needed.

The following occurs in the Clinical Summary preview when a check box is cleared:

- The topic data is cleared when the check box is cleared but the heading remains and the word Redacted appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains and the word Redacted appears below it.
- The following note appears at the top of the Clinical Summary, “Some information may have been redacted at patient’s request or legal requirement.”

Note: Refer to the Redacted Clinical Summary dialog to view an example.

3. Click the Collapse button to collapse Subheadings, as needed.

Note: The arrows in the bottom-left of the dialog are only active if the Generate CCDA for Visits/Referrals option is used and there are multiple pages available.

4. When you have completed your selections, select the Finalized check box at the bottom of the CCDA Clinical Summary dialog. The Print button becomes active.
5. Click Print. The Print dialog opens.
 - a. In Select Printer, select a printer.
 - b. Click Print.

3.2.3.3 Generate Transition of Care for Current Selected Visit

To generate a Clinical Transition of Care (TOC) for the current selected visit, select Generate Transition of Care for Current selected visit from the CCDA menu and follow these steps:

Note: If the patient has referrals for the current visit, the user sees this screen. If no referrals are available, a message displays stating that no referrals currently exist for this visit.

1. The Referrals tab with the TOC option button selected opens (default).

If you select the Visits tab, the Clinical Summary and the Transition of Care option buttons are active. If you select the Referrals tab, only the Transition of Care option button is active.
2. In the top-right portion of the dialog, if the Generate TOC option is selected, the Transition of Care option button is the default, if Clinical Summary is selected, the Clinical Summary option button is the default.
 - Clinical Summary
 - Transition of Care

3.2.3.3.1 Clinical Summary

If you select Clinical Summary, refer to the Generate Clinical Summary for Current Selected Visit topic for details.

3.2.3.3.2 Transition of Care

The following steps are for generating a Transition of Care document.

Note: Every other node within the same level or column is highlighted in blue for readability.

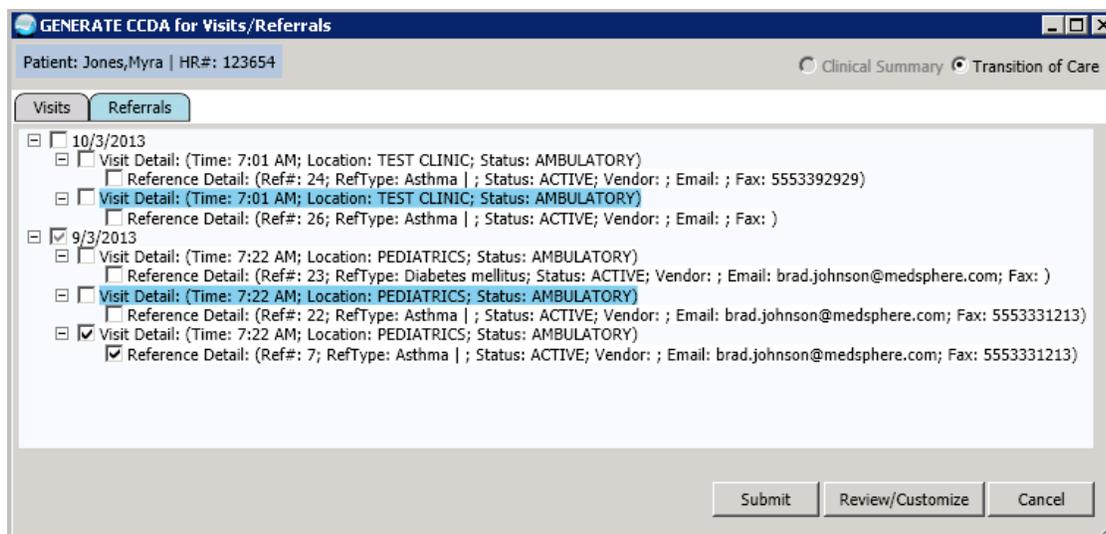


Figure 3-8: Generate Transition of Care for Current Selected Visit

1. Click the Expand button (+) to expand, or the Collapse button to collapse the document list.
2. Select the check boxes to select or to clear any referrals you want to add or remove from the list, as needed.
3. Click one of the following buttons to complete the action for the Transition of Care document:

Note: The Clinical Document list is fully expanded and all of the check boxes are pre-selected as the default.

Submit button. The following submission method opens, depending on what type of contact information is provided in the referral:

- If no contact information is provided, the Print dialog opens.
 - In Select Printer, select a printer.
 - Click Print to print the referral for faxing manually or other delivery.
- If a fax number is provided, the following information message confirms that the image was sent to VistA Imaging for faxing. Click OK and the system generates a notification to the defined mail group.

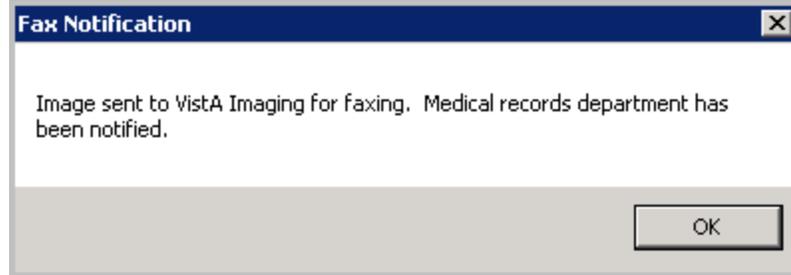


Figure 3-9: Imaging Confirmation Message

- If an e-mail address is provided, the DirectEmailForm dialog opens.

Note: If both a fax and an e-mail address are provided, the referral is sent by e-mail.

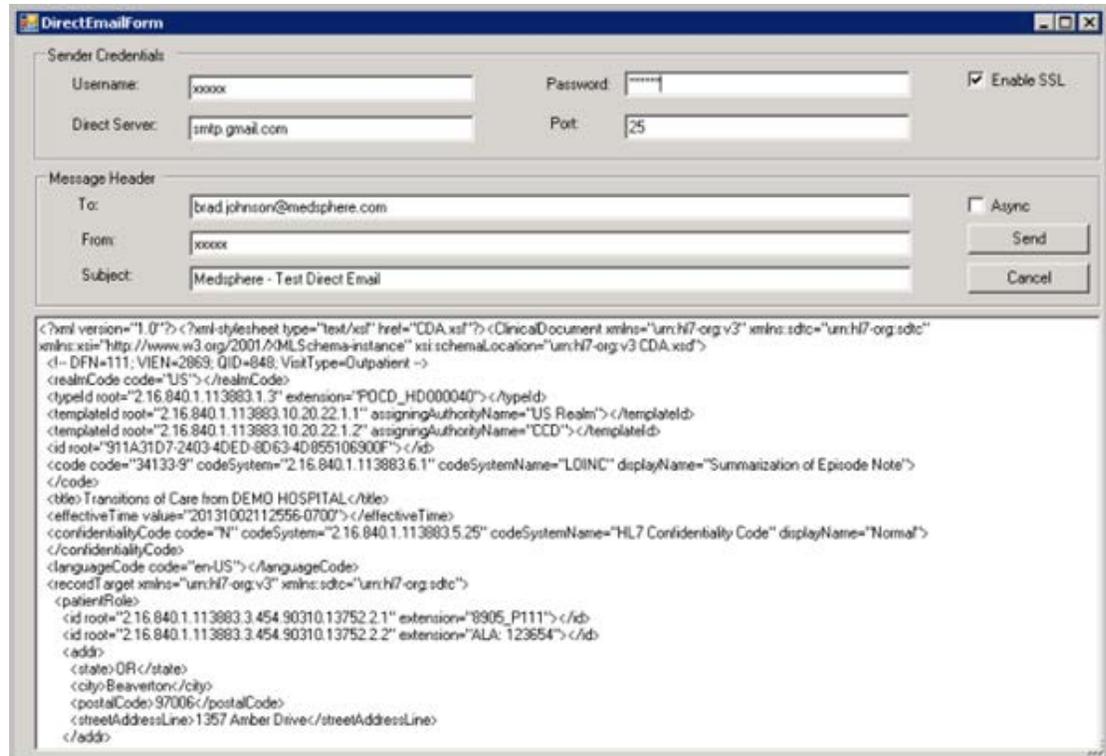


Figure 3-10: DirectEmailForm dialog

- In Username, type your user name.
- In Password, type your password.

Note: Do not change the Port, direct service is read-only.

- Click Send to send the referral.

Review/Customize button:

- Click the Review/Customize option. The CCDA Transition of Care dialog opens.

Note: The Clinical Document list is fully expanded and all of the check boxes

CCDA - Transition of Care
Patient: Jones, Myra | HR#: 123654
Visit Date: 9/3/2013 7:22:00 AM

Transitions of Care from DEMO HOSPITAL

Patient: MYRA JONES **HR#:** 8905_P111 ALA:
Date of Birth: May 1, 1947 123654
Race: **Sex:** Female
Preferred Language: English **Ethnicity:** Not Hispanic or Latino

Visit Date: September 3, 2013
Visit Location: DEMO HOSPITAL; 8100 RED BUD CT; NEWBURGH, IN 47630

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Problems/Encounter Diagnoses

Active:

- Sinus headache | [4969004]; 08/07/2013
- Neonatal jaundice | [387712008]; 09/19/2013
- *Hypertensive disorder | [38341003]; 05/01/2009
- Essential hypertension | [59621000]; 09/02/2013
- *Diabetes mellitus type 2 | [44054006]; 06/14/2013

Document 1 of 1 Finalized Submit Cancel

Figure 3-11: CCDA Transition of Care dialog

- Clear the check boxes next to any items you want to remove from the Transition of Care. Clearing a check box also clears any check boxes below it. For example, clearing the Allergies check box also clears all allergy items listed individually below it. Select any check boxes for individual sub-topics, as needed.

The following occurs in the Transition of Care preview when a check box is cleared:

- The topic data is cleared when the check box is cleared but the heading remains and the word Redacted appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains and the word Redacted appears below it.

- The following note appears at the top of the Transition of Care, "Some information may have been redacted at patient's request or legal requirement."

Note: Refer to the Redacted Clinical Summary dialog to view an example of redacted information.

- Click the Collapse button to collapse Subheadings, as needed.

Note: The arrows in the bottom-left of the dialog are only active if the Generate CCDA for Visits/Referrals option is used and there are multiple pages available.

- When you have completed your selections, select the Finalized check box at the bottom of the CCDA Transition of Care dialog. Submit: Refer to Step 3.

Cancel button: Cancels your action.

3.2.3.4 Generate Transition of Care for Current Date of Service Visits

To generate a Clinical a Transition of Care (TOC) for the current date of service visit from the CCDA menu, select Generate Transition of Care for Current Date of Service Visits and follow these steps:

Note: If the patient has referrals for the current visit, the user sees this screen. If no referrals are available, a message displays stating that no referrals currently exist for this visit.

1. The Referrals tab with the TOC option button selected opens (default).
 - If you select the Visits tab, the Clinical Summary and the Transition of Care option buttons are active.
 - If you select the Referrals tab, only the Transition of Care option button is active.
2. In the top-right portion of the dialog, select one of the following:
 - Clinical Summary
 - Transition of Care

3.2.3.4.1 Clinical Summary

If you select Clinical Summary, refer to the Generate Clinical Summary for Current Date of Service Visits topic for details.

3.2.3.4.2 Transition of Care

The following steps are for generating a Transition of Care document.

Note: Every other node within the same level or column is highlighted in blue for readability.

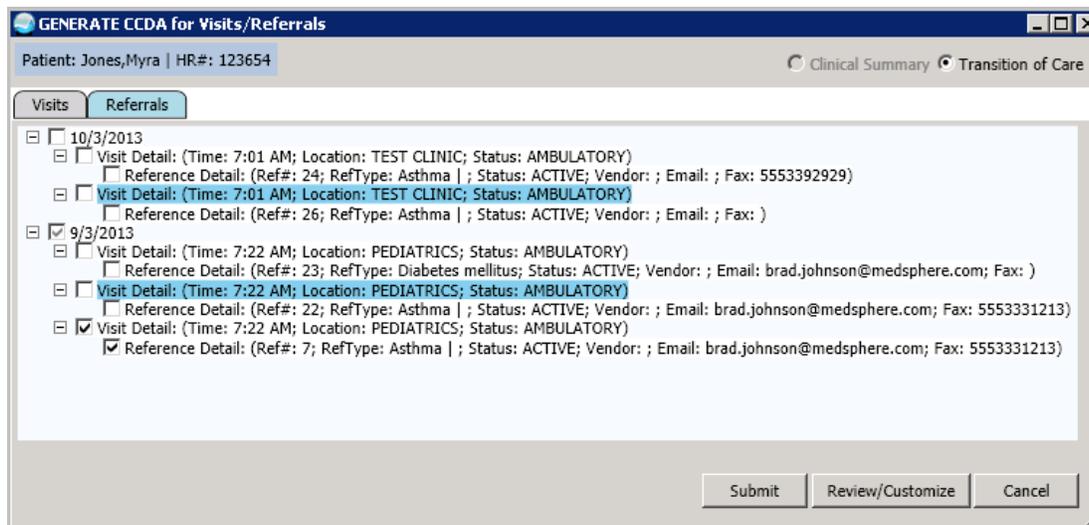


Figure 3-12: Generate Transition of Care for Current Selected Visit

1. Click the Expand button to expand, or the Collapse button to collapse the document list.
2. Select the check boxes to select or to clear any referrals you want to add or remove from the list, as needed.
3. Click one of the following buttons to complete the action for the Transition of Care document:

Note: The Clinical Document List is fully expanded and all of the check boxes are pre-selected as the default.

Submit button. The following submission method opens, depending on what type of contact information is provided in the referral:

- If no contact information is provided, the Print dialog opens.
 - In Select Printer, select a printer.
 - Click Print to print the referral for faxing manually or other delivery.
- If a fax number is provided, the following information message confirms that the image was sent to VistA Imaging for faxing. Click OK.

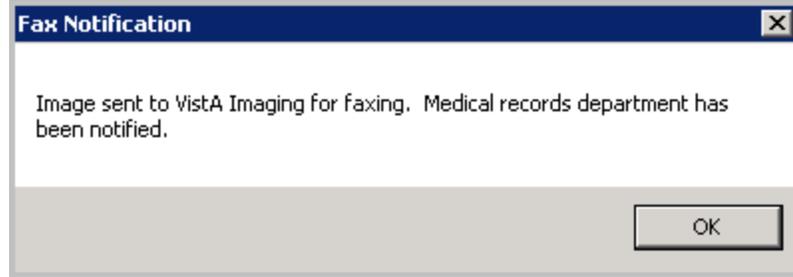


Figure 3-13: Imaging Confirmation Message

- If an e-mail address is provided, the DirectEmailForm dialog opens.

Note: If both a fax number and an e-mail address are provided, the referral is sent by e-mail.

- In Username, type your user name.
- In Password, type your password.
- The remaining fields auto-fill. Click Send to send the referral.

Review/Customize button:

- Click the Review/Customize option. The CCDA Transition of Care dialog opens.

Note: The Clinical Document list is fully expanded and all of the check boxes are pre-selected as the default.

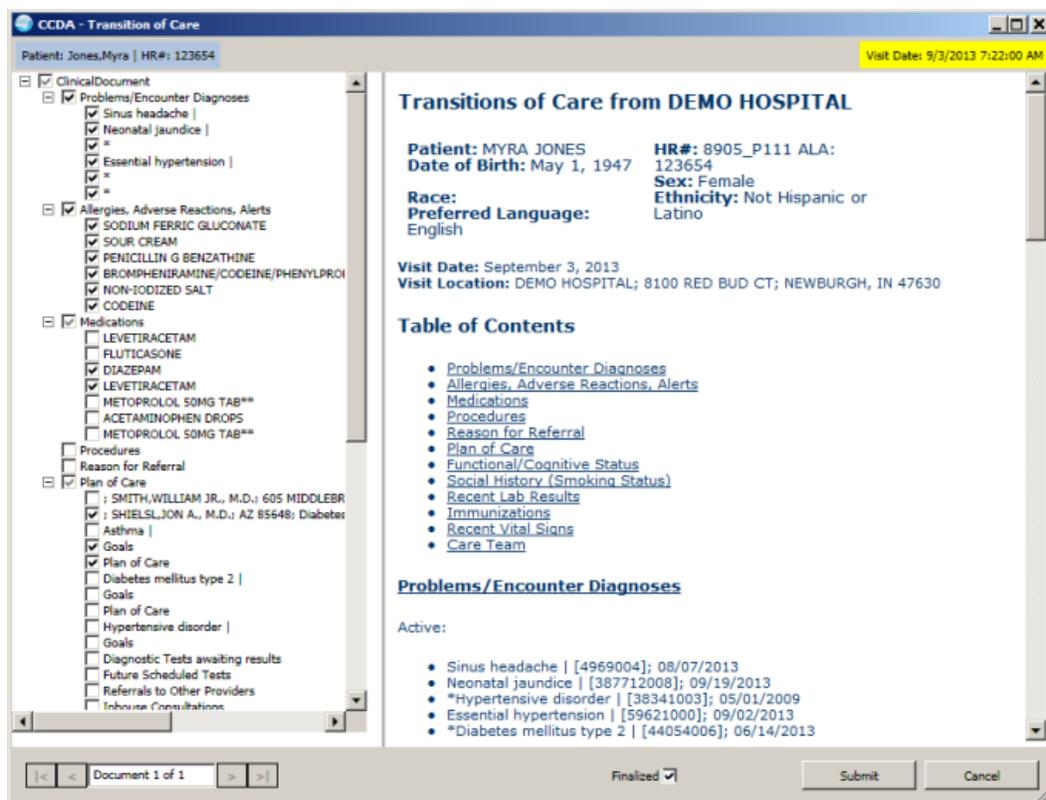


Figure 3-14: CCDA Transition of Care dialog

- Clear the check boxes next to any items you want to remove from the Transition of Care. Clearing a check box also clears any check boxes below it. For example, clearing the Allergies check box also clears all allergy items listed individually below it. Select any check boxes for individual sub-topics, as needed.

The following occurs in the Transition of Care preview when a check box is cleared:

- The topic data is cleared when the check box is cleared but the heading remains and the word Redacted appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains and the word Redacted appears below it.
- The following note appears at the top of the Transition of Care, "Some information may have been redacted at patient's request or legal requirement."

Note: Refer to the Redacted Clinical Summary dialog to view an example of redacted information.

- Click the Collapse button to collapse Subheadings, as needed.

Note: The arrows in the bottom-left of the dialog are only active if the Generate CCDA for Visits/Referrals option is used and there are multiple pages available.

- When you have completed your selections, select the Finalized check box at the bottom of the CCDA Transition of Care dialog. The Submit button becomes active. Submit: Refer to Step 3.

Cancel button: Cancels your action.

3.2.3.5 Generating CCDA for Visits/Referrals

The CCDA for Visits/Referrals option displays all of the visits for a patient by date of service, sorted from newest to oldest visit.

To generate a CCDA Clinical Summary for a visit or referral, from the CCDA menu select Generate CCDA for a Visits/Referrals. This creates multiple documents for each checked request. Follow these steps:

1. In the Generate CCDA for Visit/Referrals dialog, click the Visits tab; the Clinical Summary and the Transition of Care option buttons are active.

Notes: If you select the Referrals tab, only the Transition of Care option button is active. Every other node within the same level or column is highlighted in blue for readability.

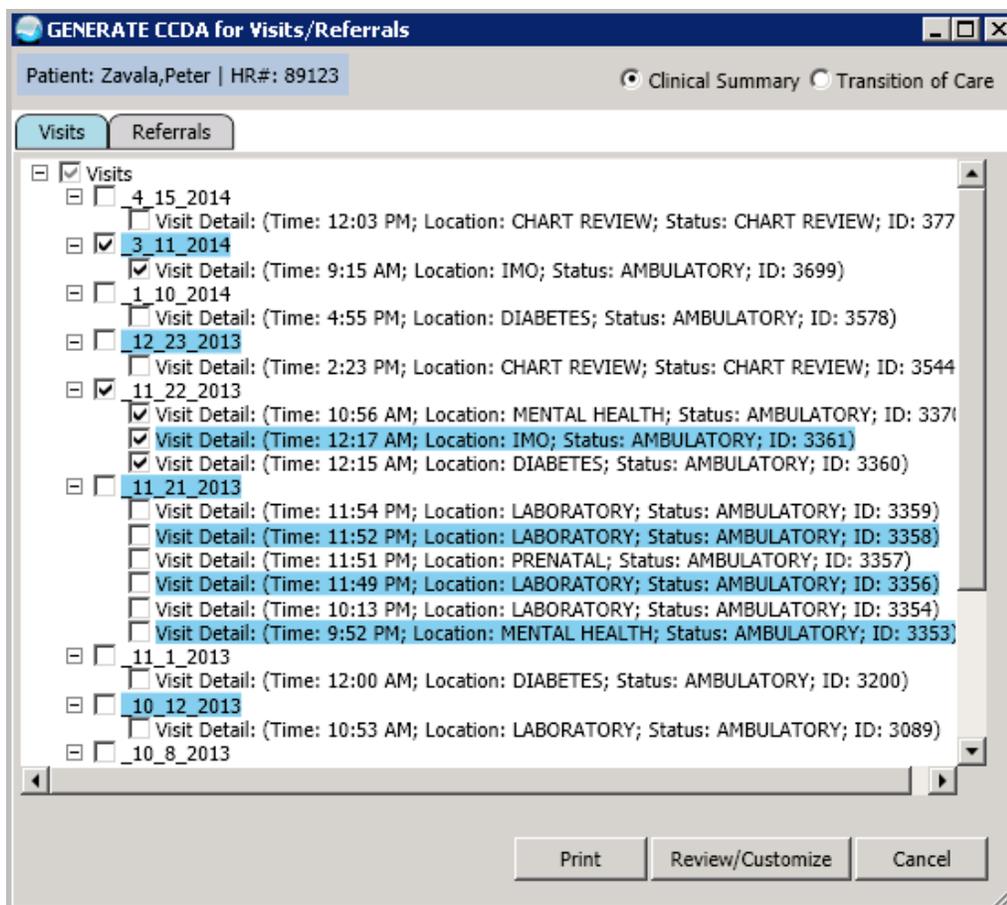


Figure 3-15: Generate CCDA for Visits/Referrals

Note: Briefly rest the mouse pointer in the Generate CCDA for Visit/Referrals dialog to view a message that instructs to press F1 to view Online Help about the topic.

- In the top-right portion of the dialog, select and create one of the following, as applicable.

Clinical Summary:

- Click the Expand button to expand, or the Collapse button to collapse the document list. The list is fully expanded by default.
- Click the check boxes to select or to clear the selection next to any items you want to add or remove from the list.
- Refer to the Generate Clinical Summary for Current Selected Visit topic for details on how to Print, Review/Customize, and Cancel.

Transition of Care:

- Click the Expand button to expand, or the Collapse button to collapse the document list. The list is fully expanded by default.
- Click the check boxes to select or to clear the selection next to any items you want to add or remove from the list.
- Refer to the Generate Transition of Care for Current Selected Visit topic for details on how to Print, Review/Customize, and Cancel.

3.3 Clinical Information Reconciliation

The CIR component assists with the reconciliation of medications, problems, and adverse reaction clinical data from an externally received CCDA xml and/or a clinical summary/transition of care/referral summary scanned. Refer to the CCDA Online Help for additional details.

The CIR tool contains the following functionality:

- Data is displayed from two or more sources in a manner that enables the user to view the data and their attributes, and includes the source and last modification date of the information.
- Users may add, merge, or remove individual data.
- Users may review and validate the accuracy of a final set of data elements, and upon a user's confirmation, automatically update the patient's medication, problem, and adverse reaction list.

3.3.1 CIR Button

CIR is launched by clicking the CIR button after selecting a patient and a visit.

- The CIR button is red if there are documents that have been received, but are not yet fully reconciled by the site. The button also indicates the number of documents that have not been reconciled in its center.



Figure 3-16: Unreconciled CIR Button

- The CIR button is green if there are received documents that have been reconciled or no documents have been received for the patient. The button also indicates the number of documents that have been received and reconciled in its center.



Figure 3-17: Reconciled CIR Button

Note: If no patient is selected, the CIR button displays in green with the initials CIR in its center and the words Clinical Information Reconciliation if you briefly rest your mouse pointer on the button. If the patient does not have any CCDA documents, the button shows a zero and a message opens, informing the user there are no attached images for the patient; CIR still launches.

With a patient and visit selected, briefly pause your mouse pointer on the CIR button to view a pop-up message that shows the number of reconciled documents versus the total number of documents.



Figure 3-18: Reconciled Message

3.3.2 Orientation

The CIR Tool contains the following panes, tabs, columns, and buttons. A description of their functionality follows.

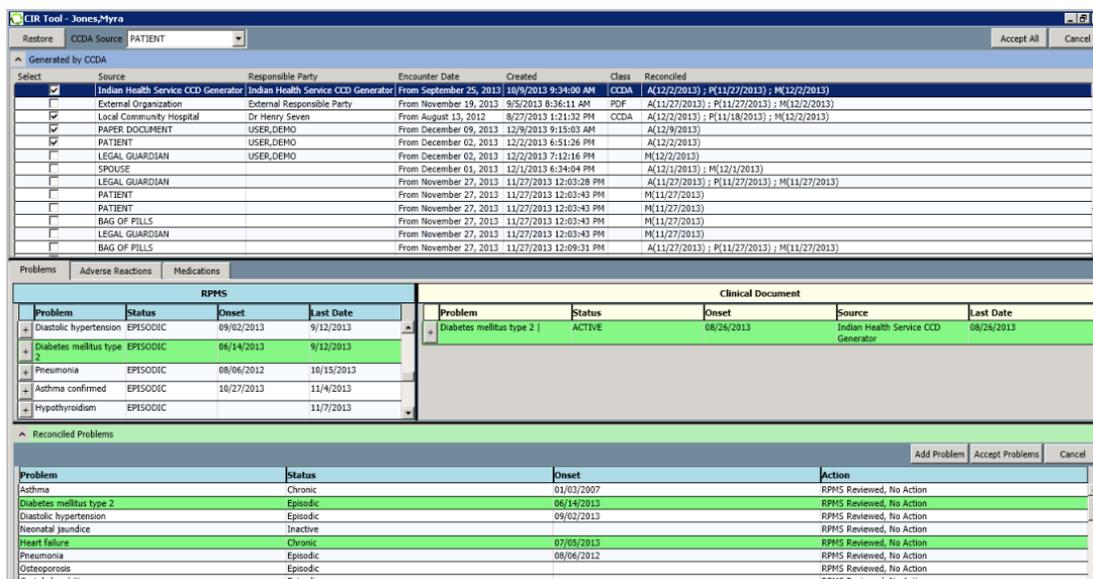


Figure 3-19: CIR Tool Main Window with Problems Tab Selected

3.3.2.1 Panes

The CIR Tool main window contains the following panes:

- Generated by CCDA pane: Contains a list of received and potentially reconciled, Continuity of Care Document Architecture documents (Clinical Summaries). The Generated by CCDA pane can be sorted by selecting one of the following sources from the CCDA Source drop-down menu:
 - Patient
 - Bag of Pills
 - Spouse
 - Legal Guardian
 - Paper DocumentIf no CCDA document is available, the ability to select an information source and reconcile the chart can be completed selecting one of the sources listed .
- RPMS pane: Contains the native list from RPMS of Medications, Problems, or Adverse Reactions, depending on which tab is selected.
- Clinical Document pane: Depending on the Class of the Generated by CCDA document selected, the following is displayed in the Clinical Document pane:
 - CCD (Continuity of Care Document): Contains the preview of the Patient Summary.
 - CCR (Continuity of Care Record): Contains the preview of the CCR.
 - CCDA (Consolidated Clinical Document Architecture): Contains the reconciled list of Problems, Adverse Reactions, or Medications, depending on which tab is selected in the RPMS pane.
 - PDF (Portable Document Format): Contains a preview of the generated .pdf file.
- Reconciled pane: At initial launch, contains only RPMS data. During the reconciliation process, additions and changes to medications, Problems, Adverse Reactions, or the CCDA data list, depending on which tab is selected in the RPMS pane, is updated into this pane from both RPMS and the Generated by CCDA pane.

Note: The panes can be re-sized, as needed, by dragging the splitter bar.

3.3.3 Tabs

The RPMS pane contains the following three tabs. When a tab is selected, the Clinical Document and Reconciled panes refresh with the applicable data, A document must be selected in the Generated by CCDA pane. Clear a document selection in the Generated by CCDA pane by double-clicking on the check box.

Click the applicable link to view instructions for working with these tabs.

- Problems Tab
- Adverse Reactions Tab
- Medications Tab

Columns can be sorted alphabetically or chronologically by clicking the column header. Refer to the applicable tabs section (Problems Tab, Adverse Reactions Tab, Adversereactions_adverse_reactio_4708, and Medications Tab) to view information about the RPMS pane, Clinical Document pane, and Reconciled pane columns.

3.3.3.1 Generated By CCDA Pane Columns

The Generated By CCDA pane contains the following columns:

- Select: Contains a check box that is selected to view a particular reconciled document's details.
- Source: Displays the source of the document, for example, the name of the clinic or Scanned List.
- Responsible Party: Provider name.
- Type: Provider type.
- Encounter Date: Date of the encounter or visit.
- Created: Date and time the document was created.
- Class: The document types include CCDA, CCD, PDF, or CCR.
- Reconciled: Date of the reconciliation. The Problem reconciliations are noted with a P before the date, Adverse Reaction reconciliations are noted with an A, and Medication reconciliations are noted with an M. For example, M(10/18/2013) indicates the Medications were reconciled on October 18th.

3.3.3.2 Right-Click Menus

3.3.3.2.1 Generated by CCDA Pane

Depending on the document Class in this pane, the right-click menus appear as follows:

- CCD: Right-click in a CCD item to select to view the full CCD.



FULL CCD

Figure 3-20: CCD Right-Click Menu

- CCR: Right-click in a CCR item to select to view the full CCR.



Figure 3-21: CCR Right-Click Menu

- CCDA: Right-click in a CCDA item and select to view the full CCDA or specific sections of the CCDA only. For example, you can select Advance Directives from the right-click menu to view only the Advance Directives section of the CCDA.

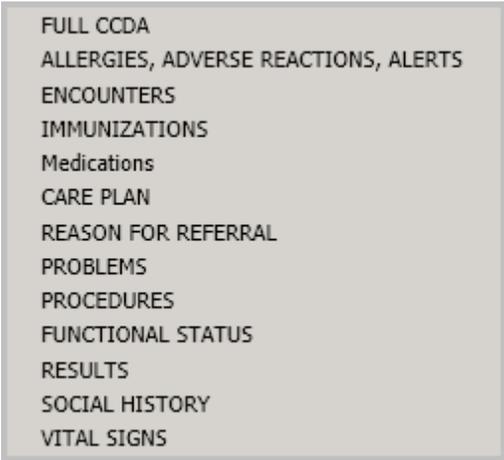


Figure 3-22: CCDA Right-Click Menu

- PDF: Right-click in a PDF item to View Details.



Figure 3-23: PDF Right-Click Menu

The PDF Viewer window opens, showing a preview of the generated .pdf file. Refer to the PDF Viewer Task Bar topic for details on how to use the task bar that appears when you pause your mouse pointer over the document, as shown in Figure 3-24.

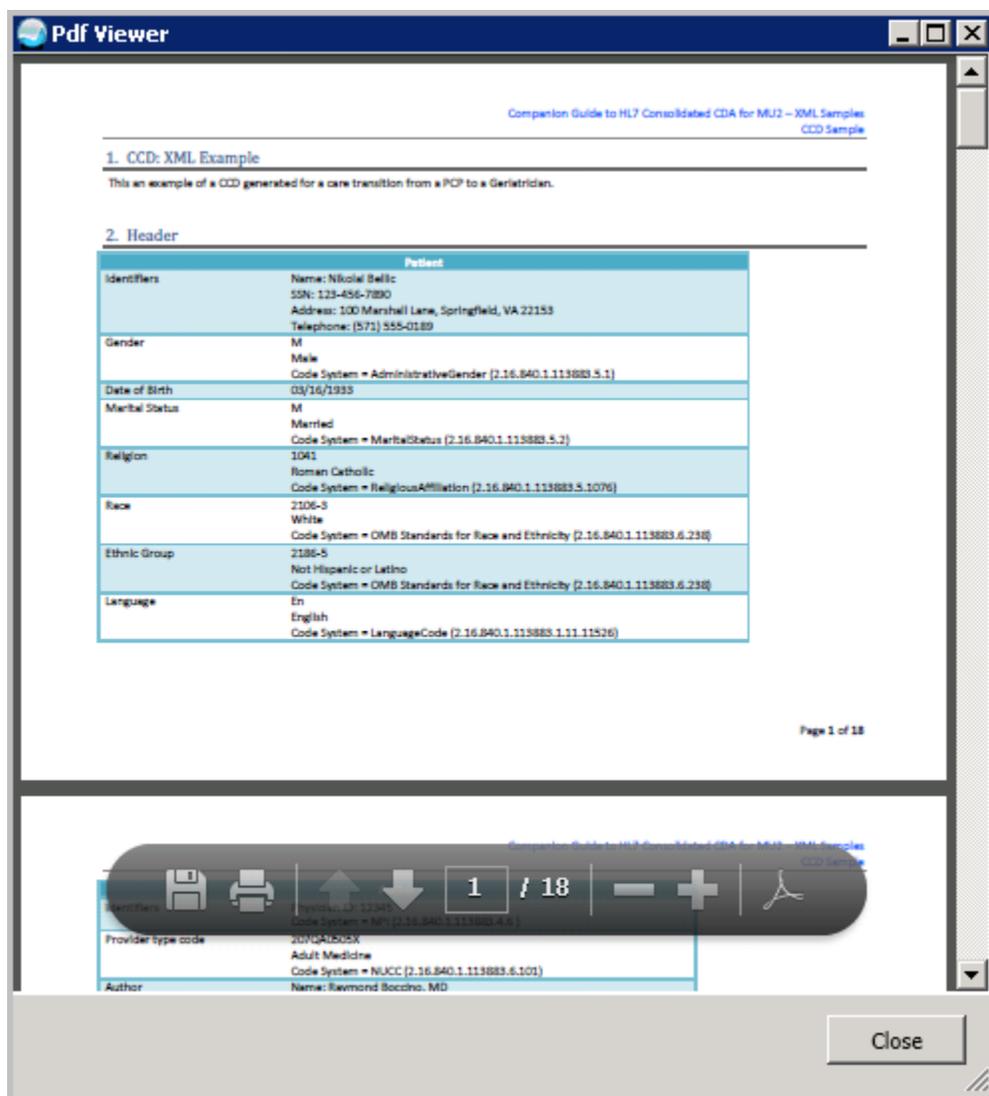


Figure 3-24: PDF Viewer

The right-click menus of the RPMS, Clinical Document, and Reconciled panes change depending on which tab (Problems tab, Adverse Reactions tab, or Medications tab) is selected. Refer to those topics for details.

3.3.3.3 Buttons

- **Restore button:** Located in the top-left portion of the CIR Tool window. Click this button to restore the original order of the RPMS pane. For example, if the user manually sorts by clicking a column heading, clicking the Restore button re-sorts the items back to their original order. Refer to the Problems tab, Adverse Reactions tab, or Medications tab, topics for details.
- **Accept All button:** Located in the top-right portion of the CIR Tool window. Click this button to accept and sign reconciled problems, adverse reactions, and

medications, or a combination of these that the user completed. Otherwise, each tab can only be reconciled individually.

- Cancel button: Closes the CIR tool.
- Maximize button: Click this button (+) in the RPMS or Clinical Document pane next an item to view additional details, such as Problem ID, Status, Description, and so on.

RPMS					Clinical Document				
Problem	Status	Onset	Last Date		Problem	Status	Onset	Source	Last Date
Asthma	Chronic	01/03/2007	8/27/2013		Diabetes mellitus type 2	Completed	08/26/2013	Indian Health Service CCD Generator	08/26/2013
Diabetes mellitus type 2	Episodic	06/14/2013	9/12/2013		Problem ID: PB762_12762N Problem: Diabetes mellitus type 2 Status: Completed Symptom: Diabetes mellitus type 2 Onset: 08/26/2013 Active Period: 08/26/2013 Concept Code: 44054006 Code System: SNOMED CT Source: Indian Health Service CCD Generator				
Diastolic hypertension	Episodic	09/02/2013	9/12/2013						
Problem ID: SOUC-4 Problem: Diastolic hypertension ID: 4 Mapped ICD: 401.9 Status: Episodic Description: Diastolic hypertension Onset: 09/02/2013 Date Entered: 9/12/2013 Recorded By: USER_DEMO Concept Code: 48146000 Desc Code: 80224019									
Neonatal jaundice	Inactive		9/19/2013						

Figure 3-25: Expand Details

3.3.4 Problems Tab

Problems may be reconciled by a nurse, pharmacist, provider, or case manager at triage. Reconciliation takes place at the time of provider appointment, pharmacy medication pickup or pharmacy medication management visit, or Public Health Nurse (PHN) or case manager visit.

Problems are reviewed and reconciled from externally received CCDA documents, for example, paper copies of clinical summaries, patient history, or transition of care xmls.

An example of the Problems tab and corresponding Clinical Document and Reconciled panes is shown in Figure 3-26.

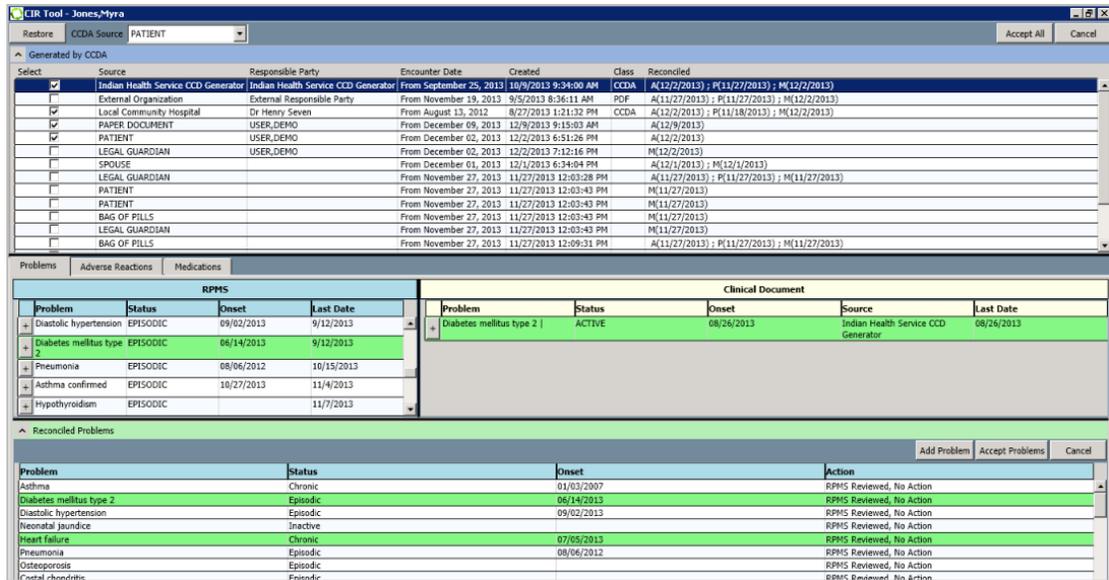


Figure 3-26: CIR Tool Problems Tab

3.3.4.1 RPMS Pane

The problems listed in the RPMS pane that have a match (by SNOMED CT Concept ID and/or by name) on incoming lists are highlighted in green when a user selects a matching event from the RPMS or CCDA pane. If a problem is not yet SNOMED CT coded, an asterisk shows before the problem name.

Note: To de-select matching events, press Ctrl and click.

3.3.4.1.1 Columns

When the Problems tab is clicked, the RPMS pane shows the following columns:

- Problem: Description of problem
- Status: Chronic, Episodic, and so on
- Onset: Date and time of problem onset
- Last Date: Date of last modification or the date entered

The problems are listed by reverse chronological Last Date order if there are no matching problems from the Generated by CCDA pane. You can sort the items by clicking any of the column headings. Click the Restore button to restore the original order.

3.3.4.1.2 Right-Click Menu

Note: The right-click menu only appears and applies if a CCDA Class item is selected in the Generated by CCDA pane.

The right-click menu of the Problems tab RPMS pane contains the following commands:

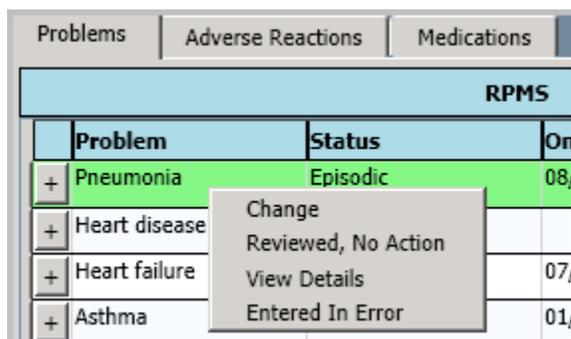


Figure 3-27: Problem RPMS Right-Click Menu

- **Change:** The Reconcile RPMS Problem dialog opens. Refer to the Reconciling RPMS Problems topic for details.
- **Reviewed, No Action:** The Problem shows as RPMS Reviewed, No Action in the Reconciled Problems pane, Action column.
- **View Details:** The View Problem Details dialog opens. Any highlighted items from the main screen containing RPMS Pane and CCDA data display in a side-by-side comparison when this menu option is selected. The View Problem Details dialog also has a right-click menu of the following options, as shown in Figure 3-28. Refer to the applicable sections in this Help for details.

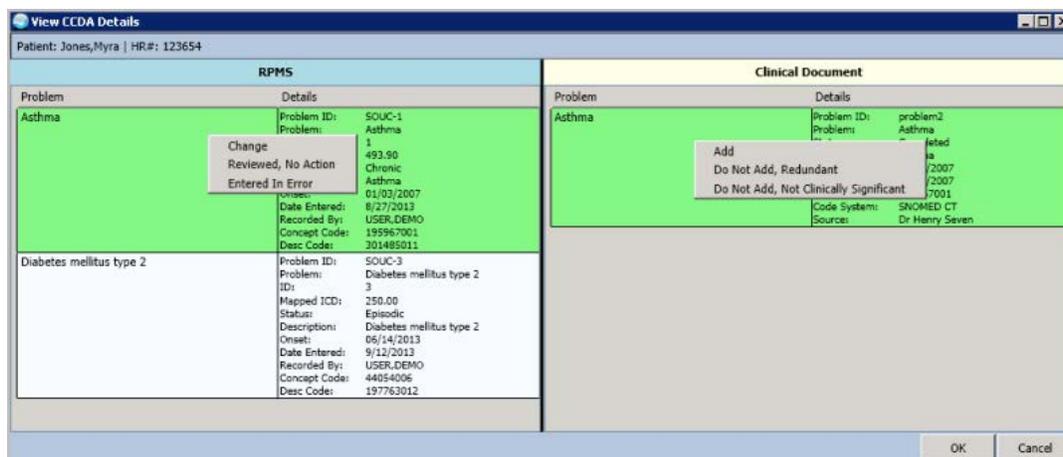


Figure 3-28: View Problem Details dialog

- **Entered in Error:** The Delete RPMS Problem dialog opens.

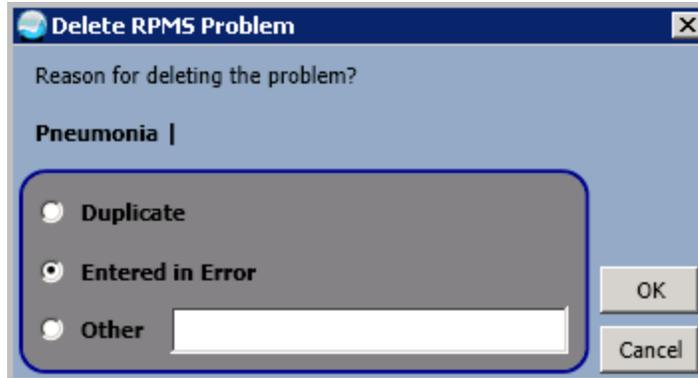


Figure 3-29 Delete RPMS Problem dialog

1. In Reason for deleting the problem, select one of the option buttons:
 - Duplicate
 - Entered in Error
 - Other
2. If Other is selected, type a reason in the free-text field.
3. Click OK. The Reconciled Problems pane is updated with an RPMS Entered in Error status in the Action column for the problem.

3.3.4.2 Clinical Document Pane

3.3.4.2.1 Columns

The Clinical Document pane shows the following columns, indicating Problem data:

- Problem: Problem name.
- Status: Active, inactive, and so on.
- Onset: Date of onset.
- Source: Clinician who entered the problem.
- Last Date: Date of last modification or the date entered.

Note: If a PDF Class item is selected in the Generated by CCDA pane, the Clinical Document pane shows the PDF document from CCDA, and the Add buttons in the Reconciliation pane are utilized to add the PDF CCDA content to RPMS.

3.3.4.2.2 Right-Click Menu

Note: The right-click menu only appears and applies if a CCDA Class item is selected in the Generated by CCDA pane.

The right-click menu of the Problems tab Clinical Document pane contains the following commands:

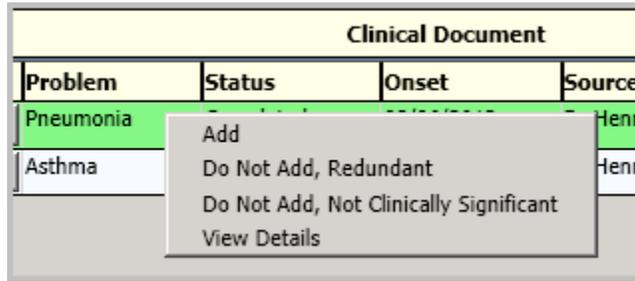


Figure 3-30: Clinical Document Right-Click Menu

- **Add:** The Add CCDA Problem dialog opens. Refer to the Adding Problems from Reconciled Problems Pane topic for details.
- **Do Not Add, Redundant:** The Problem shows as RPMS Reviewed, No Action, CCDA Do Not Add, Redundant in the Reconciled Problems pane, Action column.
- **Do Not Add, Not Clinically Significant:** The Problem shows as RPMS Reviewed, No Action, CCDA Do Not Add, Not Clinically Significant in the Reconciled Problems pane, Action column.
- **View Details:** The View Problem Details dialog opens.

3.3.4.3 Reconciled Problems Pane

3.3.4.3.1 Columns

The Reconciled Problems pane shows the following columns, indicating Problem reconciliation data:

- **Problem:** Problem name.
- **Status:** Status applied to the problem.
- **Onset:** Date of onset.
- **Action:** Action taken in the Clinical Document pane.

Note: There is no right-click menu in the Reconciled Problems pane. At initial launch, the Reconciled Problems pane displays all RPMS entries currently for the patient as Reviewed, No Action. Instead of using a right-click menu, items can be changed by using the options in the RPMS pane.

3.3.4.3.2 Buttons

The Reconciled Problems pane contains the following buttons:

Add Problem button: The Add Problem dialog opens. Refer to the Adding CCDA Problems topic for details.

Accept Problems button: The Review/Sign Changes for Patient Name dialog opens.

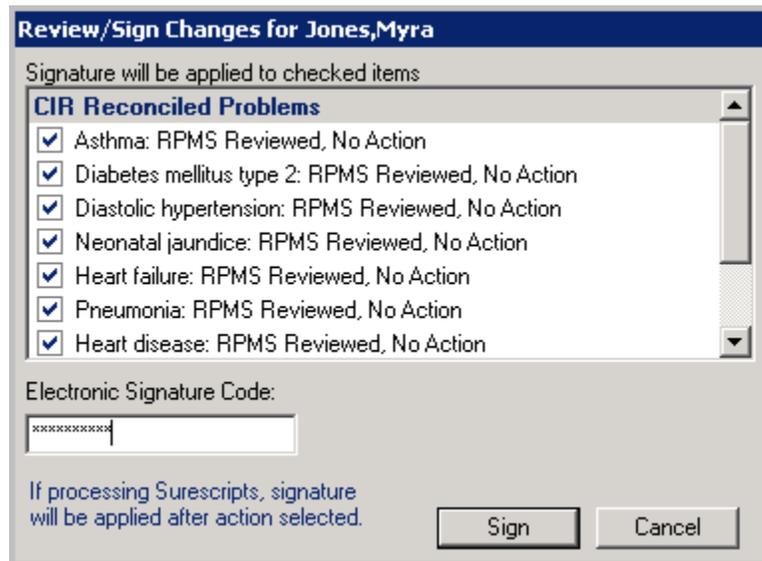


Figure 3-31: Review/Sign Changes for Patient Name dialog

1. The CIR Reconciled Problems list in the dialog is pre-selected by default.
2. In the Electronic Signature Code field, type your code, and then click Sign. Your signature is applied to the selected items.

Cancel button: Cancels the action.

3.3.5 Adding CCDA Problems

Add a CCDA Problem from the Clinical Document right-click menu by clicking the Add option. The Add CCDA Problem dialog opens. The following fields are pre-populated in the Add CCDA Problem dialog:

- SNOME CT code
- Date of Onset
- Status is Episodic by default
- A canned Comment

Figure 3-32: Completed Add CCDA Problem dialog

Note: Required fields are indicated by an asterisk and are shown in a gray section.

1. In Priority, click the Up and Down arrows to select the applicable priority, from 1-5.

Note: The Pregnancy Related and Use as POV check boxes are disabled.

2. In the SNOMED CT field, if you need to changed the problem, type the problem in the blank field and click the Ellipsis button to search for the SNOMED CT term. The SNOMED CT Lookup dialog opens. Refer to the Adding Problems from Reconciled Problems Pane topic for details on completing this dialog.

Note: Refer to the Using the Pick List Button for details on using the Pick List button from the Add CCDA Problem dialog.

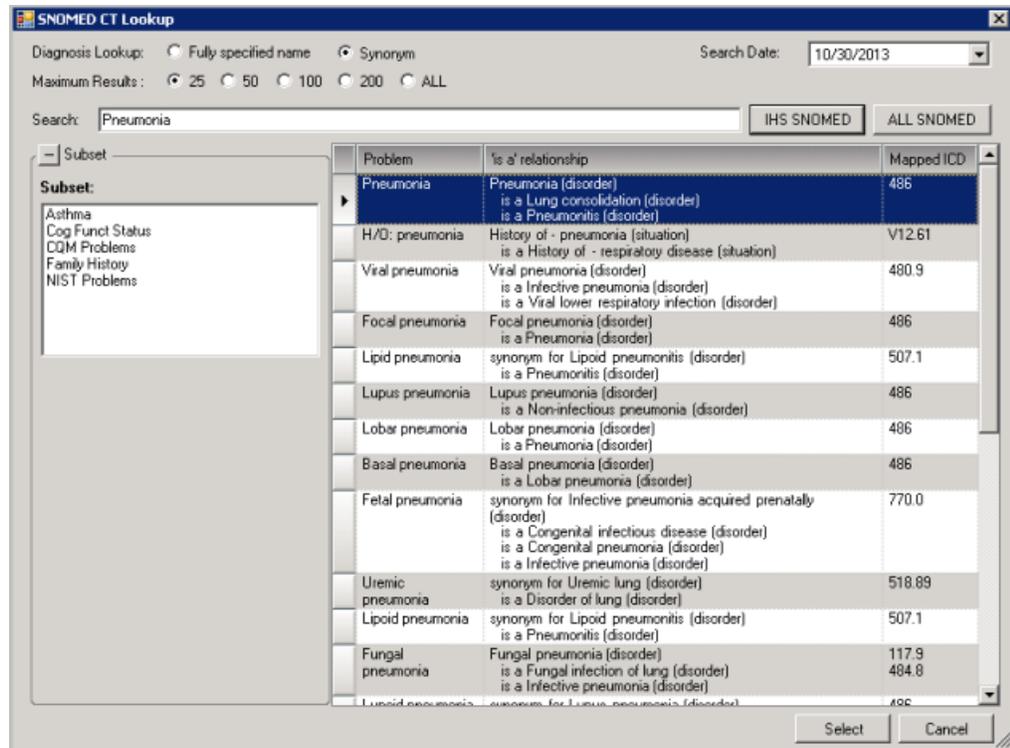


Figure 3-33: SNOMED CT dialog

3. In Status, select the applicable option button:
 - Chronic
 - Sub-acute
 - Episodic (default)
 - Social/Environmental
 - Inactive
 - Personal Hx
4. In Provider Text, type any additional instructions.

Note: You can briefly rest your mouse pointer over some of the fields to view instructions for that field.

5. In Severity, select one of the following from the drop-down menu:
 - Fatal
 - Life threatening severity
 - Mild
 - Mild to Moderate

- Moderate
 - Moderate to Severe
 - Severe
6. In Clinical Course, click the Ellipsis button. The Select Clinical Courses dialog opens. Select one or more of applicable check boxes:

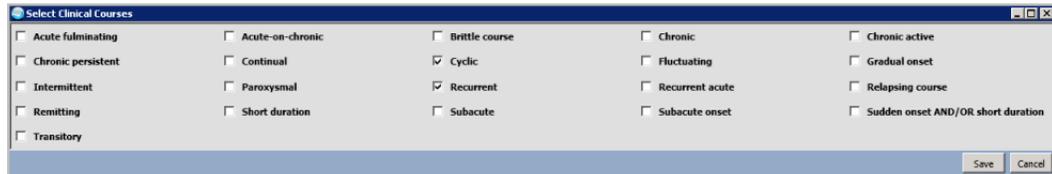


Figure 3-34: Select Clinical Courses dialog

Note: The Clinical Course field in the Add CCDA Problem dialog contains a red triangle in the top-right corner to indicate when entries exist in the field.

7. In Date of Onset, the date auto-fills from RPMS. Click the Ellipsis button to change the date by selecting a new date from the calendar, if needed.
8. In Comments, type a comment.
9. Click Save in the top-right portion of the Add CCDA Problem dialog. Your changes are saved, and the Reconciled Problems pane shows a CCDA: Add Problem status in the Action column.

If the added values match an existing entry, the Action column states, RPMS: Reviewed, No Action, CCDA do not add, redundant.

3.3.6 Adding Problems from Reconciled Problems Pane

Add a problem from the Reconciled Problems pane by clicking the Add Problem button. The Add Problem dialog opens.

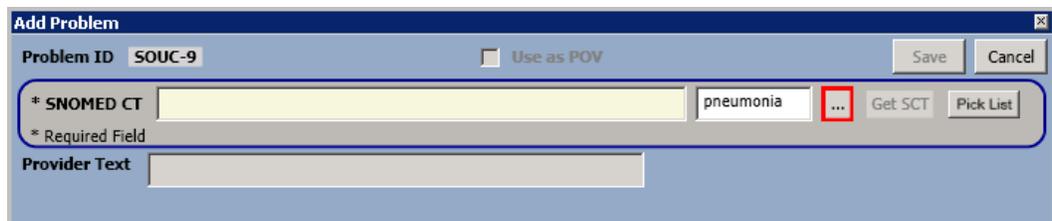


Figure 3-35: Add Problem dialog from Reconciled Problems Pane

1. In the blank field next to the Ellipsis button, type the problem name, and then click the Ellipsis button. The SNOMED CT Lookup dialog opens with the Search

field populated with your selection and a list of matching SNOMED CT terms in the list.

Note: If needed, refer to the Using the Pick List Button for details on using the Pick List button from the Add Problem dialog.

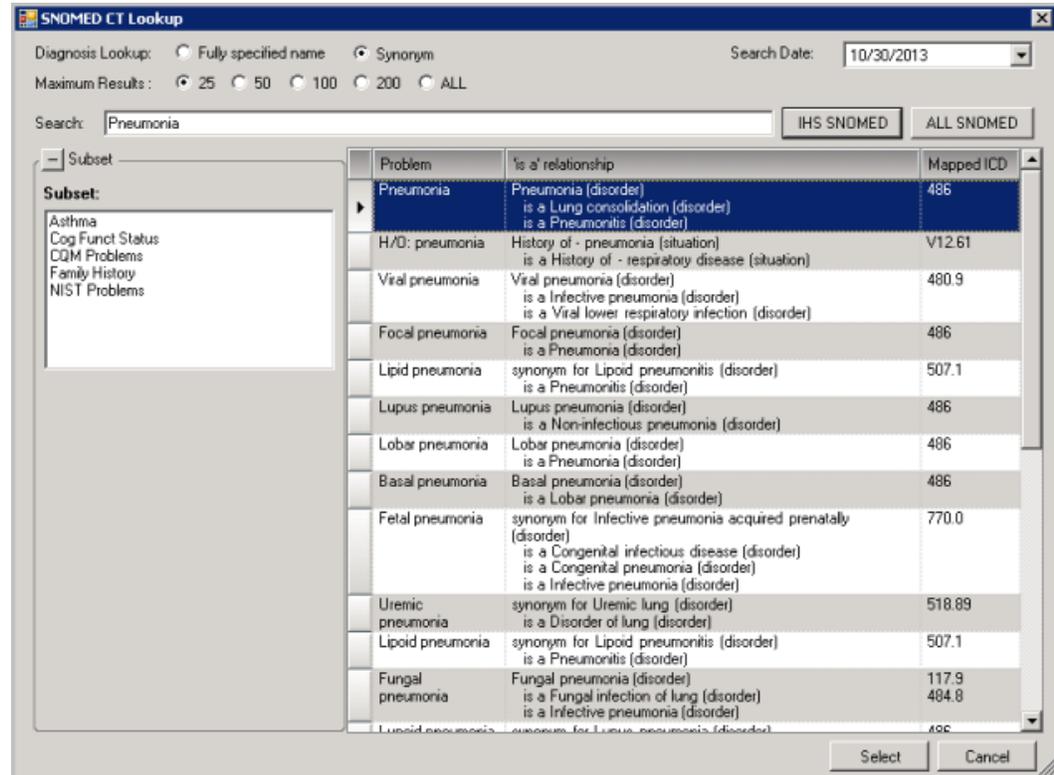


Figure 3-36: SNOMED CT dialog

- a. If the term you are looking is not in the list, select the Synonym option button. (Fully specified name is the default.)
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand button (+) next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
- b. In Maximum Results, select one of the following to limit the number of returned results (or select ALL):
 - 25 (default)
 - 50
 - 100
 - 200

- ALL
- c. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
 - d. In Search, you can type a different term by which you want to search.
 - e. In Subset, you can select a subset in which to search, if needed.
 - f. Click either the IHS SNOMED CT or the ALL SNOMED CT button. The list of SNOMED CT terms is populated.
 - g. Select and highlight a term, and then click the Select button. The Add Problem dialog opens with the SNOMED CT field populated with the SNOMED CT term you selected.
2. In Status, select the applicable option button:
 3. In Provider Text, type any additional instructions.

Note: You can briefly rest your mouse pointer over some of the fields to view instructions for that field.

4. In Severity, select one of the following from the drop-down menu:
 - Fatal
 - Life threatening severity
 - Mild
 - Mild to moderate
 - Moderate
 - Moderate to Severe
 - Severe
5. In Clinical Course, click the Ellipsis button. The Select Clinical Courses dialog opens. Select one or more of applicable check boxes:

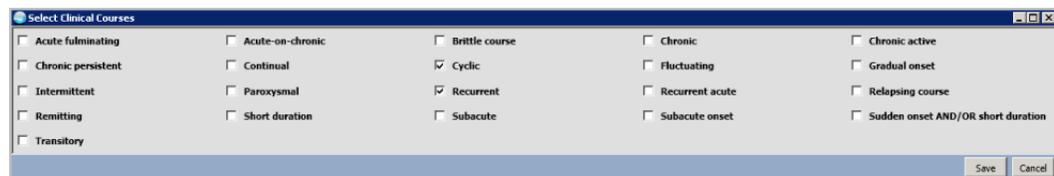


Figure 3-37: Select Clinical Courses dialog

6. In Date of Onset, the date auto-fills from RPMS. Click the Ellipsis button to change the date by selecting a new date from the calendar, if needed.
7. In Comments, type a comment in the field.

- Click Save in the top-right portion of the Add CCDA Problem dialog. Your changes are saved, and the Reconciled Problems pane shows a CCDA: Add Problem status in the Action column.

3.3.7 Changing RPMS Problems

From the PRMS Pane right-click menu, if the Change option is selected, the Edit Problem dialog opens. The following steps show how to complete the dialog.

Note: Required fields are indicated by an asterisk and are shown in a gray section.

Figure 3-38: Edit Problem dialog

- In Priority, click the Up and Down arrows to select the applicable priority, from 1-5.
- In the SNOMED CT field, the selected problem is auto-populated. Click the Ellipsis button to search for the SNOMED CT term. The SNOMED CT Lookup dialog opens.

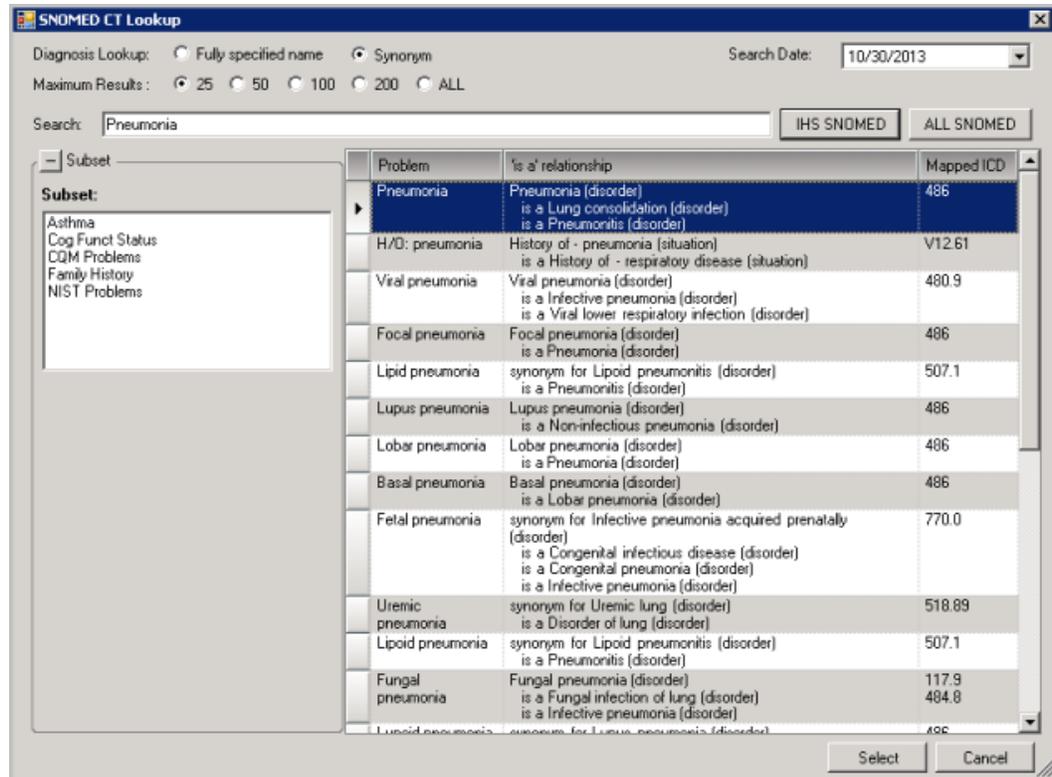


Figure 3-39: SNOMED CT dialog

- a. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Maximize button next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
- b. In Maximum Results, select one of the following to limit the number of returned results (or select ALL):
 - 25
 - 50
 - 100
 - 200
 - ALL
- c. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
- d. In Search, type the term by which you want to search.
- e. In Subset, you can select a subset in which to search, if needed.

- f. Click either the IHS SNOMED CT or the ALL SNOMED CT button. The list of SNOMED CT terms is populated.
- g. Select and highlight a term, and then click the Select button. The SNOMED CT field refreshes with the selected SNOMED CT term you selected.

If the Problem is International Classification of Diseases (ICD) coded but not SNOMED CT coded, click the Get SCT button. Refer to the Using the Get SCT Button topic for details.

3. In Status, select the applicable option button:

- Chronic
- Sub-acute
- Episodic
- Social/Environmental
- Inactive
- Personal Hx

4. In Provider Text, type any additional instructions.

Note: You can briefly rest your mouse pointer over some of the fields to view instructions for that field.

5. In Severity, select one of the following from the drop-down menu:

- Fatal
- Life threatening severity
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

6. In Clinical Course, click the Ellipsis button. The Select Clinical Courses dialog opens.

7. Select one or more of applicable check boxes:

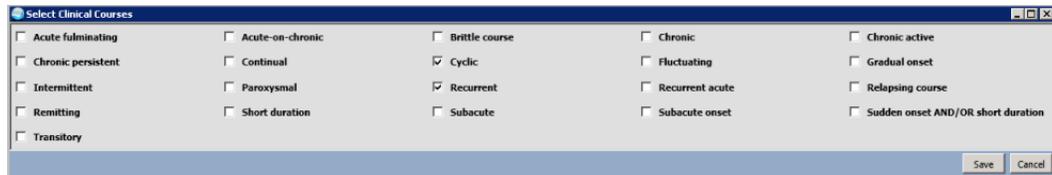


Figure 3-40: Select Clinical Courses dialog

8. In Date of Onset, the date auto-fills from RPMS. Click the Ellipsis button to change the date by selecting a new date from the calendar, if needed.
9. In Comments, type a comment in the field.
10. Click Save in the top-right portion of the Reconcile RPMS Problem dialog. Your changes are saved and the Reconciled Problems pane shows an RPMS Changed status in the Action column.

3.3.8 Using the Get SCT Button

The Get SCT button takes the ICD code from a historical entry that is not SNOMED CT coded (indicated by an asterisk in the Problem Name column of the RPMS pane), launches to Apelon, and displays a list of SNOMED CT codes that are mapped to that ICD.

Note: The Get SCT button is only active when a Problem line item does not have a SNOMED CT code assigned yet.

To add a SNOMED CT code to a problem, follow these steps:

1. From the Reconcile RPMS Problem dialog, click the Get SCT button. The ICD 9 to SNOMED CT Lookup dialog opens.

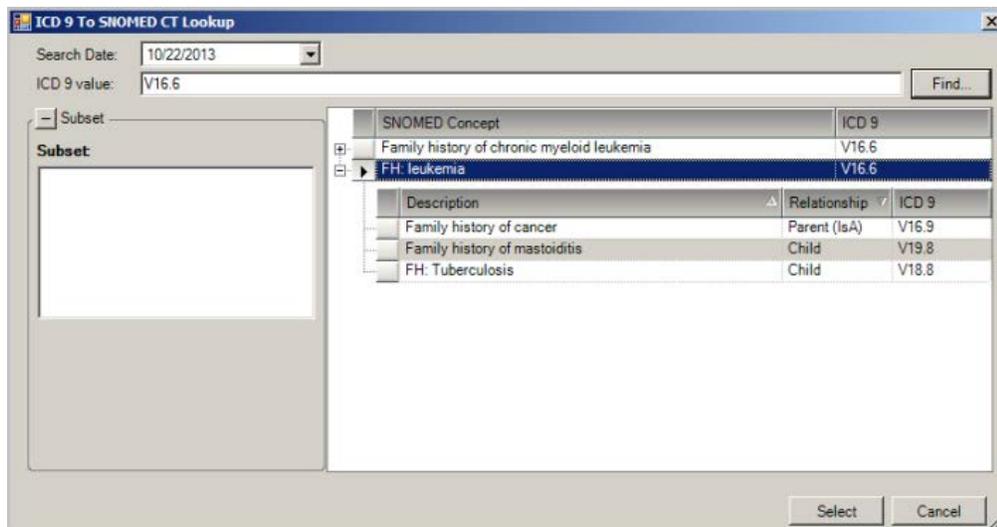


Figure 3-41: ICD 9 to SNOMED CT Lookup dialog

2. The Search Date field automatically defaults to the current date. Click the drop-down arrow to open the calendar where a new date can be selected.
3. The ICD 9 Value field is automatically populated with the ICD code from the RPMS Problem selected when the Get SCT button is clicked. You can change this by typing in a new code.
4. Click the Find button. The list of SNOMED CT terms is populated.
5. Select and highlight a SNOMED CT concept term, and then click the Select button. The SNOMED CT code is saved to the entry and the asterisk on the Problem in the RPMS pane is cleared.

3.3.9 Using the Pick List Button

When adding CCDA problems or adding problems from the reconciled problems pane, the Pick List button on the Add CCDA Problem or the Add Problem dialog can be used to narrow the results of a SNOMED CT search.

#	Narrative	Date	Author
	This problem was reconciled from CCDA 08/27/2013 submitted by Dr Henry Seven.	11/01/2013	USER, DEMO

Figure 3-42: Add CCDA Problem dialog with Pick List Button

Figure 3-43: Add Problem dialog with Pick List Problem

The Pick List button opens the Pick List dialog where the user can choose SNOMED CT descriptions by defined lists. Pick list entries may include associated qualifiers.

1. Click the Pick List button. The Picklist Selection dialog opens.

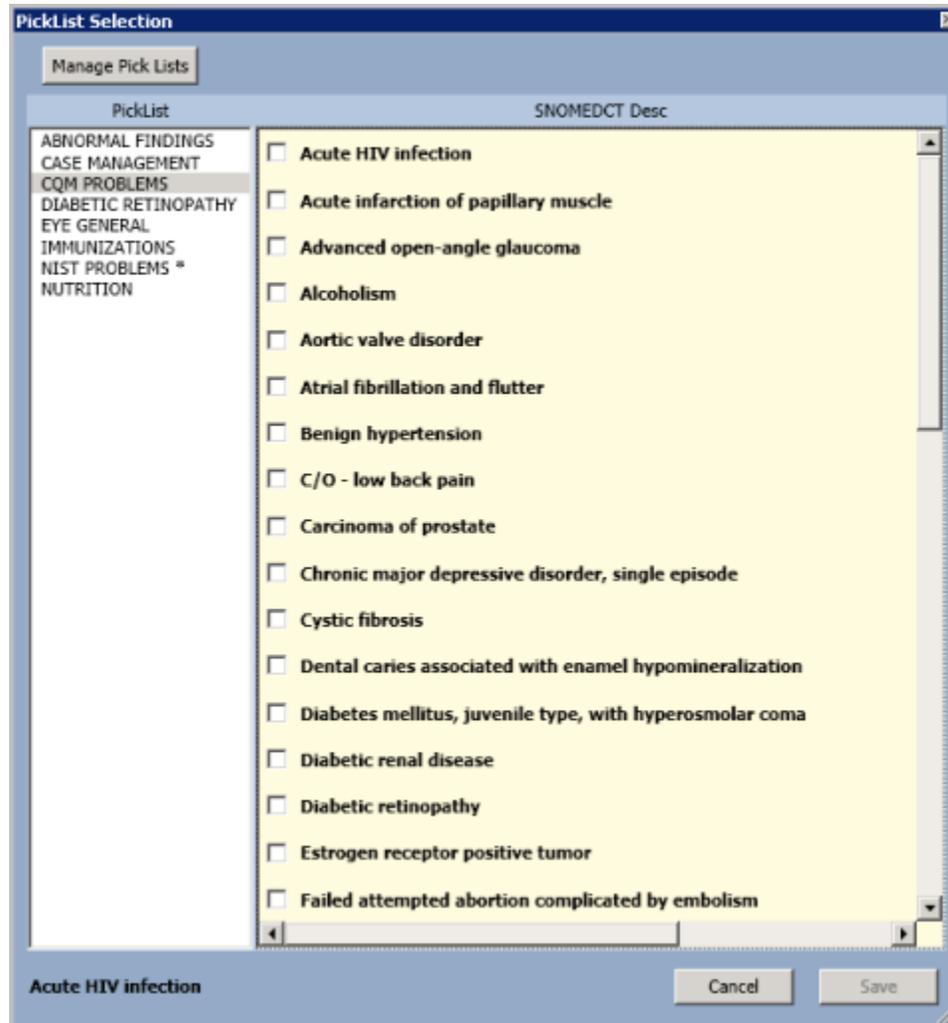


Figure 3-44: Picklist Selection dialog

Note: The Manage Pick Lists button is currently disabled.

2. The Picklist column, select one or more pick lists. The SNOMED CT Description column refreshes with the pick list you selected.

Note: Both the pick lists and their items are in alphabetical order.

3. Click Save. The Pick List disables any problem that is a duplicate and already on the patient's problem list.

3.3.10 Adverse Reactions Tab

Adverse reactions or allergies may be reconciled by a nurse, pharmacist, provider, or case manager at triage, at time of provider appointment, at pharmacy medication pickup or pharmacy medication management visit, or at PHN or case manager visit.

Adverse reactions are reviewed and reconciled from externally received CCDA documents, paper copies of clinical summaries, patient history, and so on.

An example of the Adverse Reactions tab and corresponding Clinical Document and Reconciled panes is shown in Figure 3-45.

Reactants that have a match by RxNorm (primary search, secondary search for exact text) on incoming lists are shown highlighted in green. To de-select any of the highlighted reactants, press Ctrl and click.

Note: Matching occurs on the first word of a multiple-word name. For example, with potassium sulfate, it tries to match potassium.

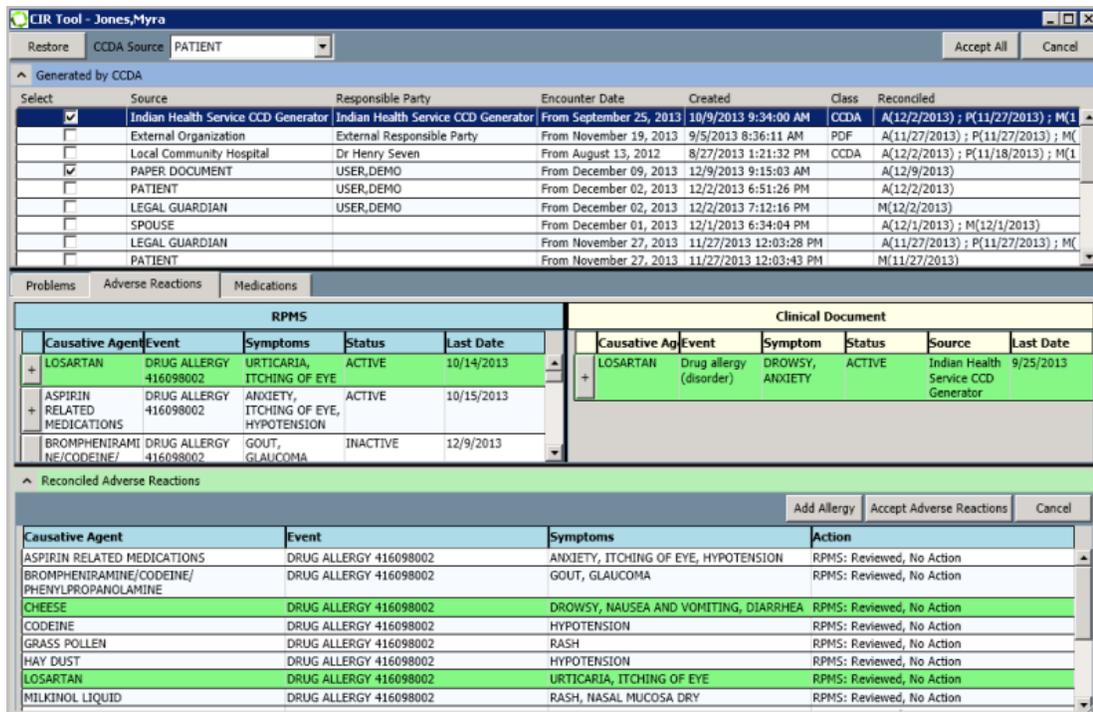


Figure 3-45: CIR Tool Adverse Reactions Tab Main Window

3.3.10.1 RPMS Pane

3.3.10.1.1 Columns

When the Adverse Reactions tab is clicked, the RPMS pane shows the following columns:

- Causative Agent: Medication or substance which causes the adverse reaction/allergy.
- Event: Name and SNOMED CT code of adverse reaction.
- Symptoms: Description of symptoms and date and time of symptom(s) onset.
- Status: Whether the adverse reaction is active, inactive, and so on.
- Last Date: Date of last modification or the date entered.

3.3.10.1.2 Right-Click Menu

Note: The right-click menu only appears and applies if a CCDA Class item is selected in the Generated by CCDA pane.

The right-click menu of the Adverse Reactions tab RPMS pane contains the following commands:

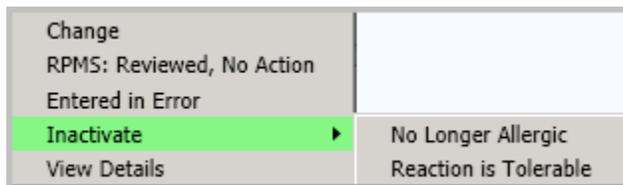


Figure 3-46: Adverse Reaction RPMS Right-Click Menu

- Change: The pre-populated Edit Adverse Reaction dialog opens. Change the applicable fields, as needed.

Figure 3-47: Edit Adverse Reaction dialog

1. The Causative Agent field auto-populates with your selection from the RPMS pane. If needed, type a different causative agent in the field and then click the Ellipsis button. The list updates with your search results.
2. In the Nature of Reaction field, select one of the following from the drop-down menu:
 - Allergy
 - Pharmacological
 - Unknown

3. In the Event Code field, select one of the following from the drop-down menu:
 - Allergy to Substance
 - Drug Allergy
 - Drug Intolerance
 - Food Allergy
 - Food Intolerance
 - Propensity to Adverse Reactions
 - Propensity to Adverse Reactions to Drug
 - Propensity to Adverse Reactions to Food
 - Propensity to Adverse Reactions to Substance
4. In the Source of Information field, select one of the following from the drop-down menu:
 - Patient
 - Spouse
 - Family
 - Friend
 - Other Source
 - Chart Review
 - Medical Provider
 - External Source
 - Other Medical Provider
5. In the Signs/Symptoms section, in the Available field, select one or more applicable symptoms. As you click, they are moved to the Selected field.

Note: You can click the Move (<<) arrows to remove all of the selected symptoms.

6. In the Source (of Signs/Symptoms) field, select one of the drop-down menu options, as listed in Step 4.
7. In Date/Time, the default is the current date and time. Click the Ellipsis button to open the Select Date/Time dialog. Do any of the following:

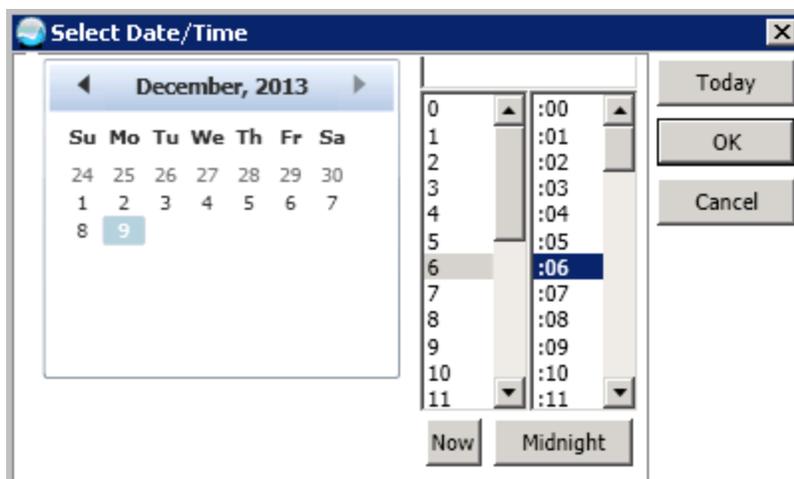


Figure 3-48: Select Date/Time dialog

- Select the applicable date and time from the calendar and time sliding scales and then click OK.
 - Click the Today button to automatically input the current date, and then click OK.
 - Click the Now button to automatically input the current date and time, and then click OK.
 - Click the Midnight button to reset the time sliding scale, select a new date/time, and then click OK.
8. Select the Imprecise Date dialog, if the exact time is not known.
 9. Click OK. The Adverse Reaction is updated with your changes in the Reconciled Adverse Reactions pane and shows RPMS: Changed, No Action in the Action column.

Note: If any of the required fields are not populated when OK is clicked, a warning message appears to complete the applicable field.

- RPMS: Reviewed, No Action: The Adverse Reaction shows as RPMS Reviewed, No Action in the Reconciled Problems pane, Action column.
- Entered in Error: The Entered in Error dialog opens.

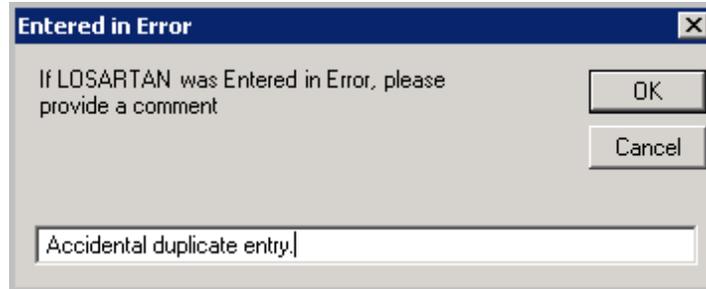


Figure 3-49: Allergy Entered in Error dialog

10. In the field, type a reason for the error.
11. Click OK. The Reconciled Adverse Reactions pane is updated with an RPMS: Entered in Error status in the Action column for the allergy.

- Inactivate: Contains the following sub-selections:
 - No Longer Allergic: Patient is no longer allergic.
 - Reaction is Tolerable: Patient's reaction is tolerable.

Note: If an inactive Adverse Reaction is selected, the Inactivate command changes to Reactivate.

- View Details: The View Allergy Details dialog opens. Any highlighted items from the main screen containing RPMS Pane and CCDA data display in a side-by side comparison when this menu option is selected. The View Allergy Details dialog also has a right-click menu of the following options, as shown in Figure 3-50. Refer to the applicable sections in this Help for details.

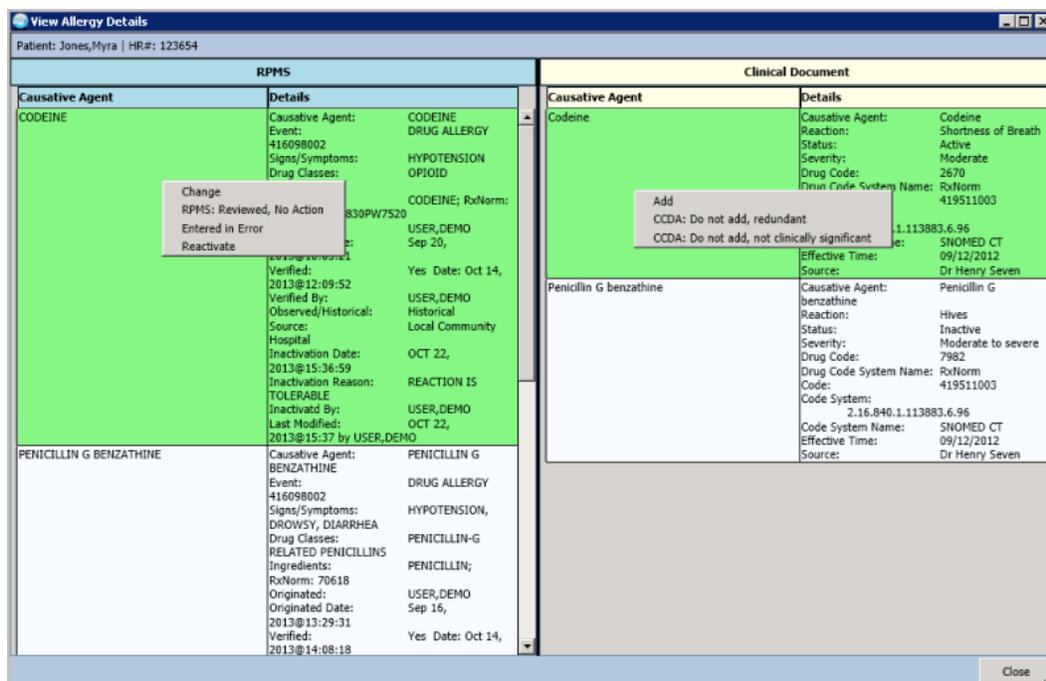


Figure 3-50: View Allergy Details dialog

3.3.10.2 Clinical Document Pane

3.3.10.2.1 Columns

The Clinical Document pane shows the following columns, indicating Adverse Reactions data:

- Causative Agent: The cause of the adverse reaction.
- Event: Name of the adverse reaction event.
- Symptom: Description of symptoms.
- Status: Whether Active, Inactive, and so on.
- Source: Clinician who entered the adverse reaction.
- Last Date: Date of last modification or the date entered.

3.3.10.2.2 Right-Click Menu

Note: The right-click menu only appears and applies if a CCDA Class item is selected in the Generated by CCDA pane.

The right-click menu of the Adverse Reactions tab Clinical Document pane contains the following commands:

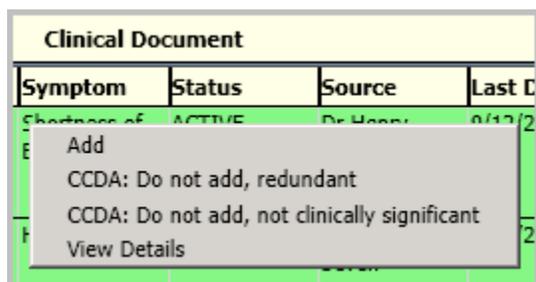


Figure 3-51: Adverse Reaction Clinical Document Right-Click Menu

- Add: The Create Adverse Reaction dialog opens. Refer to the Adding Adverse Reactions topic for details.

Note: If Add is selected and an entry already exists, a warning message appears. Select another Adverse Reaction. The system will not allow you to add a duplicate allergen.

- CCDA: Do not add, redundant: The allergy shows as RPMS Reviewed, No Action, CCDA Do Not Add, Redundant in the Reconciled Adverse Reactions pane, Action column.
- CCDA: Do not add, not clinically significant: The allergy shows as RPMS Reviewed, No Action, CCDA Do Not Add, Not Clinically Significant in the Reconciled Adverse Reactions pane, Action column.
- View Details: The View Allergy Details dialog opens.

3.3.10.3 Reconciled Adverse Reactions Pane

3.3.10.3.1 Columns

The Reconciled Adverse Reactions pane shows the following columns, indicating Adverse Reaction reconciliation data:

- Causative Agent: Name of allergen, whether a drug name, food, or substance.
- Event: Shows the SNOMED CT code for the adverse reaction. For example, Drug Allergy 416098002.
- Symptoms: The patient's symptoms when exposed to the allergen.
- Action: What reconciliation action was taken, for example, RPMS: Changed, or CCDA: Add.

Note: There are no right-click menu options in the Reconcile pane.

3.3.10.3.2 Buttons

The Reconciled Adverse Reactions pane contains the following buttons:

- Add Allergy Button: The Create Adverse Reaction dialog opens. Refer to the Adding Adverse Reactions topic for details.
 - Accept Adverse Reactions Button: The Review/Sign Changes for Patient Name dialog opens.
1. The items in the CIR Adverse Reaction Reconciliation list in the dialog are pre-selected by default. Clear any items you don't want to include for signature.
 2. In the Electronic Signature Code field, type your code, and then click Sign. Your signature is applied to the selected items.

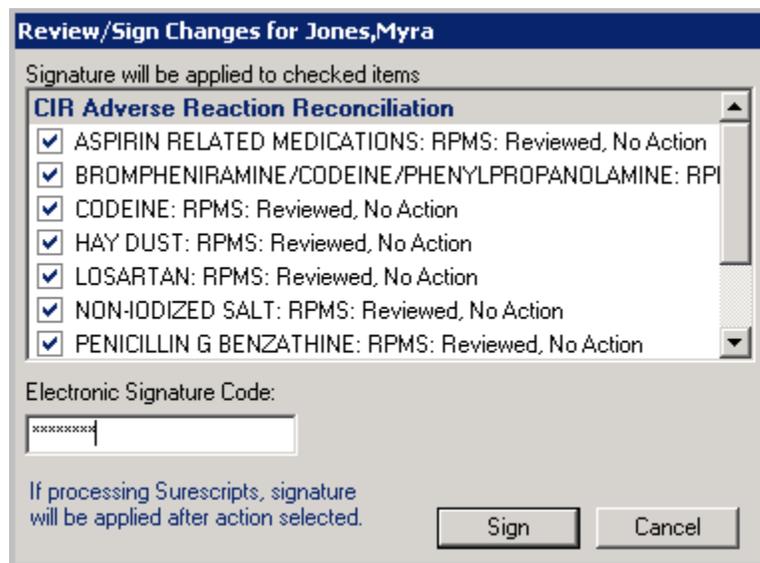


Figure 3-52: Review/Sign Changes for Patient Name dialog

If there are issues with any of the adverse reaction entries, the Order Checking - Source: IHS dialog may open instead. For Adverse Reactions, this is an informational dialog and may not require action from the user.

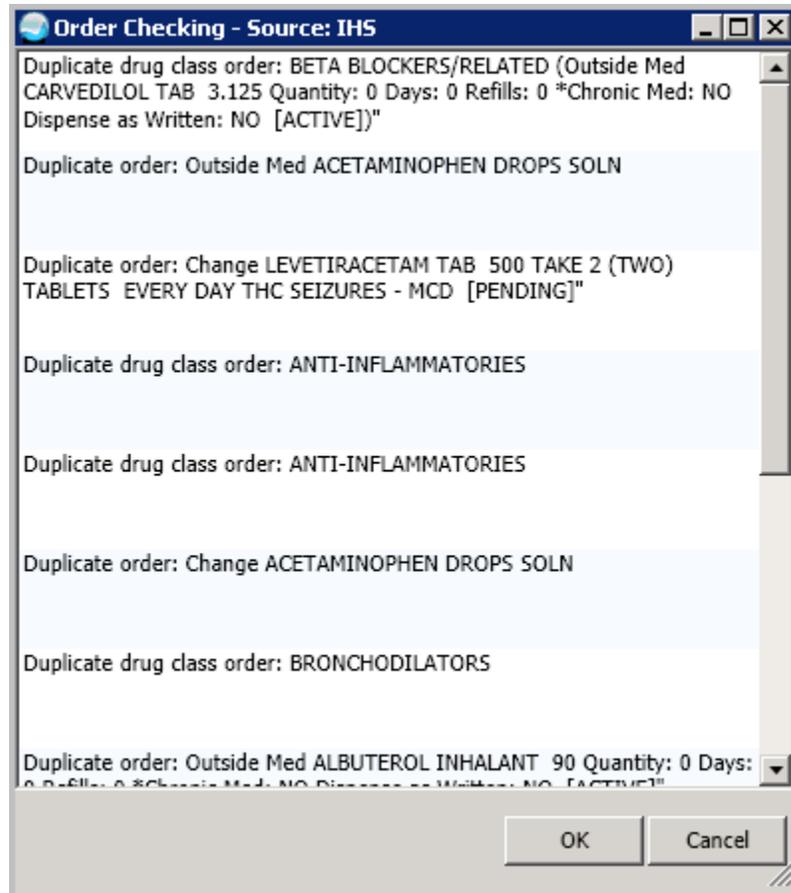


Figure 3-53: Order Checking – Source: IHS dialog when Accepting Adverse Reactions

3. Review the data, and then click OK. The Order Checking - Source: IHS dialog closes and the Review/Sign Changes for Patient Name opens.
4. Repeat Steps 1 and 2.
 - Cancel Button: Cancels the action.

3.3.11 Adding Adverse Reactions

From the Clinical Document right-click menu, if the Add option is selected or when the Add Allergy button is clicked from the Reconciled Adverse Reactions pane, the Create Adverse Reaction dialog opens.

Note: If the Add Allergy button is used, the Create Adverse Reaction dialog is not pre-filled. If the Clinical Document right-click Add is used, the Create Adverse reaction dialog opens pre-filled with some allergy data.

The steps that follow show how to complete the Create Adverse Reaction dialog:

Create Adverse Reaction

Causative Agent: Aspirin

211 matches found.

- VA Allergies File
 - ASPIRIN RELATED MEDICATIONS
 - ASPIRIN RELATED MEDICATIONS <ASPIRIN>
 - GMRD(120.82"D")
 - GMRD(120.82"D")
- National Drug File - Generic Drug Name
 - ASPIRIN/CAFFEINE/PROPOXYPHENE**

Nature of Reaction: Allergy

Event Code: DRUG INTOLERANCE

Source of Information: PATIENT

Signs/Symptoms

Available	Selected
INCREASED WBC <LEUKOCYTOSIS>	NAUSEA AND VOMITING
INHIBITED ORGASM	JOINT SWELLING
INJECTION SITE PAIN	
INSOMNIA	
INSUFFICIENT RESPONSE	
INTRAUTERINE FETAL DEATH	
IRRITATION OF PENIS	
ITCHING <PRURITUS>	
ITCHING OF THROAT <THROAT	
ITCHING PURPURA	
JERKING <SPASMODIC MOVEMENT>	
JOINT SWELLING	
KIDNEY DISEASE	
KIDNEY STONES	

Source: PATIENT

Date/Time: 10/30/2013 17:17

Comments:
Allergy reconciled from CCDA from: Dr Henry Seven received on 9/12/2012

OK Cancel

Figure 3-54: Completed Create Adverse Reaction dialog

- The Causative Agent field is either blank if being added from the Reconciled Adverse Reactions pane, or auto-populates with your selection from the Clinical Document pane. If blank, type an allergen in the field, and then click the Ellipsis button. Any matches show in the field below. Select one.
- In the Nature of Reaction field, select one of the following from the drop-down menu:
 - Allergy (default)

- Pharmacological
 - Unknown
3. In the Event Code field, select one of the following from the drop-down menu:
 - Allergy to Substance
 - Drug Allergy
 - Drug Intolerance
 - Food Allergy
 - Food Intolerance
 - Propensity to Adverse Reactions
 - Propensity to Adverse Reactions to Drug
 - Propensity to Adverse Reactions to Food
 - Propensity to Adverse Reactions to Substance
 4. In the Source of Information field, select one of the following from the drop-down menu:
 - Patient
 - Spouse
 - Family
 - Friend
 - Other Source
 - Chart Review
 - Medical Provider
 - External Source
 - Other Medical Provider
 5. In the Signs/Symptoms section, in the Available field, select one or more applicable symptoms. As you click, they are moved to the Selected field.

Note: You can click the Move arrows to remove all of the selected symptoms.
 6. In the Source (of Signs/Symptoms) field, select one of the drop-down menu options, as listed in Step 4.
 7. In Date/Time, type a date and time, or click the Ellipsis button to open the Select Date/Time dialog. Do any of the following:

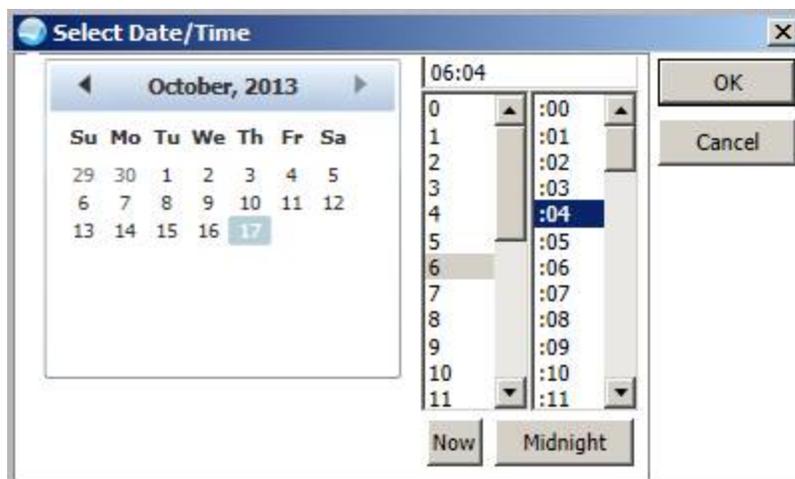


Figure 3-55: Select Date/Time dialog

- Select the applicable date and time from the calendar and time sliding scales and click OK.
 - Click the Now button from the Select Date/Time dialog to automatically input the current date and time, and then click OK.
 - Click the Midnight button to reset the time sliding scale, select a new date/time, and then click OK.
8. Select the Imprecise Date dialog, if the exact time is not known.
 9. The Comments auto-populates with a canned comment if the Clinical Document right-click menu, Add option is selected. Type a new comment, if needed.
 10. Click OK. The Adverse Reaction is updated with your changes in the Reconciled Adverse Reactions pane, indicated by CCDA: Add in the Action column.

Note: If any of the required fields are not populated when OK is clicked, a warning message appears to complete the applicable field.

3.3.12 Medications Tab

CIR enables the reconciliation of a patient's medication orders to all of the medications the patient has been taking to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

A reconciliation should be performed at every transition of care in which new medications are ordered or existing orders are rewritten. The reconciliation may be done at triage, at time of provider appointment, pharmacy medication pickup or pharmacy medication management visit, or PHN or case manager visit.

An example of the Medications tab and corresponding Clinical Document and Reconciled Medications panes is shown in Figure 3-56.

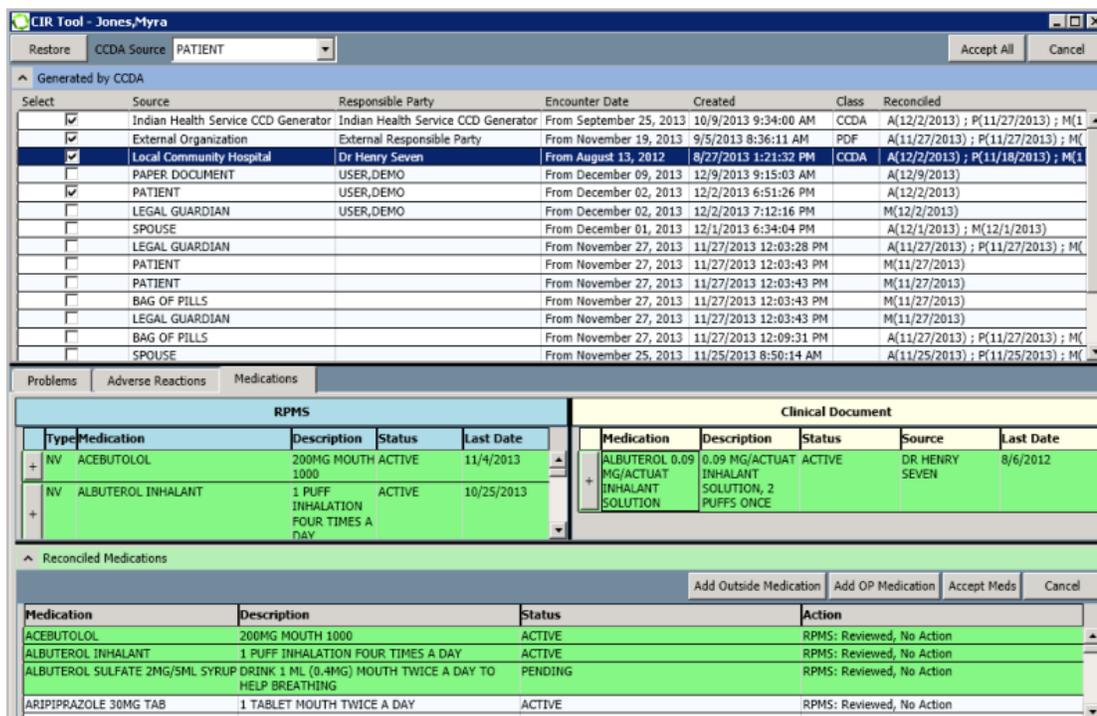


Figure 3-56: Medications Tab and Corresponding Panes

3.3.12.1 RPMS Pane

Medications that have a match by first word of medication (by RxNorm primary search, or NDC if no RxNorm match in EHR list) are shown highlighted in green and may be reconciled using the Change option in the right-click menu.

Note: To de-select matching events, press Ctrl and click.

The RPMS pane contains the following functionality:

3.3.12.1.1 Columns

When the Medications Tab is clicked, the RPMS pane shows the following columns:

- Type: Outpatient (OP), or Non-VA (NV).
- Medication: Medication name, strength, formula, class. Medications are sorted alphabetically, then by issued or last fill date.
- Description: Dosing information.
- Status: Whether the medication is Active, Pending, Hold, or Expired.
- Last Date: Date of last modification or the date entered.

3.3.12.1.2 Right-Click Menu

Note: The right-click menu only appears and applies if a CCDA Class item is selected in the Generated by CCDA pane.

The right-click menu of the Medications tab RPMS pane contains the following commands:

The screenshot shows a software interface with a 'Medications' tab and an 'RPMS' pane. The RPMS pane contains a table with columns 'Description', 'Status', and 'Last'. A right-click menu is open over a row in the table. The menu options are: Change, Discontinue, Reviewed, No Action, Renew, and View Details.

RPMS			
	Description	Status	Last
	SOLN,ORAL 80MG (0.8ML) MOUTH	ACTIVE	10/1
	SOLN,ORAL DRINK (1.6ML) MOUTH 8 HOU PAIN C FEVER		24

Figure 3-57: Medications RPMS Right-Click Menu

- **Change:** The pre-populated Edit Medication dialog opens. Complete your changes and then click Accept Order. Refer to the Medications Online Help for details on completing this dialog.
- **Discontinue:** The Discontinue Order dialog opens. Refer to the Discontinuing Medication Orders topic for instructions on completing this dialog.
- **Reviewed, No Action:** The Medication shows as RPMS Reviewed, No Action in the Reconciled Medications pane, Action column.
- **Renew:** The Order Checking - Source: Veterans Health Administration dialog opens, showing the applicable medications.
- **Click Accept Order.** The Renew Order dialog opens. Refer to the Renewing Medication Orders topic for details.
- **Click Cancel Order.** The order is cancelled.

Note: If the order cannot be renewed, an Unable to Renew Order warning message opens. Click OK.

- **View Details:** The View Medication Details dialog opens. Any highlighted items from the main screen containing RPMS Pane and CCDA data display in a side-by-side comparison when this menu option is selected. The View Medication Details dialog also has a right-click menu of the following options, as shown in Figure 3-58. Refer to the applicable sections in this Help for details.

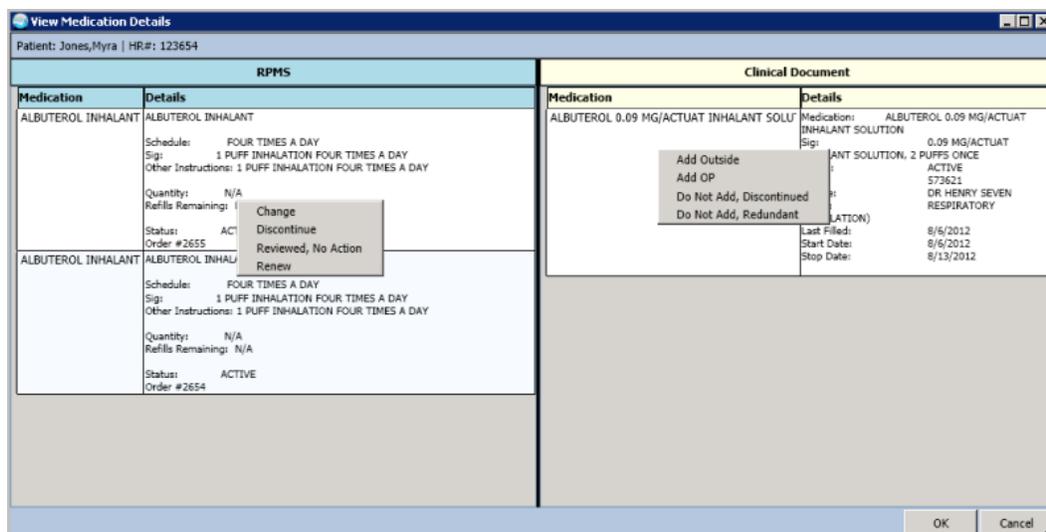


Figure 3-58: View Medication Details dialog

3.3.12.2 Clinical Document Pane

3.3.12.2.1 Columns

The Clinical Document pane shows the following columns, indicating Medication data:

- Medication: Medication name
- Description: Dosage information
- Status: Whether the medication is Active, Pending, Hold, or Expired
- Source: Clinician who prescribed the medication
- Last Date: Date of last modification or the date entered

3.3.12.2.2 Right-Click Menu

Note: The right-click menu only appears and applies if a CCDA Class item is selected in the Generated by CCDA pane.

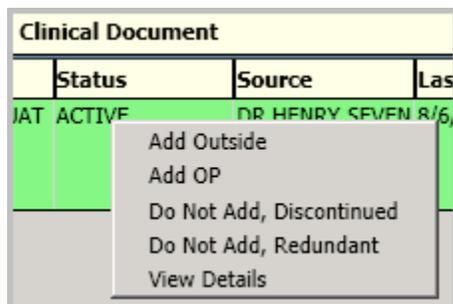


Figure 3-59: Medications Clinical Document Right-Click Menu

- **Add Outside:** The Add Non-VA Medication dialog opens. Refer to the Adding Non-VA Medications topic for details.
- **Add OP:** The Add Outpatient Medication dialog opens. Refer to the Adding Outpatient Medications topic for details.
- **Do Not Add, Discontinued:** Medication has been discontinued and should not be added. The medication shows as RPMS Reviewed, No Action, CCDA Do Not Add, Discontinued in the Reconciled Medications pane, Action column.
- **Do Not Add, Redundant:** Medication is a duplicate and should not be added. The medication shows as RPMS Reviewed, No Action, CCDA: Do Not ADD, Redundant in the Reconciled Medications pane, Action column.
- **View Details:** The View Medication Details dialog opens.

3.3.12.3 Reconciled Medications Pane

3.3.12.3.1 Columns

The Reconciled Medications pane shows the following columns, indicating Medication reconciliation data:

- **Medication:** Medication name, strength, formula, class.
- **Description:** Dosing information.
- **Status:** Whether active, expired, and so on.
- **Action:** Indicates whether the medication was reviewed, and what action (or No Action) was taken.

Note: There is no right-click menu in the Generated by CCDA pane.

3.3.12.3.2 Buttons

The Reconciled Medications pane contains the following buttons:

Add Outside Medication: The Add Non-VA Medication dialog opens. Refer to the Adding Non-VA Medications topic for details.

Accept OP Medication: The Add Outpatient Medication dialog opens. Refer to the Adding Outpatient Medications topic for details.

Accept Meds: The Review/Sign Changes for Patient Name dialog opens.

1. The items in the CIR Reconciled Medications list in the dialog are pre-selected by default. Clear any items you don't want to include for signature.

Note: You may see other items, for example Adverse Reactions or other unsigned orders (as shown in Figure 3-60), in the

Review/Sign Changes dialog if they were not signed previously.

- In the Electronic Signature Code field, type your code, and then click Sign. Your signature is applied to the selected items.

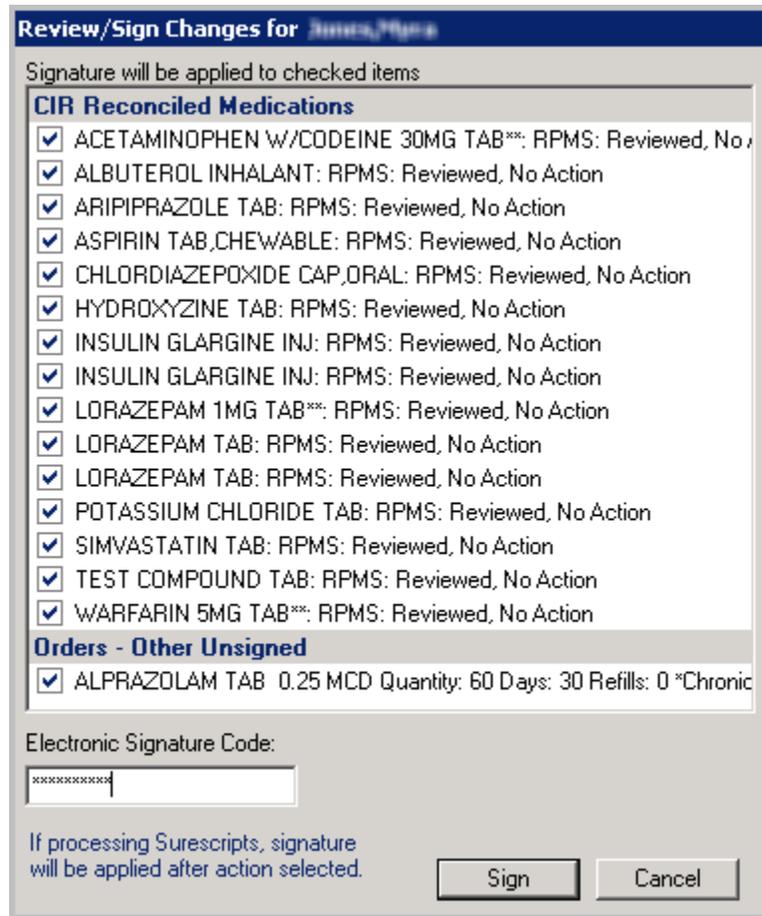


Figure 3-60: Review/Sign Changes for Patient Name dialog

If there are issues with any of the medication entries, for example, duplicate orders, the Order Checking - Source dialog may open instead. For high alerts on medications, this may require action from the user.

Order Checking - Source: Veterans Health Administration

TETRACYCLINE CAP,ORAL 250 Quantity: 20 Days: 30 Refills: 0 *Chronic Med: NO Dispense as Written: NO Indication: Asthma attack Bad coughing *UNSIGNED*

Previous adverse reaction to: TETRACYCLINES (LOCAL);ANTIBACTERIALS,TOPICAL OPHTHALMIC (LOCAL);ANTIACNE AGENTS,TOPICAL (LOCAL)

Cancel Selected Order(s)

Enter justification for overriding critical order checks:

Continue

Figure 3-61: Order Checking – Source dialog when Accepting Medications

- Review the data, and then click OK. The Order Checking - Source: IHS dialog closes and the Review/Sign Changes for Patient Name opens.

Note: You may need to correct any medication issues first, as necessary, and then sign the orders.

- Repeat Steps 1 and 2.

Cancel: Cancels the action.

3.3.13 Adding Non-VA Medications

From the Medications Clinical Document right-click menu, if the Add Outside option is selected or when the Add Outside Medication button is clicked from the Reconciled Medications pane, the Add Non-VA Medication dialog opens.

Note: If the Add Outside Medication button is used, the Add Non-VA Medication dialog is not pre-filled. If the Clinical Document right-click Add is used, the Add Non-VA Medication dialog opens pre-filled with some data.

To complete the Add Non-VA Medication dialog:

Add Non-VA Medication

ALBUTEROL INHALANT Change

Pt Wt on 10/8/2013
160 lb(72.57 kg)

Dosage	Route	Schedule
2 PUFFS	INHALATION	BID <input checked="" type="checkbox"/> PRN
1 PUFF	INHALATION	1000
2 PUFFS		BID
		DAILY
		MO-WE-FR
		MO-WE-FR-SU
		MON-WED-FRI@BID
		NOW

Comments: Take long, deep breaths.

Statement/Explanation

Outside medication not recommended by provider.
 Outside medication recommended by provider.
 Patient buys OTC/Herbal product without medical advice.
 Medication prescribed by another provider.

Home Medication List Source

Patient
 A list the patient may have
 Medications themselves
 Friend
 Family member
 Medical record
 Patient's pharmacy
 Patients primary care physician
 Other

Medication Reason:
Patient has trouble breathing.

Location of Medication

Home Hospital Other

Start Date: 10/30/2013 ... Last Dose Taken: 10/30/2013 19: ...

ALBUTEROL INHALER
 INHALE 2 PUFFS TWICE A DAY
 Quantity: 0 Days: 0 Refills: 0 Chronic Med: NO Dispense as Written: NO

Accept Order
Cancel

Figure 3-62: Completed Non-VA Medication dialog

1. The Medication field auto-populates with the medication selected in the Clinical Document pane if the right-click menu is used. If the Add Outside Medication button in the Reconciled Medications pane is used, the field is blank. Click the Change button to open the Change Medication dialog to add or change a medication.

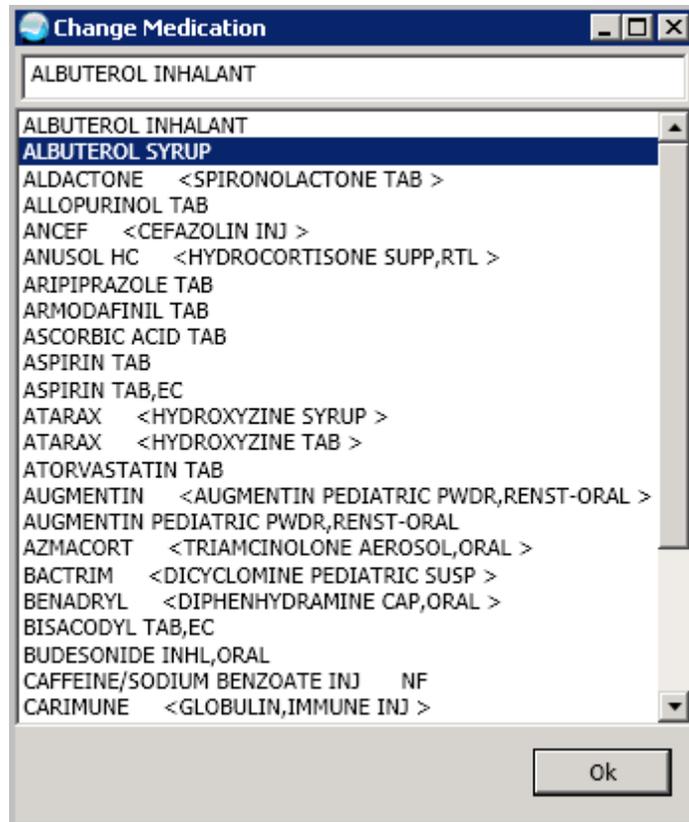


Figure 3-63: Change Medication dialog

- a. Scroll through the list as necessary and select the Medication.
 - b. Click OK. The Medication field of the Add Non-VA Medication dialog updates with your selection.
2. In Dose, select a dose from the list.
 3. In Route, select the applicable administration route.
 4. In Schedule, select the applicable dosing schedule from the list.
 5. Select the PRN check box, if applicable.
 6. In Comments, type any comments.
 7. In Statement/Explanation, select one or more of the following check boxes:
 - Outside medication not recommended by provider.
 - Outside medication recommended by provider.
 - Patient buys OTC/Herbal product without medical advice.
 - Medication prescribed by another provider
 8. In Home Medication List Source, click one of the following option buttons:

- Patient
 - A list the patient may have
 - Medications themselves
 - Friend
 - Family member
 - Medical record
 - Patient's pharmacy
 - Patient's primary care physician
 - Other
9. In Medication Reason, type a reason for prescribing a Non-VA medication.
10. In Location of Medication, click one of the following option buttons:
- Home
 - Hospital
 - Other
11. In Start Date, type a date or click the Ellipsis button () to open the Select Date/Time dialog. Do any of the following:

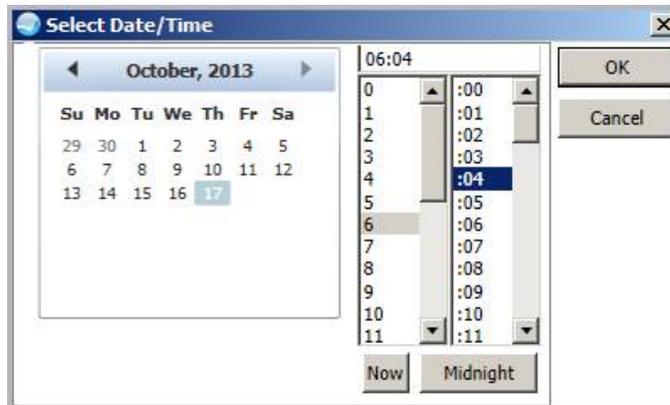


Figure 3-64: Select Date/Time dialog

- Select the applicable date and time from the calendar and time sliding scales and click OK.
- Click the Now button from the Select Date/Time dialog to automatically input the current date and time, and then click OK.
- Click the Midnight button to reset the time sliding scale, select a new date/time, and then click OK.

12. In Last Dose Taken, type a date or click the Ellipsis button to select a date from the calendar.
13. Click Accept Order.

3.3.14 Adding Outpatient Medications

From the Medications Clinical Document right-click menu, if the Add OP option is selected or when the Add OP Medication button is clicked from the Reconciled Medications pane, the Add Outpatient dialog opens.

If the Add Op option from the Medications Clinical Document right-click menu is used, the Medication field auto-populates with the medication selected in the Clinical Document pane.

If the Add OP Medication button in the Reconciled Medications pane is used, the field is blank:

1. Click the Change button on the Add Outpatient Medication dialog. The Change Medication dialog opens.

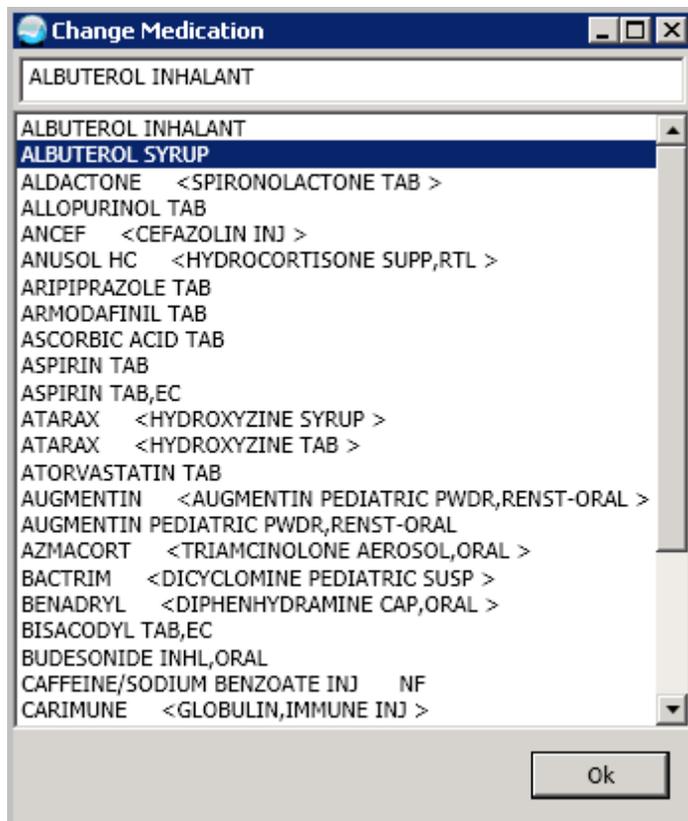


Figure 3-65: Change Medication dialog

2. Type the first few letters of a medication in the field. The list updates with matching medications when you stop typing.
3. Scroll through the list, as necessary and select the medication you want.
4. Click OK. The Medication field of the Add Outpatient Medication dialog updates with your selection.
5. Clicking the ADR's button opens the Patient Postings dialog. Click Done after reviewing the ADRs.

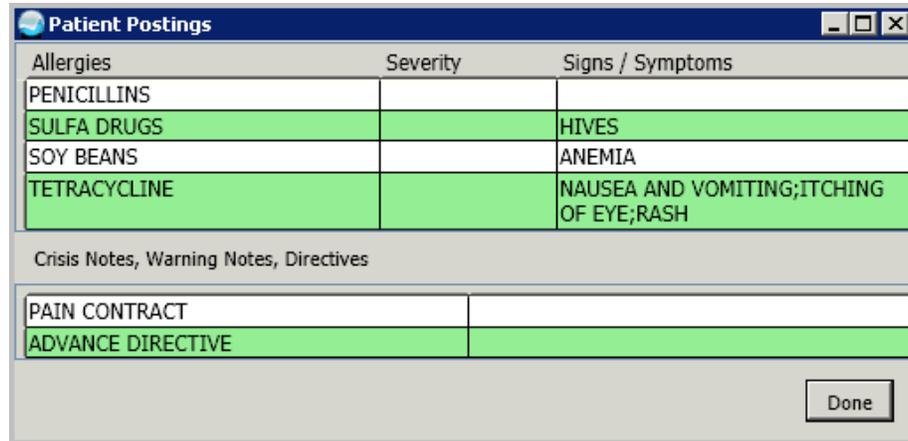


Figure 3-66: Patient Posting dialog

Refer to the Medications Online Help for details on completing Simple and Complex Dose Outpatient Medication Orders.

Figure 3-67: Completed Add Outpatient Medication dialog

3.3.15 Renewing Medication Orders

When the Renew option is selected in the right-click menu of the Medications RPMS pane, the Order Checking - Source: Veterans Health Administration dialog opens, showing the applicable medications.

Figure 3-68: Order Checking - Source: dialog when Renewing Medication Orders

- Click Accept Order. The Renew Order dialog opens. Refer to the Medications Online Help for details on completing this dialog.

- Click Cancel Order. The renewal of the medication is cancelled.

3.3.16 Discontinuing Medication Orders

From the Clinical Document Medications right-click menu, if the Discontinue option is selected, the Discontinue/Cancel Orders dialog opens.

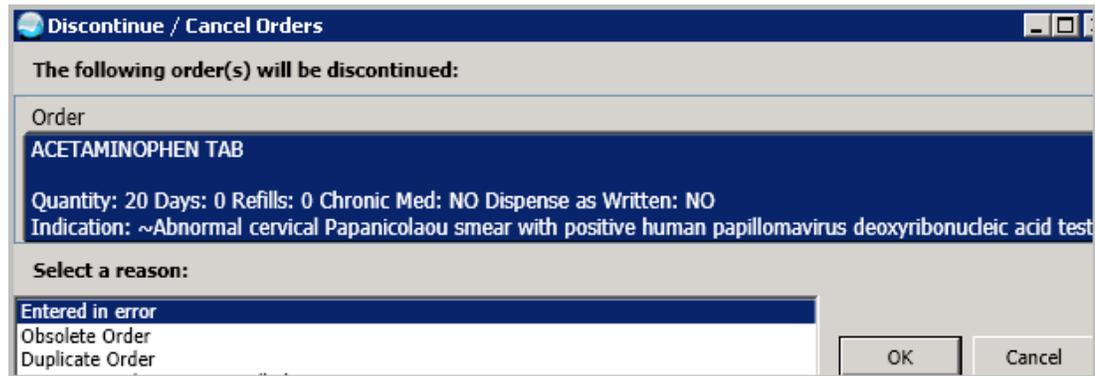


Figure 3-69: Discontinue/Cancel Orders dialog

Follow these steps to complete the Discontinue/Cancel Orders dialog:

1. In the Order section, select the orders to cancel.
2. In Select a reason, select a reason for cancelling the medication.
3. Click OK. The Reconciled Medications pane shows an RPMS: Discontinue status in the Action column.

3.4 Integrated Problem List

The IPL enables the convenient viewing of Problem List data on a main display, including:

- Status
- Onset Date
- Provider narrative
- Comments
- If the problem was added to the patient's personal history
- If the problem is Pregnancy Related
- If the problem was used for an inpatient
- ICD code

3.4.1 Orientation

At the top of the Problem List screen of the IPL component are the following features, buttons, check boxes, and columns, which have the following functionality.

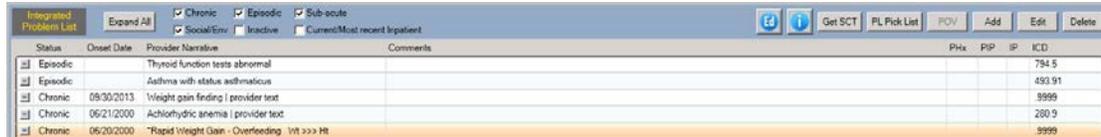


Figure 3-70: IPL Problem List Main Screen

3.4.1.1 Features

- An asterisk in the Provider Narrative column indicates problems not SNOMED CT encoded.
- For problems with a non-coded SNOMED CT code, the Edit button and POV button is disabled.
- Viewing Problem Details: Double-click anywhere in a line item to view the Problem Details screen.
- Right-Click Menu: Right-click anywhere on a line item to open the right-click menu. Select from:
 - Delete: To delete the line item. Refer to the Deleting an IPL topic for details.
 - Edit: To edit the line item. Opens the Edit Problem dialog. Refer to the Editing an IPL topic for details.
 - Get SCT: To update a historical ICD 9 entry. Opens the SNOMED CT Lookup dialog. Refer to the Using the Get SCT Button topic for details.
 - POV: To flag an outpatient problem as POV and to flag an inpatient problem as used for inpatient. Refer to the Using the POV Button topic for details.
 - Change Status:
 - Chronic
 - Episodic
 - Sub-acute
 - Personal History
 - Inactive
 - Social/Env

3.4.1.2 Buttons

- Expand All/Collapse All button: Enables the user to expand or collapse all problems to view the care planning activity. Refer to the Care Plan Feature topic for details.
- Ed button (): Click this button for a direct link to MedlinePlus. Refer to the Using the Education Information Button topic for details.
- Information button (): Click this button for a direct link to UpToDate. Refer to the Using the Web Reference Button topic for details.
- Get SCT button: Click this button to look up the SNOMED CT code. Refer to the Using the Get SCT Button topic for details.
- POV button: Click the POV button to mark the problem as the POV and to add visit, care plan, or goal activity data.
- PL Pick List button: Click the PL Pick List button to select SNOMED CT descriptions by defined pick lists.
- Add button: Click this button to add a problem. See the Adding an IPL topic for details.
- Edit button: Click this button to edit an existing problem. See the Editing an IPL topic for details.
- Delete button: Click this button to delete a selected problem. See the Deleting an IPL topic for details.

3.4.1.3 Check Boxes

Select a check box (or multiple check boxes) to filter the problem list(s) associated with that status:

- Chronic
- Social/Env
- Episodic
- Inactive
- Sub-acute
- Current/Most Recent Inpatient

3.4.1.4 Columns

Columns on the main display screen can be sorted by clicking the column heading, added or removed by the user, made wider or narrower by dragging the column heading, and set as personal setting.

- Ellipsis button: Clicking this button opens the Care Planning information. Refer to the Care Planning Feature topic for details on using this feature.
- Status column: Contains one of the following statuses, as selected by the user.
 - Chronic
 - Social/Env
 - Episodic
 - Inactive
 - Sub-acute
 - Current/Most Recent Inpatient
- Onset Date column: Contains the date of the problem's onset, as input by the user (optional).
- Provider Narrative column: Contains the data input by the user in the Provider Text field.
- Comments column: Shows any comments typed by the user.
- PHx column: A check mark in the PHx column indicates if the Personal History option was selected and the problem was added to the patient's personal history.
- PIP column: A check mark in the PIP (Pregnancy Issues and Problems) column indicates if the Pregnancy Related option was selected.
- IP column: A check mark in the IP column indicates if the Use for Inpatient option was selected.
- ICD column: Indicates the mapped ICD code from the selected SNOMED CT term.

3.4.1.5 Problem Details Screen

You can double-click anywhere in the IPL screen to open the Problem Details dialog. This dialog is informational only and provides problem data.

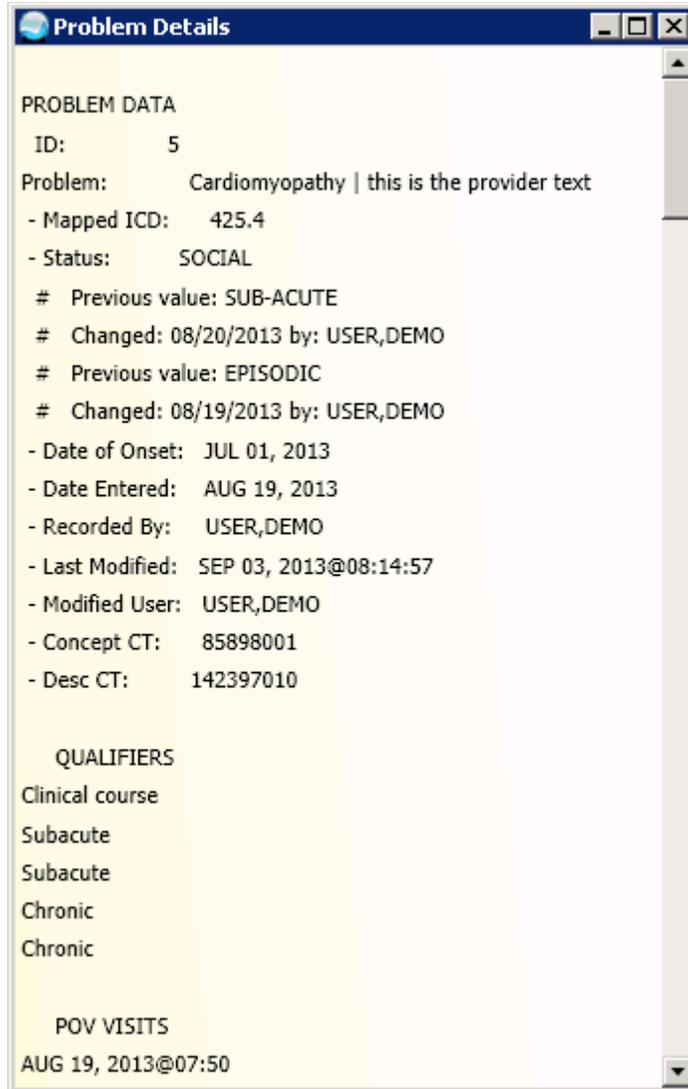


Figure 3-71: Problem Details Screen

3.4.2 Using the Get SCT Button

These instructions are for the Get SCT button on the main screen to update a historical ICD 9 entry. See the Adding an IPL or Editing an IPL topics for information on using the Get SCT button from the Add Problem or Edit Problem dialogs.

Note: A visit must be selected.

1. From the main screen, select a problem line item that does not contain a SNOMED CT term and then click the Get SCT button. The ICD 9 to SNOMED CT Lookup dialog opens showing all the SNOMED CT codes mapped to that ICD 9.

Note: Problems that do not contain a SNOMED CT term are shown preceded by an asterisk (*).

Status	Onset Date	Provider Narrative	Comments	PHx	PIP	IP	ICD
Chronic		*Mild Or Unspecified Pre-eclampsia, Antepartum					642.43
Chronic		*Routine Postpartum Follow-up					V24.2
Chronic		*Pain In Joint Involving Ankle And Foot					719.47
Chronic		*Diabetes With Ketoacidosis, Type I (juvenile Type), Not Stated As Uncontrolled					250.11
Chronic		*Hypertensive Heart And Chronic Kidney Disease, Malignant, Without Heart Failure					404.00
Episodic	05/26/2013	Depressive disorder pregnancy related					311.

Figure 3-72: Problem List with Get SCT Button Active

2. In the ICD 9 to SNOMED CT Lookup dialog, the ICD9 code for the problem shows in the ICD 9 Value field, with the related SNOMED CT concepts listed below each. Click the Expand button next to the Problem name to expand the section to view the list of Synonyms associated with that problem. (Click the Collapse button ([-]) to collapse.). If needed:
 - a. Type a new ICD number in the ICD 9 Value field.
 - b. In Subset, select one or multiple subset lists to search.
 - c. In Search Date, leave the current date default, or click the drop-down arrow to open a calendar from which you can select a new date.
 - d. Click Find. The SNOMED CT Concept list refreshes with your findings.

ICD 9 To SNOMED CT Lookup

Search Date: 09/19/2013

ICD 9 value: 719.47

Find...

Subset

- IHS Problem List
- Asthma
- Cog Funct Status
- CQM Problems
- Family History
- NIST Problems

SNOMED Concept

- Ankle joint - painful on movement
- Ankle joint pain
- Ankle pain

Description	Relationship
Finding of ankle region	Parent (IsA)
Pain in lower limb	Parent (IsA)

SNOMED Concept

- Arthralgia of the ankle and/or foot
- First metatarsophalangeal joint pain
- Foot joint - painful on movement
- Foot joint pain
- Interphalangeal joint of toe pain
- Joint pain in ankle and foot
- Lesser metatarsophalangeal joint pain
- Metatarsophalangeal joint pain
- Subtalar joint - painful on movement
- Subtalar joint - tender
- Subtalar joint pain
- Talonavicular joint pain
- Toe joint painful on movement

Select Cancel

Figure 3-73: ICD-9 to SNOMED CT Lookup

3. Select the SNOMED CT line item you want to use, and then click Select. The problem updates with the asterisk (*) removed from the problem list, the ICD code in the ICD column updates with your selection, and the Get SCT button is no longer active for this problem.

3.4.3 Using the POV Button

These instructions are for the POV button on the main screen to store the SNOMED CT code for an outpatient visit or inpatient discharge diagnosis marked as Primary.

Note: The POV button is only active for problems without an associated SNOMED CT code. The POV button is not active for problems with an INACTIVE ICD 9 code. Inactive problems may be POV.

Refer to the Adding an IPL or Editing an IPL topics for information on using the POV button from the Add Problem or Edit Problem dialogs.

Note: An unlocked visit must be selected.

1. From the main screen, select one or more problem line items and then click the POV button. The POV dialog opens, which shows the selected problems.

Note: A red triangle in the upper-right corner of a column indicates there are multiple entries. Click in the column to expand and view the entries.

Figure 3-74: POV dialog

2. The ID column shows a system-generated ID.
3. The Status column shows the selected status for the problem.
4. The Prov. (Provider) Narrative column contains SNOMED CT concept description and provider text.

5. The next column either shows a POV or INPT column and check box to indicate if the problem is POV or for an inpatient. Clear the check box if you no longer want to set the problem as POV or use for inpatient.

Note: The POV check box can only be selected if a SNOMED CT code has been applied to the problem.

6. The Episodicity column contains the following option buttons. Select or to clear, as applicable:
 - First episode
 - New episode
 - Old episode
 - Ongoing episode
 - Undefined episodicity
7. The following columns have a right-click menu:
 - Prov. Text
 - Goal Notes
 - Care Plans
 - Visit Instructions
8. Right-click in the column to view the following options:

Note: Only the available options for a particular column are active in the right-click menu, depending on the column selected. Various examples follow.

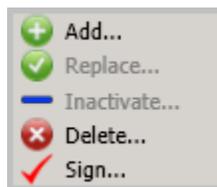


Figure 3-75: POV Right-Click Menu

- Add: The Add dialog opens. Type your text and click OK. The text shows in the column.

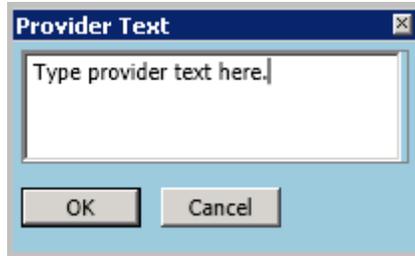


Figure 3-76: Add dialog

- **Replace:** A dialog showing the original text and Replacing text opens. Type your new text in the Replacing Text and click OK. The new text shows in the column.

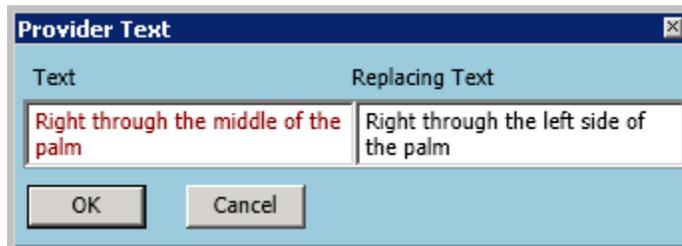


Figure 3-77: Replace dialog

- **Inactivate:** A dialog showing the item you want to inactivate and a Comment field opens. Type a comment, and then click Yes.

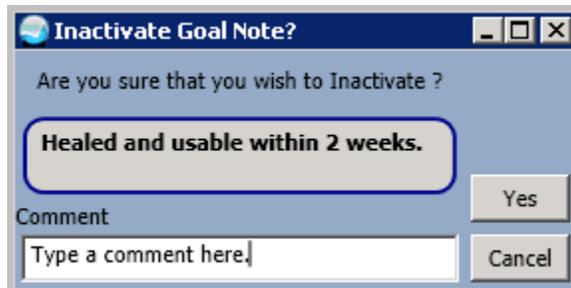


Figure 3-78: Inactivate Item dialog

- **Delete:** The Delete dialog opens to confirm your deletion. Click OK.

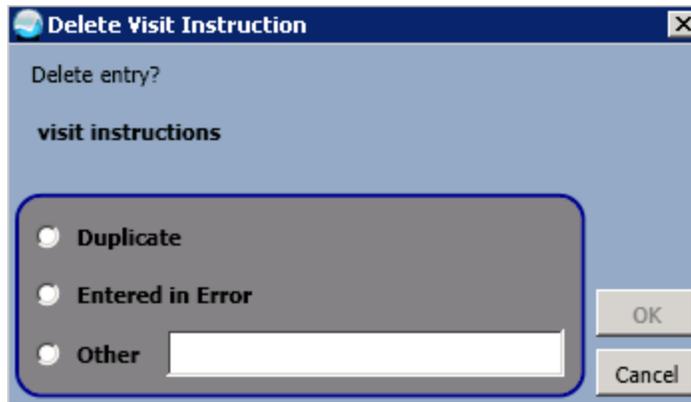


Figure 3-79: Delete Confirm dialog

- **Sign:** The Review/Sign dialog opens with a list of the items you added for you to sign. Type your electronic signature, and then click OK.

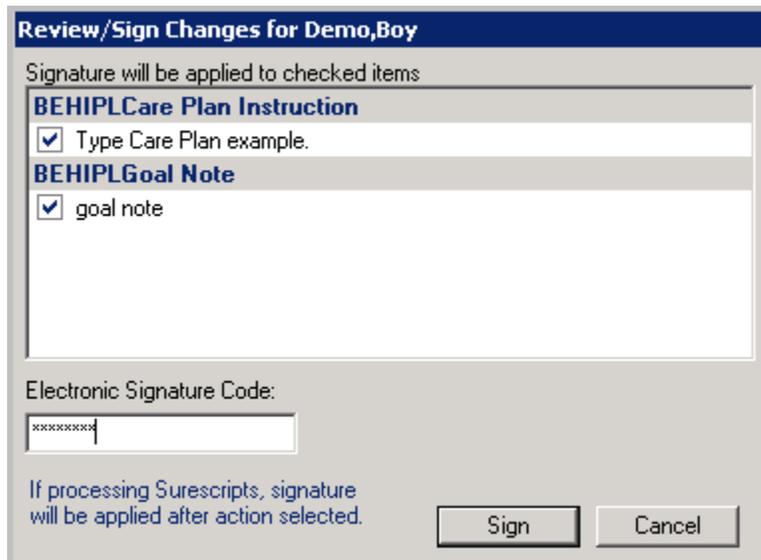


Figure 3-80: Review/Sign Changes for Patient Name for POV

9. Add any free-text information in the Prov. (Provider) Text column by selecting Add from the right-click menu. The Provider Text dialog opens.

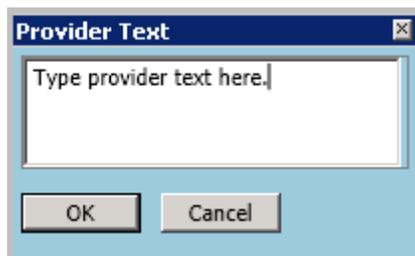


Figure 3-81: Provider Text dialog

- a. Type provider text to assist with the definition of a problem in the dialog.

- b. Click OK.
If Provider Text already exists, the Replace item will be active in the right-click menu. The Provider Text dialog with (existing) Text and Replacing Text fields opens.
 - c. Type the new provider text in the Replacing Text field.
 - d. Click OK. Your change shows in the Prov. Text column.
10. The Goal Notes column contains goals set for the patient to improve the problem, for example to reduce their cholesterol. You can Add a Goal Note by selecting Add from the right-click menu. The Goal Note dialog opens. Click the Template button () to select a template, if needed.

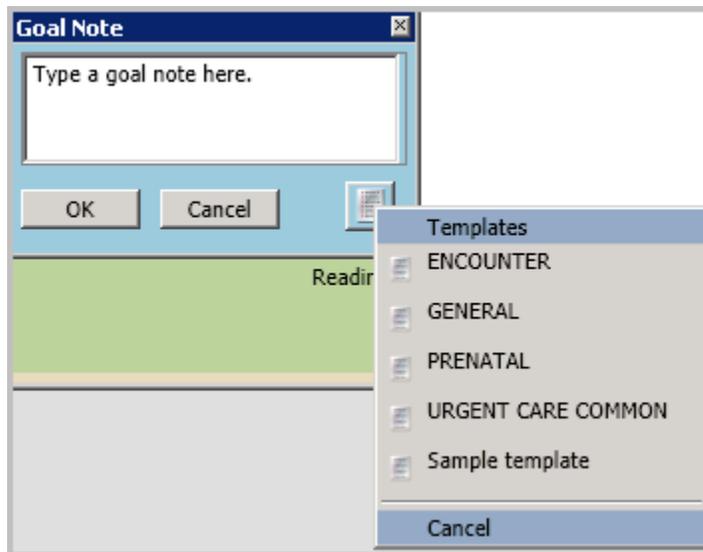


Figure 3-82: Goal Notes dialog with Templates Menu

You can also type over an existing Goal Note by clicking in the text and making your changes.

11. The Care Plans column contains instructions for the patient, for example, walk three times per week, and so on. You can add a Care Plan by selecting Add from the right-click menu. The Care Plan dialog opens. Click the Template button to select a template, if needed.

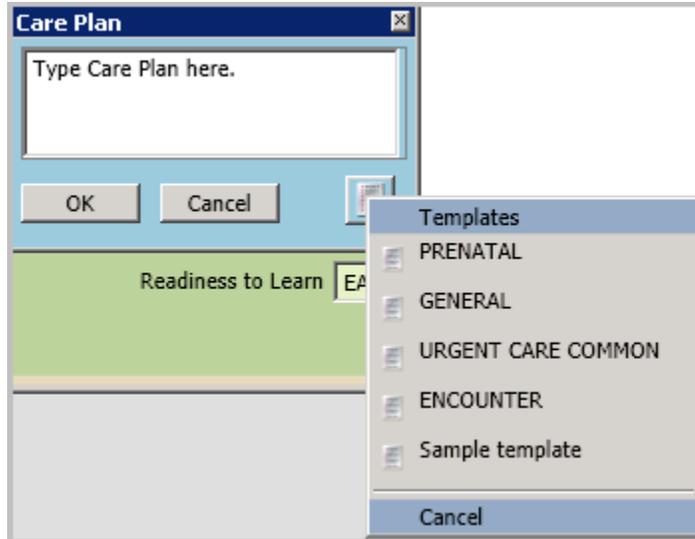


Figure 3-83: Care Plan dialog with Templates Menu

You can also type over an existing Care Plan by clicking in the text and making your changes.

12. The Visit Instructions column contains patient visit instructions for the selected visit. You can add a Visit Instruction by selecting Add from the right-click menu. The Visit Instruction dialog opens. Click the Template button to select a template, if needed.

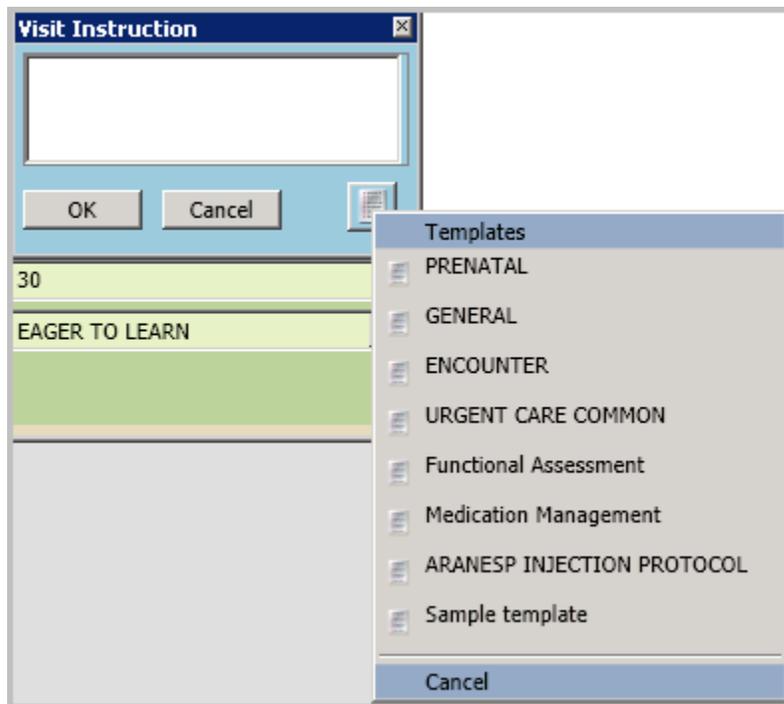


Figure 3-84: Visit Instruction dialog with Templates Menu

You can also type over an existing Visit Instruction by clicking in the text and making your changes.

13. The Pt Ed (Patient Education) column contains the following Subtopic check boxes. Select one or more, as applicable:

- DP (Disease Process)
- EX (Exercise)
- LA (Lifestyle Adaptation)
- MED (Medication)
- N (Nutrition)
- P (Prevention)

14. When a Pt Ed check box is selected, the following fields appear below the column. Select the applicable item from the drop-down list or type in the field, as applicable:

- Comprehension Level:
 - Poor
 - Fair
 - Good
 - Group-No Assessment
 - Refused
- Length (minutes): Type the length of the education in minutes.
- Readiness to Learn:
 - Distraction
 - Eager to Learn
 - Intoxication
 - Not Ready
 - Pain
 - Receptive
 - Severity of Illness
 - Unreceptive

15. The Tx/Regimen/FU column contains the Treatment/Regimen button. Click the Treatment/Regimen button to open the Treatment/Regimen dialog:

- a. Click the Expand button next to the applicable list heading to view the options. Other is shown in the example.

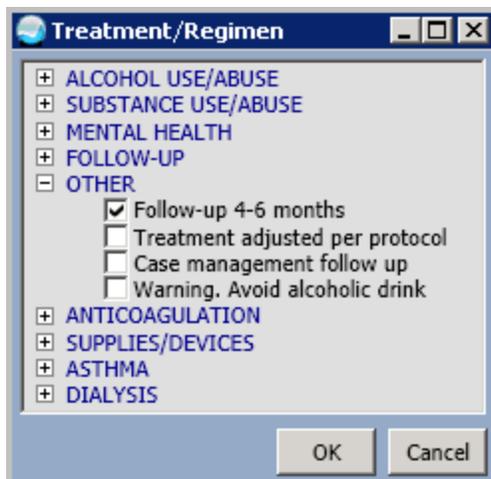


Figure 3-85: Treatment/Regimen dialog With Alcohol Abuse Expanded

- b. Select one or more check boxes to indicate the Treatment or Regimen for the patient.
 - c. Click OK. The Tx/Regimen/FU Display Only column updates with your selection.
16. The Tx/Regimen/FU display only column shows the Visit Instructions, Patient Education, and Tx/Regimen/FU information. For example, Given a Visit Instruction: exercise three times per week, Had Disease Process education, Follow-up: arranged. If data is added to any of these items, for example, an additional Patient Education is selected, the Tx/Regimen/FU display only column updates with the new data.
 17. The Primary POV drop-down menu contains a list of the patient's POVs. Select the POV that you want to make the Primary from the drop-down menu.

Note: If a POV was previously set for the visit as primary, it displays in the drop-down menu, but can be changed by the user.

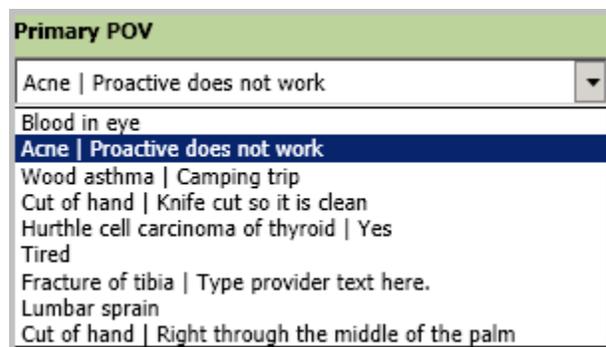


Figure 3-86: Primary POV Drop-down Menu Sample

18. Click Save.

If any items were added to Goal Notes, Care Plan, or Visit Instructions in the POV dialog, the Review/Sign Change for Patient Name dialog opens, listing the items to be signed.

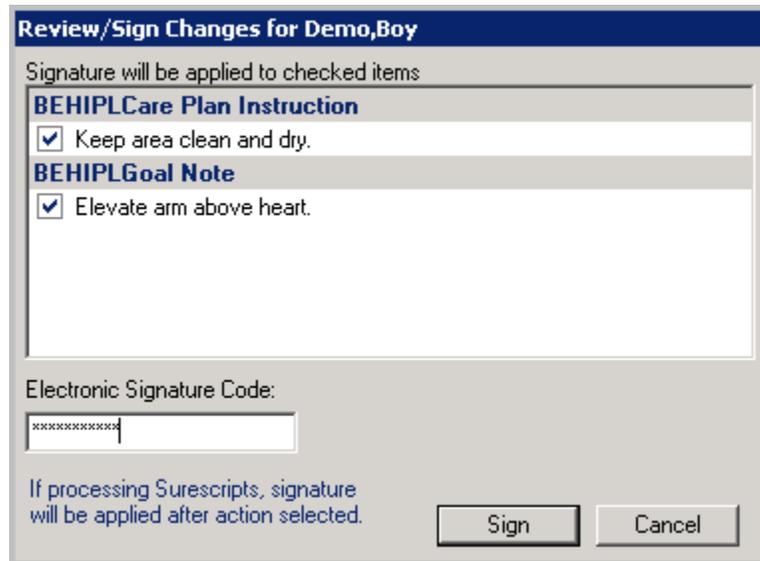


Figure 3-87: Review/Sign Changes for Patient Name

The Problem List screen updates with your changes. If an outpatient, the POV shows in the Visit Diagnosis component.

If you click Cancel, the Rollback Operations Already Executed dialog opens. If needed, select the Rollback check box to indicate that a care planning instruction was created, and then click OK.

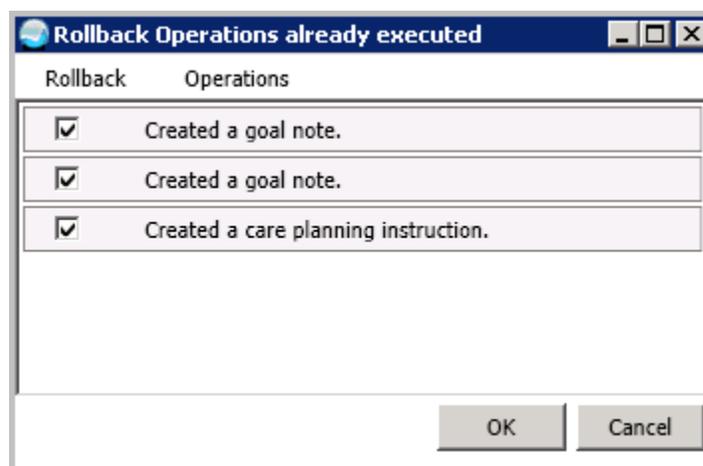


Figure 3-88: Rollback Operation Already Executed dialog

3.4.4 Using the PL Pick List Button

These instructions are for the Pick List button on the main screen to update a Pick List. See the Adding an IPL or Editing an IPL topics for information on using the Pick List button from the Add Problem or Edit Problem dialogs.

Note: If the Pick List button is clicked from the main IPL screen, more than one pick list can be selected. If the Pick List button is clicked from the Add an Integrated Problem List or the Edit an Integrated Problem List screen, only one pick list can be selected.

The PL Pick List button opens the Pick List dialog where the user can choose SNOMED CT descriptions by defined pick lists. Pick list entries may include associated qualifiers.

Providers can edit the Pick List, as well as users holding the BGOZ VPOV EDIT key.

Note: The Pick List button is enabled and pick lists can be managed if no visit is selected.

3.4.4.1 Selecting Problems from a Pick List

1. Click the Pick List button from the IPL main screen. The Picklist Selection dialog opens.

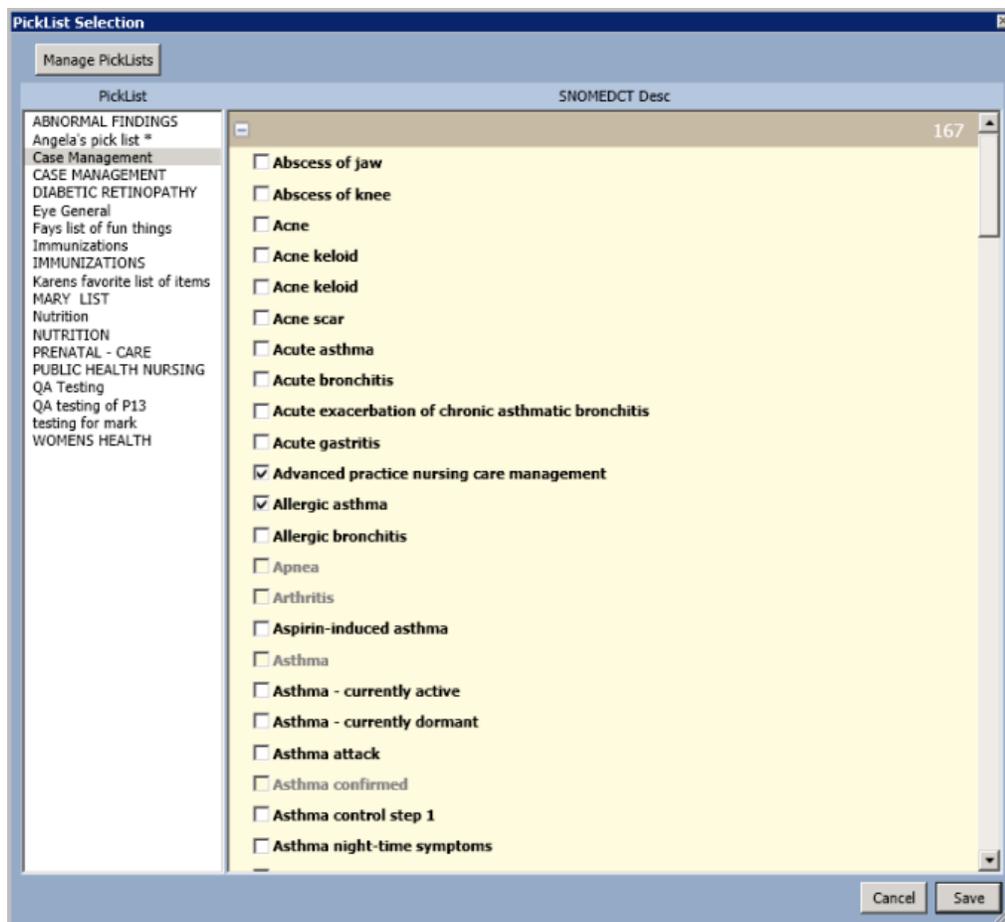


Figure 3-89: Pick List dialog

2. In the Picklist column:

- One or more pick lists can be selected if the Pick List button from main IPL screen is used.
- Only one pick list can be selected if the Pick List button from the Add or Edit an Integrated Problem List screen is used.

The SNOMED CT Description column refreshes with the items related to the pick list(s) you selected.

Note: Both the pick lists and their items are in alphabetical order. The top-right corner of the dialog indicates the number of SNOMED CT descriptions associated with the selected pick list.

3. Click Save. New pick list items display as newly added problems. The Pick List disables any problem that is a duplicate and already on the patient's problem list.

3.4.4.2 Managing Pick Lists

You can manage pick lists by performing the following steps for the associated problems:

1. Click the Manage PickLists button from the PickList Selection dialog. The Manage Quick Picks dialog opens.
2. From the Pick Lists drop-down menu, select a Pick List to manage. The Pick List Items list refreshes with the problems associated with that Pick List.
3. Click to select a problem or select multiple problems by clicking on the problem while holding down the Ctrl key. The problem shows highlighted in orange.

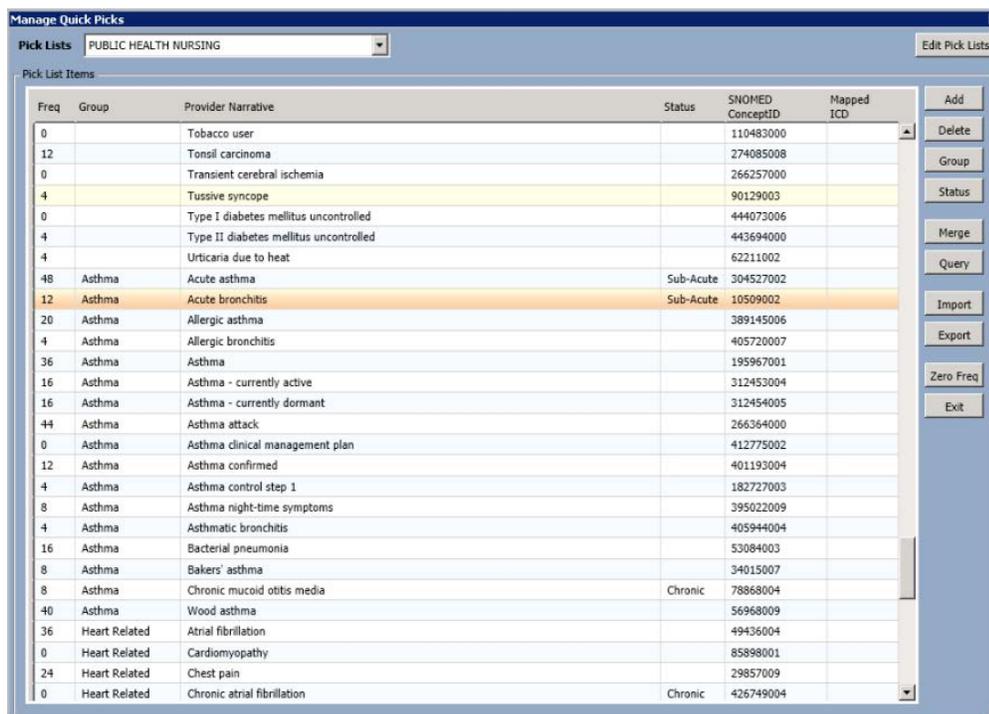


Figure 3-90: Manage Quick Picks dialog

4. Click any of the following buttons to perform the necessary actions:

3.4.4.2.1 Adding

1. Click the Add button from the Manage Quick Picks dialog. The SNOMED CT Lookup dialog opens.
2. In the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand button next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.

3. In Maximum Results, click one of the following option buttons to limit the number of results (or click ALL):
 - 25
 - 50
 - 100
 - 200
 - ALL
4. In Search, type the term by which you want to search.
5. In Subset, you can select a subset in which to search, if needed.
6. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
7. Click either the IHS SNOMED CT or ALL SNOMED CT button. The list of SNOMED CT terms is populated.
8. Select a problem from the list and then click Select.

3.4.4.2.2 Deleting

1. Click the Delete button from the Manage Quick Picks dialog. The Delete 1 (or number selected) Items confirmation message appears.

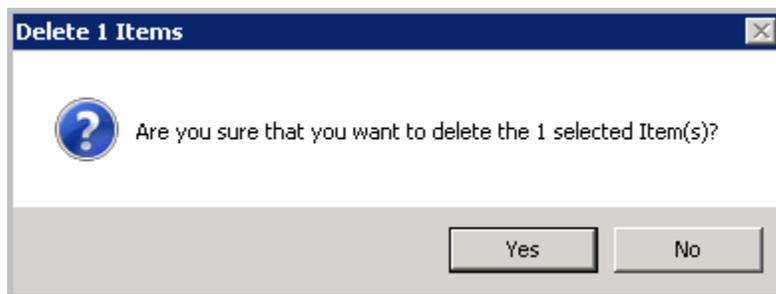


Figure 3-91: Delete Pick List Item Confirmation Message

2. Click Yes to Delete, No to cancel. If Yes is clicked, the item is removed from the Pick List.

3.4.4.2.3 Changing Group

1. Click the Group button from the Manage Quick Picks dialog. The Change the Group values for 1 (or number selected) Pick List Items dialog opens.



Figure 3-92: Change the Group dialog

2. In Group, select the group to which you want to move the item from the drop-down menu.
3. Click Save to save the new Group.

3.4.4.2.4 Changing Status

1. Click the Status button from the Manage Quick Picks dialog. The Change the Status values for 1 (or number selected) Pick List Items dialog opens.

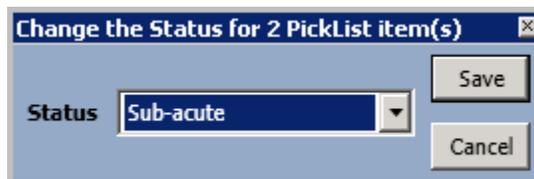


Figure 3-93: Change the Status Values dialog

2. In the Status drop-down, select a status to assign:
 - Chronic
 - Sub-acute
 - Episodic
 - Social/Environmental
 - Interactive
 - Personal Hx
3. Click Save.

Merging:

1. Click the Merge button from the Manage Quick Picks dialog. The Merge PickList dialog opens.

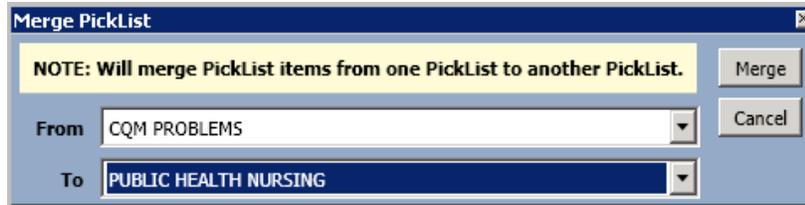


Figure 3-94: Merge PickList dialog

2. In From, select the Pick List to merge the item or items from.
3. In To, select the Pick List to merge the item or items to.
4. Click Merge.

3.4.4.2.5 Querying

1. Click the Query button from the Manage Quick Picks dialog. The Query for PickList Items dialog opens.

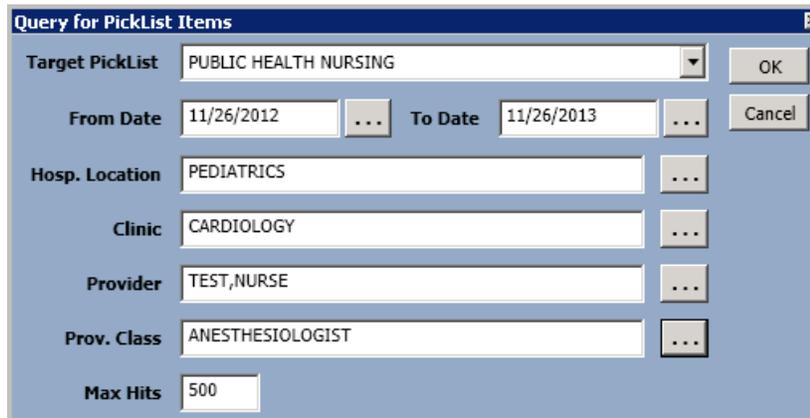


Figure 3-95: Query for PicList Items dialog

2. In Target PickList, select a pick list to query from the drop-down menu.
3. In From Date, click the Ellipsis button to select a date from the calendar.
4. In To Date, click the Ellipsis button to select a date from the calendar.

Note: The From and To date defaults to the current date.

5. In Hosp. Location, click the Ellipsis button to select a location. The Lookup Hospital Location dialog opens.

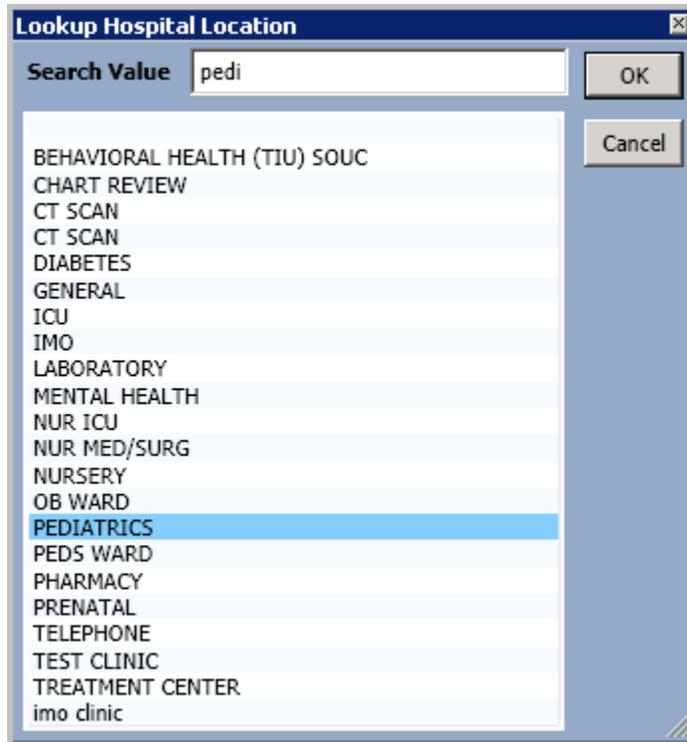


Figure 3-96: Lookup Hospital Location dialog

- a. In Search Value begin typing the first few letters of the location name. The list refreshes with your location.
 - b. Click to select the location, and then click OK. Your selection is populated in the Hosp. Location field.
6. In Clinic, click the Ellipsis button to select a clinic. The Lookup Clinic dialog opens.

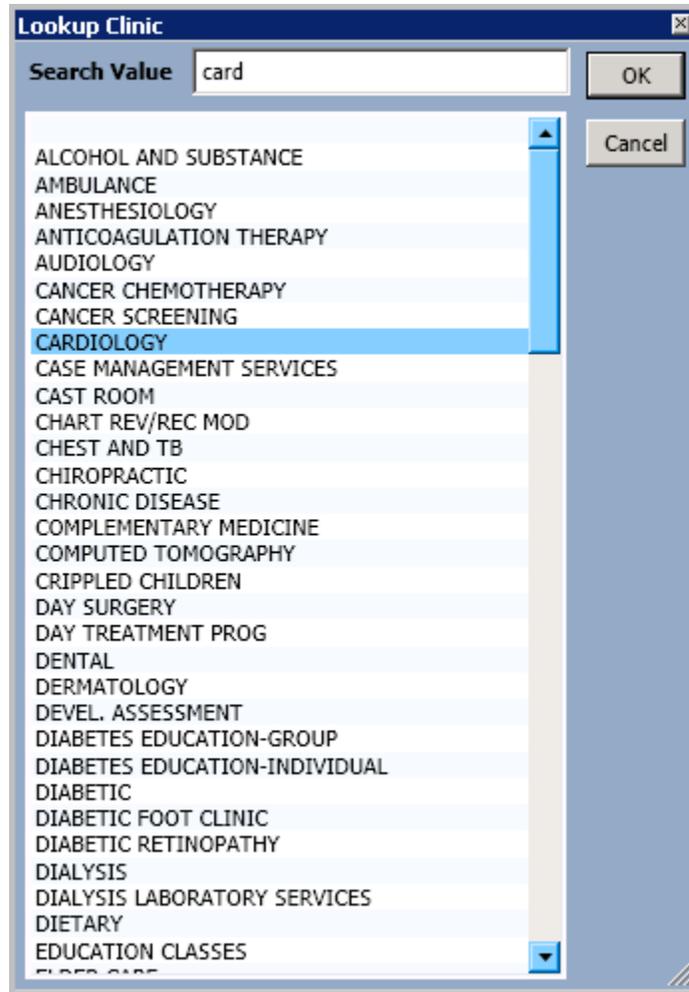


Figure 3-97: Lookup Clinic dialog

- a. In Search Value, begin typing the first few letters of the clinic name. The list refreshes with your clinic.
 - b. Click to select the clinic, and then click OK. Your selection is populated in the Clinic field.
7. In Provider, click the Ellipsis button to select a provider. The Lookup Provider dialog opens.

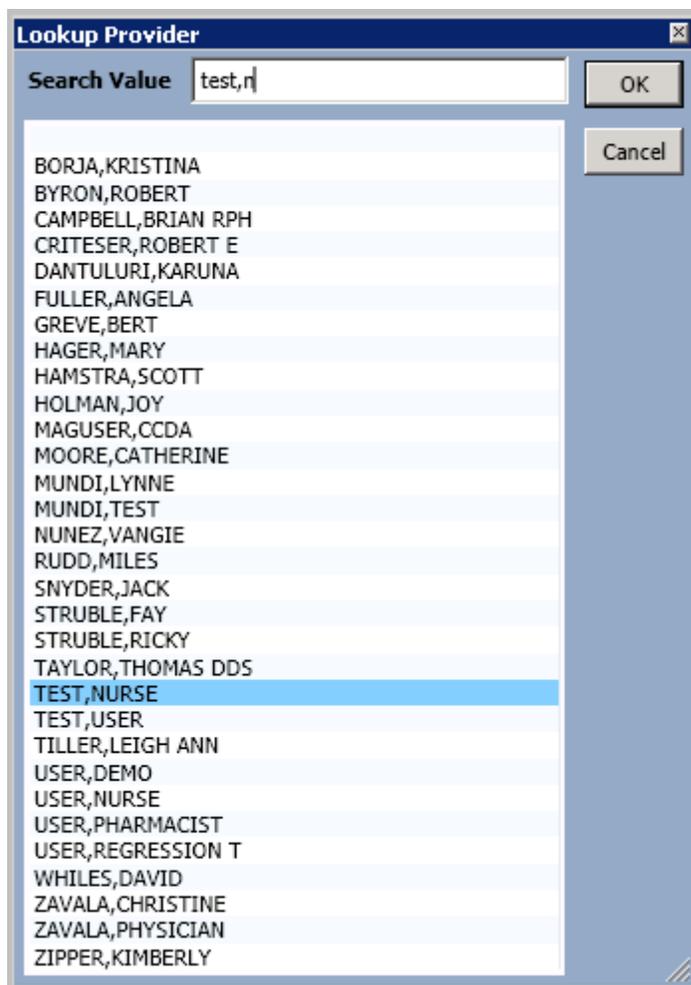


Figure 3-98: Lookup Provider dialog

- a. In Search Value begin typing the first few letters of the provider name. The list refreshes with providers.
 - b. Click to select the provider, and then click OK. Your selection is populated in the Provider field.
8. In Prov. Class, click the Ellipsis button to select a provider class. The Lookup Provider Class dialog opens.

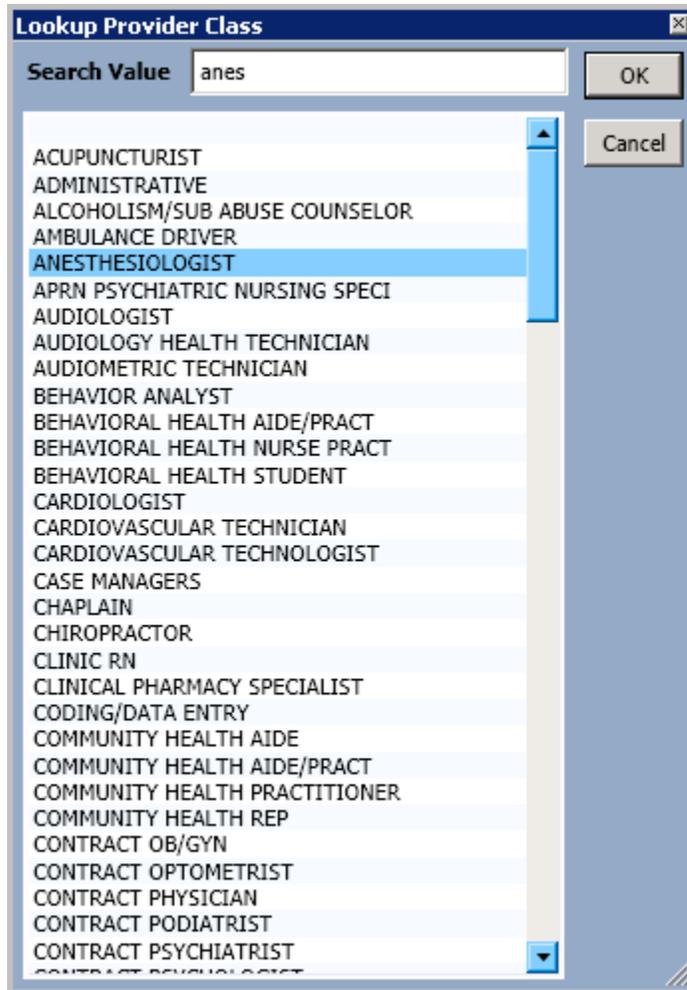


Figure 3-99: Lookup Provider Class dialog

- a. In Search Value begin typing the first few letters of the provider's class. The list refreshes with provider classes.
 - b. Click to select the provider class, and then click OK. Your selection is populated in the Prov. Class field.
9. In Max hits, 500 is the default. Type a number of hits to return if you want to change the number of hits returned.
 10. Click OK on the Query for Pick List Items dialog. An information message appears, showing the number of returned records.



Figure 3-100: Query PickLists Finished Information Message

3.4.4.2.6 Importing

1. Click the Import button from the Manage Quick Picks dialog. The Import SNOMED CT PickLists dialog opens.

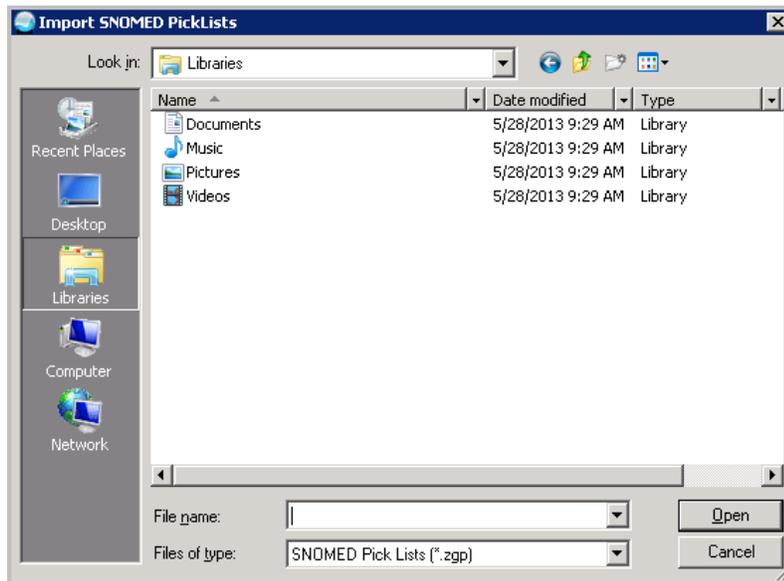


Figure 3-101: Import SNOMED CT PickLists dialog

2. In Look in, select a location from which to import.
3. Locate the file you wish to import. The Files of Type defaults to SNOMED CT Pick Lists (*.zgp).
4. Click Open. Your file is imported.

3.4.4.2.7 Exporting

1. Click the Export button from the Manage Quick Picks dialog. The Save As dialog opens.

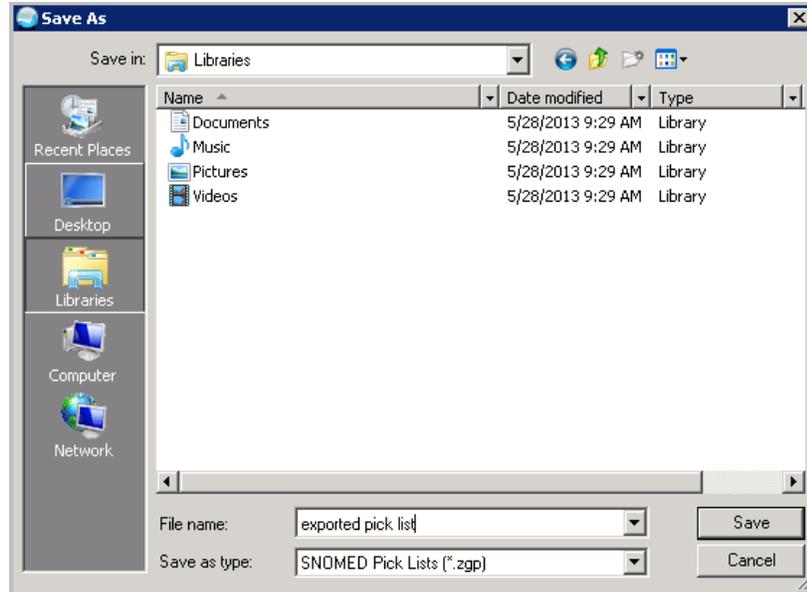


Figure 3-102: Save As (Export Pick List) dialog

2. Select a location to save and type a file name and then click Save. Your SNOMED CT Pick List is saved as .zgp file type, ready for exporting.

3.4.4.2.8 Marking Zero Freq(ency)

1. Click the zero Freq button from the Manage Quick Picks dialog. A frequency of zero (0) is assigned to the pick list item.
2. Click Exit to close the Manage Quick Picks dialog.

3.4.4.3 Edit Pick List Button

From the Manage Quick Picks dialog, click the Edit Pick Lists button to add, edit, delete or import a subset to an existing pick list.

1. Click the Edit Pick Lists button. The Manage PickLists dialog opens.

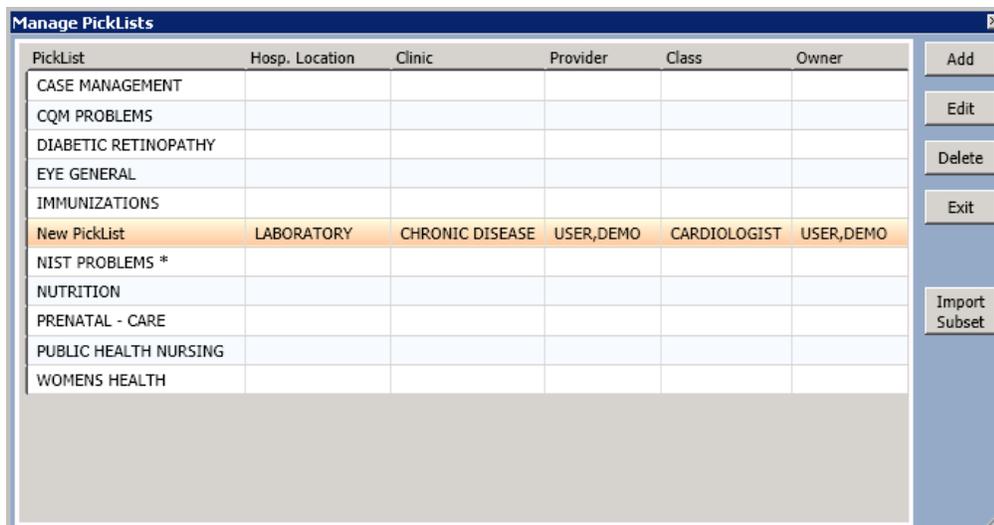


Figure 3-103: Manage Pick Lists dialog

2. Select a PickList from the list, and click one of the following buttons:

3.4.4.3.1 Add

1. Click Add from the Manage PickLists dialog. The Add PickList dialog opens.

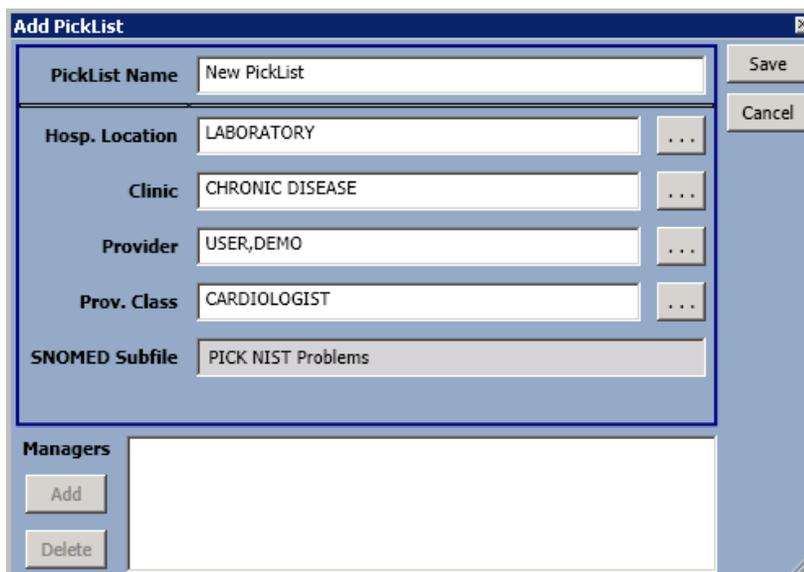


Figure 3-104: Add Pick List dialog

- a. In PickList Name, type a name for the pick list.
- b. In Hosp. Location, click the Ellipsis button to select a location. The Lookup Hospital Location dialog opens.

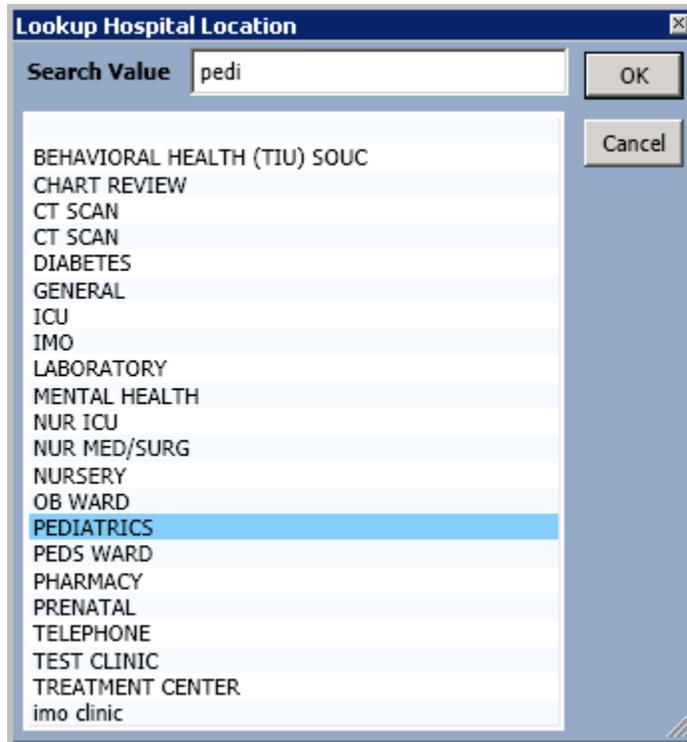


Figure 3-105: Lookup Hospital Location dialog

- c. In Search Value begin typing the first few letters of the location name. The list refreshes with your location.
 - d. Click to select the location, and then click OK. Your selection is populated in the Hosp. Location field.
2. In Clinic, click the Ellipsis button to select a clinic. The Lookup Clinic dialog opens.

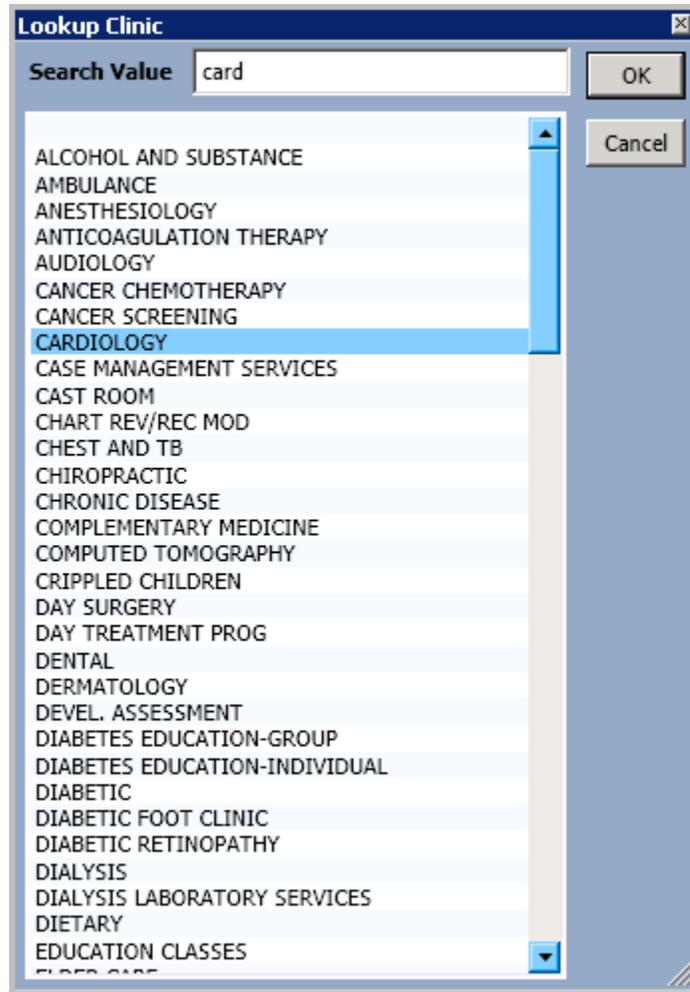


Figure 3-106: Lookup Clinic dialog

- a. In Search Value begin typing the first few letters of the clinic name. The list refreshes with your clinic.
 - b. Click to select the clinic, and then click OK. Your selection is populated in the Clinic field.
3. In Provider, click the Ellipsis button to select a provider. The Lookup Provider dialog opens.

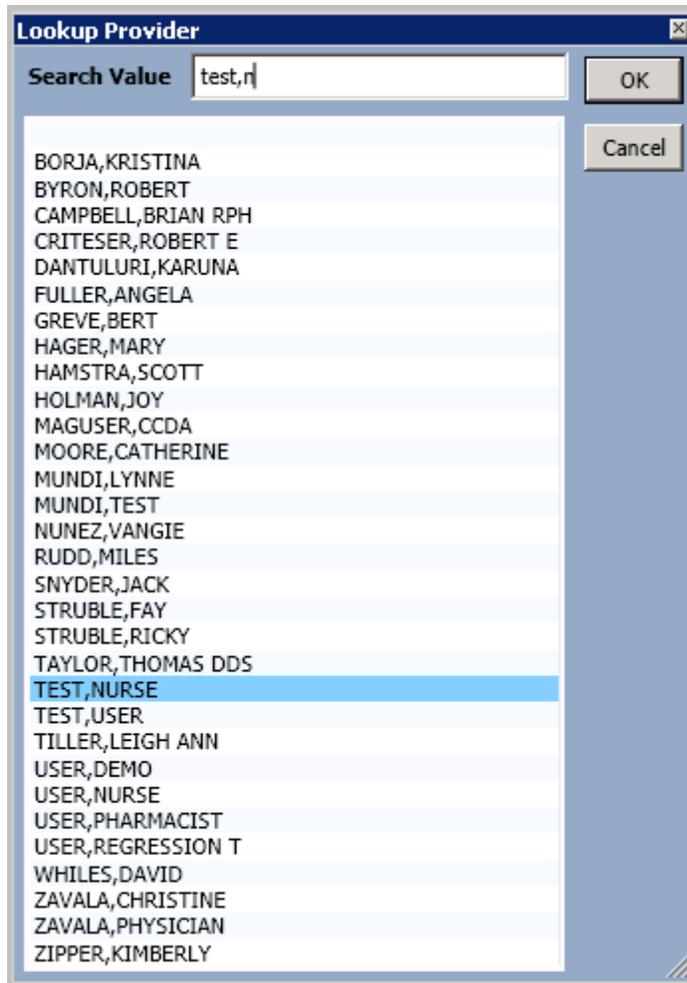


Figure 3-107: Lookup Provider dialog

- a. In Search Value begin typing the first few letters of the provider name. The list refreshes with providers.
 - b. Click to select the provider, and then click OK. Your selection is populated in the Provider field.
4. In Prov. Class, click the Ellipsis button to select a provider class. The Lookup Provider Class dialog opens.

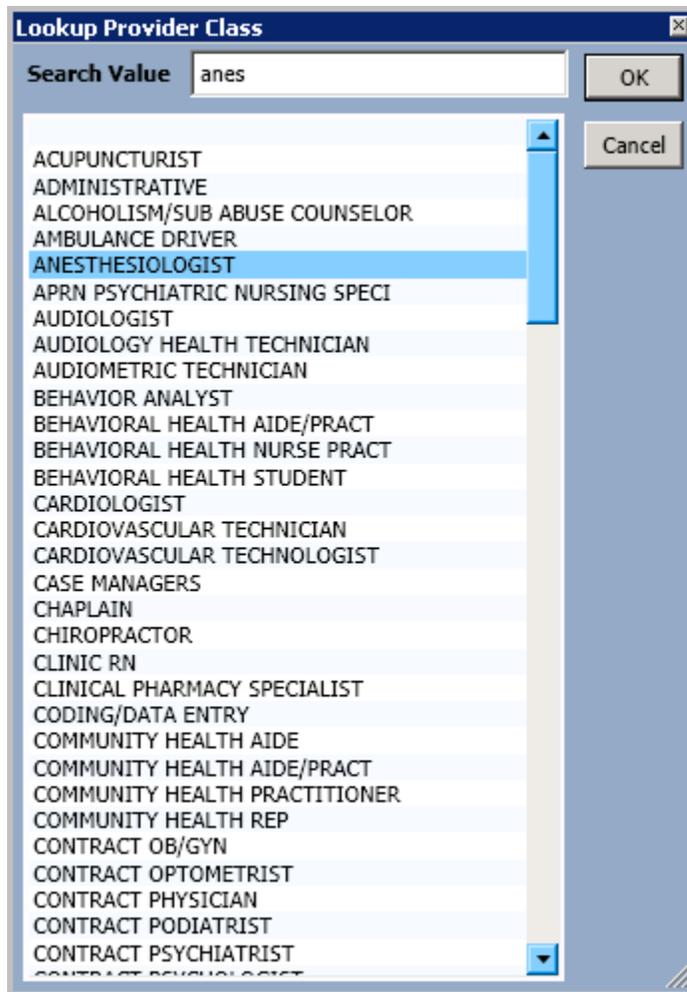


Figure 3-108: Lookup Provider Class dialog

- a. In Search Value begin typing the first few letters of the provider's class. The list refreshes with provider classes.
 - b. Click to select the provider class, and then click OK. Your selection is populated in the Prov. Class field.
5. The SNOMED CT Subfile field is not editable, but shows the file the list is based from. For example, if a subset was imported, that subset shows in the SNOMED CT Subfile field.
 6. The Managers section is inactive until a pick list is created and edited. Refer to Section 3.4.4.3.2.
 7. Click Save. Your entries show in the Manage PickLists dialog.

3.4.4.3.2 Edit

1. Click to select a pick list to edit from the Manage PickList dialog. The Edit PickList dialog opens.

The screenshot shows the 'Edit PickList' dialog box. It features a title bar with a close button. The main area contains several input fields with labels and values: 'PickList Name' (QA Testing), 'Hosp. Location' (TEST CLINIC), 'Clinic' (DIABETIC), 'Provider' (HAGER, MARY), and 'Prov. Class' (CLINIC RN). Each of these fields has a three-dot menu button to its right. Below these is a 'SNOMED Subfile' field. At the bottom, there is a 'Managers' section with 'USER, DEMO' listed, and 'Add' and 'Delete' buttons. On the right side of the dialog, there are 'Save' and 'Cancel' buttons.

Figure 3-109: Edit PickList dialog

2. If applicable, click the Add button in the Managers section to add a PickList manager. The Add Managers dialog opens.

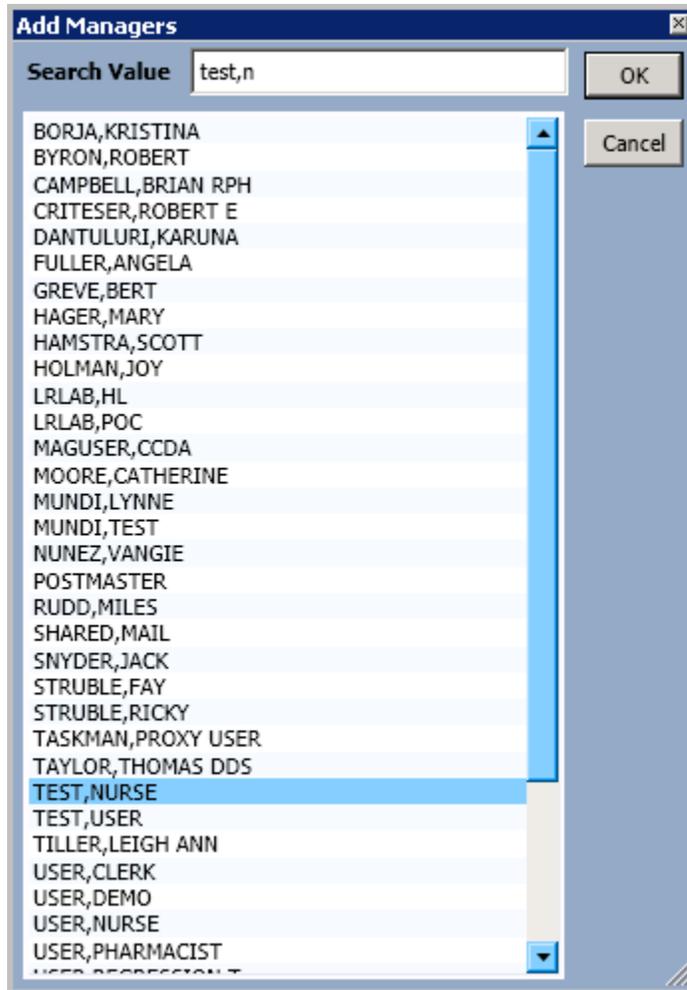


Figure 3-110: All Managers dialog

3. In Search Value begin typing the first few letters of the person's name. The list refreshes with your selection.
4. Click the name, and then click OK. The Managers field populates with your entry.
5. Make your changes, and then click Save. Refer to the Add PickList steps for details on completing the fields.

3.4.4.3.3 Delete

1. Click to select a pick list to delete.
2. Click the Delete button. A Delete Picklist information message appears.

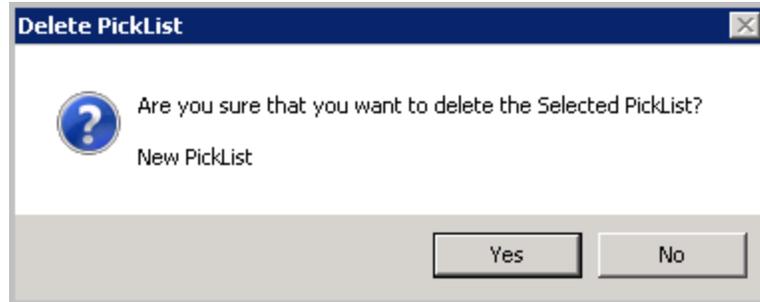


Figure 3-111: Delete PickList Information Message

3. Click Yes to delete the list, or no to cancel. If Yes, the pick list is deleted from the list.

3.4.4.3.4 Import Subset

1. Click to select a pick list, and then click the Import Subset button. The Import Subset dialog opens.
2. In Subset, select a subset to import from the drop-down menu. The New Subset Name field populates with your selection.
3. Click Import.
4. Click Exit to exit the Manage PickLists dialog.

3.4.5 Using the Education Information Button

The Education Information search depends whether any records are present or not.

- Condition 1: If there are records present, select one and click the Education Information button to go to the MedlinePlus Reference Web site for the topic associated with the selected record.
- Condition 2: If there are no records present or no record is selected, click the Education Information button to display the Web Reference Search dialog.

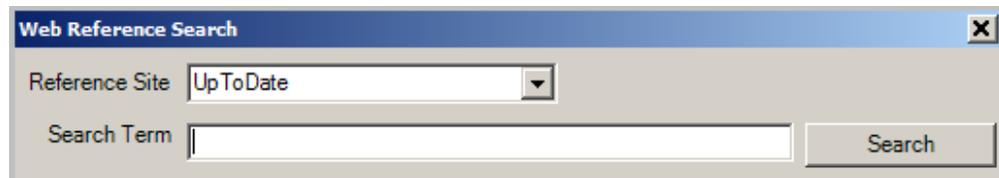


Figure 3-112: Web Reference Search

Select a Reference Site, if needed; the default is the UpToDate site. After entering a term and clicking Search, you are taken to the selected Web site for the specified term.

Note: The Add Patient Education Event dialog also opens when the Education Information button is clicked. Patient education is tracked for Meaningful Use; therefore, the Add Patient Education Event dialog should be completed. Refer to the Patient Education Online Help for details on completing this dialog.



Figure 3-113: MedlinePlus

3.4.6 Using the Clinical Decision Support Button

The Clinical Decision Support button functionality depends whether any records are present or not.

- Condition 1: If there are records present, select one and click the Clinical Decision Support button () to go to the UpToDate Reference Web site for the topic associated with the selected record.
- Condition 2: If there are no records present or no record is selected, click the Clinical Decision Support button to display the Web Reference Search dialog.

Note: You will also see this dialog if your site is not licensed for UpToDate.

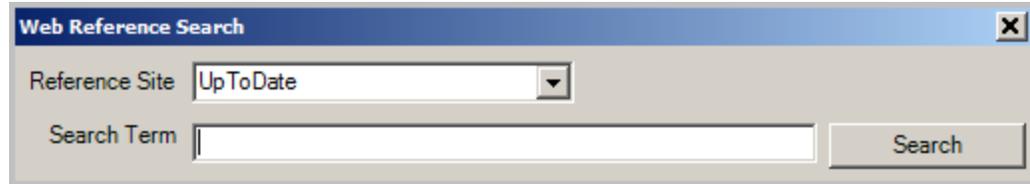


Figure 3-114: Web Reference Search

Select a Reference Site if needed. The default is the UpToDate site. After entering a term and clicking Search, you are taken to the selected Web site for the specified term.

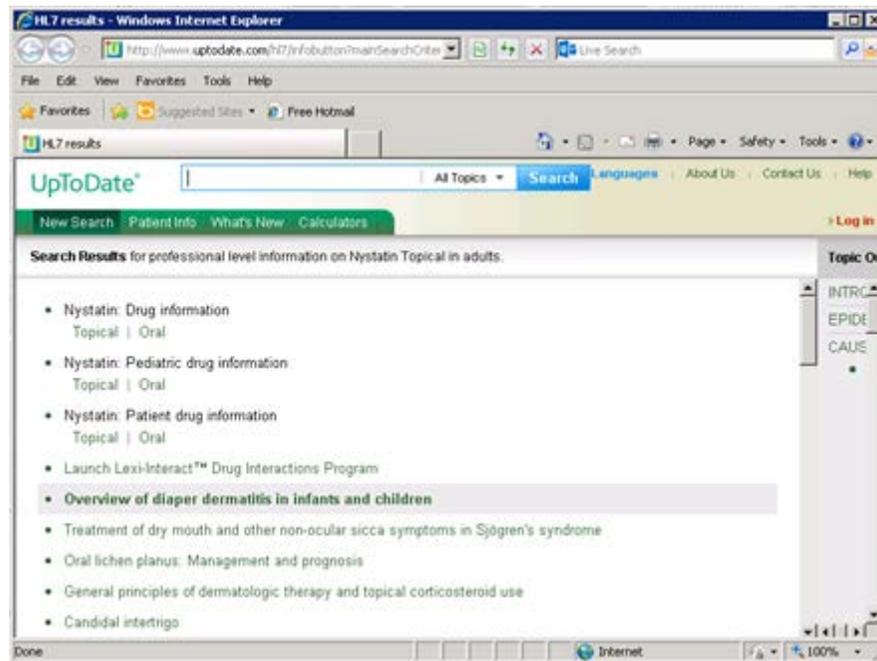


Figure 3-115: UpToDate Website

You can change to another Web site by selecting from the Reference Site drop-down list (on the Web site). The drop-down list for the Reference Site field (on the Web Reference Search dialog) can be configured.

3.4.7 Care Planning Feature

Clicking Expand All on the main Integrated Problem List window shows the following Care Planning information.

Note: The Expand All button changes to Collapse All if Care Plan information is already expanded.

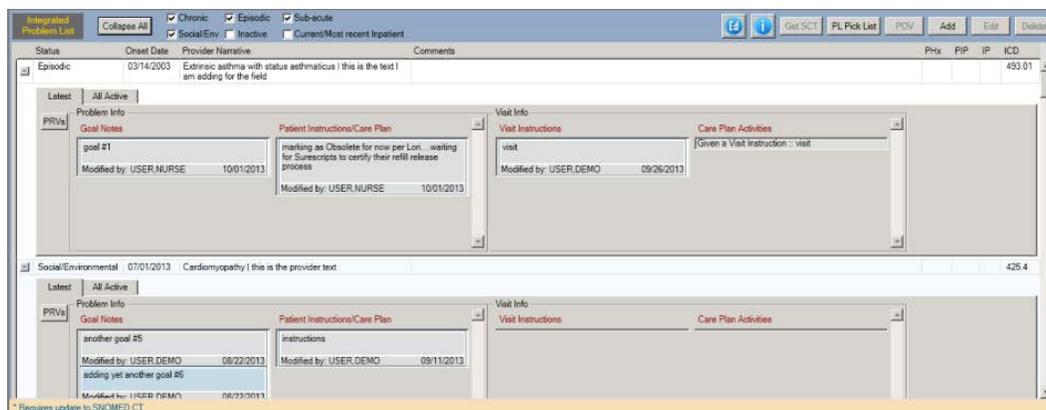


Figure 3-116: Expanded Care Plan

- Goal Notes with a status for each date entered.
- Care Plan with a status for each date entered.
- Visit Instructions for each visit.
- Care planning activities for each visit.
- Whether any of the items were modified, and if so, by whom and when (date/time).

3.4.7.1 Latest Tab

On the Latest tab of the Care Plan, the most recent active planning entries (all entries for most recent date for goal), patient instructions, last visit for visit instructions, and care planning activities are shown.

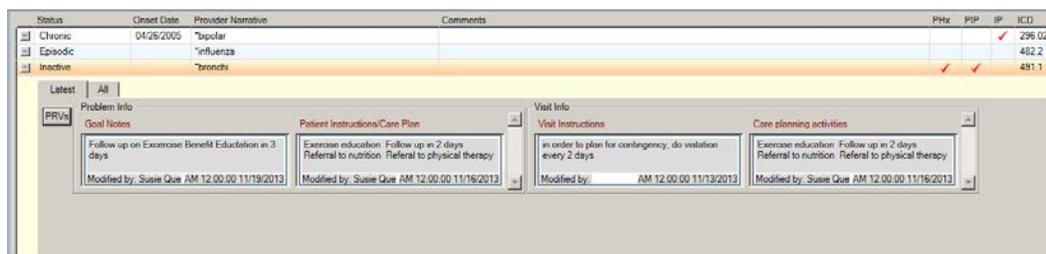


Figure 3-117: Latest Care Plan

Selecting a Provider View Using the PRVs Button:

1. Click the PRVs button to select a provider for which to view data. The Provider List dialog opens.

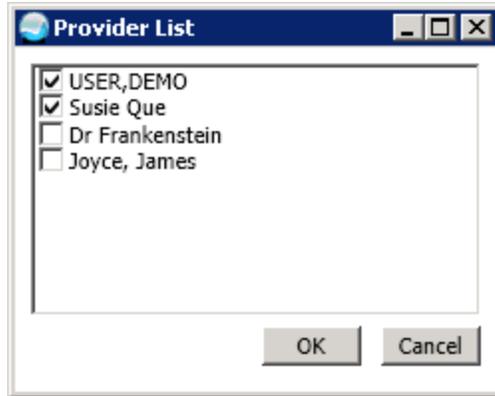


Figure 3-118: Provider List dialog

2. Click the check boxes to select one or more providers, and then click OK.

A new tab is created for each provider selected. The new tab name is the provider name and enables easy viewing of that provider's entries for the patient and problems in the Goal Notes, Care Plan, Visit Instructions, and Services.

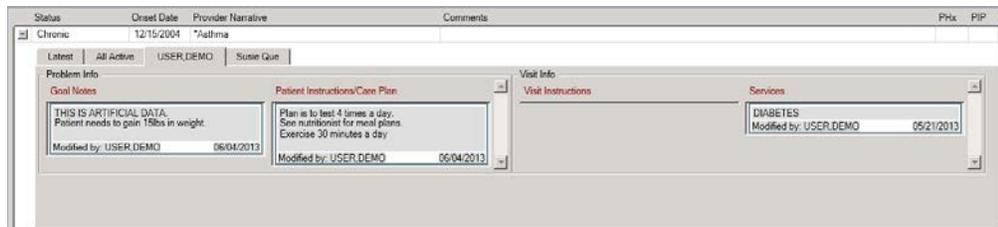


Figure 3-119: Provider List Results

3.4.7.2 All Tab

On the All tab, all care planning activities (active, inactive, and replaced) are shown.

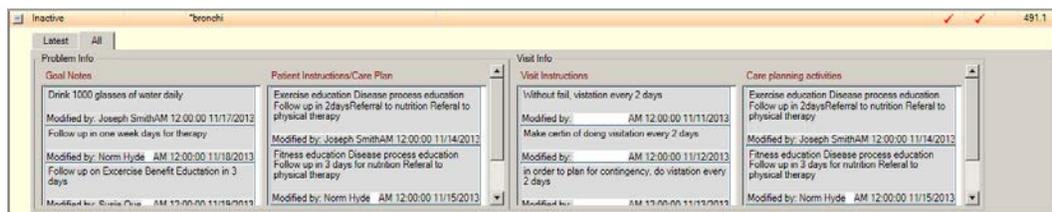


Figure 3-120: All Care Plans

3.4.8 Adding an IPL

To add an IPL to a patient record, complete the following steps:

1. On the main IPL screen, click the Add button. The Add Problem dialog opens.

Figure 3-121: Initial Add Problem dialog

Note: A visit is not required to view the IPL details; however a visit must be selected to enable the Add button.
The Problem ID field is system populated.

2. Select the Use for Inpatient check box, if applicable. The Use for Inpatient check box is only available for inpatients.
3. Select the Use as POV check box, if applicable. The POV check box is available only for outpatients.

Note: If Use as POV is selected, and if any fields have been changed or added, an information message appears, advising the user that the problem has been stored, if new, or updated, if edited. The problem is stored as Reviewed and Updated in the V Reviewed/Updated file. Inactive problems may be POV.

4. Populate the SNOMED CT field using one of the following methods:

Ellipsis button:

- a. Click the Ellipsis button. The SNOMED CT Lookup dialog opens.

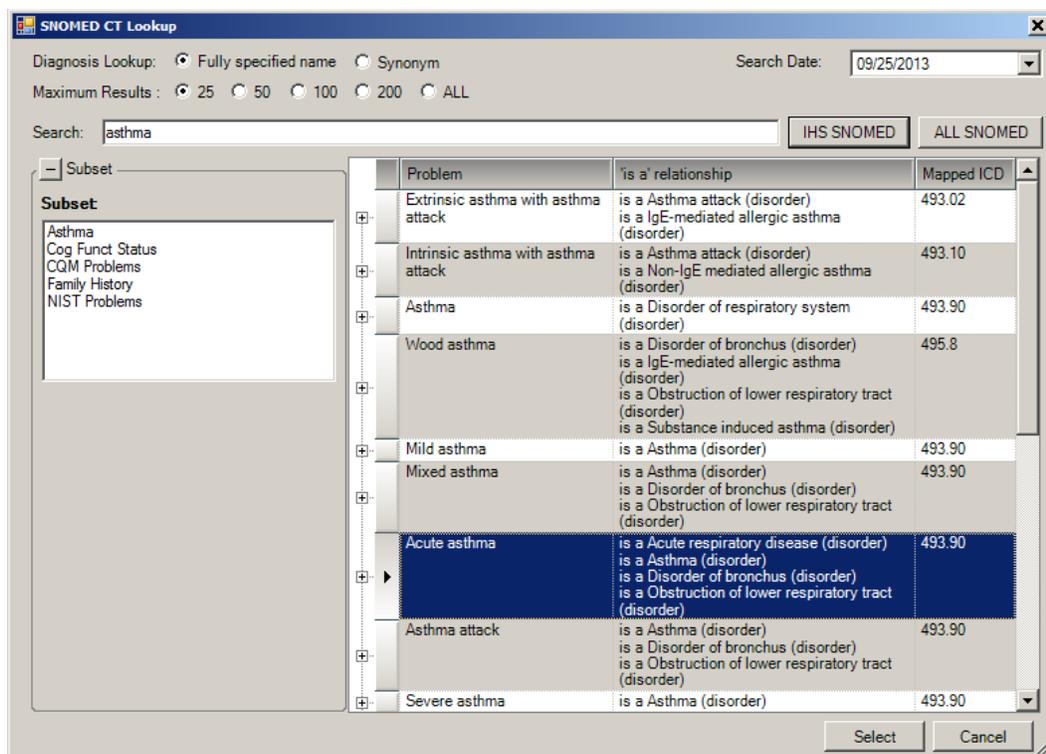


Figure 3-122: SNOMED CT Lookup dialog

- b. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand button next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
- c. In Maximum Results, click one of the following option buttons to limit the number of results (or click ALL):
 - 25
 - 50
 - 100
 - 200
 - ALL
- d. In Search, type the term by which you want to search.
 - In Subset, you can select a subset in which to search, if needed.
 - In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.

- Click either the IHS SNOMED CT or ALL SNOMED CT button. The list of SNOMED CT terms is populated.
- Select and highlight a term, and then click the Select button. The SNOMED CT field of the Add Problem dialog refreshes with the selected SNOMED CT term you selected.
- If you attempt to assign the same SNOMED CT code as an existing problem, the following Error message displays. Click OK and select a different SNOMED CT code from the SNOMED CT Lookup dialog.

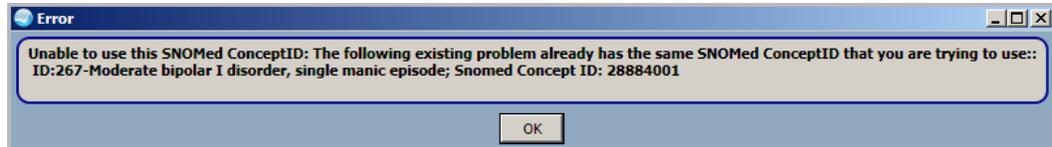


Figure 3-123: Duplicate SNOMED CT Code Error Message

Get SCT button:

- Click the Get SCT button to open the ICD 9 to SNOMED CT Lookup dialog. Refer to the Using the Get SCT Button topic for details on completing this dialog.

PL Pick List button:

- Click the PL Pick List button to open the Pick List dialog. Refer to the Using the PL Pick List Button topic for details on completing this dialog.

After you populate the SNOMED CT code, the Add Problem dialog expands with additional fields.

Figure 3-124: Expanded Add Problem dialog with Asthma

5. In Priority, use the Up and Down arrows to select a priority level.
6. If primary problem, click the Primary check box.
7. In Status, click the applicable option button:
 - Chronic
 - Sub-acute
 - Episodic
 - Social/Environmental
 - Inactive
 - Personal Hx
8. In Provider Text, type any applicable text. (Optional, 60-character limit.)

Note: You can briefly rest your mouse pointer over this field to view an information pop-up.

9. In Severity, select one or more of the following:
 - Fatal
 - Life Threatening
 - Mild
 - Mild to moderate
 - Moderate
 - Moderate to severe
 - Severe
10. Click the Clinical Course Ellipsis to populate the Clinical Course field. The Select Clinical Courses dialog opens.

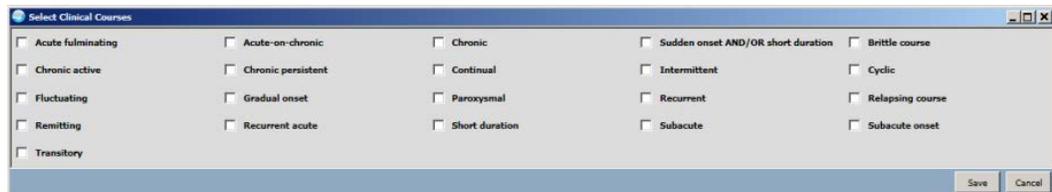


Figure 3-125: elect Clinical Courses dialog

- a. Select one or more courses.
- b. Click Save. The Clinical Course field updates with your selections.

Note: If you selected an Asthma Subset or the mapped ICD is in the Asthma taxonomy, the Asthma Classification drop-down menu appears below the Qualifiers section.

11. The Episodicities drop-down menu is currently disabled.
12. Select the applicable Asthma Classification from the drop-down menu.

Note: The Asthma Classification drop-down menu only appears if an Asthma Subset is selected or the mapped ICD is in the Asthma taxonomy, AND the Use as POV check box was selected.
Only one Asthma Control entry is allowed per visit.

13. In the Date of Onset field (optional), type a date in xx/xx/xxxx format or click the Ellipsis button. The Select Date dialog opens. Select a date from the calendar, and then click OK.
14. If applicable, select the Is Injury check box. The Injury section opens in the Add Problem (or Edit Problem) dialog.

Note: The Use as POV check box must be selected for the Is Injury check box to appear. If the problem ICD code points to an injury taxonomy or if an injury-related SNOMED CT is selected, the Is Injury check box is automatically selected and the Injury section expands when the Use as POV check box is selected.

The screenshot shows a form titled "Injury ::". It has two radio buttons: "First Visit" (selected) and "Re-visit". To the right is an "Injury Date" field with the value "11/04/2013" and an ellipsis button. Below this is a "Place" dropdown menu with "HOME-INSIDE" selected, and an "Associated with" dropdown menu with "ALCOHOL RELATED" selected. At the bottom left is a "Caused by" field with the value "MV COLL W OTH OBJ-MOCYCL" and a text input field with "fall" and an ellipsis button. At the bottom right is a checked checkbox labeled "Is Injury".

Figure 3-126: Injury Section

- a. Select either the First Visit or Re-visit option button, as applicable.
- b. In Injury Date, the date defaults to the current date. Click the Ellipsis button to open the calendar and select a new date or type a new date in the field.
- c. In Place, select a location for where the injury occurred:
 - Home - Inside
 - Home - Outside
 - Farm
 - School
 - Industrial Premises
 - Recreational Area
 - Street/Highway
 - Public Building
 - Resident Institution
 - Hunting/Fishing
 - Other
 - Unknown
- d. In Associated With, select one of the following from the drop-down menu:
 - Hospital Acquired
 - Alcohol Related
 - Battered Child
 - Employment Related

- Domestic Violence Related
- e. To populate the Cause by field, type an injury term in the field, and then click the Ellipsis button. The Injury Causes dialog opens, showing only E coded items.

Code	Description
E815.0	MV COLL W OTH OBJ-DRIVER
E815.1	MV COLL W OTH OBJ-PASNGR
E815.2	MV COLL W OTH OBJ-MOCYCL
E815.3	MV COLL W OBJ-MCYCL PSGR
E815.4	MV COLL W OBJ-ST CAR
E815.5	MV COLL W OBJ-ANIM RIDER
E815.6	MV COLL W OBJ-PED CYCL
E815.7	MV COLL W OBJ-PEDEST
E815.8	MV COLL W OBJ-PERS NEC

Figure 3-127: Injury Causes with E Codes dialog

- In Lookup Option, click either the Lexicon or ICD option button.
 - In Search value, type a different search value if your initial search did not return the applicable injury item, and then click Search. The returned results list shows a list of E Code items with their description.
 - In the returned results list, select the applicable item, and then click OK. Your selection shows in Caused By in the Injury section.
15. Type a comment in the Comments section, if needed.
 16. If the Use as POV check box was selected, the Add Visit/Care Plan/Goal Activities button is active. To add data, click the Add Visit/Care Plan/Goal Activities button. The Add Visit Instructions/Care Plan Activities dialog opens. Refer to the Adding Visit Instructions/Care Plan Activities topic for instructions on how to complete this dialog.

- Entries in this section preceded by an S indicate the Goal Note, Care Plan, or Visit Instructions have been signed. Entries preceded by a U indicate the entry is unsigned.
17. Click Save in the top-right of the Add Problem dialog. Your data is saved to the Integrated Problem List grid.

Note: Selecting the Use as POV check box (outpatients only) also saves (stores) the problem in the V Reviewed/Updated file.

3.4.9 Editing an IPL

To edit an IPL, follow these steps:

1. Select a visit.
2. Select a problem from the Problem List on the main IPL screen.

Note: A visit and a problem must be selected in order for the Edit button to become active.

3. Click the Edit button. The Edit Problem dialog opens.

Note: Unsigned problems may be edited.

Integrated Problem Maintenance - Edit Problem

Problem ID: SOUC-27 Priority: 2 Pregnancy Related Use as POV Primary Save Cancel

* SNOMED CT: Asthma with status asthmaticus ... Get SCT Pick list

* Status: Chronic Sub-acute Episodic Social/Environmental Inactive Personal Hx

* Required Field

Provider Text :: Provider text here.
Asthma with status asthmaticus | Provider text here. 493.91

Qualifiers :: Severity: Moderate to severe Clinical Course
Severity: Moderate to severe Clinical Course: ... Episodicities: Ongoing episode

Asthma :: Classification: MODERATE PERSISTENT Control: WELL CONTROLLED

Date of Onset: 11/11/2013 ... Is Injury

Comments :: Add Delete

Narrative	Date	Author
Type comments here.	11/11/2013	USER, DEMO

Care Plan Info :: Add Visit Instruction / Care Plans / Goal Activities

Goal Notes: S asdfasdf
Care Plans: S marcel, S Edit test.
Visit Instructions:
Care Planning Activities:

Figure 3-128: Integrated Problem Maintenance – Edit Problem dialog

4. Edit fields as applicable. Refer to the Adding an IPL topic for instructions on completing the fields.

Note: A SNOMED CT code must be selected in order to save your changes.

5. In the Comments section you can add or delete comments. To add comments:
 - a. Click the Add button. The Add Comment dialog opens.

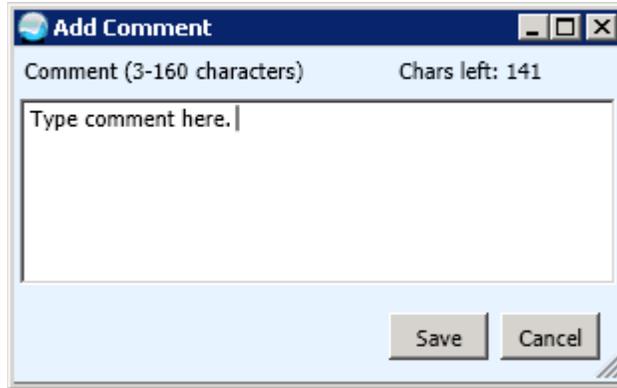


Figure 3-129: Add Comment dialog

- b. In the Comment field, type a comment of 3-160 characters.
- c. Click Save. Your comment appears in the Comments section, with a number automatically assigned and shown in the # column, your comment in the Narrative column, the date entered in the Date column, and the logged in user name in the Author column.

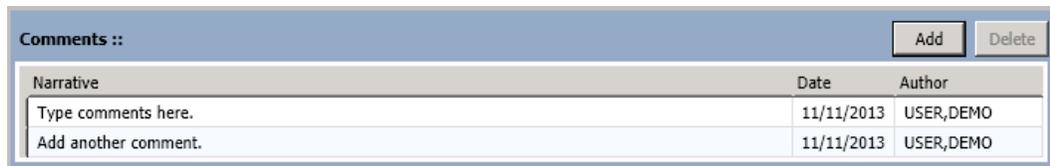


Figure 3-130: Comments List

To delete comments:

- a. Select one or more comments you want to delete. The line items are highlighted and the Delete button becomes active.
- b. Click the Delete button. The following message appears:

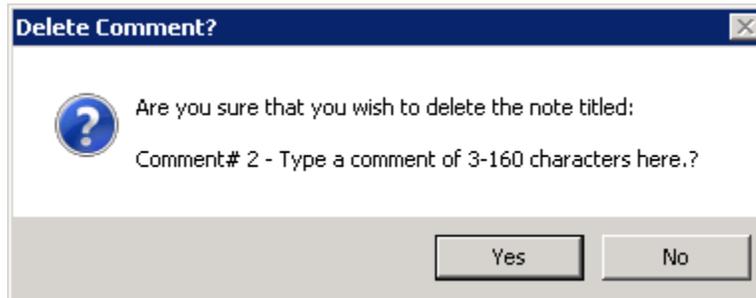


Figure 3-131: Delete Comment Confirmation Message

- c. Click Yes. Your comment no longer appears in the list.
6. Click Save in the top-right of the Add Problem dialog.

Note: Clicking the Use as POV check box (outpatients only) also saves (stores) the problem in the V Reviewed/Updated file. If data in any fields has been updated, a message displays warning that the problem has been stored if new or updated if edited.

When editing a problem, clicking Save or selecting the Use as POV check box saves (stores) the problem only if any fields have been changed.

3.4.10 Adding Visit Instructions/Goal Notes/Care Plan Activities

When Adding or Editing an Integrated Problem List, if the Use as POV check box is selected, the Add Visit/Care Plans/Goal Activities button is enabled for adding visit instructions, goals, or Care Plan information.

Figure 3-132: Add Visit Instructions/Care Plan/Goal Notes/Care Planning Activities dialog

1. In the Visit Instructions, Goal Notes, or Care Plans sections:
 - a. In the Visit Instructions, Goal Notes, or Care Plans field, type a free-text comment, or click the Template button to select a template. The Templates List opens.

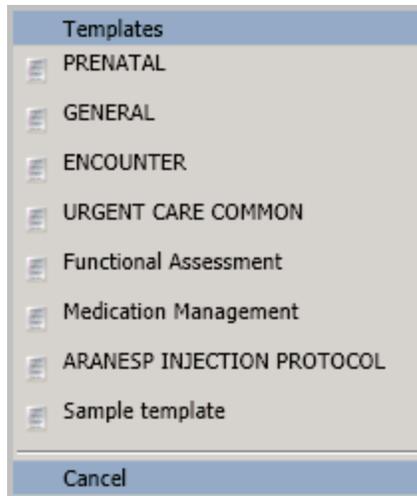


Figure 3-133: Templates List

- b. Select a template. The template window opens. Make any necessary changes, such as font size, and click OK. Your selected template name appears in the Visit Instructions, Goal Notes, or Care Plans field, as selected.

Note: The Functional Assessment Template in the Visit Instructions field is shown in the Add Visit Instructions/Goal Notes/Care Planning Activities dialog, .

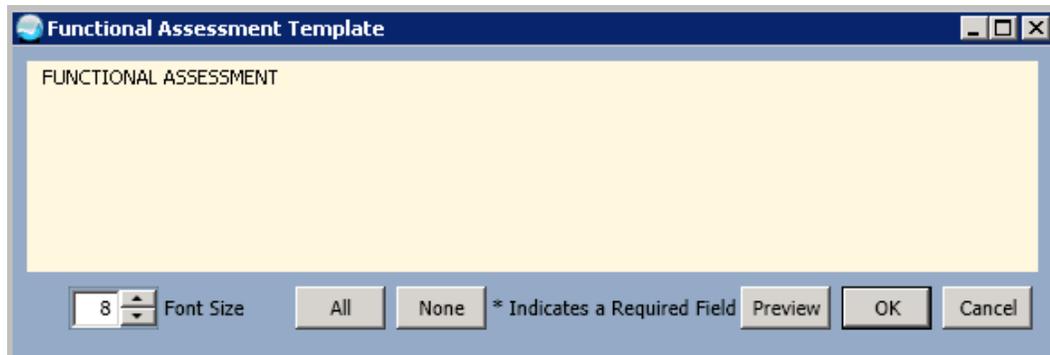


Figure 3-134: Template Window Functional Assessment Template Sample

- c. Repeat Steps a and b for the other fields, as needed.
2. In the Patient Education provided section, complete the following:
 - a. Select one or more of the education check boxes.
 - b. In Comprehension Level, select one of the following from the drop-down menu:
 - Poor
 - Fair

- Good
 - Group – No Assessment
 - Refused
- c. In Length, type the length in minutes.
- d. In Readiness to Learn, select one of the following from the drop-down menu:
- Distraction
 - Eager to Learn
 - Intoxication
 - Not Ready
 - Pain
 - Receptive
 - Severity of Illness
 - Unreceptive

Your selections show in the Education Provided section.

3. If treatment, regimen, or follow-up is needed, click the Treatment/Regimen/Follow-up button. The Treatment/Regimen dialog opens.

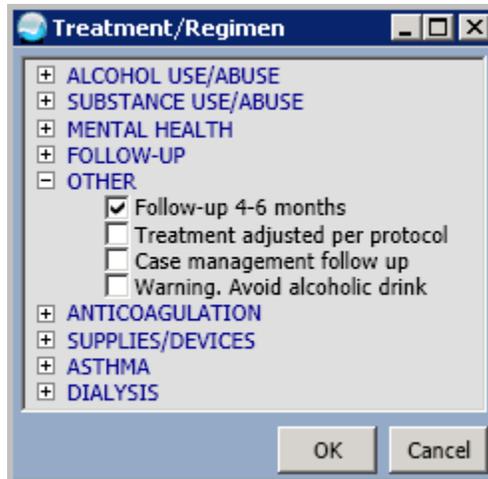


Figure 3-135: Treatment/Regimen dialog

- a. Click the Expand button on an item in the list to expand the list.
 - b. Select one or more treatment or regimen items.
 - c. Click OK. Your selections show in the Treatment/Regimen/Follow-up section.
4. Click OK. The Review/Sign Changes for Patient Name opens, showing a list of the items you added or changed. Sign by adding your Electronic Signature.

Note: Additional Visit Instructions may be added to the same visit after signing.
Click Cancel from the Add Visit Instructions/Care Plan/Goal Notes/Care Planning Activities dialog or the Review/Sign Changes dialog to delete your changes.

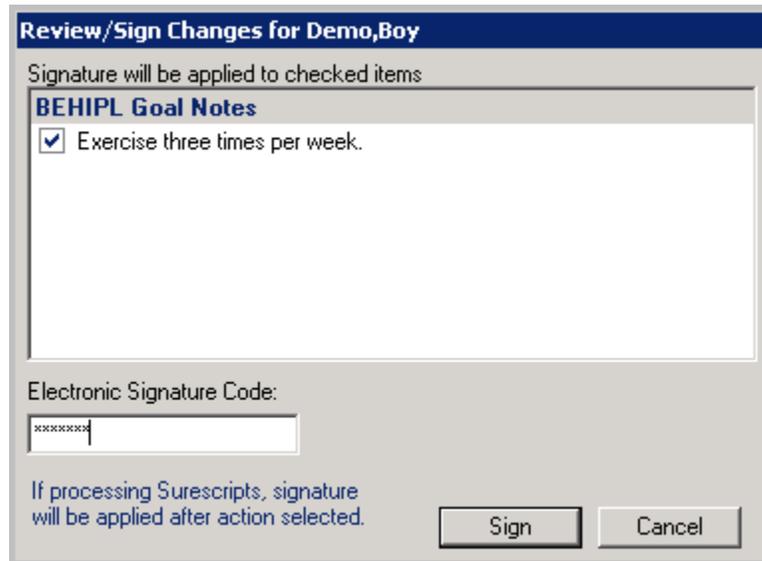


Figure 3-136: Review/Sign Changes for Patient Name

3.4.11 Deleting an IPL

- Only the Chief MIS or author can delete a problem.
- The visit must be unlocked.
- Problems with any Goal Notes, Care Plan, Visit Instructions, or Treatment/Regimen entries may not be deleted. However, they can be inactivated. Refer to the Orientation section for details. Problems cannot be deleted if marked as Use as POV or Use as Inpatient.

Problems may be deleted by one of the following methods:

- Right-clicking the line-item and then selecting Delete from the right-click menu.
- Selecting the line item and then clicking the Delete button on the main screen.

The problem is cleared from the Integrated Problem List grid.

3.5 Stroke Tool

The Stroke tool captures specific SNOMED CT stroke data, including possible stroke symptoms, date and time of onset if witnessed, last known well (baseline) state if not witnessed, and NIH Stroke Scale score.

This component is delivered disabled with the EHR p13 release. This component will be enabled in the EHR p14 release.

4.0 Updated Components

The following components are updated for p13.

4.1 Consults

Consults are requests from one clinician to a hospital, service, or specialty for a service; in addition, this tab enables hospital services to track the progress of a consult order from the point of receipt through its final resolution. The clinician can enter an order for a consultation from within the patient's EHR on the Consults tab.

Note: Because there is no Medicine Package in RPMS-EHR, any function involving Procedures is not used by the IHS. All procedures are included in the available consults. Also, the Medicine Results and Remove Medicine Results are not used.

4.1.1 Basic Operation

The Consults process involves the following steps.

1. The clinician orders a consult. From within the patient's EHR medical record, the clinician enters an order for a consultation. The ordering clinician may first need to enter Encounter Information.
2. The consult service receives an alert and a printed report (SF 513). The receiving service can then accept the consult, forward it to another service, or send it back to the originating clinician for more information.
3. The consult service accepts or rejects the consult request. To accept the consult, the service uses the receive action. The service can also discontinue or cancel the consult. Cancelled consults can be edited and resubmitted by the ordering clinician. A consult service clinician sees the patient.
4. The Edit/Resubmit action is available for cancelled consults. The consult must be capable of being resubmitted and the user must be authorized to resubmit consults.
5. The consult service enters results and comments. Resulting is primarily handled by writing a note to complete the consult.
6. The originating clinician receives a CONSULT/REQUEST UPDATED alert that the consult is complete. The results can now be examined and further action can be taken on behalf of the patient.
7. The SF 513 report becomes part of the patient's medical record. A hard copy can be filed and the electronic copy is online for paperless access.

8. The Consults component presents a list of consults in a tree view.
9. Right-clicking the Consults text enables the selection of Find in the Selected Consult option from the pop-up menu. This option enables a search of the displayed text. A Replace Text option is also available, but is only active when a consult is being edited.
10. The field below the list of consults shows a list of documents related to the highlighted consult. These related documents are also in a tree view.

4.1.2 Status of a Consult

The following table describes the status of a consult.

Abbreviation	Name	Description
a	ACTIVE	Orders that are active or have been accepted by the service for processing.
c	COMPLETE	Orders that require no further action by the ancillary service.
dc	DISCONTINUE	Orders that have been stopped prior to expiration or completion.
p	PENDING	Orders that have been placed but not yet accepted by the service filling the order.
Pr	PARTIAL RESULTS	All or part of a consult completion report has been entered, but has not yet been signed.
s	SCHEDULED	The receiving clinic has scheduled an appointment for the patient.
x	CANCELLED	Orders that have been rejected by the ancillary service without being acted on.

4.1.3 Defaults for Editing/Saving Consult Notes

The defaults for editing and auto-saving consult notes can be configured. This action defines the interval to auto-save any notes, as well as identify any default cosigners.

Follow these steps to set the defaults for editing and saving consult notes:

1. From the Tools menu, select Options. The Options dialog opens.

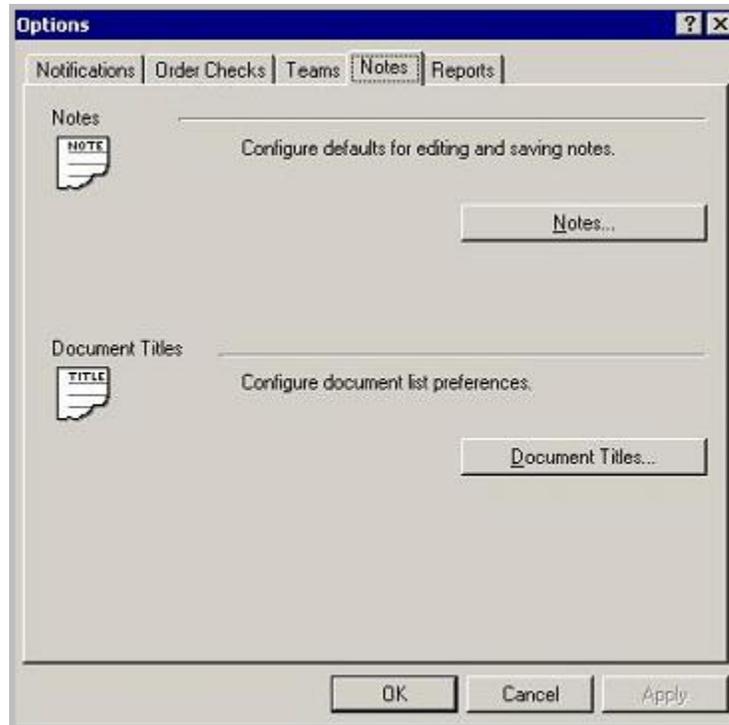


Figure 4-1: Options dialog

2. Click the Notes tab.
3. Click Notes to display the Notes dialog.

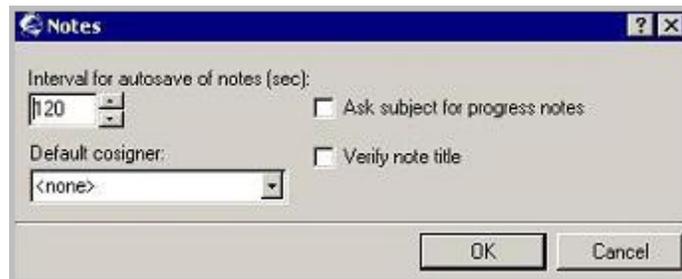


Figure 4-2: Notes dialog

4. Change the interval for auto-saving your notes, if necessary. The units of measure are seconds. Type the new interval, or click the up and down arrows to change the settings in five second intervals.
5. If a default cosigner is desired for consult notes, select the user from the drop-down list for the Default cosigner field. This name appears in the Expected Cosigners field on the Identify Additional Signers dialog when the Identify Additional Signers is selected on the Consults tab.
6. Check Ask Subject for Progress Note to enter a subject line when a new note is written. This groups your notes by particular subjects. The sort and search options

in TIU can use the subject line to find them. This means a subject line for bronchitis may exist and then be used to locate any notes written for patients with bronchitis.



Figure 4-3: New Note for Entering a Subject Line

7. Use the Verify Note Title if a default note title is selected. Create a selection list of titles used most often and then make one of them the default. This way the note title comes up automatically even if a different title is used. This is a reminder to ask the provider if this is the correct title to use.
8. When the Notes dialog is complete, click OK. Otherwise, click Cancel.

4.1.4 Document List Preferences for Consults

Users can configure their document list preferences. This means that when a note title is selected, the users preferences are listed at the top. In addition, when a default title is selected; that note title comes up automatically if the Verify Note Title option box was selected on the Notes dialog.

Follow these steps to set list preferences:

1. From the Tools menu, select Options. The Options dialog opens.
2. Click the Notes tab.

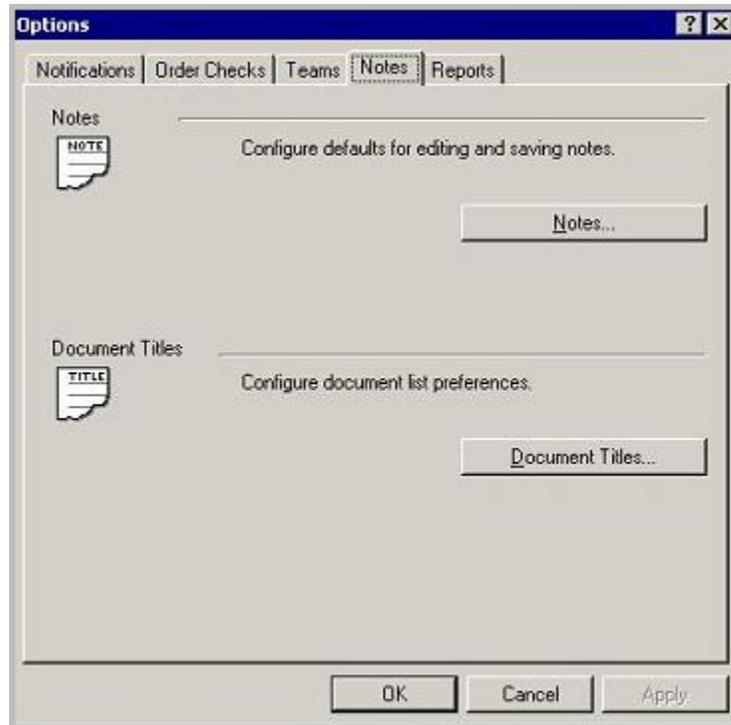


Figure 4-4: Options dialog

3. Click Document Titles. The Document Titles dialog opens.

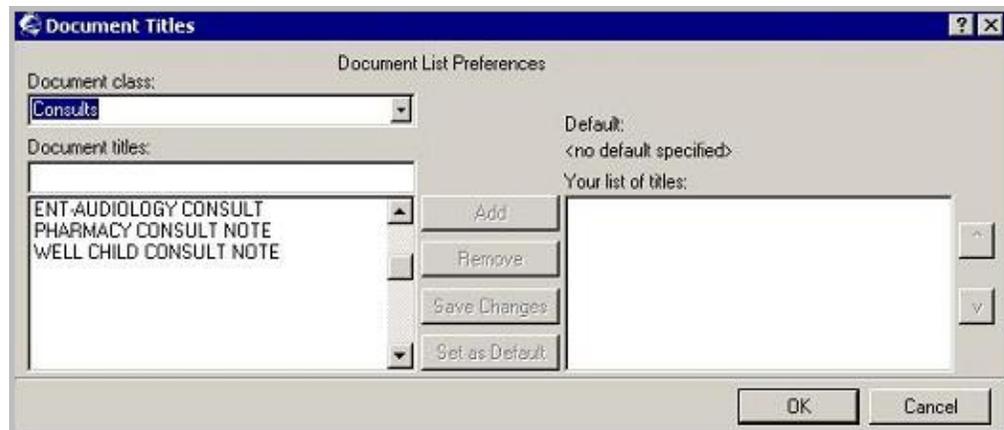


Figure 4-5: Document Titles dialog

4. Select Consults from the drop-list list for the Document class field.
5. In Document Titles, select a title from the list.
6. Click Add to add the selected title to Your List of Titles field.
7. Multiple titles may be added your list, as needed.
8. If there is a title you do not want in your list, highlight it and click Remove.

9. If needed, arrange the order of the list of titles by using the up and down arrows.
10. Select a title in the list to be the default by highlighting it and clicking Set as Default. In this case, the title appears below the Default label on the dialog. If this is the correct default, click Save Changes.
11. If needed, remove the default by selecting it and clicking Remove Default.



Figure 4-6: Document Titles dialog to Remove Default

12. When the Document Titles dialog is complete, click OK.

4.1.5 Consult Participants

- The Consult Originator initiates a new consult. The Consult Receiver takes the appropriate action concerning the consult.
- The SERVICE INDIVIDUAL TO NOTIFY field (in the Set Up Consult Services command) identifies the person as having primary responsibility for receiving consults.
- The SERVICE TEAM TO NOTIFY field determines the name of the Service Team to receive notifications of any actions taken on a consult.
- The UPDATE USERS W/O NOTIFICATIONS field (in the Set Up Consult Services menu) identifies users who can perform update tracking, but will not receive a notification.
- The UPDATE TEAMS W/O NOTIFICATIONS field (in the Set Up Consult Services menu) Identifies the OE/RR team who can perform update tracking, but will not receive a notification.
- The UPDATE USER CLASS W/O NOTIFICATIONS field in the Set Up Consult Services menu) Identifies the TIU USER CLASS who can perform update tracking, but will not receive a notification.

- The ADMINISTRATIVE UPDATE USER field (in the Set Up Consult Services menu) allows users to perform administrative user updates.
- The ADMINISTRATIVE UPDATE TEAM field (in the Set Up Consult Services menu) allows users to perform administrative team updates.

4.1.6 Creating Consults

4.1.6.1 Initiating Consults

Consult requests can be initiated by using either the Consults or the Orders component. Both techniques are described.

When the new consult is complete, this triggers a notification so that the recipient can take appropriate action.

4.1.6.2 New Consults using Consults Component

The following steps describe how to enter a generic consult. Your site may have quick orders to replace the generic consult. Refer to the New Consult Using Quick Orders for details.

Make sure that a visit is selected. Follow these steps to enter a new consult on the Consults tab:

1. Select the Consults component.
2. Click the New Consult button or click the Action drop-down menu and select New, then Consult. The Order a Consult dialog opens.

Figure 4-7: Order a Consult dialog

3. There are two ways to select a consult:

- **Method 1:** Click the button to display the tree view of the consult services.

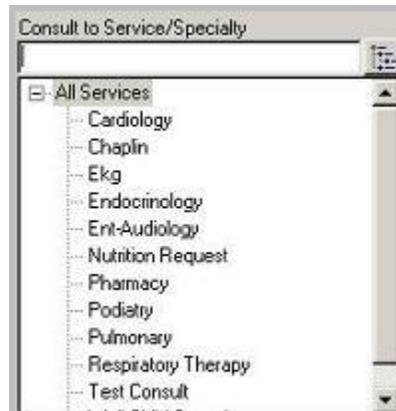


Figure 4-8 Tree View of Consult Services

After selecting a consult service from the tree view, complete the following steps.

- **Method 2:** Select a consult from the list below the Consult to Service/Specialty field.



Figure 4-9: Consult Service to Select

There may be template associated with the selected consult that will complete the Reason for Request field.

After completing the template, complete the following steps, with the exception of the Reason for Request field, if it does not need to be edited.

4. The Urgency field defaults to Routine. Select a different urgency from the drop-down list, if needed.
5. In Attention, select a name if someone was involved in the consult.
6. If needed, change the Inpatient or Outpatient selection using the applicable option button.
7. If needed, change the Place of Consultation field by selecting a different location from the drop-down menu.
8. In the Reason for Request field (required), type a reason for the request. The field has a right-click menu to aid in editing the text.
9. The message box in the lower-left panel gives critical information. This panel has a right-click menu to enable the user to select the text and paste it into another free-text field in the RPMS-EHR or into another application (like MS Word).
10. In the Clinical Indicator field (required), select the applicable indication from the drop-down menu.

If Other is selected, the SNOMED CT Lookup dialog opens. Complete the following steps:

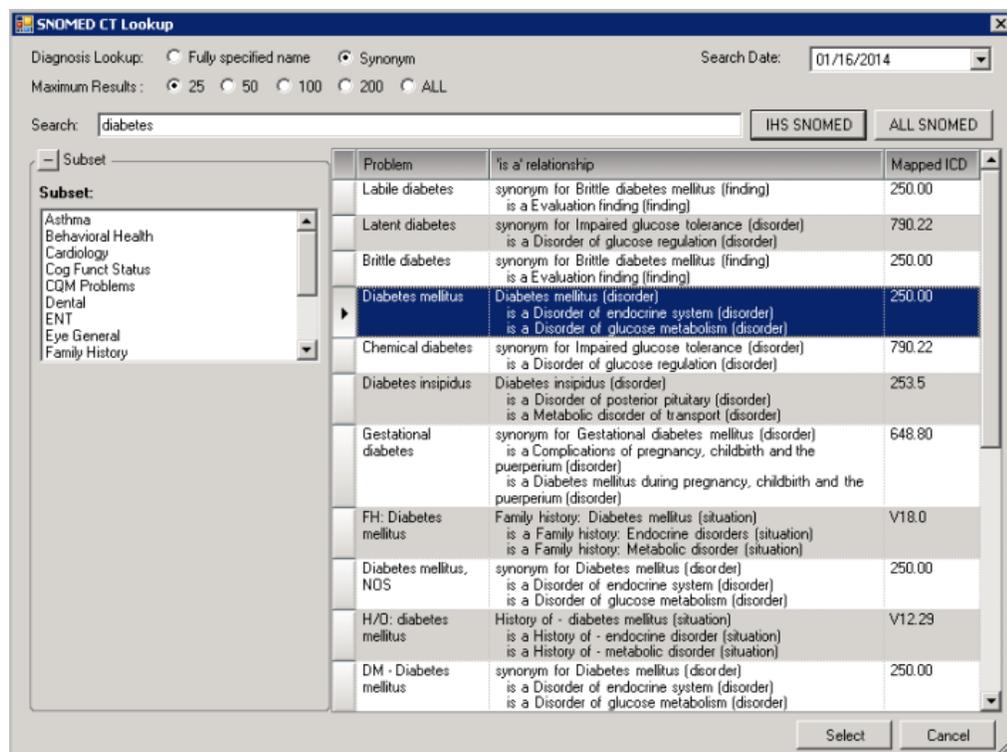


Figure 4-10: SNOMED CT Lookup dialog

- a. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand sign next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
 - b. In Search, type the term by which to search.
 - c. In Subset, select a subset in which to search, if needed.
 - d. The Search Date field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
 - e. Click the Find button. The list of SNOMED CT terms is populated.
 - f. Click to select and highlight a term, and then click the Select button. The Clinical Indication field refreshes with the selected SNOMED CT term and code you selected.
11. Click Accept Order. If there are no other consults for this patient, click Quit.
 12. The consult can be signed now or later.

If signed later, it does not appear on the Consults tab. In addition, the application notifies the user that the consult requires his or her electronic signature. The status

of the consult is (p) for Pending (showing that it has not been accepted by the service filling the order).

4.1.6.3 New Consult Using Orders Component

The following steps describe how you enter a generic consult. Your site may have quick orders to replace the generic consult. Refer to the New Consult Using Quick Orders for details.

Make sure that a visit is selected and that the view is Active Orders. Follow these steps to order a consult using the Orders component:

1. Select the Orders component.
2. Select Consult from the Write Orders list. The Consults dialog opens.



Figure 4-11: Consults from Orders Tab dialog

3. Select a consult type from the list. The Order a Consult dialog opens with your selection populated in the Consult to Service/Specialty field.

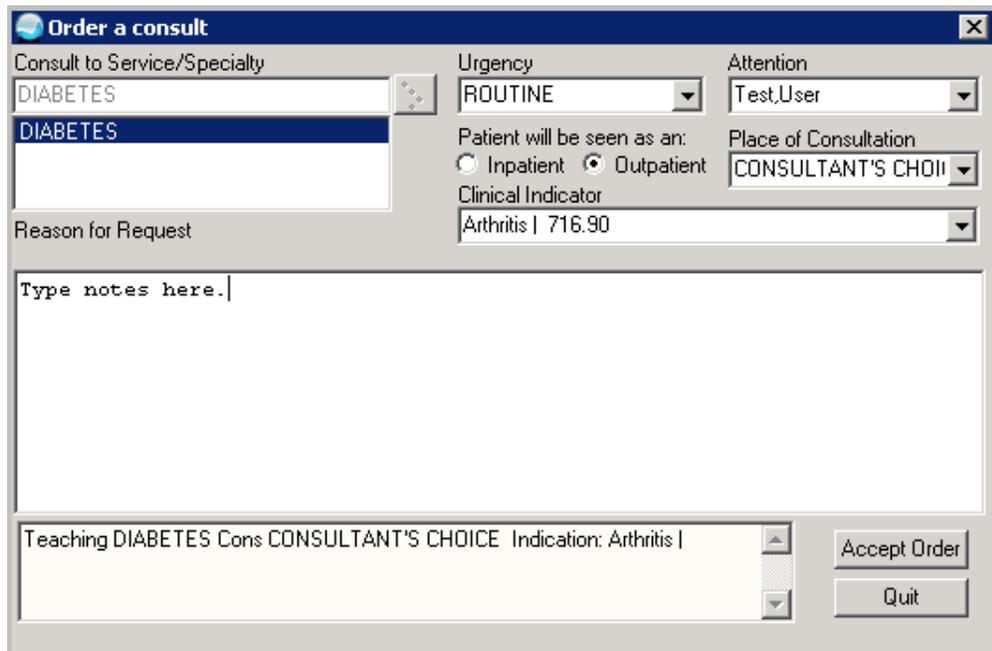


Figure 4-12: Order a Consult dialog

4. The Urgency field defaults to Routine. Select a different urgency from the drop-down list, if needed.
5. In Attention, select a name if someone was involved in the consult.

6. If needed, change the Inpatient or Outpatient selection using the applicable option button.
7. If needed, change the Place of Consultation field by selecting a different location from the drop-down menu.
8. In the Reason for Request field (required), type a reason for the request. The field has a right-click menu to aid in editing the text.
9. The message box in the lower, left panel shows critical information. This panel has a right-click menu to allow you to select the text and paste it into another free-text field in the EHR or into another application (like MS Word).
10. In the Clinical Indicator field (required), select the applicable indication from the drop-down menu.

If Other is selected, the SNOMED CT Lookup dialog opens. Complete the following steps:

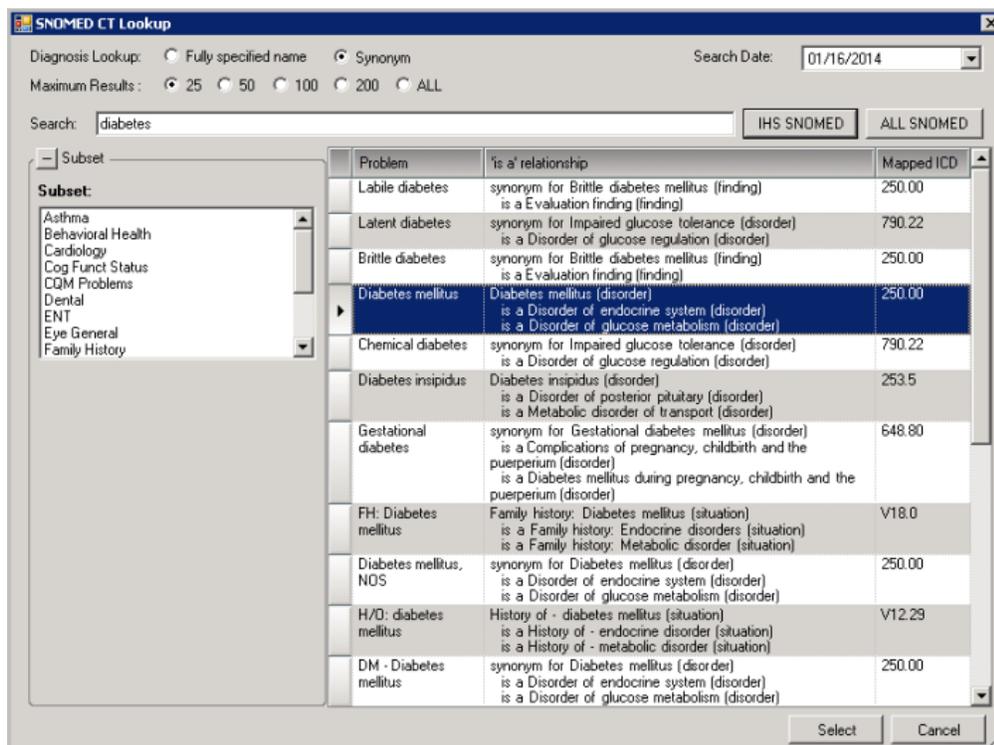


Figure 4-13: SNOMED CT Lookup dialog

- a. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand sign (±) next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.

- b. In Search, type the term by which to search.
 - c. In Subset, select a subset in which to search, if needed.
 - d. The Search Date field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
 - e. Click the Find button. The list of SNOMED CT terms is populated.
 - f. Click to select and highlight a term, and then click the Select button. The Clinical Indication field on the Order a Consult dialog refreshes with the selected SNOMED CT term and code you selected.
11. Click Accept Order. If there are no other consults for this patient, click Quit.
 12. If there are other consults, select another consult type from the Consults dialog. Otherwise, click Done to close the Consults dialog.
 13. The consult can be signed now or later.
 - If signed now, the consult appears on both the Orders tab and the Consults tab.
 - If signed later, the consult appears on the Orders tab (only) with a status of the consult as (p) for Pending. This shows that it has not been accepted by the service filling the order.

4.1.6.4 New Consult Using Quick Orders

Your site may choose to only use Quick Orders for consults or create menus of Consult Quick Orders. The Consult button on the Consults window is controlled by the following parameter:

```
ORWDX NEW CONSULT
```

At the new Consult dialog default:

1	User	USR	Choose from NEW PERSON
2	Location	LOC	Choose from HOSPITAL LOCATION
3	System	SYS	DEMO.MEDSPHERE.COM
4	Package	PKG	ORDER ENTRY/RESULTS REPORTING

Enter selection 3, System DEMO.MEDSPHERE.COM. The following appears:

```
--- Setting ORWDX NEW CONSULT for System: DEMO.MEDSPHERE.COM ---
```

Setting this parameter replaces the generic consult dialog with your consult menu.

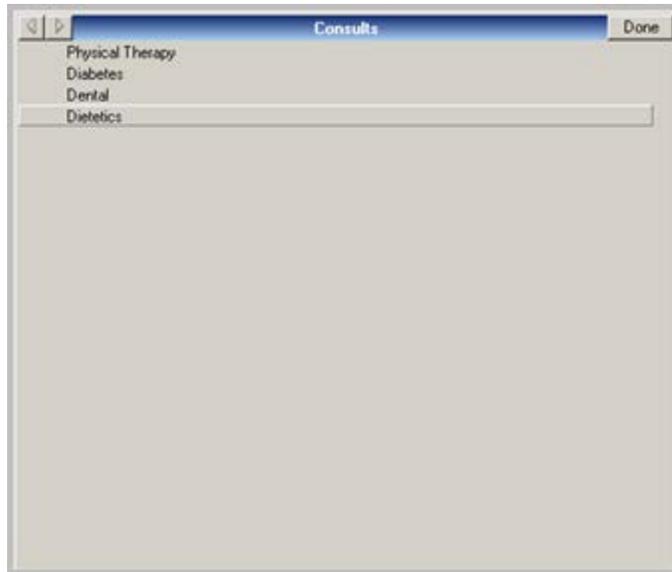


Figure 4-14: Generic Consult dialog

Consult quick orders can have most or all of the fields already pre-populated with the data to do the consult order quickly.

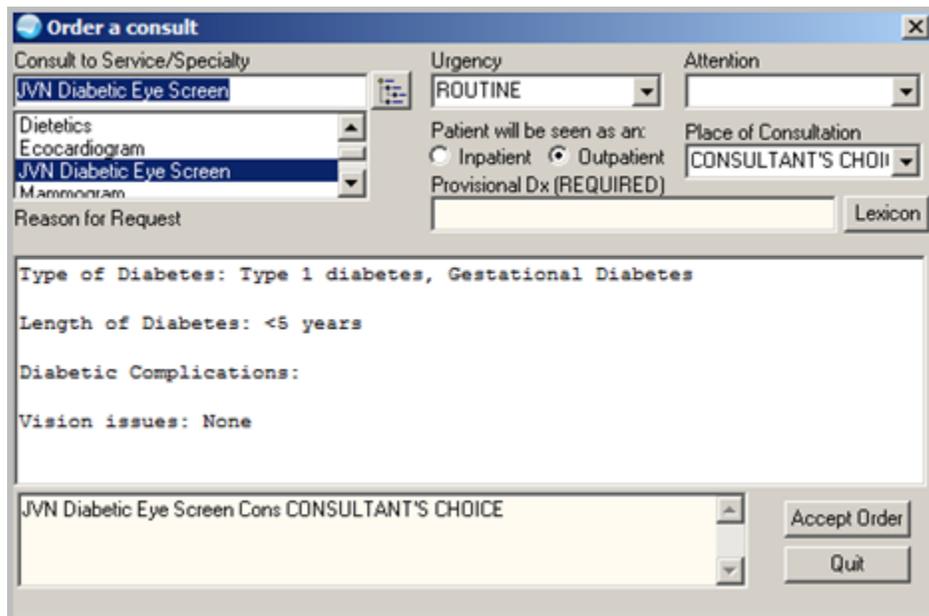


Figure 4-15: Quick Orders Pre-Populated Fields

4.1.7 Completing Consults

A consult can be completed using either the Consults component or the Notes component. Both methods are described.

The Complete action updates the CPRS status of a consult from Active to Completed. The Completed status links to TIU so findings can be entered.

This action informs the system that the consult is finished.. An alert is sent to the Consult Originator and marks the record as complete.

This action not only updates the current status on the consult but also updates the Last Activity field to COMPLETED.

This topic contains the following information:

- Completing a Consult using the Consults Component
- Completing a Consult using the Notes Component
- Administratively Complete a Consult

4.1.7.1 Completing a Consult Using the Consults Component

Select a visit, and then follow these steps to complete a consult using the Consults component:

1. Select the Consults component.
2. From the Action menu drop-down click Consult Results, and then Complete/Update Results. The Consult Note Properties dialog displays.

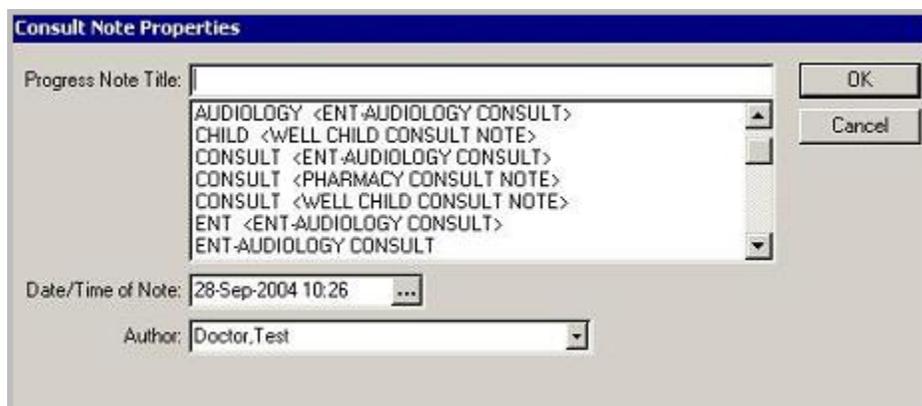


Figure 4-16: Consult Note Properties dialog

3. In the Progress Note Properties dialog, select a consult note title for the Progress Note Title field so the note can be auto-saved.

4. The application automatically populates the date and time of the note as well as the author. These fields can be corrected, if necessary.

The note titles listed on the Consult Note Properties dialog come from the CONSULT document class. The Clinical Coordinator is responsible for this document class.

5. Click OK
6. Create a note by typing the text in the right panel, by using templates (click the Templates button), and by including any reminders (click the Reminders button). Be sure to include any test results.
7. To change the title of the note, click the Change button (above the text of the note in the right panel) or select Consult Results from the Action menu drop-down, and then click Change Title. The Consult Note Properties dialog opens.
8. The right panel has a right-click menu for editing the text of the note. These features are the top-most options on this menu.

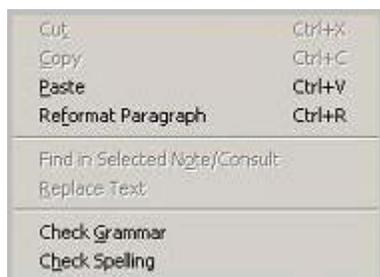


Figure 4-17: Edit Options on Right-Click Menu

The Reformat Paragraph option can be used when there are two sentences that are separated by a return and one paragraph is desired. In that case, place the cursor before the first sentence and then select the Reformat Paragraph option.

9. From the Action, and then Consult Results menu, select either Sign Note Now or Save without Signature. These features are also available from the right-click menu.
 - If you Save Without Signature, the status of the consult becomes (pr) for Partial Results.
 - If you Sign Note Now, the status of the consult becomes (c) for Completed.

4.1.7.2 Completing a Consult Using the Notes Component

Select a visit, and then follow these steps to complete a consult using the Notes component:

1. Select the Notes component.

2. Click New Notes. Or select Action, and then New Progress Note.
3. In the Progress Note Properties dialog, select a consult note title for the Progress Note Title field so the note can be auto-saved.
4. In Progress Note Title, select which consult to which to attach the note. A consult must be selected. The options appear in a Progress Note Properties dialog below the other note data.

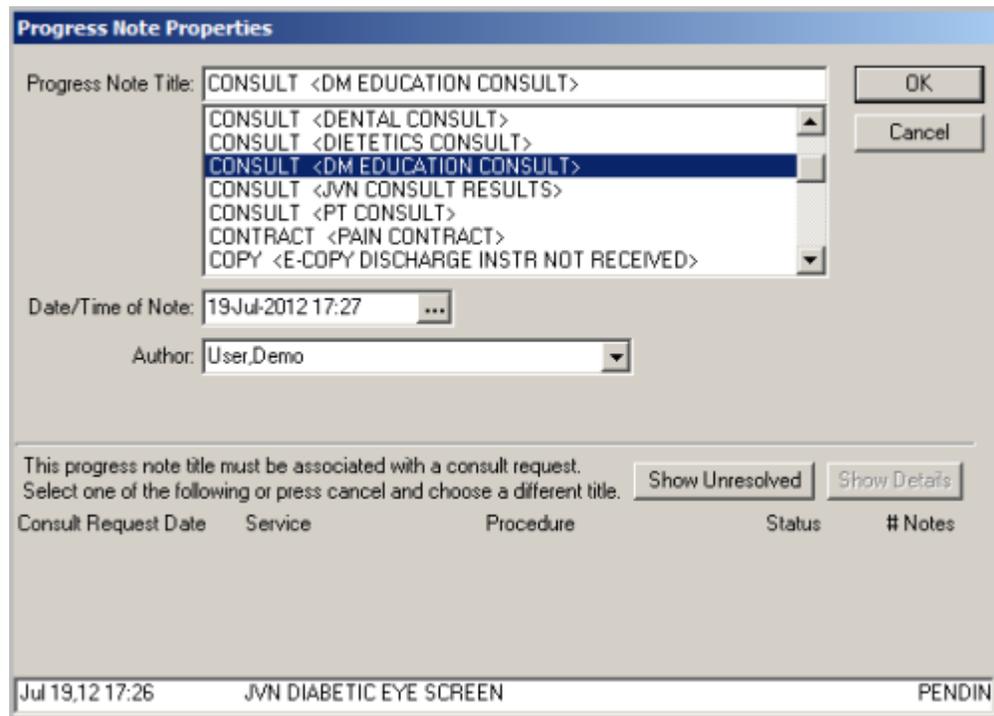


Figure 4-18: Progress Note Properties Title List

If there is no consult waiting for resolution, that title is not selectable and a warning message appears.

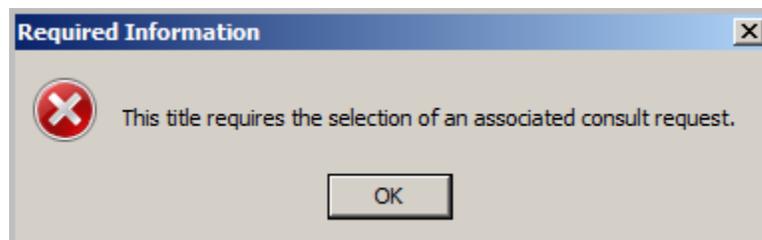


Figure 4-19: No Consults Waiting Warning Message

Additional items appear on the dialog for titles that require entry of a cosigner or an associated consult after the Consult Title is completed.

5. If necessary, change the note date by clicking the Ellipsis button next to the Date/Time of Note field and selecting a new date.
6. If necessary, change the note author by making a selection from the Author: drop-down list.
7. Select the Consult, and then click OK.
8. Type a note, including any test results.

The Templates button may be used to insert template information in the text of the note. In addition, there is a right-click menu to aid in editing the text.

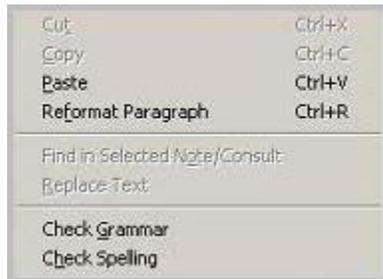


Figure 4-20: Edit Options on Right-Click Menu

9. From the Action menu, select either Sign Note Now or Save without Signature. These same options are available on the right-click menu in the text of the note.

The note appears on the Notes tab, as well as on the Consults tab.

If you Save Without Signature, the status of the consult becomes (pr) for Partial Results. If you Sign Note Now, the status of the consult becomes (c) for Completed. Refer to the Electronic Signature topic for more information about signing the note.

4.1.7.3 Administratively Complete a Consult

If a user is set up as either an Administrative User or on an Administrative User Team, this option exists to perform an Administrative Complete action. An Administratively Complete does not have results attached to it.

Follow these steps to administratively complete a consult.

1. Select the Consults component.
2. Select the consult to administratively complete.
3. From the Action drop-down, select Consult Tracking, and then Administratively Complete. The Administratively Complete dialog opens.

The image shows a dialog box titled "Administratively Complete". At the top, there is a section for "Significant Findings - Current status: Yes" with three radio buttons: "Yes" (selected), "No", and "Unknown". Below this is a "Comments" text area containing the text "Administratively completed this consult 9-9-04". At the bottom, there are two fields: "Date/time of this action" with an ellipsis button and "Responsible Person" with a dropdown menu showing "Johnson, Carolyn". "OK" and "Cancel" buttons are at the bottom right.

Figure 4-21: Administratively Complete dialog

4. Select the appropriate option button in the Significant Findings panel.
5. Type comments about the consult in the Comments field. This field has a right-click menu to aid in editing the text.
6. Enter the date and time in the Date/time of this action field, or click the Ellipsis button to select the date and time from a calendar.
7. When the Administratively Complete dialog is finished, click OK. The Activity Grid of the text of the consult shows COMPLETE/UPDATE, along with any comments below that row in the grid.

4.1.8 Using the Information in a Signed Consult

The text can be selected in the consult. The right-click menu contains text-editing options (like copy). Then you can paste the selected text into another free-text field with the EHR application or into another application, like MS Word.

4.1.9 Consult Tracking and Consult Results Features

Individuals chosen as a service individual to notify an update user or an administrative user are able to track the consults using the RPMS-EHR. This means, if that user updates status for cardiology, that user is not be able to track ENT consults, for example.

The Consult Tracking menu in the Action drop-down contains several features for tracking a consult.

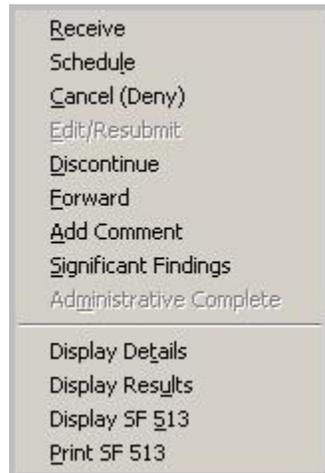


Figure 4-22: Tracking Consult Options

Only the active options available for a particular consult can be selected. Non-active options are disabled on the menu.

The Consult Results menu in the Action drop-down contains several features for entering results for a consult.

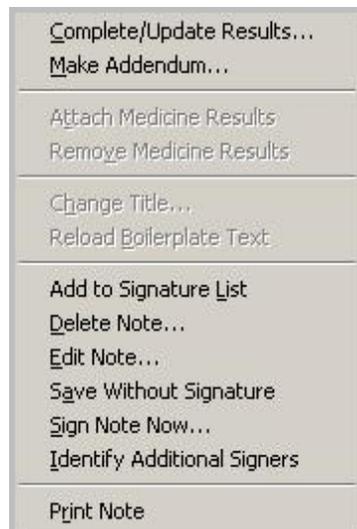


Figure 4-23: Consult Results Options

The RPMS-EHR does not use the Attach Medicine Results nor the Remove Medicine Results options. These options require a medicine package currently unavailable in the IHS RPMS-EHR.

The following table explains consult information and its function:

Information Type	What it Does
Comments	Adds a note to the text of a consult regarding how to administer the consult.
Note	Updates the consult and changes its status from Active to Complete. The note becomes a Related Document of the consult.
Addendum	Allows one or more people to add their medical opinions about the consult. This becomes a Related Document of the consult.
Significant Findings	Allows the Consult Receiver to enter significant findings about a consult. This marks the consult with an asterisk (*).

4.1.10 Add a Comment to a Consult

The Add Comment action enables the user to append a comment to a consult when important information about the consult needs to be added to the original order, or when a caregiver needs to furnish information before the consult is ready to be closed out.

Anyone can add comments to a consult. These differ from Addendums in that a comment contains information needed to administer the consult, while an addendum is a medical statement by a patient care professional about a specific note.

Follow these steps to add a comment to a consult:

1. Select the Consults component.
2. Select the consult to which you want to add a comment.
3. From the Action drop-down, select Consult Tracking.
4. Click Add Comment. The Add Comment to Consult dialog opens.

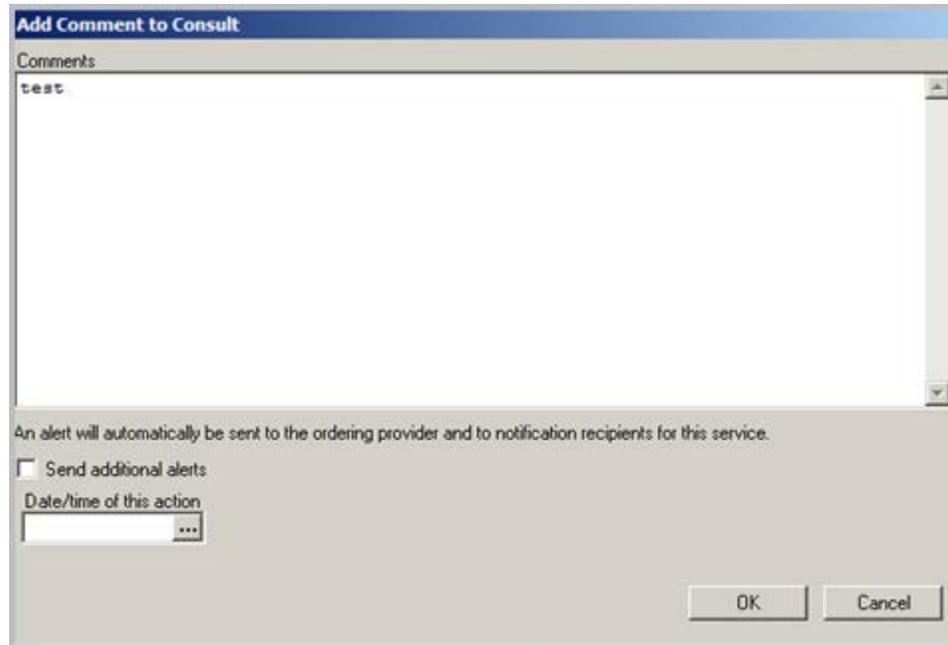


Figure 4-24: Add Comment to Consult dialog

5. Type the text of the comment in the Comments field. This field has a right-click menu to aid in editing the text.
6. Enter the date and time in the Date/time of this action field, or click the Ellipsis button to select the date and time from a calendar.
7. If you want to send an alert about this comment, check Send alert to display the Send Alert dialog.



Figure 4-25: Send Alert dialog

8. In the Select or enter name field, choose a name from the list or type a name. That name appears in the Currently selected recipients field.

9. To remove a name from the Currently selected recipients field, select it.
10. When the Send Alert dialog is complete, click OK to have an alert sent.
11. When the Add Comment to Consult dialog is complete, click OK.
12. The added comment information is added to the text of the consult in the Activity grid, followed by any comments that were added.

Facility	Date/Time/Zone	Responsible Person	Entered By
Activity			
CPRS RELEASED ORDER	09/28/04 10:25	DOCTOR,TEST	DOCTOR,TEST
PRINTED TO	09/28/04 10:25		
BAO OHCP 33 COMPR			
ADDED COMMENT	10/07/04	DOCTOR,TEST	DOCTOR,TEST
(entered)	10/07/04 09:53		
The patient also needs to be checked for blocked nasal passage on the right side of the nose.			

Figure 4-26: Added Comment in the Text of the Consult

4.1.11 Cancel (Deny) a Consult

The Consult Receiver uses this feature to cancel a consult for completion. You must enter a comment concerning the reason for this action.

The Consult Originator is automatically sent an alert that the request has been cancelled. The Consult Originator then has the option of editing and resubmitting the request.

Follow these steps to cancel a consult:

1. Select the Consults component.
2. Select the Consult to cancel.
3. From the Action drop-down menu, select Consult Tracking.
4. Select Cancel (Deny). The Cancel (Deny) Consult dialog opens.

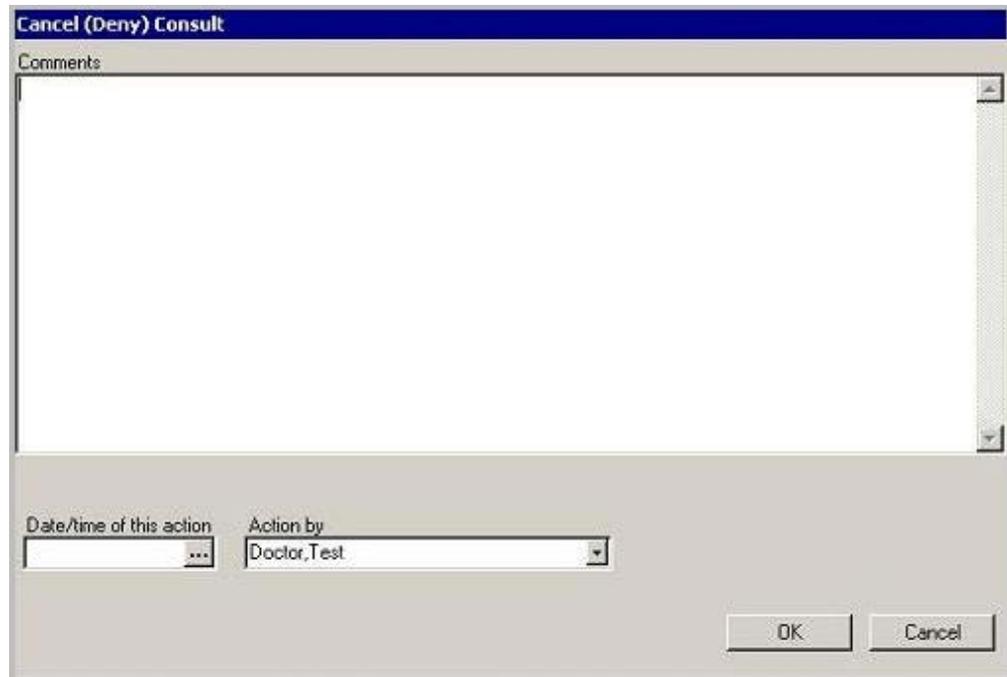


Figure 4-27: Cancel (Deny) Consult dialog

5. Type the reason for the denied consult in the Comments field. Be specific enough so that the Consult Originator can correct and resubmit the consult. This field has a right-click menu to aid in editing the text.
6. Enter the date and time in the Date/time of this action field, or click the Ellipsis button to select the date and time from a calendar.
7. If this action should be by another person, select a name from the drop-down list for the Action by field.
8. When the Cancel (Deny) dialog is complete, click OK to have the cancelled consult information added to the text of the consult in the Activity grid, followed by any comments that were added. The status of the consult becomes (x) for Cancelled.

4.1.12 Discontinue a Consult

The Consult Originator uses this feature to stop a consult request after it has been signed (the Consult Receiver uses Cancel). A comment can be added concerning the reason for discontinuing the consult. For example, use this feature to cancel a duplicate consult order.

The Discontinue action differs from the Cancel action in that there is no Edit/Resubmit action available on a discontinued order.

This action changes the status of the consult to (dc) for discontinued. A notification is automatically sent to the Consult Service, with information about why the consult was discontinued.

Follow these steps to discontinue a consult:

1. Select the Consults component.
2. Select the consult that you want to discontinue.
3. From the Action drop-down, select Consult Tracking.
4. Select Discontinue. The Discontinue Consult dialog opens.

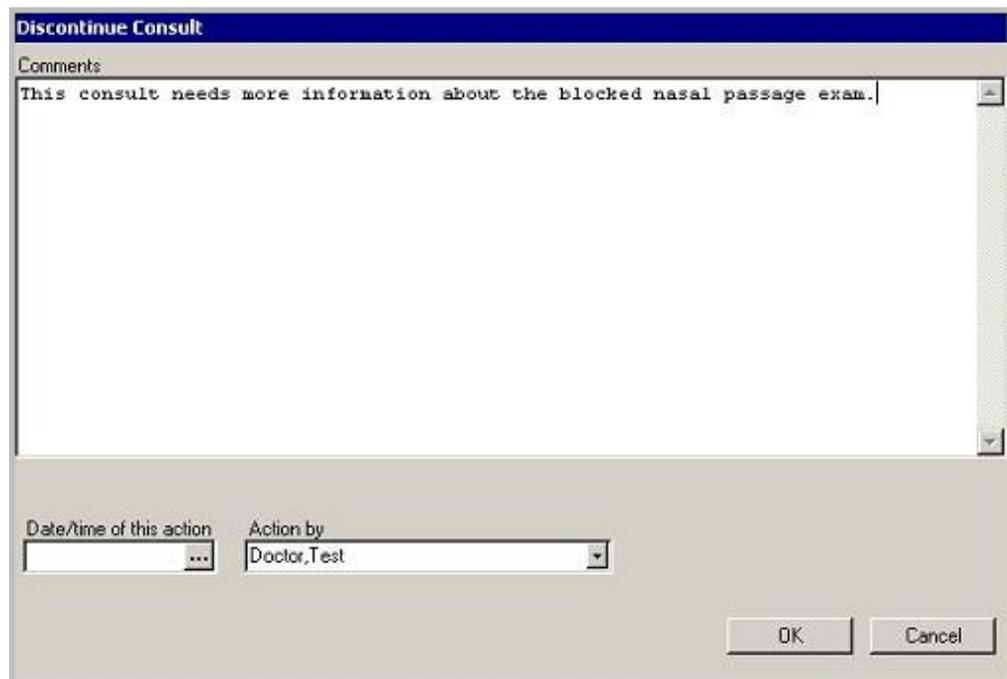


Figure 4-28: Discontinue Consult

5. Type the reason for discontinuing the consult in the Comments field. This field has a right-click menu to aid in editing the text.
6. Enter the date/time in the Date/time of this action field, or click the Ellipsis (...) button to select the date and time from a calendar.
7. If this action should be by another person, select a name from the drop-down list for the Action by field.
8. When the Discontinue Consult dialog is complete, click OK.

The status of the consult changes to (dc) for discontinue. The discontinue consult information is added to the text of the consult in the Activity grid, followed by any comments that were added.



Figure 4-29: Discontinued Information About the Consult

4.1.13 Display Details of a Consult

The details of a consult include:

- Current Primary Care information
- Current Eligibility information
- Order information
- Activity record
- All signed notes
- Information about unsigned notes
- Notes, Results, and Addenda
- All other fields associated with the consult

Use this feature when to return to the details of a consult when the results of a consult are displayed. Follow these steps to display the details of a consult:

1. Have the results of a consult displayed in the right panel.
2. From the Action drop-down, select Consult Tracking.
3. Select Display Details. The details about the consult display in the right panel.

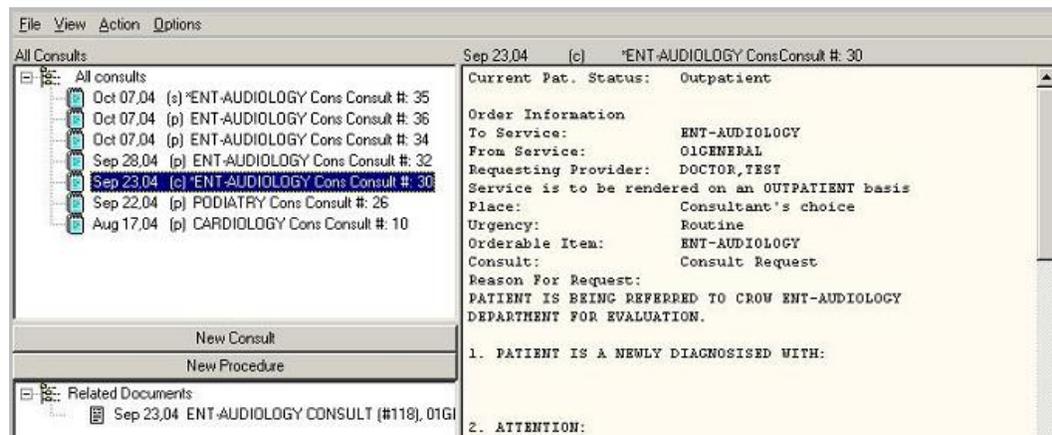


Figure 4-30: Details of a Consult

4.1.14 Display SF 513 for a Consult

Follow these steps to display the SF 513 information about a consult:

1. Select the Consults component.
2. Select the consult about which to display SF 513 information.
3. From the Action drop-down, select Consult Tracking.
4. Select Display SF 513. The SF 513 information displays in a pop-up.

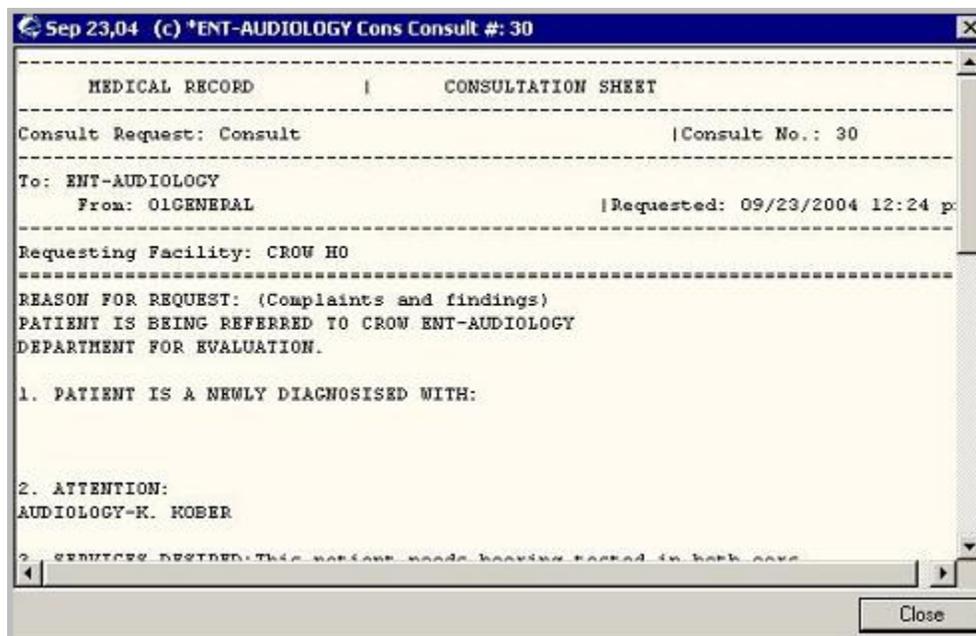


Figure 4-31: SF 513 Information About a Consult

5. Click Close to dismiss the pop-up.

4.1.15 Edit/Resubmit a Consult

The Consult Originator or the Consult Receiver uses this feature to edit a cancelled or denied consult and then resubmit the consult. When a consult is cancelled or denied for clerical reasons (such as insufficient data), then the information on the consult can be edited and resubmitted with this action. Alternatively, the Consult Originator can perform this function from the alert.

Follow these steps to edit and resubmit a consult:

1. Select the Consults component.
2. Select the cancelled or denied consult that you want to edit and resubmit.
3. From the Action drop-down, select Consult Tracking.

4. Select Edit/Resubmit. The Edit/Resubmit a Cancelled Consult dialog opens.

Figure 4-32: Edit/Resubmit a Cancelled Consult

5. Click Cancellation to review the reason for denial on the Cancellation Comments pop-up.

Figure 4-33: Cancellation Comments Pop-up

6. Click Close to dismiss the pop-up.
7. You can add a new comment in the Reason for Consult field.
8. If needed, more comments can be added in the New Comments field. This field contains a right-click menu to aid in editing the text.
9. When the Edit/Resubmit a Cancelled Consult dialog is complete, click Resubmit.

The edit/resubmit information is added to the text of the consult in the Activity grid.

EDIT/RESUBMITTED	10/07/04 17:15	DOCTOR,TEST	DOCTOR,TEST
------------------	----------------	-------------	-------------

Figure 4-34: Edit/Resubmitted Information in Text of Consult

4.1.16 Forward a Consult

Use this feature when the incorrect service receives the consult. For example, this action could be used when Cardiology Service has mistakenly received a consult that should have been sent to Hematology Service.

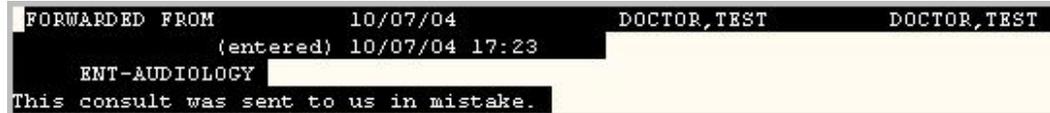
Follow these steps to forward a consult:

1. Select the Consults component.
2. Select the consult that you want to forward.
3. From the Action drop-down, select Consult Tracking.
4. Select Forward. The Forward Consult dialog opens.

Figure 4-35: Forward Consult dialog

5. Select the correct service in the To service panel.
6. If applicable, type in or select the Attention care giver in the Attention field.

7. Type the reason for forwarding the consult in the Comments field. This field has a right-click menu to aid in editing the text.
8. Enter the date/time in the Date/time of this action field, or click the Ellipsis button to select the date and time from a calendar.
9. When the Forward Consult dialog is complete, click OK.
10. The forward consult information is added to the text of the consult in the Activity grid, followed by any comments that were added.

A screenshot of a text field containing forwarded consult information. The text is as follows:

```
FORWARDED FROM      10/07/04      DOCTOR, TEST      DOCTOR, TEST
(entered) 10/07/04 17:23
ENT-AUDIOLOGY
This consult was sent to us in mistake.
```

Figure 4-36: Forwarded Consult Information in Text of the Consult

4.1.17 Make Addendum to a Consult

An Addendum is a medical statement by the patient care professional about a specific Note; it supplies supplementary information on the patient. It differs from a Comment in that an Addendum is about medical matters, where Comments, which can be written by anyone, should contain information needed to administer the consult.

This action allows one or more people to add their comments to the results of a consult. Contrast this to Add Comment, which adds a note to the consult before it is resulted.

Follow these steps to add an addendum to a consult.

1. Select the Consults component.
2. Select the note about the Consult.
3. From the Action drop-down, select Consult Results.
4. Select Make Addendum.

Note: Alternatively, you can also select Make Addendum on the right-click menu.

5. Type the supplementary information about the patient's condition in the right panel.
6. As with other TIU objects, information can be added to the addendum by clicking the Templates button and/or the Reminders button. Both buttons add boilerplate information to the addendum text.

7. To change the properties of the addendum, click the Change button, or select Consult Results from the Action drop-down, and then Change Title. The Addendum Properties dialog opens.

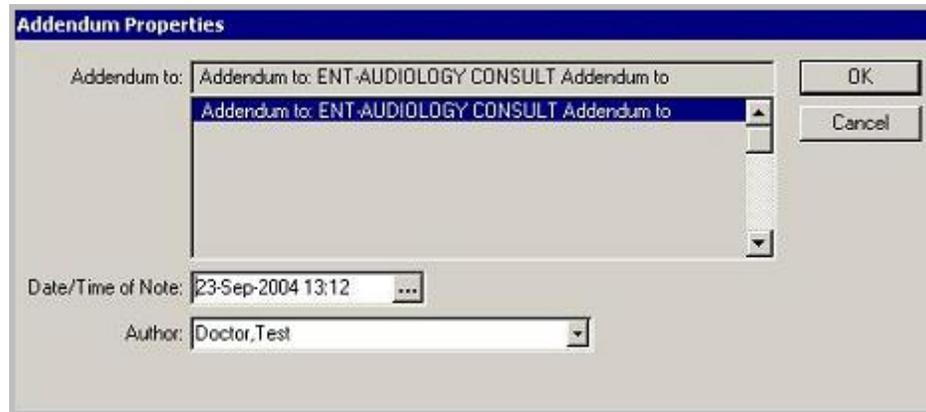


Figure 4-37: Addendum Properties dialog

8. Change the information on the Addendum Properties dialog as needed. Then click OK. The information above the text of the addendum shows your changes.
9. When the addendum is complete, it can be saved without a signature or signed now.
 - To save it without a signature, from the Action drop-down select Consult Results, and then Save Without Signature, or select Save Without Signature on the right-click menu.
 - To sign it now, from the Action drop-down, select Consult Results, and then Sign Note Now, or select Sign Note Now on the right-click menu. Add your electronic signature to the next dialog.

4.1.18 Print SF 513 for a Consult

Follow these steps to print the SF 513 information about a consult:

1. Select the Consults component.
2. Select the consult about which you want to print SF 513 information.
3. Select from the Action drop-down, select Consult Tracking.
4. Select Print SF 513. The Print SF 513 dialog opens.



Figure 4-38: Print SF 513 dialog

5. Enable the appropriate option button in the Print panel.
6. Normally, the right margin and the page length values (measured in characters) are already defined by the print. Select a printer to which you want to output the information.
7. Whatever is selected adds a label to the dialog, such as: Print Chart Copy on: <selected device>.
8. Check Save as user's default printer, if appropriate.
9. Click OK to have the information output to the selected printer.

4.1.19 Receive a Consult

The Consult Receiver uses this feature to acknowledge receipt of a new consult in the Service and to change the current CPRS status of the consult from Pending to Active.

This action puts the receiving service on record as accepting responsibility for completing the consult.

Follow these steps to receive a consult:

1. Select the Consults component.
2. Select the Consult to receive.
3. From the Action drop-down, select Consult Tracking.
4. Select Receive. The Receive Consult dialog opens.

Figure 4-39: Receive Consult dialog

5. Enter comments about receiving the consult in the Comments field, for example, if there is anything unusual about the consult. This field has a right-click menu to aid in editing the text.
6. Change the date and/or time, if needed. Enter the date/time in the Date/time of this action field, or click the Ellipsis button to select the date and time from a calendar.
7. If this action should be by another person, select a name from the drop-down list for the Action by field.
8. When the Receive Consult dialog is complete, click OK. The status of the consult becomes (a) for Active.

The received consult information is added to the text of the consult in the Activity grid, followed by any comments added.

Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	10/07/04 13:36	DOCTOR,TEST	DOCTOR,TEST
PRINTED TO	10/07/04 13:36		
BAO OHCP 33 COMPR			
RECEIVED	10/07/04	DOCTOR,TEST	DOCTOR,TEST
(entered)	10/07/04 13:37		
Consult received and handled over to G. Jeanotte			

Figure 4-40: Received Consult in the Text of the Consult

4.1.20 Schedule a Consult

The Consult Receiver uses this action. The Schedule a Consult does not actually schedule an appointment or link to a scheduling package. It does allow a convenient way to annotate a consult after an appointment has been scheduled by some other means. The Comments most likely will explain when the consult is scheduled.

This action changes the status of the consult to (s) for Scheduled.

Follow these steps to schedule a consult:

1. Select the Consults component.
2. Select the Consult to receive.
3. From the Action drop-down, select Consult Tracking.
4. Select Schedule. The Schedule Consult dialog opens.

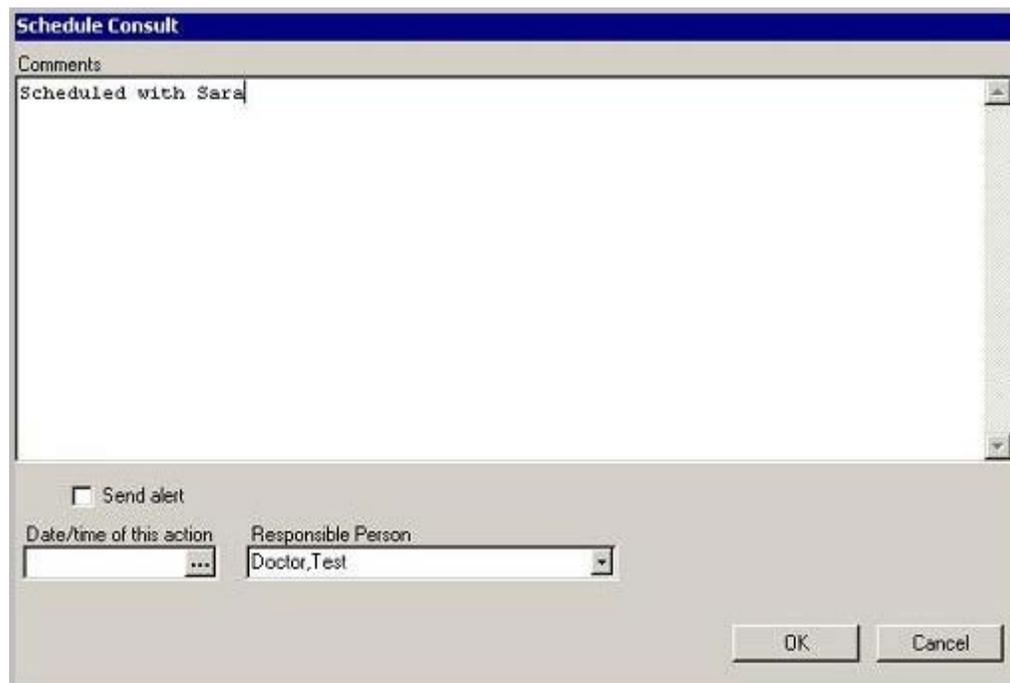


Figure 4-41: Schedule Consult dialog

5. Type the comments about the scheduled consult in the Comments field. This field has a right-click menu to aid in editing the text.
6. Enter the date/time in the Date/Time of this action field, or click the Ellipsis button to select the date and time from a calendar. The date/time here must be established by the healthcare facility as to its meaning. Either it is the date the Schedule a Consult dialog was completed or it is the date for which the consult is scheduled.

7. If this action should be by another person, select a name from the drop-down list for the Responsible Person field.
8. If you want to send an alert about the scheduled consult, check Send alert to display the Send Alert dialog.

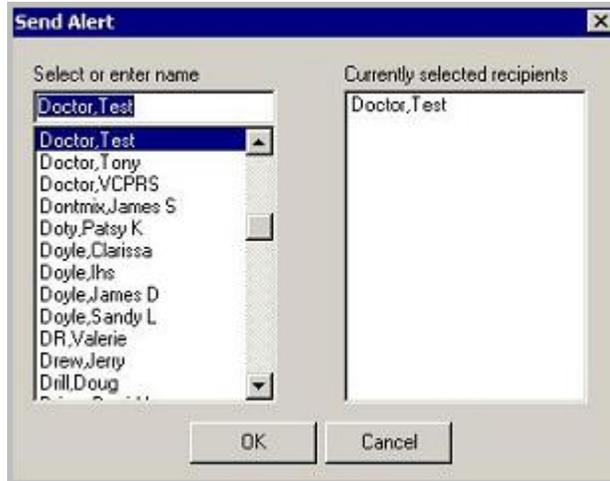


Figure 4-42: Send Alert dialog

- a. Select a name in the Select or enter name field. That name will appear in the Currently selected recipients field.
 - b. To remove a name from the Currently selected recipients field, select it.
 - c. When the Send Alert is complete, click OK to have an alert sent. Otherwise, click Cancel to not send an alert.
9. When the Schedule Consult dialog is complete, click OK. The status of the consult changes to (s) for Scheduled.
 10. The scheduled consult information is added to the text of the consult in the Activity grid, followed by comments that were added.

Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	10/07/04 13:36	DOCTOR,TEST	DOCTOR,TEST
PRINTED TO	10/07/04 13:36		
BAO OHCP 33 COMPR			
RECEIVED	10/07/04	DOCTOR,TEST	DOCTOR,TEST
(entered)	10/07/04 13:37		
Consult received and handled over to G. Jeanotte			
SCHEDULED	10/07/04	DOCTOR,TEST	DOCTOR,TEST
(entered)	10/07/04 13:44		
Scheduled consult with Dana			

Figure 4-43: Scheduled Consult in Text of the Consult

4.1.21 Significant Findings for a Consult

The Consult Receiver uses this action to mark a consult as having significant findings. When this action is completed, an asterisk (*) precedes the name of the consult.

The significant findings action allows a clinic or service to append a significant findings flag onto a consult, whether completed or not.

Follow these steps to enter significant findings for a consult:

1. Select the Consults component.
2. Select the consult to which you want to add significant findings.
3. From the Action drop-down menu, select Consult Tracking.
4. Select Significant Findings. The Update Significant Findings dialog opens.

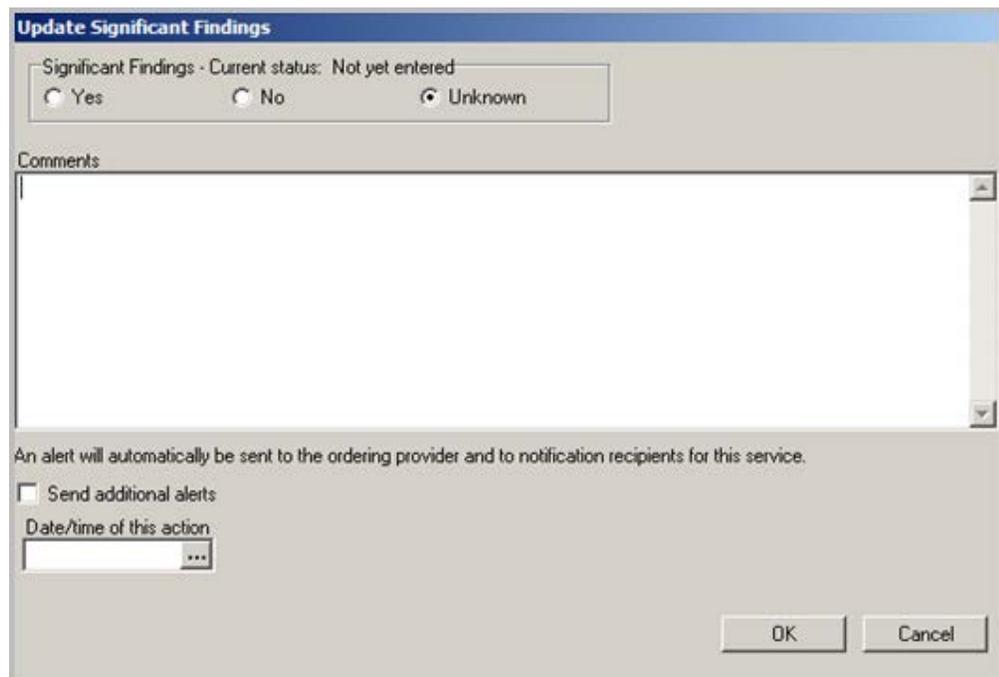


Figure 4-44: Update Significant Findings dialog

5. Enable the appropriate option button in the Significant Findings panel.
6. Type information about the findings in the Comments field. This field has a right-click menu to aid in editing the text.
7. Enter the date/time in the Date/time of this action field, or click the Ellipsis button to select the date and time from a calendar.

8. To send an alert about the significant findings, check Send alert to display the Send Alert dialog.

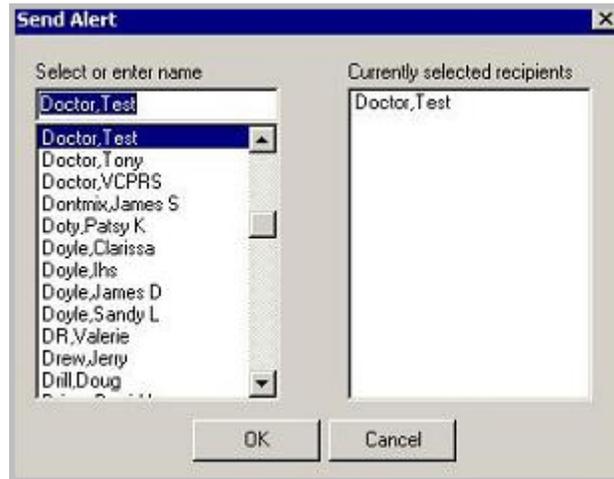


Figure 4-45: Sent Alert dialog

- a. Select a name in the Select or enter name field. The name is added to the Currently selected recipients field.
 - b. To remove a name from the Currently selected recipients field, select it.
 - c. When the Send Alert is complete, click OK to have an alert sent. Otherwise, click Cancel to not send an alert.
9. When the Update Significant Findings dialog is complete, click OK.

An asterisk (*) shows before the consult containing significant findings.

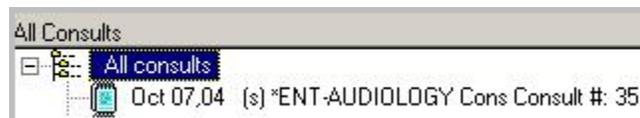


Figure 4-46: Consult with Significant Findings in Left Panel

The significant findings information is added to the text of the consult in the Activity grid, along with comments that were added.

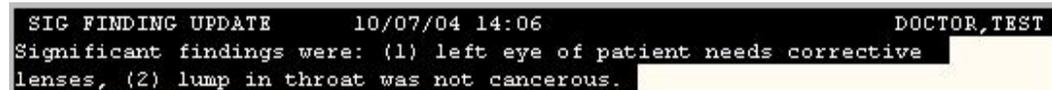


Figure 4-47: Significant Findings in the Text of the Consult

4.1.22 Viewing Consults

When a specific consult is selected, an area that lists any notes associated with the consult is shown. Alternatively, a note entry may be clicked to view the full text of the note.

An asterisk (*) preceding the title indicates that there are significant findings for that consult. See the section Status of a Consult to review the meaning of the status of each consult.

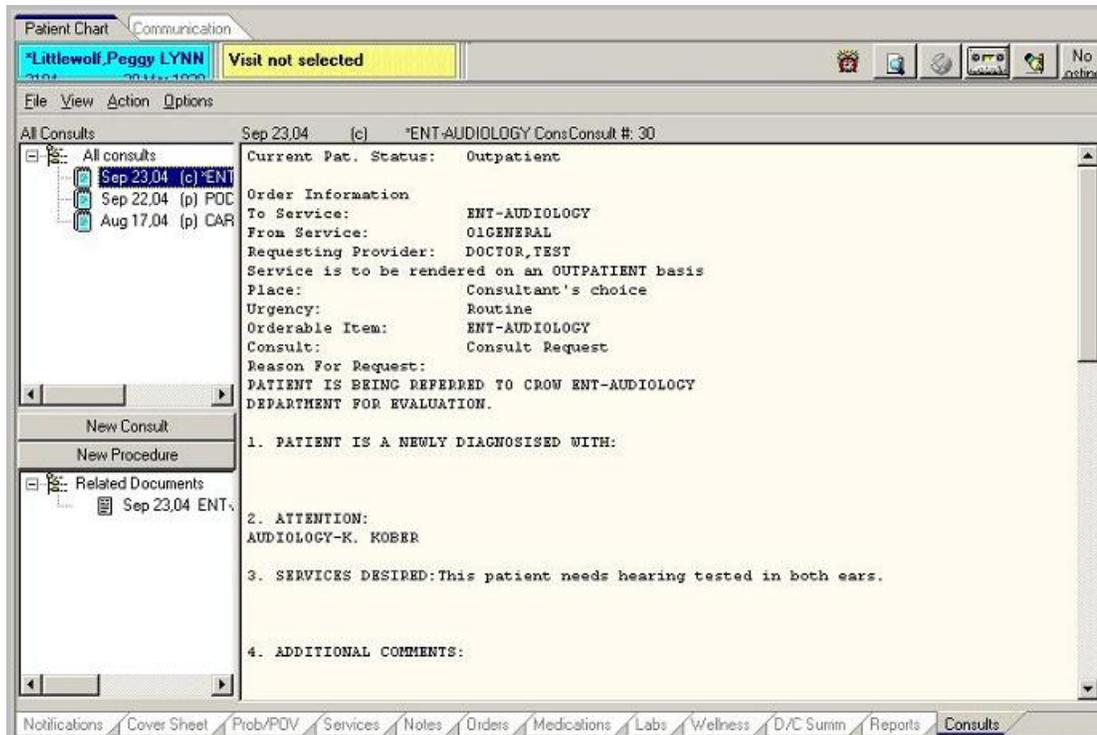


Figure 4-48: Text of Selected Consult

Follow these steps to view consults for the selected patient:

1. Select the Consults tab.
2. Select the consult to view from the All Consults list.
3. The text of the consult appears in the right panel. Any notes associated with that consult appear in the Related Documents panel. To view the text of a related note, select the note.
4. The contents of a selected consult may be printed by selecting File, and then Print.

4.1.23 Changing Views

Changing the view of the Consults list enables the viewing of the list of consults based on one of several criteria which speeds up the selection process.

The Consults view can be set to only include the following problems:

- All Consults (displays all consults for the current patient)
- Consults by Status (select a status and sort order)
- Consults by Service (select a service and sort order)
- Consults by Date Range (select a date range and sort order)

To change the view, select the View menu and then select the desired list items. This action changes what consults are listed in the upper-left panel of the Consults tab.

Select the Custom View option on the menu to further focus the list of consult notes which to view.

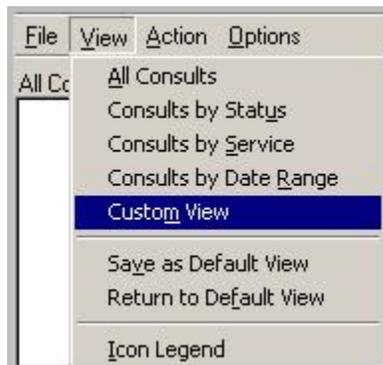


Figure 4-49: Selecting the Custom View Option

From the List Selected Consults dialog, opt to display consults by any combination of service, status, date range, group, and sort order.

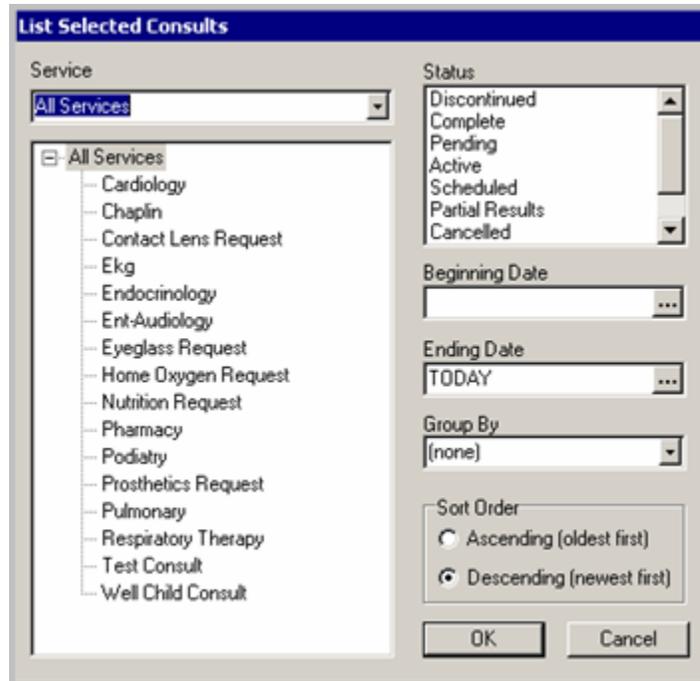


Figure 4-50: List Selected Consults dialog for Custom View

After clicking OK, the consults with the specified features display in the upper, left panel of the Consults tab.

4.1.24 Consult Notes

4.1.24.1 Notes Associated with a Consult

The notes associated with a consult appear in the lower left panel of the Consults tab under Related Documents.

The  icon indicates a note, while the  icon indicates an addendum.

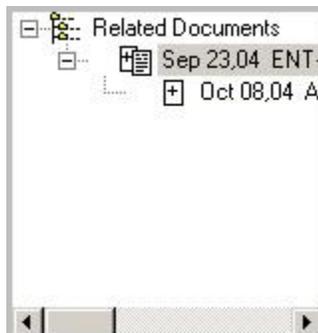


Figure 4-51: Related Documents for a Consult

There are several edit features associated with notes. They are found on the Consult Results menu as well as on the right-click menu in the text of the note.

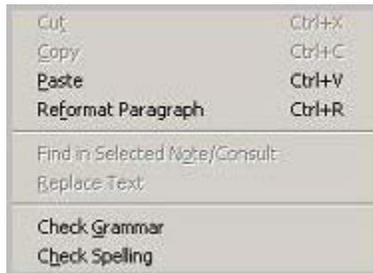


Figure 4-52: Edit Features for Notes

4.1.24.2 Add to Signature List for Notes of Consult

The Add to Signature List feature places the unsigned note with other orders and documents which need signatures for the current patient on the Notification tab.

Follow these steps to add the note of a consult to your signature list:

1. Select the Consults component.
2. Select the consults having the unsigned note.
3. Select an unsigned note.
4. From the Action drop-down menu, select Consult Results.
5. Select Add to Signature List. Alternatively, select the Add to Signature List option on the right-click menu.

The selected note appears on the Notifications tab (along with other documents and orders).

4.1.24.3 Delete Note of Consult

The delete note applies to a note or addendum associated with a consult that is not complete.

Follow these steps to delete a note:

1. Select the Consults component.
2. Select the note (or addendum) of a consult that is not complete.
3. From the Action drop-down menu, select Consult Results.
4. Select Delete Note. Alternatively, select Delete Note from the right-click menu. The Confirm Deletion message appears.

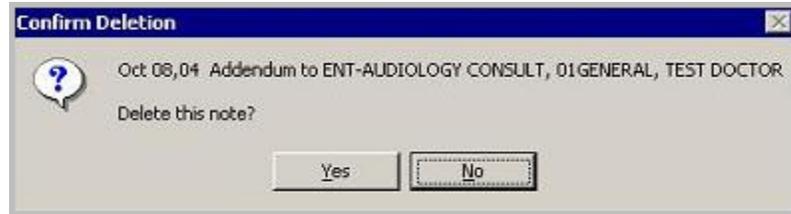


Figure 4-53: Confirm Deletion of Note

5. Click Yes to delete the note. Otherwise click No. If you selected to delete the note, it is removed from the Related Documents of the selected consult.

4.1.24.4 Edit Note of Consult

The edit note applies to a note or addendum associated with a consult that is not complete.

Follow these steps to edit a note:

1. Select the Consults component.
2. Select the note (or addendum) of a consult that is not complete.
3. From the Action drop-down menu, select Consult Results.
4. Select Edit Note. Alternatively, select Edit Note from the right-click menu. The text of the note appears in the right panel where you can change the note.
5. Use the Templates button or the Reminders button to add text to the note.
6. When the note is complete, sign now or save without signature.
 - To save it without a signature, from the Action drop-down menu, select Consult Results, and then select Save Without Signature. Alternatively, select Save Without Signature from the right-click menu.
 - To sign it now, from the Action drop-down menu, select Consult Results, and then Sign Note Now. Alternatively, select Sign Note Now from the right-click menu. Add your electronic signature to the next dialog.

4.1.24.5 Identify Additional Signers for Consult Note

Use the Identify Additional Signers feature to need additional signers, such as for users in a training capacity.

Follow these steps to identify additional signer for a signed note associated with a consult:

1. Select the Consults component.
2. Select the note of the consult for additional signers.

3. From the Action drop-down menu, select Consult Results.
4. Select Identify Additional Signers. Alternatively, select Identify Additional Signers from the right-click menu. The Identify Additional Signers dialog opens.

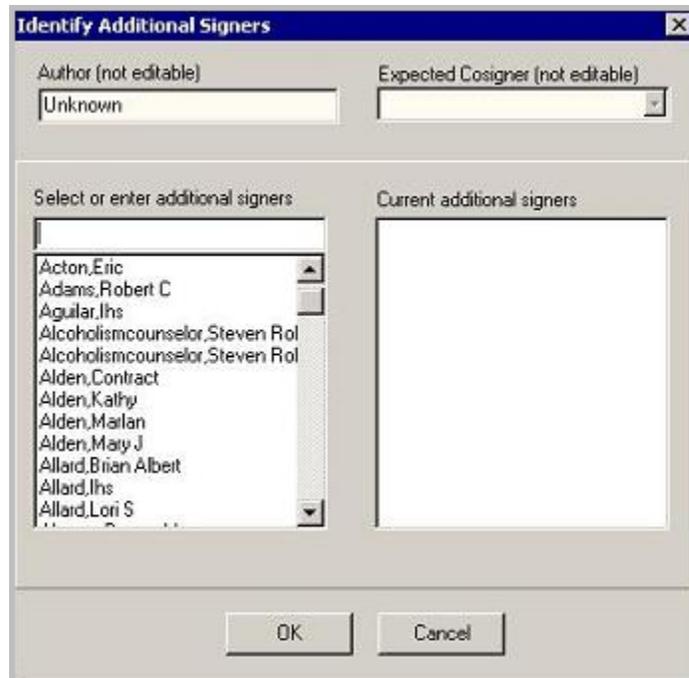


Figure 4-54: Identify Additional Signers dialog for Notes to Consults

5. Select the additional signers from the scroll list of the Select or enter additional signers panel.
6. The additional signer names appear in the Current additional signers panel. To remove a particular name in this panel, select it and the name is removed from the panel.
7. When this dialog is complete, click OK. In the text of the progress note near the bottom, the following is shown:

* AWAITING SIGNATURE * <selected names>

4.1.24.6 Print Note

The print note action prints the information about the selected note.

Follow these steps to print the information within a note:

1. Select the Consults component.
2. Select the note of the consult to print.
3. From the Action drop-down menu, select Consult Results.

4. Select Print Note. Alternatively, select Print Note from the right-click menu. The Print dialog opens.

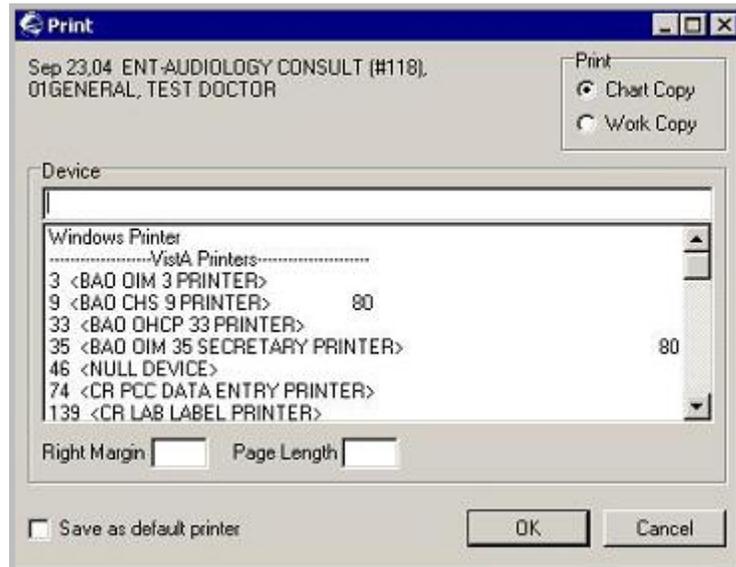


Figure 4-55: Print dialog

5. Select the appropriate option button in the Print panel.
6. Select a printer.
7. Normally the right margin and the page length values (measured in characters) are already defined by the printer. Your selections add a label to the dialog, such as: Print Chart Copy on: <selected device>.
8. Select the Save as default printer check box, if applicable.
9. Click OK. The information about the note outputs to the selected printer.

4.1.25 Consult Addendum

An Addendum is a medical statement by the patient care professional about a specific Note; it supplies supplementary information on the patient. It differs from a Comment in that an Addendum is about medical matters, where Comments, which can be written by anyone, contain information needed to administer the consult.

This action enables one or more users to add comments to the results of a consult. Contrast this to Add Comment, which adds a note to the consult before it is resulted.

Follow these steps to add an addendum to a consult.

1. Select the Consults component.
2. Select the note about the Consult.

3. From the Action drop-down menu, select Consult Results.
4. Select the Addendum option. Alternatively, select Make Addendum from the right-click menu.
5. Type the supplementary information about the patient's condition in the right panel.
6. As with other TIU objects, information can be added to the addendum by clicking the Templates button and/or the Reminders button. Both buttons add boilerplate information to the addendum text.
7. To change the properties of the addendum, click the Change button. Alternatively, from the Action drop-down menu, select Consult Results, and then Change Title. The Addendum Properties dialog opens.

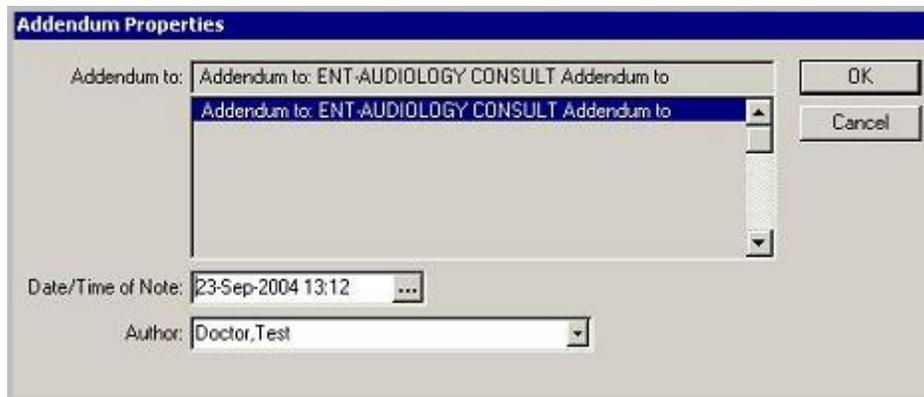


Figure 4-56: Addendum Properties dialog

8. Change the information on the Addendum Properties dialog as needed, and then click OK. The information above the text of the addendum reflects your changes.
9. When the addendum is complete, save it without a signature or sign it now.
 - To save it without a signature, from the Action drop-down menu, select Consult Results, and then select Save Without Signature. Alternatively, select Save Without Signature from the right-click menu.
 - To sign it now, from the Action drop-down menu, select Consult Results, and then Sign Note Now. Alternatively, select Sign Note Now from the right-click menu. Add your electronic signature to the next dialog.

4.2 Exams

The Exams panel is used to add, edit, or delete a patient exam. To view information regarding the meaning of the results, click the Result heading.

Exams:						Add	Edit	Delete
Visit Date	Exams	Result	Comments	Provider	Location			
01/29/2004	DIABETIC EYE EXAM			MOORE,CATHERINE M	CROW HO			
01/29/2004	RECTAL EXAM	NORMAL/NEGATIVE	test	MOORE,CATHERINE M	CROW HO			

Figure 4-57: Exams Panel

When viewing the Location of the exam (not historical), it is defaulted to the provider's location (in the Exams grid).

This component can be configured so that a particular user or class cannot add/edit an exam.

4.2.1 Adding an Exam

The Add function creates a current or historical exam, or creates a refusal for an exam. To add an exam:

1. Select a visit.
2. Click Add in the Exams panel (or select the Add Patient Exam option on the right-click menu) to display the Exam Selection dialog.

Note: Use the scroll bar to view all available exams. You can sort either column by clicking its heading.

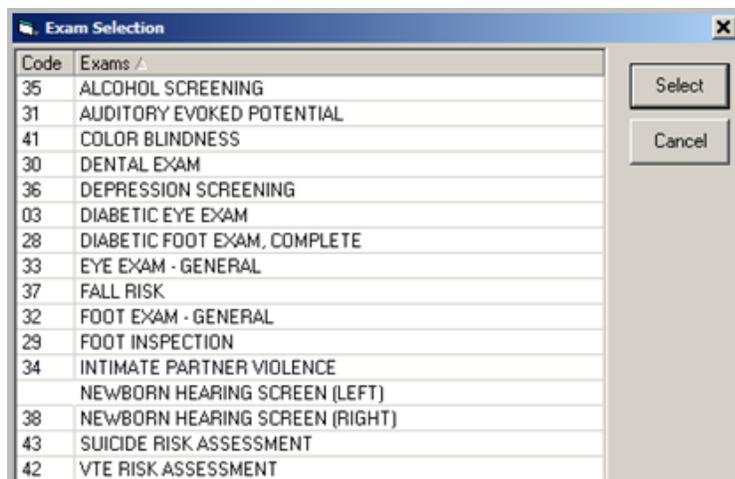


Figure 4-58: Exam Selection dialog

3. Highlight the exam you want to add.
4. Click Select. The Document an Exam dialog opens. (Otherwise, click Cancel.)

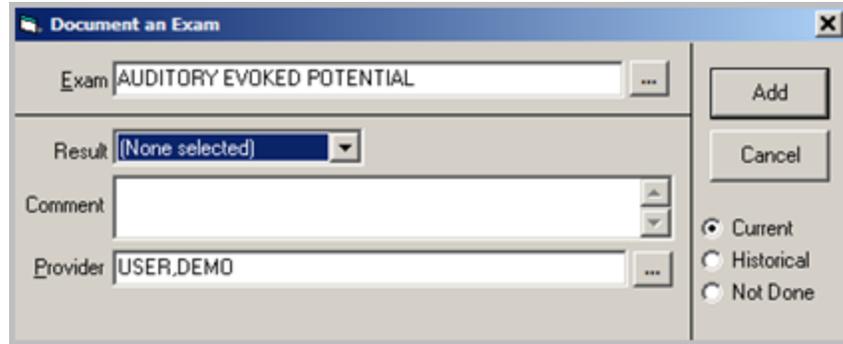


Figure 4-59: Document an Exam dialog

Note: To re-display the Exam Selection dialog, click the Ellipsis button next to the Exam field.

5. Select one of the following option buttons:

- Current Exam
- Historical Exam
- Not Done

4.2.1.1 Current Exam

To view an exam that is current:

1. Select the Current option button when the exam is for the current visit.

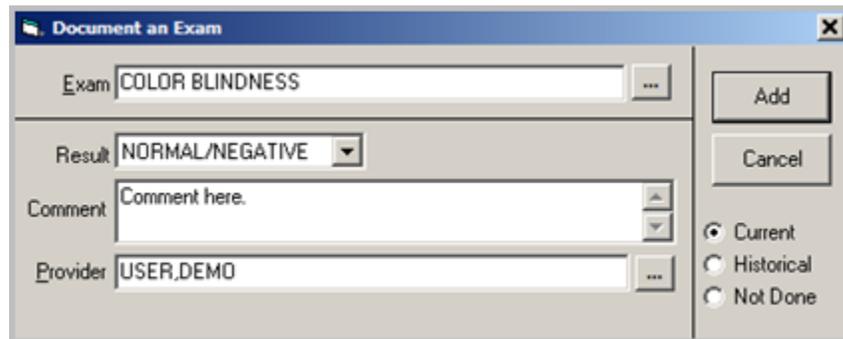


Figure 4-60: Document an Exam dialog

2. In Result, select the result for the exam from the drop-down list:

- Abnormal
- Normal/Negative
- Referral Needed

3. In the Comment field, type a comment about the exam (if applicable). This field has a right-click menu to aid in editing the text. Use this field to note abnormal findings, for example.
4. If the provider of the exam is different from what is displayed in the Provider field, click the Ellipsis button to display the Lookup Utility. There you can select the proper provider. See Using the Lookup Utility dialog for Provider for more information.
5. Complete the Document an Exam dialog. Refer to Completing the Document an Exam dialog for details.

4.2.1.2 Historical Exam

You can add a historical exam by having no visit selected and clicking the Add button. The Document an Exam dialog displays with the Historical option button selected.

1. Select the Historical option button when the exam is for an historical visit.

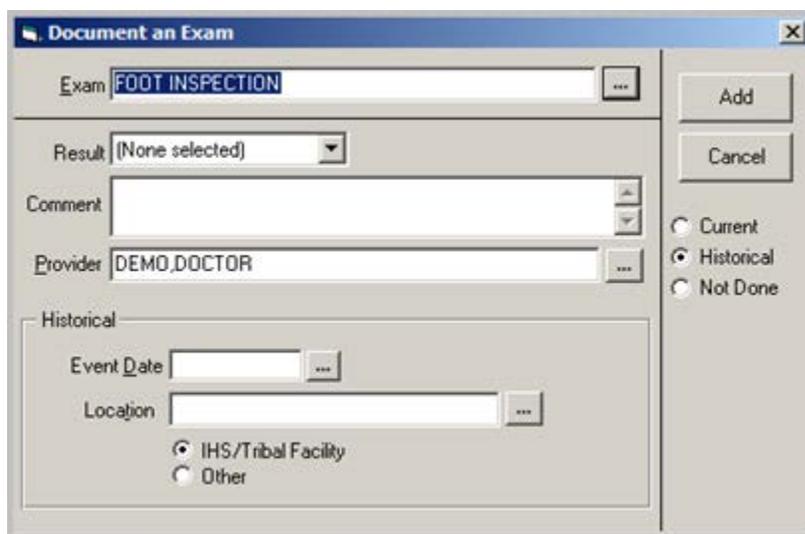


Figure 4-61: Historical Event Panel

2. In Result, select the result for the exam from the drop-down list:
 - Normal/Negative
 - Positive
 - Referral Needed
3. In Comment, type a comment about the exam (if applicable). This field has a right-click menu to aid in editing the text. You use this field to note abnormal findings, for example.

4. If the provider of the exam is different from what is displayed in the Provider field, click the Ellipsis button to display the Lookup Utility, where you can select the proper provider. See Using the Lookup Utility for Provider for more information.
5. Complete the Historical group box:
 - Enter a date in the Event Date field by either manually typing it or by clicking the Ellipsis button to select from a calendar. It must be a past date.
 - The Location field has a right-click menu to aid in editing the information.
 - If the location is an official IHS facility, select the IHS/Tribal Facility Option button.

You can select the location from the Lookup Utility dialog by clicking the Ellipsis button. If you manually enter a facility name, it must be an official IHS facility. If not, when you leave the field the Lookup Utility dialog displays. See Using the Lookup Utility dialog for Location for more information.

 - If your site has been configured with a default outside location, type OTHER in the Location field. Then, when the View Visit Detail dialog displays, the default outside location displays at the LOC. OF ENCOUNTER field.
 - If the location is not an official IHS facility, select the Other option button. Enter the non-official location (for example, Dr. Example Doctor).
6. Complete the Document an Exam dialog. Refer to Completing the Document an Exam dialog for details.

4.2.1.3 Exam Not Done

1. Select the Not Done option button when the exam was not performed.

Figure 4-62: Exam Not Done dialog

2. In Reason, select the reason for the exam was not performed from the drop-down list.

3. In Comment, type a comment regarding the exam not being done (if applicable). This field has a right-click menu to aid in editing the text.
4. If the provider of the exam is different from what is displayed in the Provider field, click the Ellipsis button next to display the Lookup Utility where you can select another provider. See Using the Lookup Utility dialog for Provider for more information.
5. Complete the Document an Exam dialog. Refer to Completing the Document an Exam dialog for details.

4.2.1.4 Completing the Document an Exam dialog

After all fields have been completed, click Add to add the exam to the Exams panel. (Otherwise, click Cancel.)

- After clicking Add on the current or historical dialog, the record, including any associated SNOMED CT or LOINC, is added to the Exams component.
- After clicking Add on the refusal dialog, the record, including any SNOMED CT or LOINC, is added to the Exams component as well as to the Personal Health component.

4.2.1.5 Using the Lookup Utility dialog for Provider

Access the Lookup Utility by clicking the Ellipsis button at the end of the Provider field. Use this dialog to search for and select a name for the Provider field.

Follow these steps to complete the Lookup Utility dialog for Provider.

1. Type a few characters in the Search Value field and click Search.
2. The appropriate names display in the lower panel of the dialog. If this is not the data you are searching for, repeat Step 1.

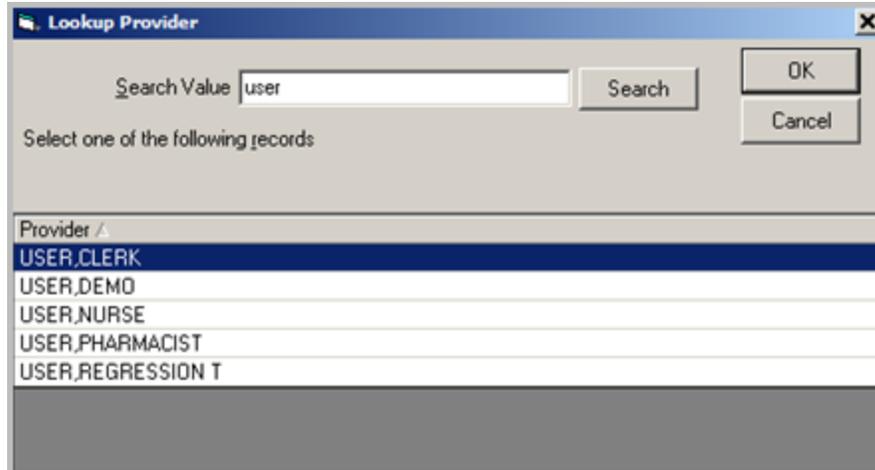


Figure 4-63: Lookup Provider dialog After Search

3. Highlight the appropriate name in the lower panel and click OK. The selected record populates the Provider field. (Otherwise, click Cancel.)

4.2.1.6 Using the Lookup Utility dialog for Location

Access the Lookup Utility by clicking the Ellipsis button at the end of the Location field. Use this dialog to search for and select a location for the Location field.

Follow these steps to complete the Lookup Utility dialog for Location.

1. Scroll the list to the location and select it. Or, you can search for a location.
2. To search for a location, type a few characters in the Search Value field and click Search.

The appropriate locations display in the lower part of the dialog. If this is not the location you are searching for, repeat Step 2.

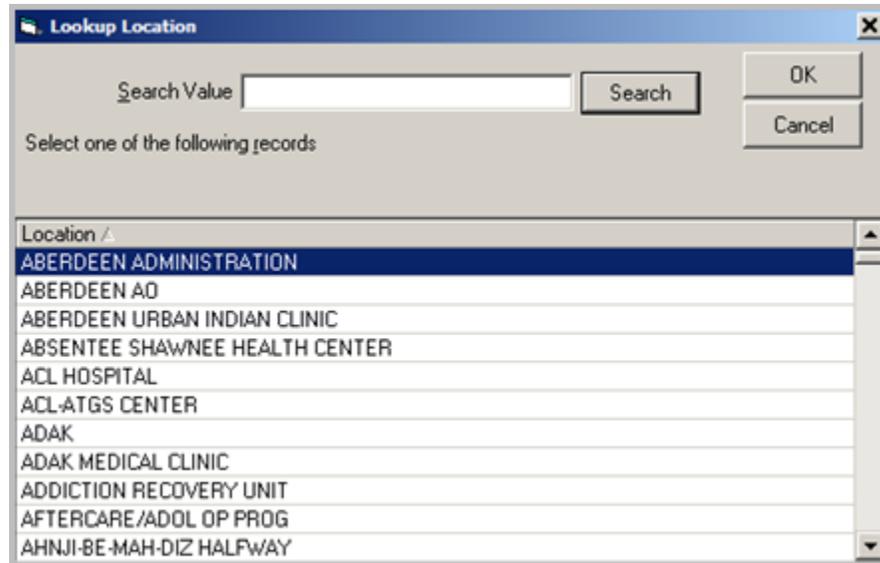


Figure 4-64: Lookup Location dialog After Search

3. Highlight the appropriate record in the lower panel and click OK. The selected record populates the Location field. (Otherwise, click Cancel.)

4.2.2 Editing an Exam

An exam can only be edited until the visit attached to it is locked. At that time the edit option is grayed out and not selectable.

1. You can edit a selected exam by clicking the Edit button (or by selecting the Edit Patient Exam option on the right-click menu). The Document an Exam dialog displays, with the option button selected (you cannot change) and the fields populated with data entered during the Add process.
2. Edit any of the fields on the dialog. See Adding an Exam for more information about the fields.
3. After all fields have been edited, click Save. (Otherwise, click Cancel.)

4.2.3 Deleting an Exam

Exams can only be deleted while the visit is unlocked. After that date, the delete option is not selectable.

1. Click the Delete button (or select the Delete Patient Exam option on the right-click menu) to display the Remove Patient Exam? information message.

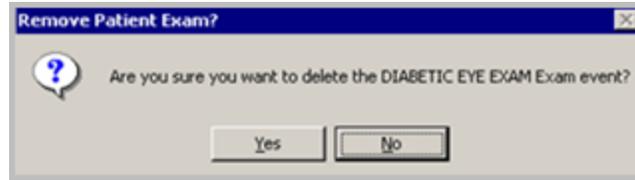


Figure 4-65: Remove Patient Exam Information Message

- Click Yes to have the selected exam deleted from the Exam component. (Otherwise, click No.)

Clicking Yes removes the record from the Exam component. This also removes it from the Personal Health component. (The reverse is also true.)

4.3 Family History

The Family History component displays any family history information about the patient.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Provider Narrative Condition	Age of Diagnosis	Date Modified	ICD
NATURAL FATHER	FRED	LIVING					*Family History Of Malignant Neoplasm Of Other Respiratory And		09/24/2009	V16.2
NATURAL MOTHER	BETTY	DECEASED	60 and	Natural causes.	YES	TWIN.	*Family History Of Deafness Or Hearing Loss		12/30/2009	V19.2
NATURAL MOTHER	BETTY	DECEASED	60 and	Natural causes.	YES	TWIN.	FH: leukemia	30 (approx)	08/28/2013	V16.6
BROTHER	Robert						*Family History, Genetic Disease Carrier	10 (approx)	12/28/2009	V18.90
UNKNOWN							*Family History Of Malignant Neoplasm Of Other Respiratory And	20 (approx)	12/28/2009	V16.2
AUNT	Patty						Family history of ischemic heart disease		07/17/2013	V17.3

Figure 4-66: Family History Component

This information comes from the Family History of the PCC patient record. It can appear on the Health Summary report. The Family History actually stores data in two files, one is a relationship file and the other is the Family History diagnoses. You can enter, edit, and delete both relationships and diagnoses in this one component. Just be aware of which you are working with.

The view contains one line for each condition, so there may be multiple lines for the same Relation.

No visit is needed to use this component.

To view the UpToDate or other Web information about a Condition, refer to the Web Reference topic.

To search for SNOMED CT codes mapped to an ICD, refer to the Get SCT Button topic.

4.3.1 Get SCT Button

The Get SCT button takes the ICD code from a historical entry that is not SNOMED CT coded, launches to Apelon, and displays a list of SNOMED CT codes that are mapped to that ICD.

An entry that is not SNOMED CT coded yet displays with an asterisk (*) in the Provider Narrative/Condition column of the Family History component main window. If the Provider Narrative/Condition column is empty, this also indicates the entry has not been SNOMED CT coded yet.

The Get SCT button is only active when a Family History line item does not have a SNOMED CT code assigned yet.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Provider Narrative Condition	Age at Diagnosis	Date Modified	ICD
NATURAL FATHER	FRED	LIVING					*Family History Of Malignant Neoplasm Of Other Respiratory And		09/24/2009	V16.2
NATURAL MOTHER	BETTY	DECEASED	60 and	Natural causes.	YES	TWIN.	*Family History Of Deafness Or Hearing Loss		12/30/2009	V19.2
NATURAL MOTHER	BETTY	DECEASED	60 and	Natural causes.	YES	TWIN.	FH: leukemia	30 (approx)	08/28/2013	V16.6
BROTHER	Robert						*Family History, Genetic Disease Carrier	10 (approx)	12/28/2009	V18.90
UNKNOWN							*Family History Of Malignant Neoplasm Of Other Respiratory And	20 (approx)	12/28/2009	V16.2
AUNT	Patty						Family history of ischemic heart disease		07/17/2013	V17.3

Figure 4-67: Family History Main Screen with SNOMED CT Coded and Not Coded Entries

To add a SNOMED CT code to a family history entry, follow these steps:

1. From the Family History component main window, select a family history line item where the Provider Narrative/Condition column either contains an asterisk or is blank, and then click the Get SCT button. The ICD 9 To SNOMED CT Lookup dialog opens.

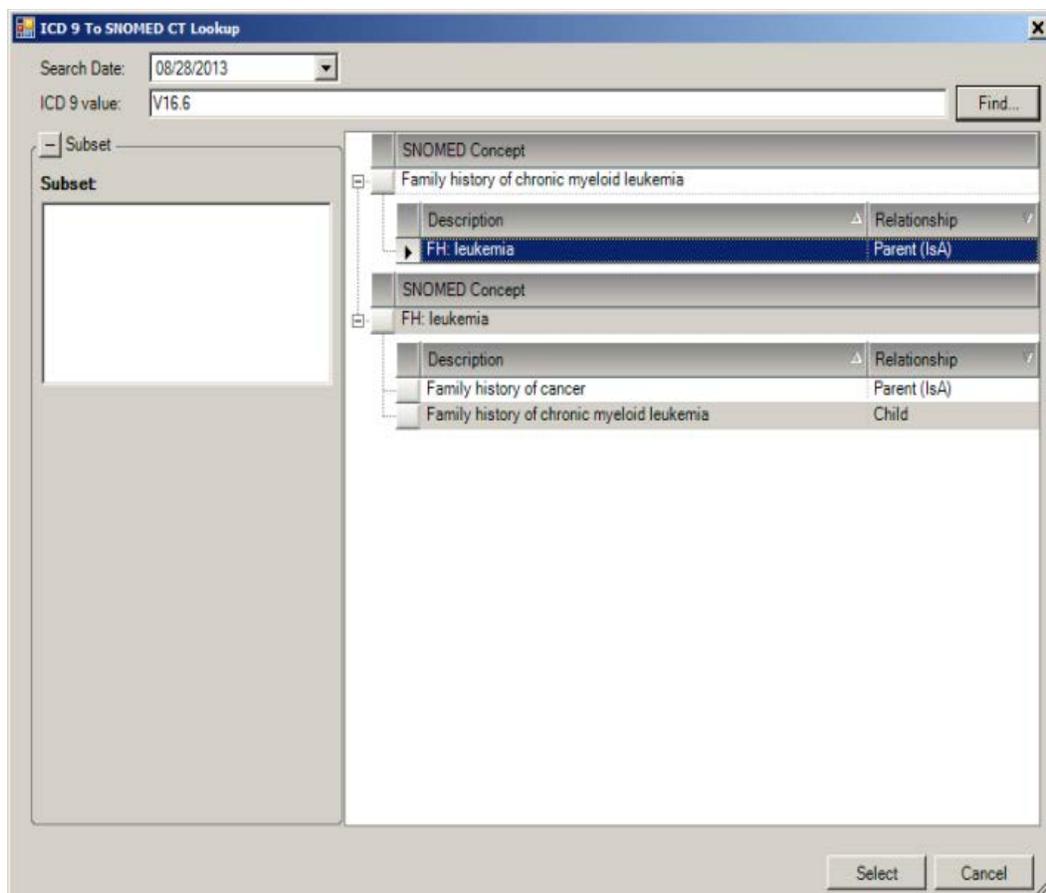


Figure 4-68: ICD 9 to SNOMED CT Lookup dialog

2. The Search Date field automatically defaults to the current date. Click the drop-down arrow to open the calendar where a new date can be selected.
3. The ICD 9 Value field is automatically populated with the ICD code from the Family History condition selected when the Get SCT button is clicked. You can change this by typing in a new code.

Note: The Subset field automatically defaults to Family History and cannot be unselected. No other subsets are allowed.

4. Click the Find button. The list of SNOMED CT terms is populated.
5. Select and highlight a SNOMED CT concept term, and then click the Select button. The SNOMED CT code is saved to the entry and shows in the Provider Narrative/Condition column and the asterisk on the main Family History component is cleared.

4.3.2 Adding Family History

To add Family History, follow these steps:

1. From the Family History component main window, click the Add Relation button (or select Add Relation on the right-click menu) to display the Family History form where you can add family history data.

The screenshot shows a 'Family History' window with the following fields and values:

- Relation: BROTHER
- Name: Michael
- Status: DECEASED
- Cause of Death: Leukemia
- Age at Death: At age 20-29
- Multiple Birth: NO
- Multiple Birth Type: (empty)

Below the form is a table with the following data:

Provider Narrative Condition	SNOMED Desc Text	Age at Diagnosis	ICD
Sudden onset.	FH: leukemia	29	V16.6

Figure 4-69: Family History

1. In Relation, select the applicable relation from the drop-down menu.

Note: Only one relation can be added at a time. However, multiple problems can be added for one relation.

2. In Name, type the relation's name.
3. In Status, select the applicable status from the drop-down menu:
 - Living
 - Deceased
 - Unknown
 - Patient refused to answer

4. In Age at Death, if Deceased was selected in Status, select the applicable age at the relation's death from the drop-down menu:

Note: If Deceased was not selected in Status, the Age at Death field is disabled.

- In Infancy
 - Before age 20
 - At age 20-29
 - At age 30-39
 - At age 40-49
 - At age 50-59
 - 60 and older
 - Age Unknown
5. In Cause of Death, type the cause of the relation's death.
 6. In Multiple Birth, select Yes or No from the drop-down menu.
 7. In Multiple Birth Type, if Yes was selected in Multiple Birth, select the applicable multiple birth type from the drop-down menu:

Note: If No was selected in Multiple Birth, the Multiple Birth Type field is disabled.

- Twin, Unspecified
 - Identical Twin
 - Fraternal Twin
 - Triplet
 - Other Multiple
8. Add a Condition by clicking the Add button in the Condition section of the Family History dialog. The SNOMED CT Lookup dialog opens.

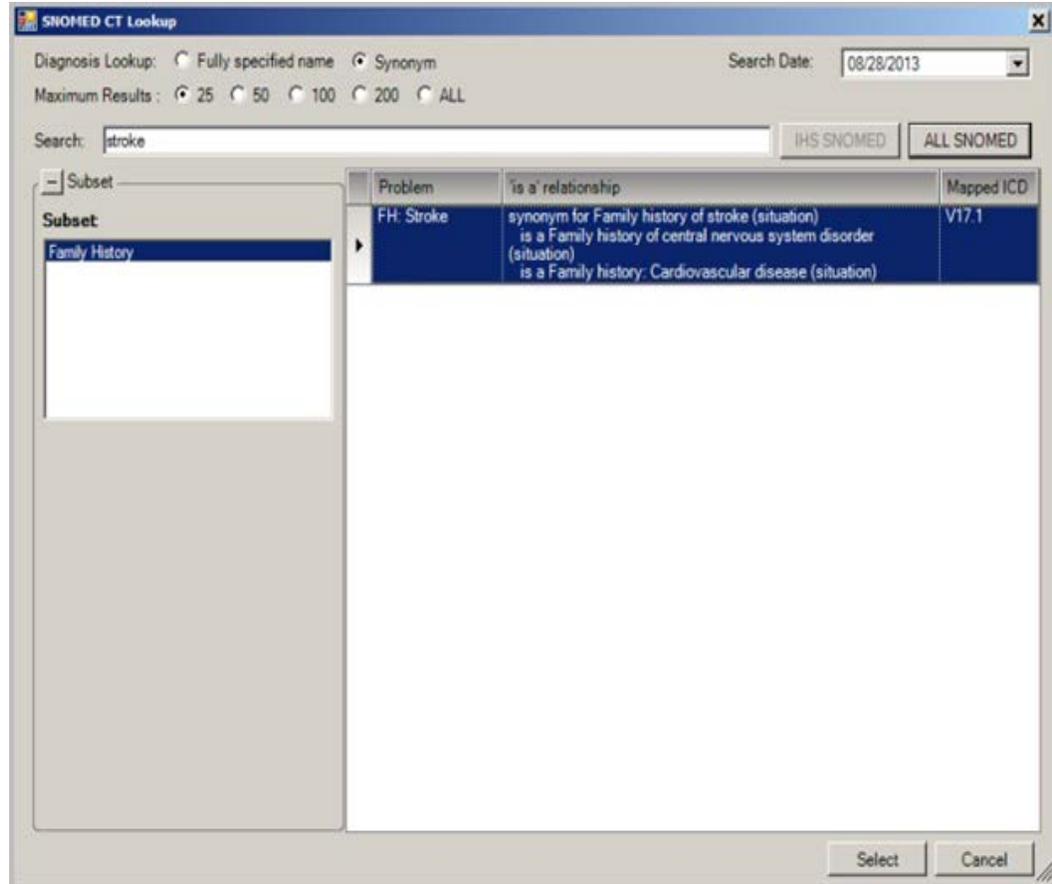


Figure 4-70: SNOMED CT Lookup

- a. In Diagnosis Lookup, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the plus sign (+) next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
- b. In Maximum Results, select the applicable option button to select the number of returned search results:
 - 25
 - 50
 - 100
 - 200
 - All
- c. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.

d. In Search, type the term by which you want to search.

Note: The Subset field automatically defaults to Family History and cannot be unselected. No other subsets are allowed.

e. Click the ALL SNOMED CT button. The list of SNOMED CT terms and their corresponding mapped ICD codes is populated.

f. Select and highlight a term, and then click the Select button. The Family History Condition dialog opens with the SNOMED CT Description field of the Family History Condition dialog containing the SNOMED CT term description you selected.

Figure 4-71: Family History Condition

- If you need to change ICD Code, click the Change button to re-open the SNOMED CT Lookup dialog and repeat Steps a. through e.
- g. In Provider Text, type any notes or comments.
- h. In Age at Diagnosis, type the relation's age at the time of their diagnosis.
- If the actual age is unknown, type an approximate age and click the Approximate check box.
- i. Click Save. The Family History Condition dialog closes and your entries are populated in the Condition section of the Family History dialog.
9. In the Family History dialog, click Save. Your entry shows in the Family History list.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Provider Narrative Condition	Age at Diagnosis	Date Modified	ICD
COUSIN	Robbie	LIVING					FH: Bronchus cancer No lymph node expansion 411039013	46	06/12/2013	V16.1
PATERNAL/NAUNT	Anabel	LIVING					FH: Diabetes mellitus Controlled by insulin		06/10/2013	V18.0
BROTHER	Matthew	LIVING					FH: leukemia Bone marrow transplant completed/in remission	25	06/10/2013	V16.6
NATURAL MOTHER	Mabel	DECEASED	60 and	Pneumonia	NO		Family history: neoplasm - trachea/bronchus/lung Sudden onset.	62	07/17/2013	V16.1
NATURAL SISTER	Martha	DECEASED	60 and	Pneumonia	NO		FH: Bronchus cancer Provider text here.	68	07/17/2013	V16.1
BROTHER	Michael	DECEASED	At age	Leukemia	NO		FH: leukemia Sudden onset.	23	07/17/2013	V16.6

Figure 4-72: Family History with Relation Added

To edit or delete a relation, refer to the Editing Family History or the Deleting Family History topics for details.

4.3.3 Editing Family History

To edit an existing family history relation, follow these steps:

1. In the Family History tab, select the record you want to change, and then click Edit Relation. The Family History dialog opens.

Note: You can also right-click in the line item and select Edit Relation from the menu.

2. Make the changes, as applicable. Refer to the Adding Family History topic for details about each field.
3. Add, edit, or delete Condition, in the Family History Condition dialog, select the line item of the condition, and then:
 - To add a Condition, refer to the Add a Condition section of the Adding Family History topic.
 - To edit a Condition, select the line item of the condition you want to edit, and then click the Edit Relation button (or right-click in the line item and select Edit Relation). The SNOMED CT Lookup dialog opens.
 - To delete a Condition, select the line item of the condition you want to delete, and click the Delete Relation button (or right-click in the line item and select Delete Relation). The Condition is deleted.
4. Click Save in the Family History dialog. Your changes show in the Family History list.

4.3.4 Deleting Family History

To delete an existing family history relation, follow these steps:

1. In the Family History tab, select the record you want to delete, and then click the Delete Relation button. The Delete Relation? information message appears.

Note: You can also right-click in the line item and select Delete from the menu.



Figure 4-73: Confirm Relation Delete Information Message

2. Click one of the following:
 - Click Yes to delete the selected record.
 - Click No to not delete the selected record.
 - Click Cancel to immediately leave the information message (no action taken).

Note: When you delete a Relation, it also deletes ALL conditions for that relation.

4.3.4.1 Deleting a Condition

If you only want to delete a condition:

1. Select the Relation line item, and then click Edit Relation. The Family History dialog opens.
2. In the Condition section of the Family History dialog, select the Condition you want to delete, and then click the Delete button (or right-click and then select Delete).

The screenshot shows a 'Family History' dialog box with the following fields:

- Relation: NATURAL MOTHER
- Name: Mabel
- Status: DECEASED
- Cause of Death: Pneumonia
- Age at Death: 60 and older
- Multiple Birth: NO
- Multiple Birth Type: (empty)

Below the fields is a table of conditions:

Provider Narrative Condition	SNOMED Desc Text	Age at Diagnosis	ICD
Family history: neoplasm -		62	V16.1
FH: Bronchitis Present since		8 (approx)	V17.6

Buttons: Save, Cancel, Add, Edit, Delete.

Figure 4-74: Delete Condition Line Item

The Delete Family? information message appears.

The screenshot shows a 'Delete Family?' dialog box with the following text:

Are you sure that you wish to delete the condition titled:
FH: Bronchitis | Present since childhood.

Buttons: Yes, No.

Figure 4-75: Delete Family (Condition) Information Message

- Click Yes to delete the condition (or click No to cancel the action).

4.3.5 Web Reference

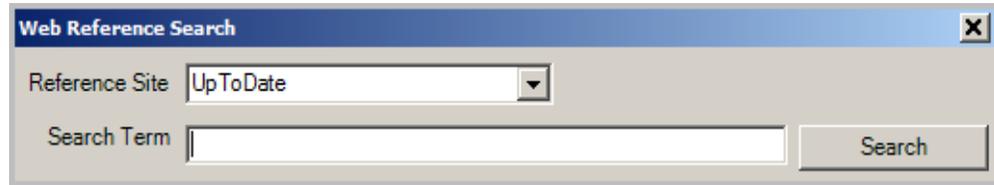
The Web Reference Search for the Family History component depends whether any records are present or not.

4.3.5.1 Web Reference Condition 1

If there are records present, select one and click the Information button (i) to go to the UpToDate Reference Web site for the topic associated with the selected record.

4.3.5.2 Web Reference Condition 2

1. If there are no records present or no record is selected, click the Information button to display the Web Reference Search dialog.



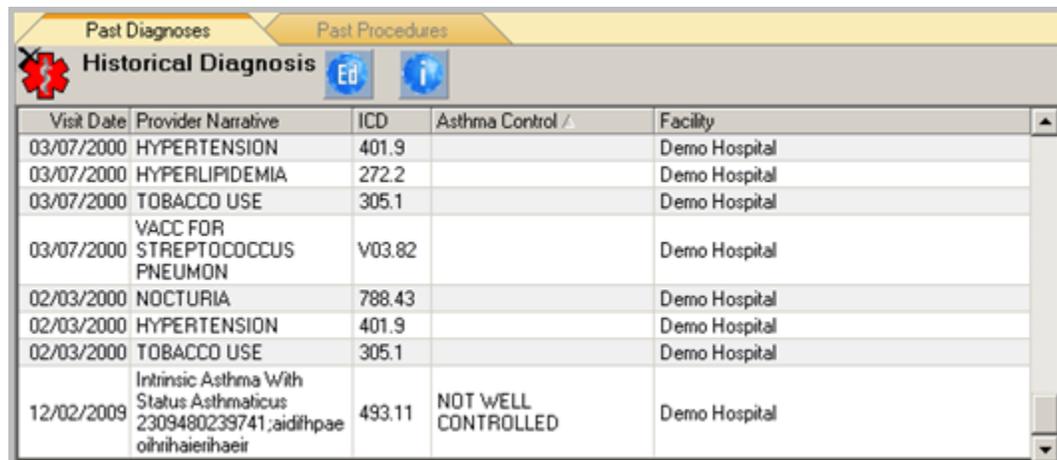
The image shows a dialog box titled "Web Reference Search". It has a close button (X) in the top right corner. Below the title bar, there is a "Reference Site" dropdown menu currently set to "UpToDate". Below that is a "Search Term" text input field. To the right of the input field is a "Search" button.

Figure 4-76: Web Reference Search

2. Select a Reference Site, if needed. The default is the UpToDate site.
3. After entering a term and clicking Search, you are taken to the selected Web site for the specified term.
4. You can change to another Web site by selecting from the Reference Site drop-down list (on the Web site). The drop-down list for the Reference Site field (on the Web Reference Search dialog) can be configured.

4.4 Historical Diagnosis

The Historical Diagnosis is a view-only component that shows the historical visits for the current patient and information regarding the diagnosis for the visit.



The image shows a screenshot of the "Historical Diagnosis" panel. At the top, there are tabs for "Past Diagnoses" and "Past Procedures". Below the tabs is a header area with a red cross icon, the text "Historical Diagnosis", and two circular icons labeled "EB" and "I". Below the header is a table with the following columns: "Visit Date", "Provider Narrative", "ICD", "Asthma Control", and "Facility".

Visit Date	Provider Narrative	ICD	Asthma Control	Facility
03/07/2000	HYPERTENSION	401.9		Demo Hospital
03/07/2000	HYPERLIPIDEMIA	272.2		Demo Hospital
03/07/2000	TOBACCO USE	305.1		Demo Hospital
03/07/2000	VACC FOR STREPTOCOCCUS PNEUMON	V03.82		Demo Hospital
02/03/2000	NOCTURIA	788.43		Demo Hospital
02/03/2000	HYPERTENSION	401.9		Demo Hospital
02/03/2000	TOBACCO USE	305.1		Demo Hospital
12/02/2009	Intrinsic Asthma With Status Asthmaticus 2309480239741;aidihpae oihrihaerhaeir	493.11	NOT WELL CONTROLLED	Demo Hospital

Figure 4-77: Historical Diagnosis Panel

View visit information by selecting a record and then selecting View Visit Detail on the right-click menu. The Visit Detail dialog opens.

4.4.1 Web Reference Search Function

There are two Web Reference search options available from the Historical Diagnosis component that enables the user to look up information on a highlighted diagnosis from the Provider Narrative column on the Historical Diagnosis dialog:

- Education Information button
- Clinical Decision Support button

The Web Reference search depends on if any records are present or not when you click either button.

- **Condition 1:** If there are records present, select a record and click either the Ed Information or the Clinical Decision Support button.

Note: You can change to a different Web site, if desired, by selecting from the Reference Site drop-down list.

- **Condition 2:** If there are no records present or if no record is selected, click either the Education Information button or the Clinical Decision Support button to display the Web Reference Search dialog. The UpToDate Web site is the default.

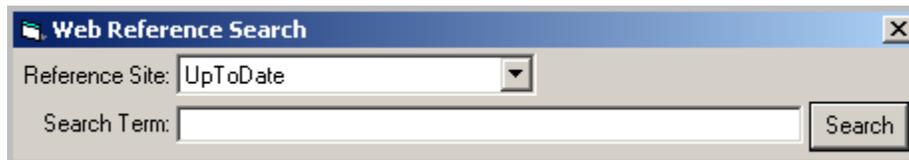


Figure 4-78: Web Reference Search dialog

Select a different Reference Site from the drop-down menu, if needed. After entering a term and clicking Search, the selected Web site opens for the specified term.

4.4.1.1 Education Information Button

When a patient diagnosis is selected, click the Education Information button. This sends a call to the MedlinePlus Web site to provide information regarding the selected topic and the MedlinePlus Web site opens to the related page.

Note: The Add Patient Education Event dialog also opens when the Education Information button is clicked. Patient education is tracked for Meaningful Use, therefore, the Add Patient Education Event dialog should be completed. Refer to the Patient Education Online Help for details on completing this dialog.



Figure 4-79 Medline Plus Web Site

4.4.1.2 Clinical Decision Support Button

When a patient diagnosis is selected, click the Clinical Decision Support button. This sends a call to the UpToDate Web site to provide information regarding the selected topic and the UpToDate Web site opens to the related page.

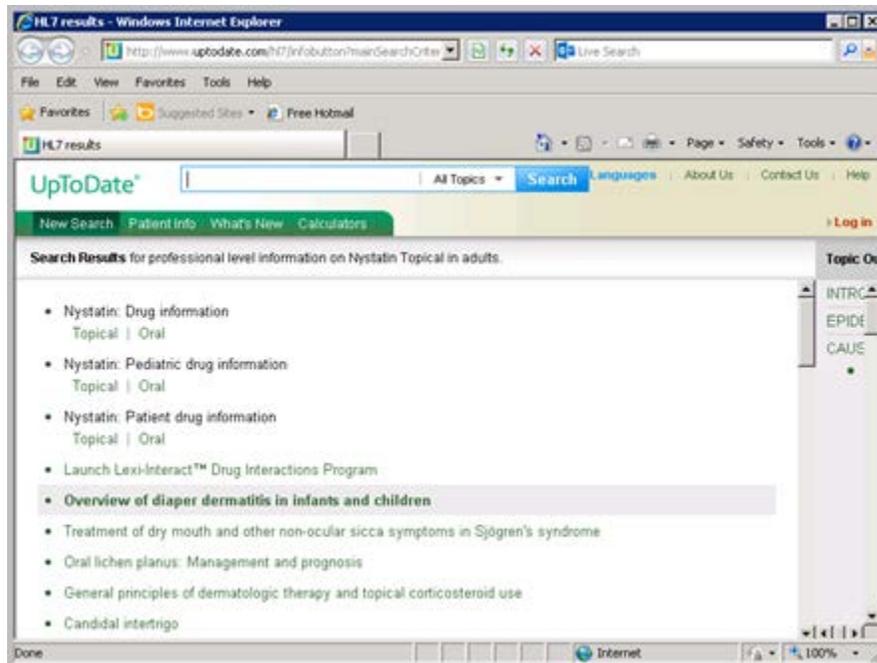


Figure 4-80: UpToDate Web Site

4.5 Immunizations

The Immunizations component enables the viewing, editing, and adding of immunization information for patients into the RPMS. It requires that version 8.0, or later, of the RPMS Immunization package be installed. This component enables the provider to see immediately which vaccines the patient has received and which ones are needed.

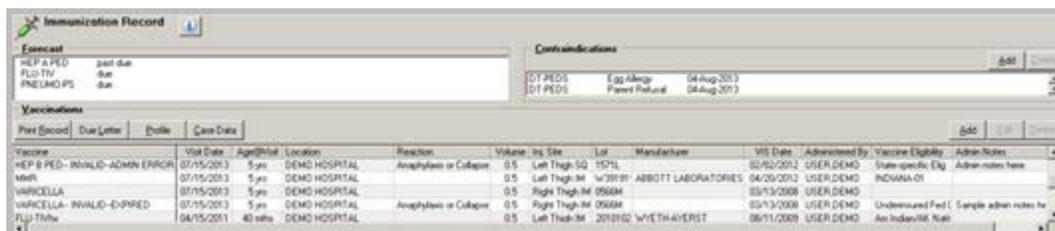


Figure 4-81: Immunization Panel

- The Forecast field contains the vaccinations that the patient needs, as derived from the ImmServe Forecasting System.
- The Contraindications field displays the patient's contraindications, such as a history of chicken pox or refusals for specific vaccines.
- The Vaccinations grid displays all vaccinations that have been entered into the RPMS. The vaccinations can be sorted by selecting a column heading. If no Vaccination information is present in the RPMS for a patient, the grid is empty.
- This component can be configured so that particular user or class cannot add/edit the immunization record.
- The Vaccinations panel has the Display Visit Detail option on the right-click menu. Use this option to display the Visit Detail for a selected record. See Display Visit Detail for more information

4.5.1 Selecting a Vaccine

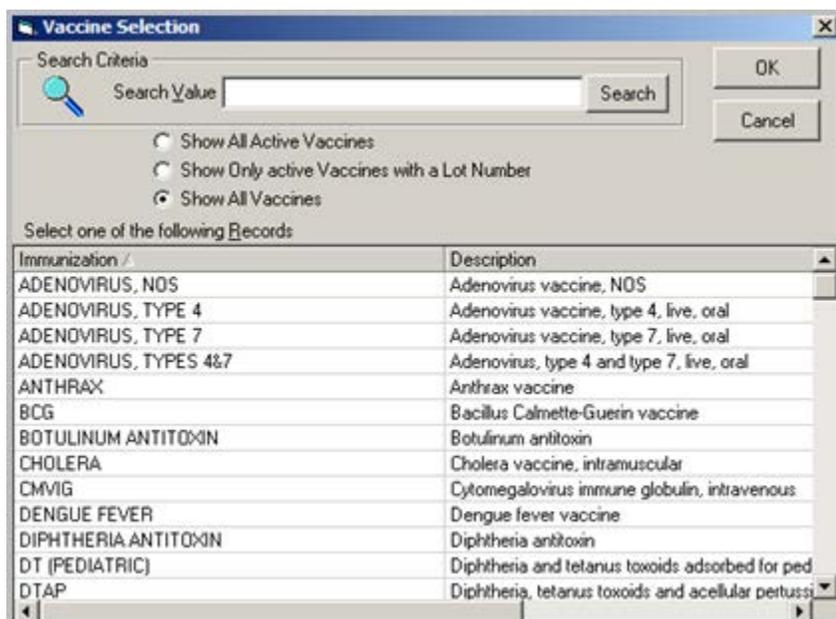


Figure 4-82: Selecting a Vaccine dialog

Follow these steps to select a vaccine:

1. The selection list on the Vaccine Selection dialog is initially populated with all vaccines. This can be changed to Show Only Active Vaccines with a Lot Number or Show All Active Vaccines by clicking that option button.

Note: If you select an Inactive vaccine, it is marked as a historical vaccination entry.

2. You can filter the list by entering a search value. The search value can either be the first few letters of an Immunization name, HL7-CVX code, or a Brand name. A long description of the vaccine can be displayed by briefly resting your mouse pointer on a vaccine entry in the grid.
3. To select an entry, double-click the vaccine entry in the grid, highlight it, and click OK, or highlight it and press Enter. (Otherwise, click Cancel).

4.5.2 Web Reference

The Web Reference Search for the Immunization component depends on whether any records are present or not.

- Condition 1: If there are records present, select one and click the Information button (or select the Web Reference option on the right-click menu) to go to the MedlinePlus Web site for the topic associated with the selected record. You can

change to another Web site by selecting from the Reference Site drop-down list (on the Web site).

- Condition 2: If there are no records present or if no record is selected, click the Information button (or select the Web Reference option on the right-click menu) to display the Web Reference Search dialog.

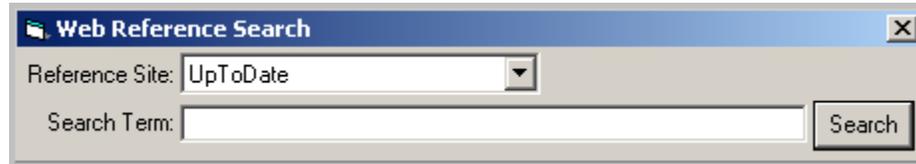


Figure 4-83: Web Reference Search dialog

Select a Reference Site, if needed. The default is the MedlinePlus Web site. After entering a term and clicking Search, the selected Web site for the specified term appears. You can change to another Web site by selecting from the Reference Site drop-down list (on the Web site).

4.5.3 Vaccinations Group Box

You can add new or historical immunizations regardless of whether the patient is a child or adult, or is included in the immunization registry or not. New immunizations are those that are given for a visit, whereas historical or those that were given in the past and typically would be for an outside facility or place. It is important to note that for non-historic visits, the date and location of the immunization correspond to the currently selected encounter in the EHR, which can be for past dates.

4.5.3.1 Adding a Vaccination

Follow these steps to add a Vaccination:

1. Click Add on the Vaccinations group box (or select Add Vaccination on the right-click menu) to display the Vaccine Selection dialog. Here you select a vaccine. See Selecting a Vaccine for more information.
2. The selected vaccine populates the Vaccine field on the Add Immunization dialog.

If you choose to add an Immunization for which the patient has a related contraindication, the application displays an alert and asks if you want to continue.

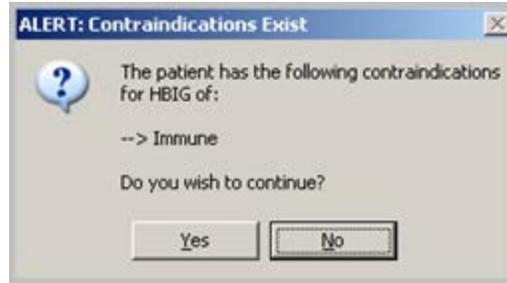


Figure 4-84: Contraindication Alertuser123u

The following topics address information about the Current, Historical, and Not Done option buttons.

4.5.3.1.1 Current

1. If a compound vaccine is selected, then a separate immunization record is added for each component.

Figure 4-85: Add Immunization dialog

2. You can change the Administered By field, if necessary. Click the Ellipsis button to select another person.

3. In the Lot field, select the applicable lot and manufacturer from the drop-down menu.
4. Populate the Injection Site field by selecting from the drop-down list.
5. For common vaccines, the application automatically loads default values for the Volume, Vaccine Information Sheet, and Given fields. You can change any of these fields.

Note: If you select an expired lot number, a warning message is displayed in bold red lettering above the Lot field.

6. The Given field contains the exact date and time that the immunization was administered. The default is the current date and time. You can change the date by clicking the Ellipsis button and selecting from a calendar.
7. If you counseled the patient/family about the immunization, select the Patient/Family Counseled by Provider check box. If you selected this check box and saved the record, the EHR populates the Vaccinations component with a record and populates the Education component with a record.
8. In the Vac. Eligibility field, select an applicable vaccination eligibility from the drop-down menu.
9. In the Admin Notes field, type any applicable notes.
10. When the Add Immunization dialog is complete, click OK to add the vaccination to the Vaccinations group box. (Otherwise, click Cancel.)

4.5.3.1.2 Historical

Historical immunizations are those that were given in the past and typically would be for an outside facility or place.

Adding a historic immunization results in an historic visit being created that cannot be billed or exported.

Note: You can add a historical record by not selecting a visit and clicking the Add button on the Vaccinations group box. The Add Historical Immunization dialog displays.

To add a historical record:

1. Select the Historical option button on the Add Immunization dialog to display the Add Historical Immunization dialog.

Figure 4-86: Add Historical Immunization dialog

2. Manually type the event date (must be historical) or click the Ellipsis button to select from a calendar.
3. Populate the Location field. This field has a right-click menu to aid in editing the information.
 - If the location is an official IHS facility, make sure the IHS/Tribal Facility option button is checked. You can select the location from the Lookup Utility dialog by clicking the Ellipsis button. If you manually enter a facility name, it must be an official IHS facility. If not, when you leave the field, the Lookup Utility dialog displays.
 - If the location is not an official IHS facility, check the Other option button. Enter the non-official location (for example, Dr. Name Example).
 - If your site has been configured with a default outside location, type OTHER in the Location field. Then, when the View Visit Detail dialog displays, the default outside location displays at the LOC. OF ENCOUNTER field.
4. In the Admin Notes field, type any notes, as needed.
5. When the Add Historical Immunization dialog is complete, click OK to add the historic vaccination to the Vaccinations group box. (Otherwise, click Cancel.)

4.5.3.1.3 Not Done

Enter the immunization refusal information on the Add Immunization dialog by selecting the Not Done option button to display the Add Immunization Not Provided/Refused dialog.

Figure 4-87: Add Immunization Refusal dialog

1. If the Vaccine is incorrect, click the Ellipsis button to select another one. See Selecting a Vaccine for more information.
2. If needed, change the Documented By field by clicking the Ellipsis button to select another person.
3. The Event Date defaults to the current date. If needed, change the event date by clicking the Ellipsis button to select from a calendar.
4. Select the Reason from the drop-down list.
5. Click OK when the dialog is complete. This adds an immunization refusal record to the Vaccinations group box, as well as adding a Not Done record to the Personal Health component. (Otherwise, click Cancel.)

4.5.3.2 Editing a Vaccination

Make sure a visit is selected. Follow these steps to edit a vaccination:

1. Highlight a vaccination record on the Vaccinations grid that you want to edit.

Note: Vaccinations can only be edited until the visit is locked.

2. Click Edit on the Vaccinations group box (or select Edit Vaccination on the right-click menu) to display the Edit Immunization dialog. The existing information about the selected record displays.

Figure 4-88: Edit Immunization dialog

3. To edit the fields above the Reaction field, see Adding a Vaccination.
4. You can edit the Dose Override field only if you have been assigned the BIZ EDIT PATIENTS security key and would typically not be specified.
5. The Dose Override field affects the forecasting. It ignores invalid doses and counts forced valid doses. The field is used to force a dose valid (if given a day or so early but will not affect school) or invalid (due to expired vaccine, and so on).
6. Enter a reaction by selecting from the drop-down list for the Reaction field.
7. When a reaction is entered, if it is either: 'Anaphylaxis, Convulsions, Lethargy, or Fever>104', then a corresponding contraindication is automatically added.
8. Otherwise, you are asked if it should be added as a contraindication for the patient. If you answer yes, a contraindication of Other Allergy is added.

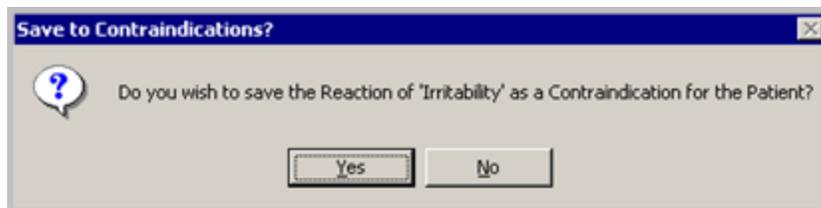


Figure 4-89: Information Message when Saving Contraindication

9. Click Yes to save the reaction as a contraindication. (Otherwise, click No.)
10. When the Edit Immunization dialog is complete, click OK to change the information about the selected record. (Otherwise, click Cancel.)

4.5.3.3 Deleting a Vaccination

To delete a vaccination:

1. Highlight a vaccination record in the Vaccinations group box that you want to delete.

Note: Vaccinations can only be deleted on an unlocked visit.

2. Click Delete (or select Delete Vaccination on the right-click menu) to display the Remove Vaccination? information message.

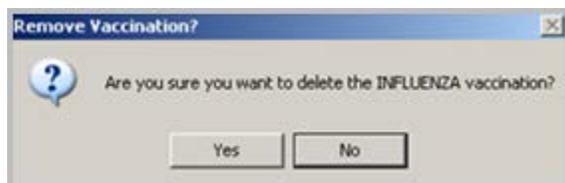


Figure 4-90: Remove Vaccination Information Message

3. Click Yes to remove the vaccination from the Vaccinations grid. (Otherwise, click No.)

4.5.4 Vaccinations Group Box Buttons

The following information provides information about the buttons on the Vaccinations group box.

4.5.4.1 Print Record Button

1. Click the Print Record button (or select Print Official Record on the right-click menu) in the Vaccinations group box to display/print the Official Immunization Record information for the current patient.

The Print Record button requires that a letter template has been selected (in RPMS).

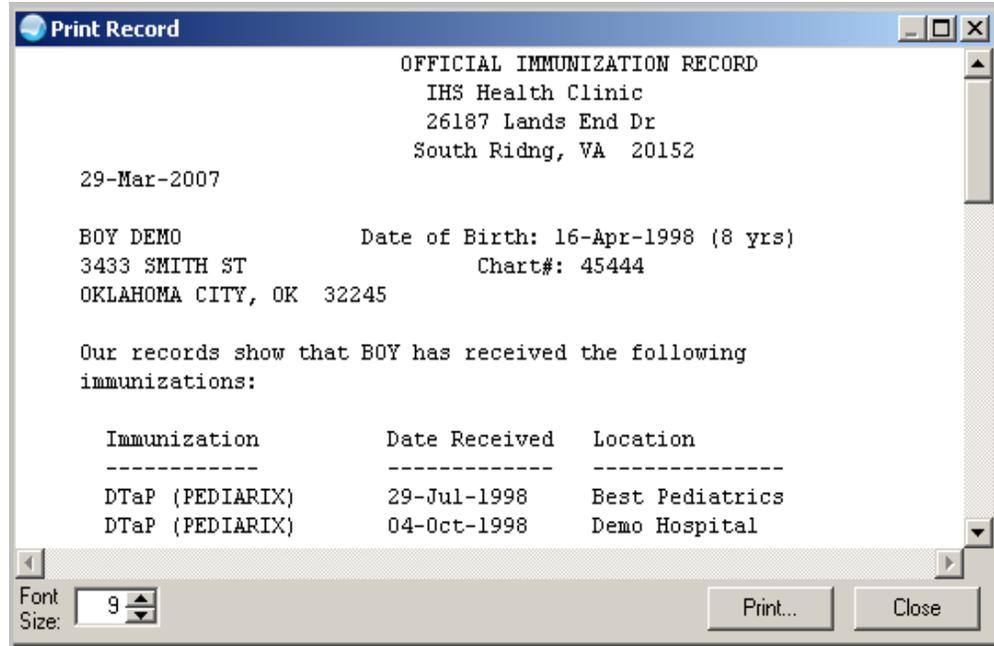


Figure 4-91: Official Immunization Record

- You can change the font size of the text displayed in this dialog by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows).

Note: This does not change the size of the text on the output (when you print).

- Click Print to choose a printer and to output the (entire) contents of this dialog to the specified printer. The dialog has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

Note: The Print button may not appear. It depends on how your application is configured.

- Click Close to dismiss the dialog.

4.5.4.2 Due Letter Button

- Click the Due Letter button (or select Print Due Letter on the right-click menu) in the Vaccinations group box to display/print the Due Letter. This letter is a reminder to make an appointment for the patient for the needed immunizations.

The Due Letter button requires that a letter template has been selected (in RPMS).



Figure 4-92: Due Letter

- You can change the font size of the text displayed in this dialog by adjusting the size in the Font Size field (enter manually or use the up and down arrows).

Note: This does not change the size of the text on the output (when you print).

- Click Print to choose a printer and to output the (entire) contents of this dialog to the specified printer. The dialog has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

Note: The Print button may not appear. It depends on how your application is configured.

- Click Close to dismiss the dialog.

4.5.4.3 Profile Button

- Click the Profile button (or select Print Profile on the right-click menu) in the Vaccinations group box to display/print the Immunization Profile dialog. This provides information about the patient's immunization profile.

This button requires that the forecaster is installed and the immunization site parameters need to be configured to point to the forecaster.

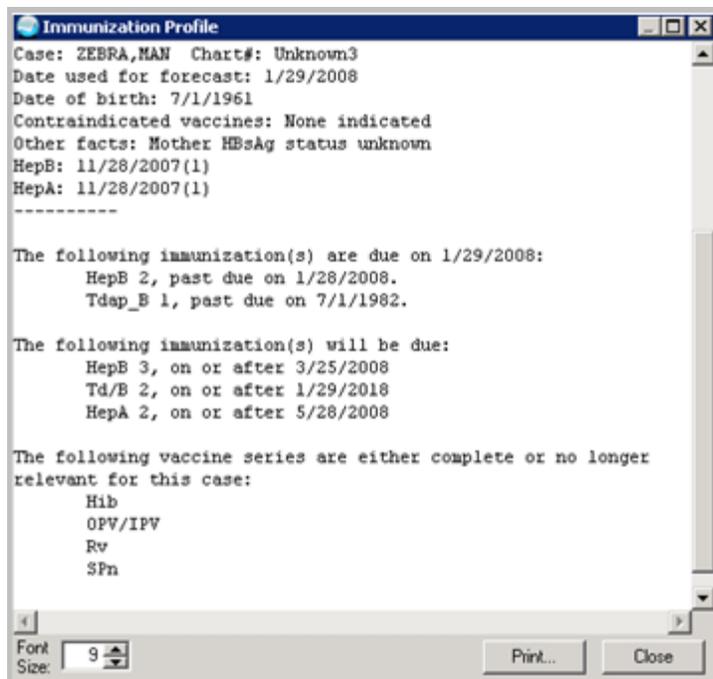


Figure 4-93: Immunization Profile Information

- You can change the font size of the text displayed in this dialog by adjusting the size in the Font Size field (enter manually or use the up and down arrows).

Note: This does not change the size of the text on the output (when you print).

- Click Print to choose a printer and to output the (entire) contents of this dialog to the specified printer. The dialog has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

Note: The Print button may not appear. It depends on how your application is configured.

- Click Close to dismiss the dialog.

4.5.4.4 Case Data Button

Click the Case Data button (or select Case Data on the right-click menu) in the Vaccinations group box to view/edit the Immunization Register data for the patient. The user must have the BIZ EDIT PATIENTS key turned off in order to use this button.

Since the Immunization Register is a very actively managed register and reports only those patients that have an ACTIVE status, the panel is used to case manage the immunization register.

Click the Case Data button to display the Edit Patient Case Data dialog.

Figure 4-94: Edit Active Patient Case Data

4.5.4.4.1 Active/Inactive (Option Buttons)

This indicates the status of the patient in the immunization register. All children from birth to 36 months that live in Government Performance and Results Act of 1993 (GPRA) communities are automatically ACTIVE. On review of children, some are changed to INACTIVE if they fit the MOGE (Moved or Going Elsewhere) criteria.

When you choose to change to INACTIVE status, you need to justify or explain why. In the Moved To/Elsewhere field, you indicate where the patient went, such as El Rio Clinic, for example. The Inactive Date is very important because the child is included in all reports up to that inactive date. Since children and their parents do not report that they have moved away (they just stop coming to the clinic), this function gives those producing GPRA reports a way to have a more accurate denominator to track and do the GPRA reports.

Figure 4-95: Inactive Data Group Box Fields

- If you include the name in the Parent/Guardian field, that information is included in the reminder letters.
- The Other Info field is where the case manager can enter anything that might be valuable.
 1. You can populate the remaining field by selecting from the drop-down lists.
 2. Click OK to update the immunization register with the entered data. (Otherwise, click Cancel.)

4.5.5 Contraindications Group Box

If the patient has had a contraindication or refusal to an immunization, you can record it with the corresponding reason being specified. Any contraindications entered for the patient are displayed in the Immunization component, and you are alerted if the associated vaccine is subsequently selected.

4.5.5.1 Adding a Contraindication

Make sure a visit is selected. To add patient contraindications, follow these steps:

1. Click Add on the Contraindications group box (or select Add Contraindication on the right-click menu) to display the Enter Patient Contraindication dialog.

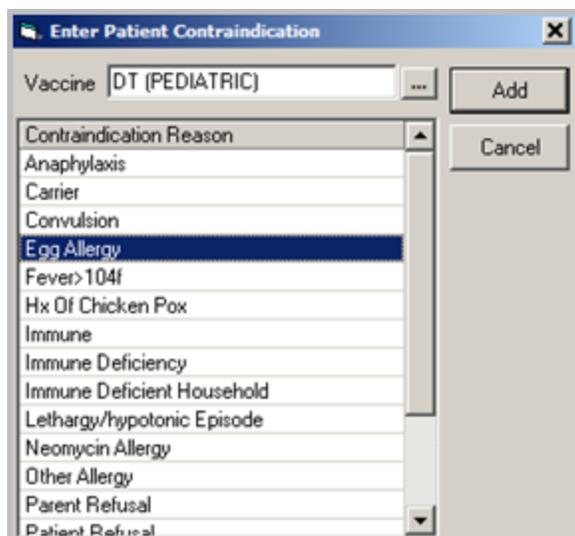


Figure 4-96: Adding a Contraindication dialog

2. Click the Ellipsis button at the end of the Vaccine field to display the Vaccine Selection dialog. Here you select a vaccine. See Selecting a Vaccine for more information. The selected vaccine displays in the Vaccine field of the Enter Patient Contraindication dialog.
3. Click Yes to continue on the Enter Patient Contraindication dialog. (Otherwise, click No).
4. Highlight the Contraindication Reason. You may need to use the scroll bars to find the correct reason.
5. When the Enter Patient Contraindication dialog is complete, click Add to add the contraindication to the Contraindications panel. (Otherwise, click Cancel.)

The contraindication shows in the Contraindications group box and in the patient's Official Immunization Record.

4.5.5.2 Deleting a Contraindication

To delete a contraindication:

1. Highlight a contraindication record in the Contraindications group box that you want to delete.
2. Click Delete (or select Delete Contraindication on the right-click menu) to display the Remove Contraindication? information message.

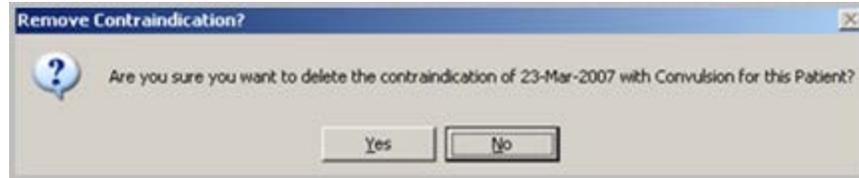


Figure 4-97: Remove Contraindication Information Message

3. Click Yes to remove the contraindication from the Contraindication field. (Otherwise, click No.)

4.5.6 Display Visit Detail

The Immunization component has the Display Visit Detail option on the right-click menu.

1. Select any record and select the Display Visit Detail option. The Visit Detail displays.

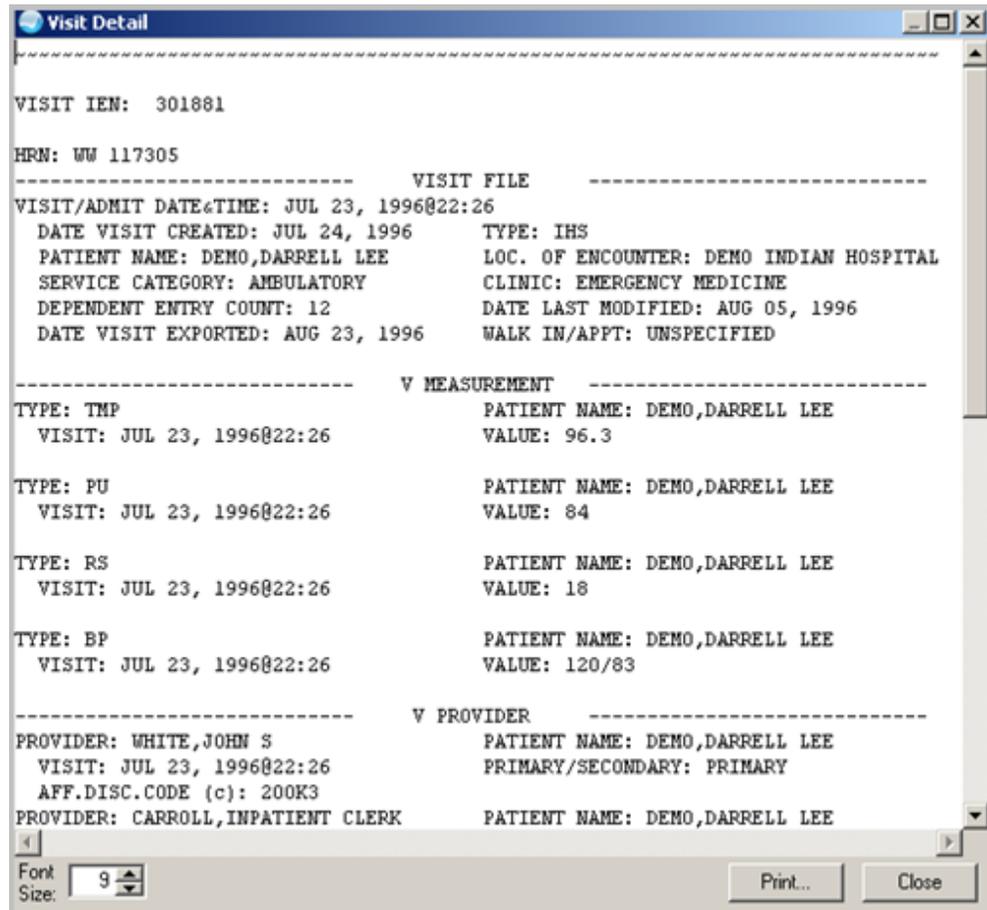


Figure 4-98: Visit Detail

- You can change the font size of the text displayed in the Visit Detail dialog by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows).

Note: This does not change the size of the text on the output (when you print).

- Click Print to choose a printer and to output the (entire) contents of the Visit Detail to the specified printer.

Note: The Print button may not be there. It is according to how your application is configured.

- The Visit Detail has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).
- Click Close to dismiss the Visit Detail dialog.

4.5.7 Using the Lookup Utility dialog for Location

Access the Lookup Utility by clicking the Ellipsis button at the end of the Location field. This dialog can be used to search for and select a location for the Location field.

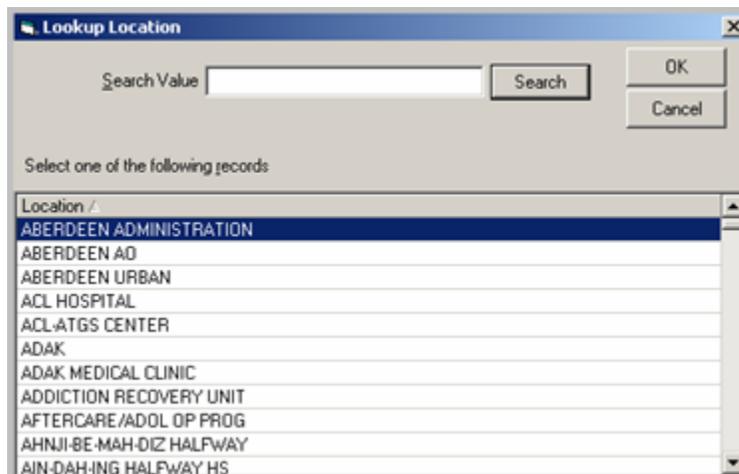


Figure 4-99: Initial Lookup Location dialog

To complete the Lookup Location dialog:

- You can scroll the list to the location and select it. Otherwise you can search for a location.
- To search for a location, type of few characters in the Search Value field and click Search.

The appropriate locations display in the lower part of the dialog. If this is not the location you are searching for, repeat Step 2.

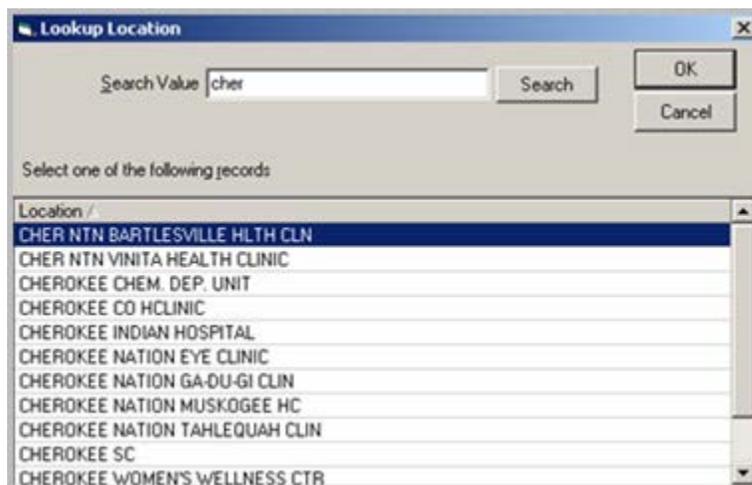


Figure 4-100: Lookup Location dialog After Search

- Highlight the appropriate record in the lower panel and click OK. The selected record populates the Location field. (Otherwise, click Cancel.)

4.6 Infant Feeding

The Infant Feeding component is only active for children less than five years old. Otherwise, the Not Applicable message displays.

Infant Feeding			
Infant Feeding History			
	Feeding Choice	Entry Date	Secondary Fluids
0	1/2 & 1/2 BREAST AND FORMUL	08/07/2013 14:08	
0	MOSTLY BREASTFEEDING	08/07/2013 14:02	MILK (2%)
1	1/2 & 1/2 BREAST AND FORMUL	07/29/2013 14:07	MILK (Milk twice a day), FRUIT JUICE (Juice Once a day)
1	MOSTLY BREASTFEEDING	07/12/2013 07:51	
1	FORMULA ONLY	05/28/2013 11:51	

Figure 4-101: Active Infant Feeding Component

- The Infant Feeding History grid displays the feeding choices, the event dates already entered for the current (infant) patient, and any secondary fluids given to the infant. The records are listed in date order, with the most recent on top. This component requires that a visit is selected in order to update the data.
- A red 1 in the column before the Feeding Choice column indicates the visit is locked (and the record cannot be edited), and a zero indicates the visit is not locked and can be edited.
- This data is collected because it is used in conjunction with the Childhood Weight Control GPRA measure. This is a long-term measure to support the reduction of

the incidence of childhood obesity. Breastfeeding rates are used in the PART report for congress and Office of Management and Budget (OMB). Additionally, facilities can use this data to track infant feeding patterns and breastfeeding rates within their own patient populations.

4.6.1 Add/Update Feeding Choice

Click the Add or Edit button on the Infant Feeding component, or [right-click](#) and select Add or Edit to add or update the feeding choice record. The Infant Feeding Choice dialog opens.

Figure 4-102: Infant Feeding Choice dialog

The list allows only one selection. To change a selected option button, click the new option button to de-select the previous selection.

The selections are defined as follows:

- Exclusive Breastfeed: Formula supplementing less than three times per week (<3x per week).
- ½ Breast, ½ Formula: Half the time breastfeeding, half the time formula feeding.
- Formula only: Baby receives only formula.
- Mostly Breastfeed: Formula supplementing three or more times per week (>3x per week) but otherwise mostly breastfeeding.
- Mostly Breastfeed, some Formula.
- Mostly Formula, some Breastfeed.
- Mostly Formula: The baby is mostly formula fed, but breastfeeds at least once a week.

4.6.1.1 Secondary Fluids

The Secondary Fluids section becomes active when any option besides Exclusive Breastfeed, 1/2 Breast 1/2 Formula, or Formula only is selected. Select one or more of the following, as applicable:

Note: An optional comment can be typed in the field next to your selection (for example, to specify the fat content of the milk given).

- Milk
- Fruit juice
- Carbonated drink
- Sports drink
- Glucose
- Water

Click OK to add the record to the Infant Feeding component (otherwise, click Cancel). The application displays the feeding choice, the event date (today's date), and any secondary fluids for the record in the Infant Feeding component and stores the SNOMED CT codes associated with the feeding choices in the V Infant Feeding Choices file.

4.6.2 Right-Click Menu

A right-click menu is available in the Infant Feeding component.

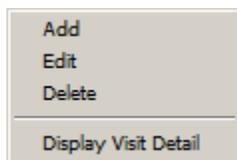


Figure 4-103: Infant Feeding Right-Click Menu

- Add: Select to add infant feeding data. Refer to Add/Update Feeding Choice for details.
- Edit: Select to edit infant feeding data. Refer to Add/Update Feeding Choice for details.
- Delete: Select to delete the record. Refer to Delete Feeding Choice for details.
- Display Visit Detail: Opens the Visit Detail dialog which can be used to view and print visit information.

4.6.3 Delete Feeding Choice

If the visit associated with the particular record is not locked, the Delete button can be used to remove a particular record in the Infant Feeding component.

Select a record in the grid and then click Delete, or right-click and select Delete. The Remove Record? information message opens.

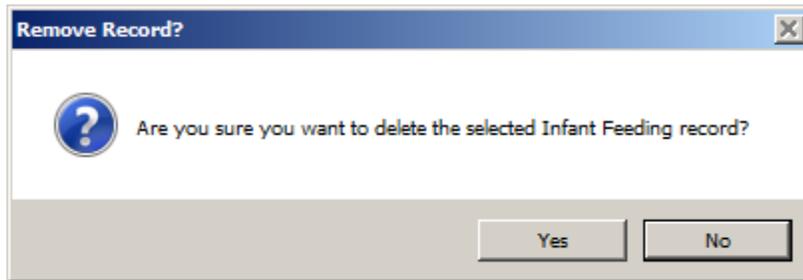


Figure 4-104: Remove Record? Information Message

Click Yes to delete the record. (Otherwise, click No.)

4.7 Lab

4.7.1 Viewing Laboratory Test Results

To view lab test results, follow these steps:

1. Select the Labs component.
2. In the Lab Results box, click the type of results you want to see.

Note: A  sign by a lab test means it has a schedule.

3. Some of the results need you to determine which test results you want to see. If the Select Lab Test dialog appears, you need to choose the tests you want to see.
 - a. If necessary, select the tests for which you want to see the results.
 - b. Also, you may need to choose a date range (Today, One Week, Two Weeks, One Month, Six Months, One Year, Two Years, or All Results).

4.7.1.1 Most Recent

The Most Recent lab result view shows you the lab tests in reverse chronological order. You can then Step through one at a time using the forward and backward buttons or go to the first or last using the buttons with the double arrows.

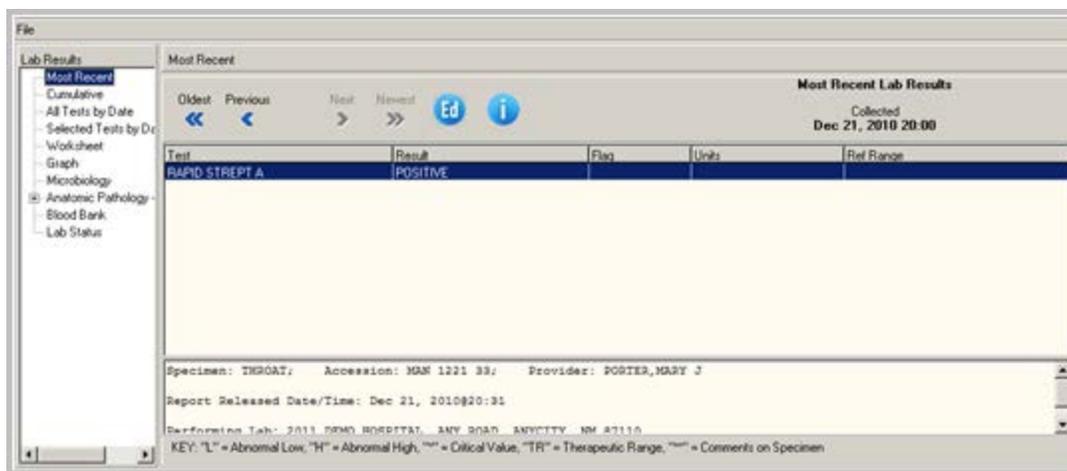


Figure 4-105: Most Recent Laboratory Results Window

4.7.1.2 Cumulative

The cumulative report is the most comprehensive lab report. It displays all of the patient’s lab results. When selecting a large data range, this report may take some time before being displayed. The results are organized into sections. You can automatically scroll to that section by selecting it in the Headings list box.

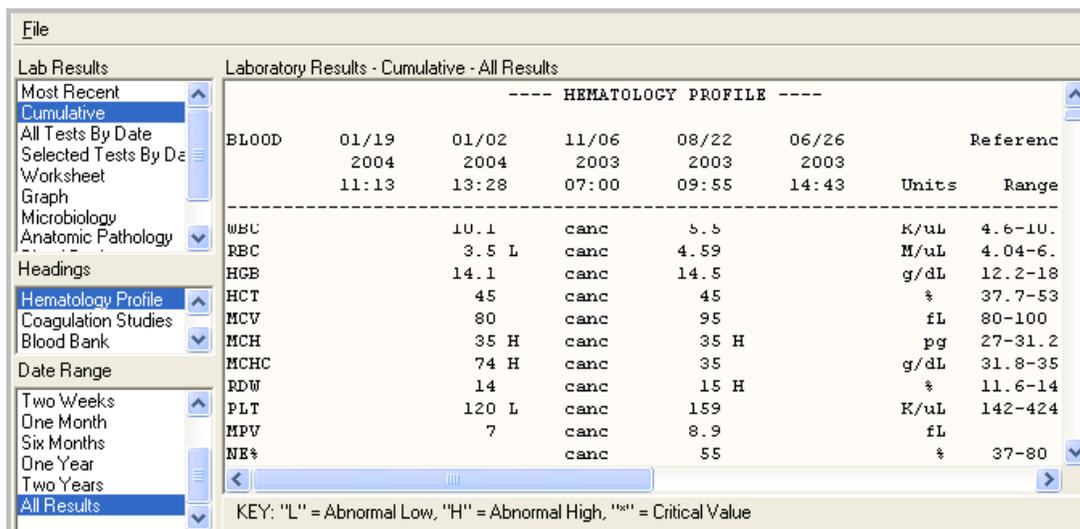


Figure 4-106: Cumulative Report

4.7.1.3 All Tests by Date

This report displays all lab results (except anatomic pathology and blood bank). The data is displayed in the order of the time of collection.

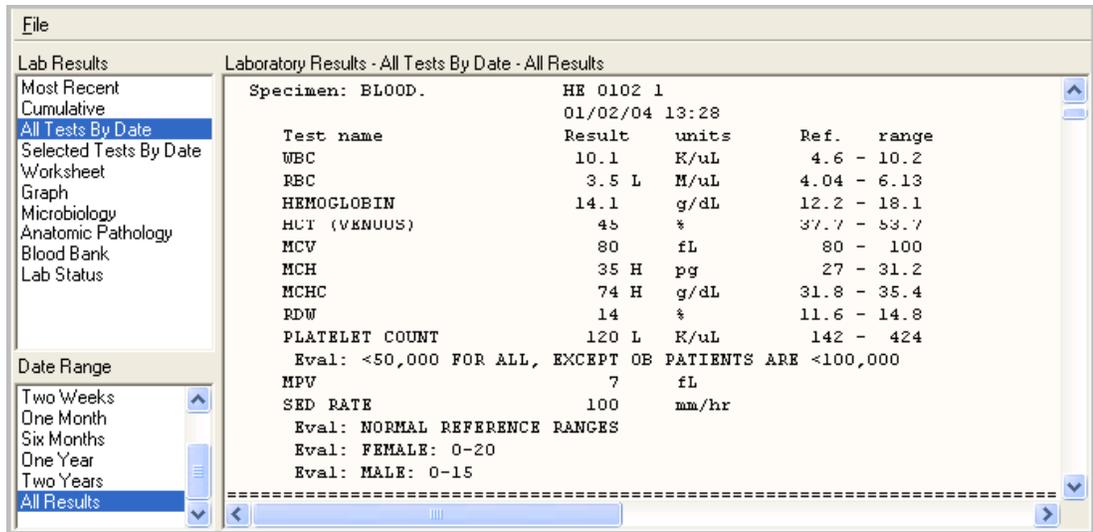


Figure 4-107: All Tests by Date Laboratory Results Report

4.7.1.4 Selected Tests by Date

This report is useful when you only want to review only specific tests. Microbiology results can also be selected. You will be prompted to select any lab tests:

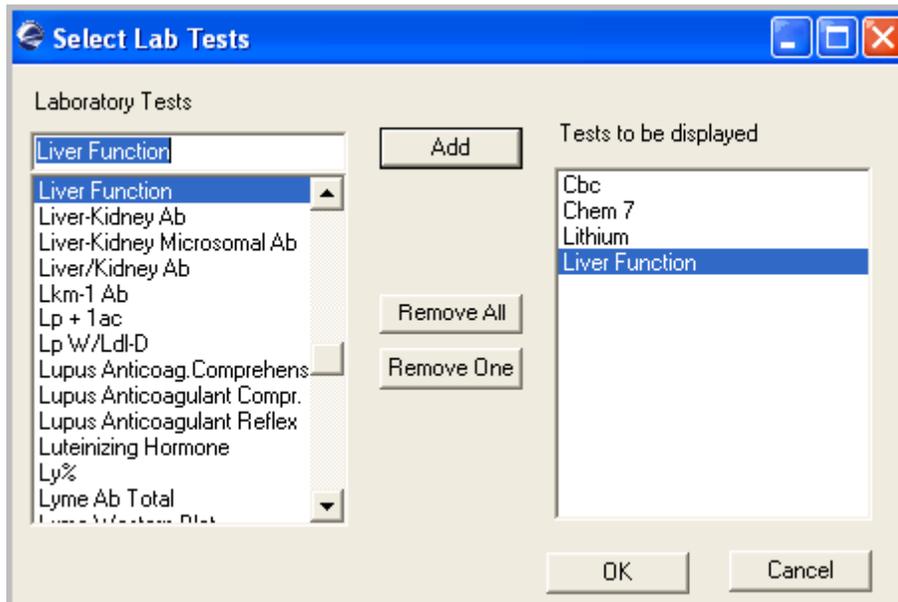


Figure 4-108:Select Laboratory Tests dialog

In the example, if you select CBC, Chem 7, Lithium, and Liver Functions, only the results for those tests would be displayed:

File

Lab Results

Laboratory Results - Selected Tests By Date - Six Months

RBC	3.5 L	M/uL	4.04 - 6.13
HEMOGLOBIN	14.1	g/dL	12.2 - 18.1
HCT (VENOUS)	45	%	37.7 - 53.7
MCV	80	fL	80 - 100
MCH	35 H	pg	27 - 31.2
MCHC	74 H	g/dL	31.8 - 35.4
RDW	14	%	11.6 - 14.8
PLATELET COUNT	120 L	K/uL	142 - 424
Eval: <50,000 FOR ALL, EXCEPT OB PATIENTS ARE <100,000			
MPV	7	fL	

Provider : OSBORN,REBEKAH O
Specimen: BLOOD.
CH 1113 57
11/13/03 13:27

Test name	Result	units	Ref.	range
GLUCOSE	120 H	mg/dL	70	- 110
UREA NITROGEN	23 H	mg/dL	6	- 20

KEY: "L" = Abnormal Low, "H" = Abnormal High, "!" = Critical Value

Figure 4-109: Select Lab Results

4.7.1.5 Worksheet

The Worksheet is similar to the Selected Test by Date report. It does not display microbiology results, but it has many features for viewing lab results. It is very useful for displaying particular types of patterns of results.

Tests can be selected individually or by test groups. Any number of tests can be displayed. When selecting a panel test, such as CBC, the panel will be expanded to show the individual tests. Tests can be restricted to only display results for a specific specimen type. For example, displaying glucose results only on CSF can be accomplished by selecting the specimen CSF and then selecting the test Glucose.

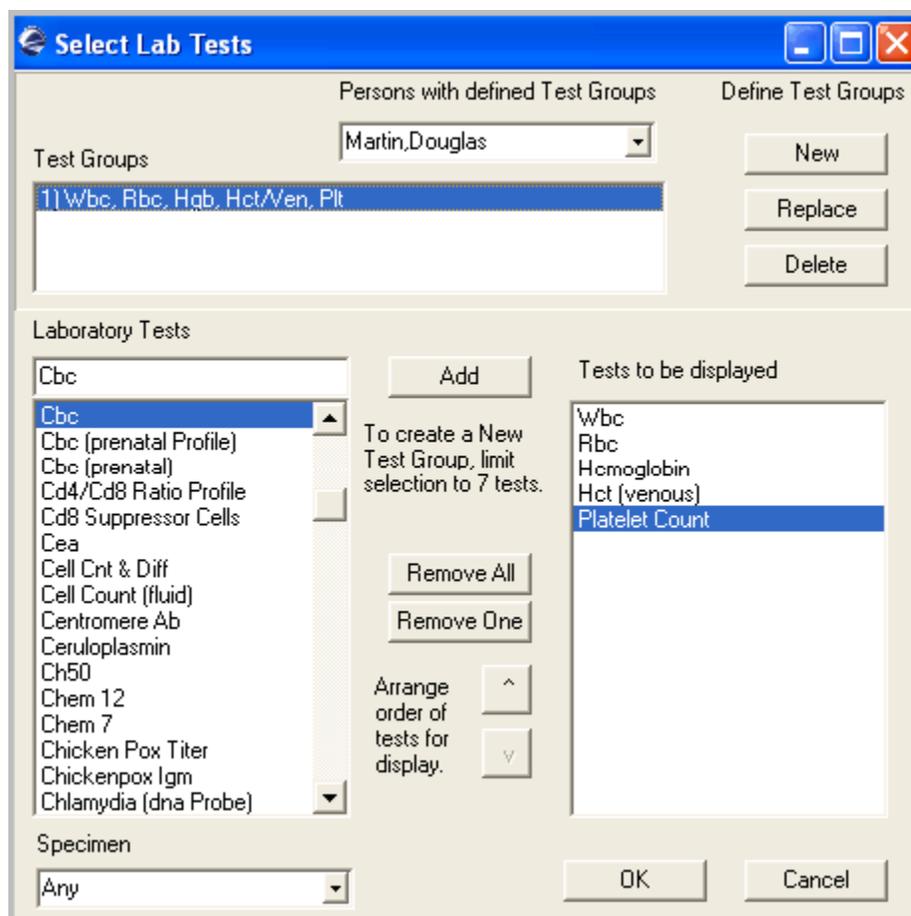


Figure 4-110: Select Laboratory Test Worksheet

Test groups enable you to combine tests in any manner. For example, a test group could combine CBC, BUN, Creatinine, and Platelet count. You can save those test groups for later use. You can also select test groups that other users have created. You cannot exchange or delete other's test groups, only your own. Test groups are limited to seven tests, but you may have an unlimited number of test groups.

To define your own test groups, select those tests you want and click the New button. If more than seven tests are selected, the New button will be disabled. If you want to delete a test group, deselect it and click the Delete button. If you want to replace an existing test group with other tests, select the test group, make any changes to the tests to be displayed and click the Replace button.

Note: These test groups are the same as those you may have already created using the Lab package. The seven-test restriction is a limitation of the Lab package.

The Worksheet display is a table of results that can be displayed vertically or horizontally. Since only results are displayed in a table, comments are footnoted with

a ** and shows in the panel below the table. You can filter the results to only show abnormal values. This will quickly show tests that have results beyond their reference values.

Date/Time	Specimen	WBC	RBC	HGB	HCT/VEN	MCV	MCH	MCHC
01/02/04 13:28	Blood	10.1	3.5 L	14.1	45	80	35 H	74 H
11/13/03 13:27	Blood							
11/11/03 12:13	Blood **							
11/06/03 07:00	Blood	canc	canc	canc	canc	canc	canc	canc
08/22/03 09:55	Blood **	5.5	4.59	14.5	45	95	35 H	35
08/21/03 16:57	Blood							
08/01/03 09:24	Urine							
08/01/03 09:07	Urine							

Nov 11, 2003@12:13 ** Comments:
DEMO
GLUCOSE reported incorrectly as 110 by [5183].

Figure 4-111: Worksheet Display

4.7.2 Graphing Lab Results

You can choose to view lab test results as a graph. Each occurrence of a test is a point on the graph. EHR draws lines between the points to form a visual representation that can help you see trends. The results are shown in blue. Dotted red lines show the high and low reference values for the test.

You can use the following features by clicking the check box when viewing the graph:

- **Zoom:** Enables the enlargement of a part of the graph by clicking and dragging from above and to the left of the area to below and to the right of it.
- **3D:** Makes the graph into a simple three-dimensional representation.
- **Values:** Places the numerical results next to each point on the graph.

The following figure shows an example of the graph feature being used.

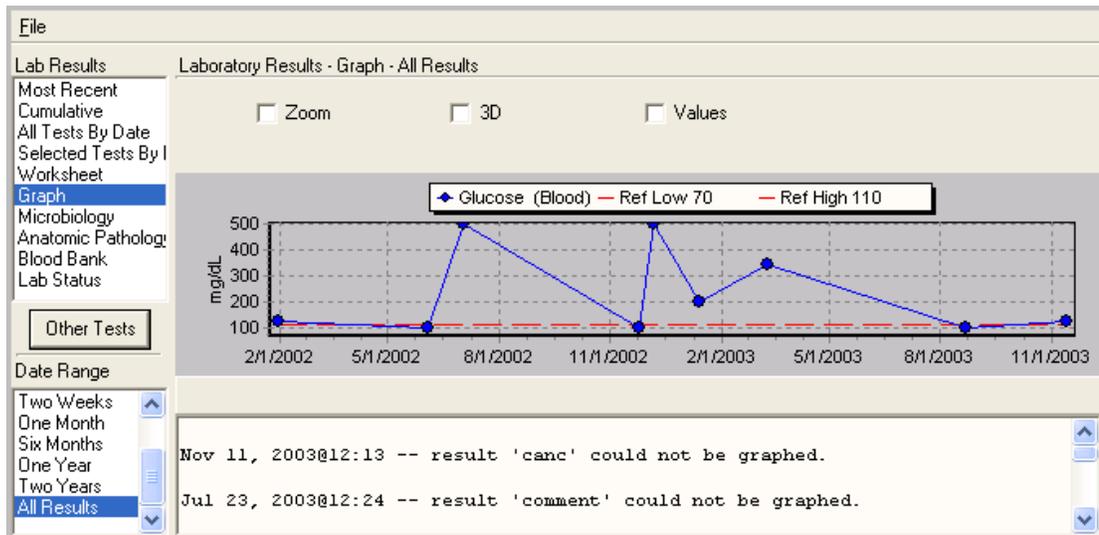


Figure 4-112: Laboratory Graph Feature

If you have created the clinical indexes, the updating graphing will be available on the Lab tab.

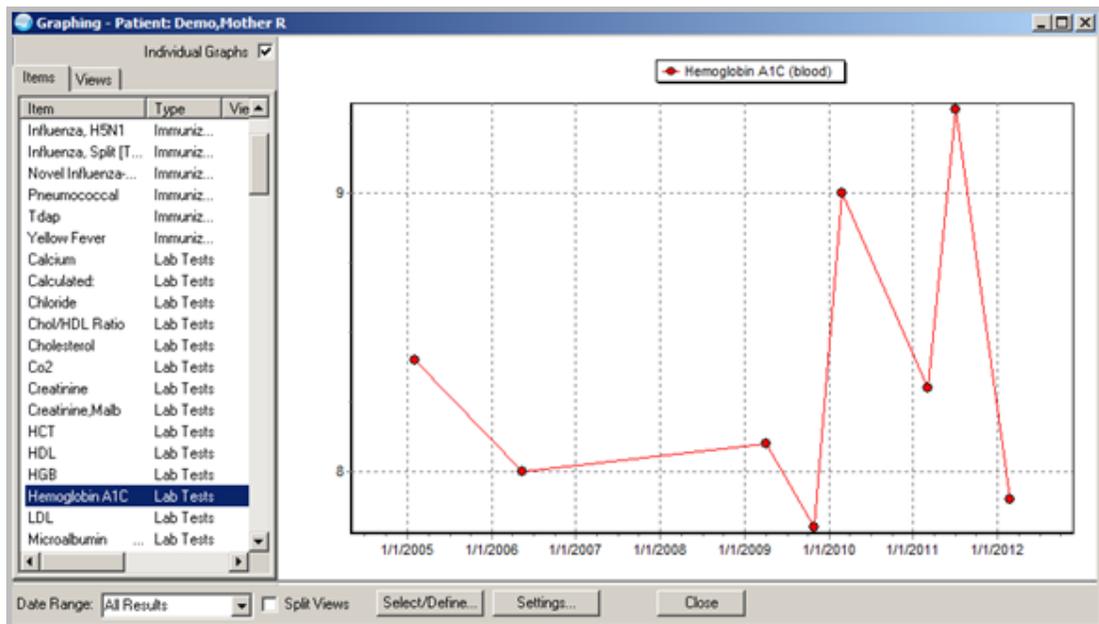


Figure 4-113: Updated Lab Graphing

Users can select multiple labs at a time and either view them separately or all together. Lab results can also be graphed with other data elements such as medications and vital signs.

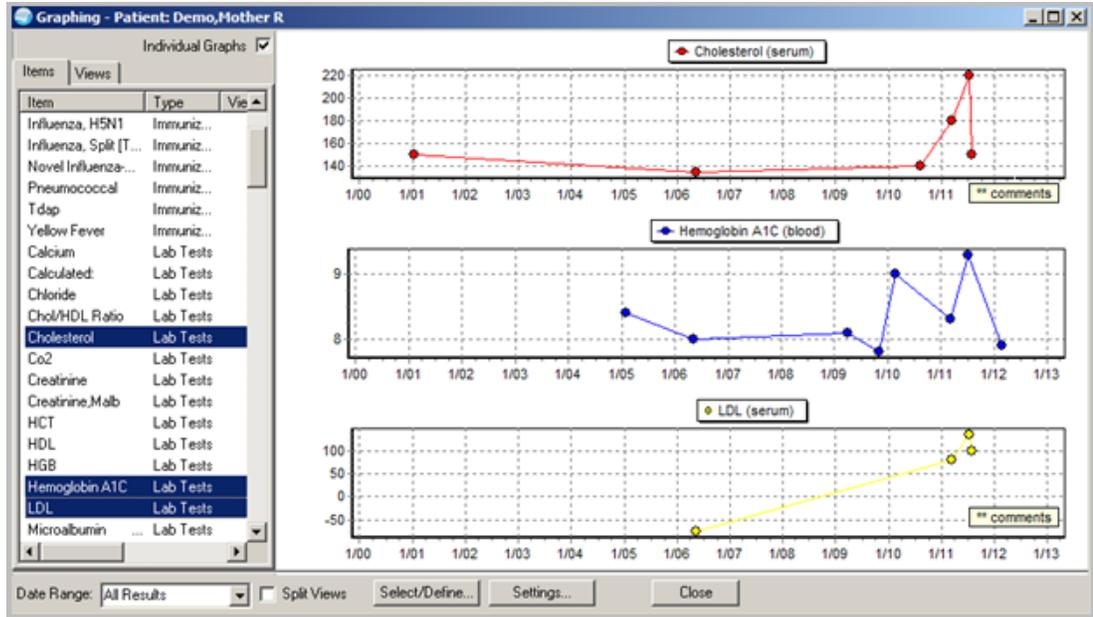


Figure 4-114: Separate Graphs for Tests

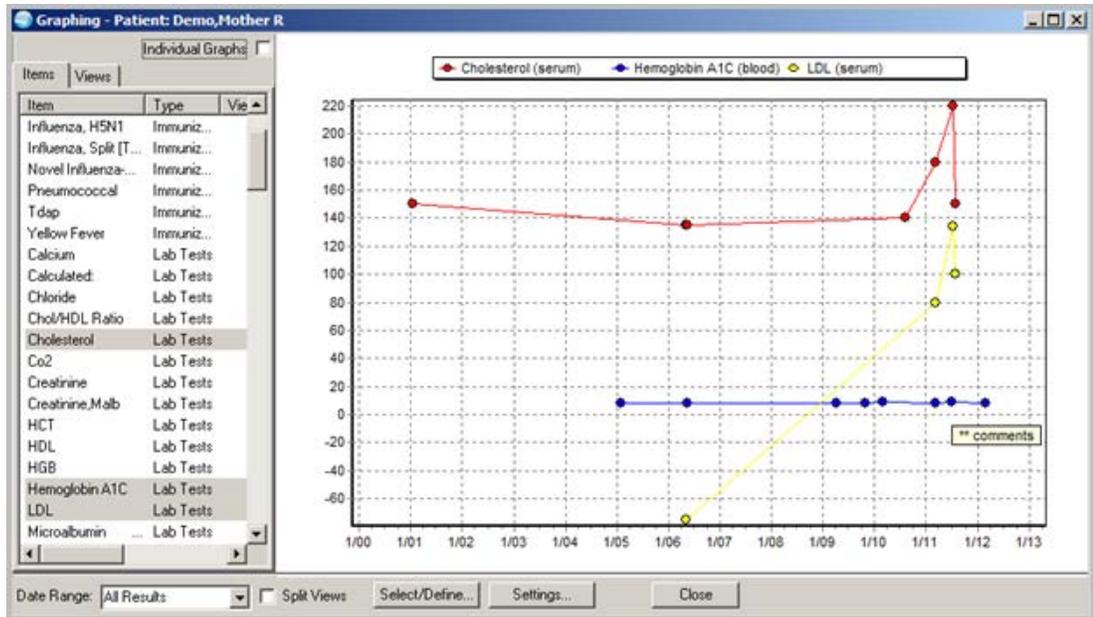


Figure 4-115: Combined Graph for Tests

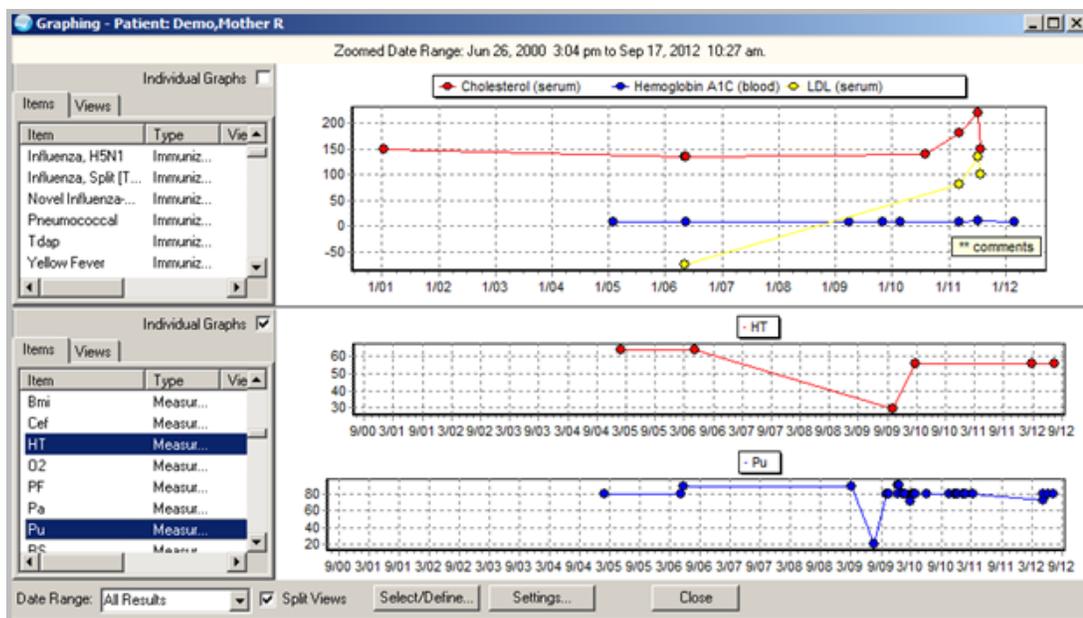


Figure 4-116: Split Views with Multiple Graphs

Users can set which items they want to appear in the graph and save them as a personal default. Only users with specific graphing keys can make public views.

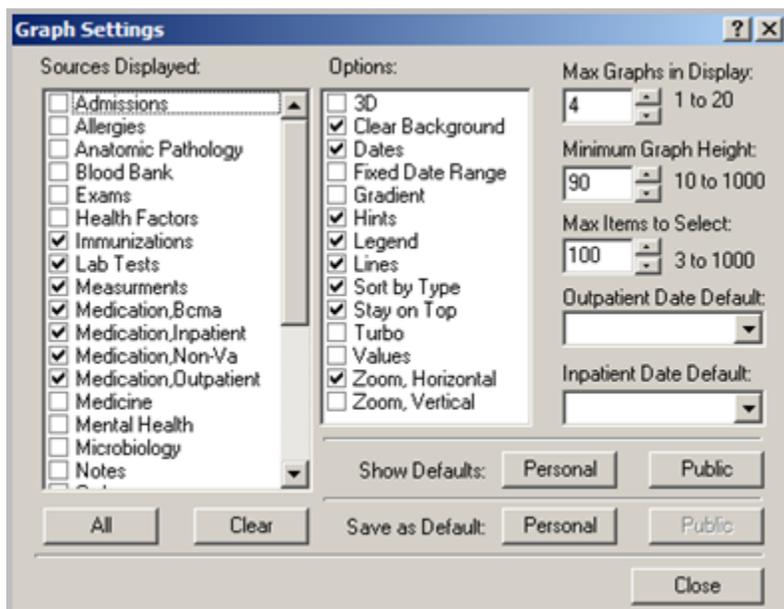


Figure 4-117: Graph Settings dialog

Users can still make their own Lab groups and then use them for graphing.

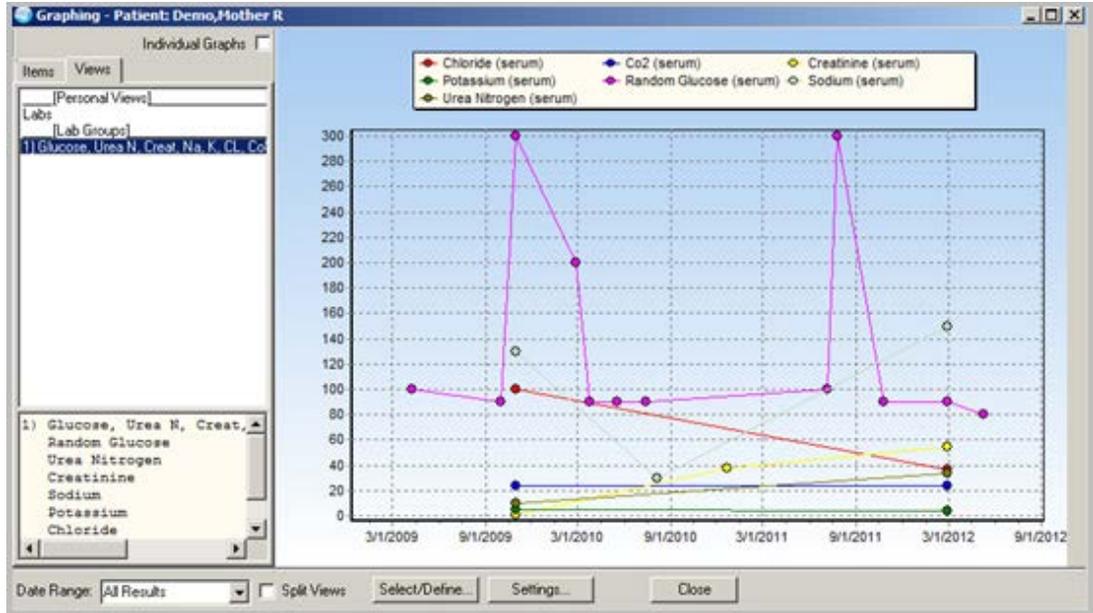


Figure 4-118: Lab Groups

Refer to Graphing for additional information.

4.7.3 Microbiology

Microbiology shows you the results from microbiology for the specified time period.

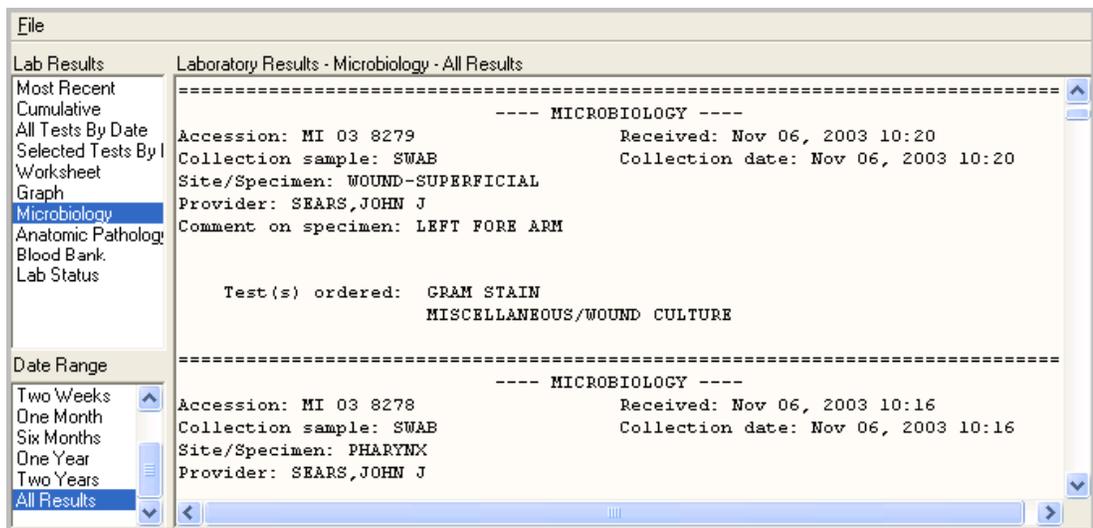


Figure 4-119: Microbiology Laboratory Results

4.7.4 Anatomic Pathology

Anatomic Pathology shows you the results in this section for the specified time period.

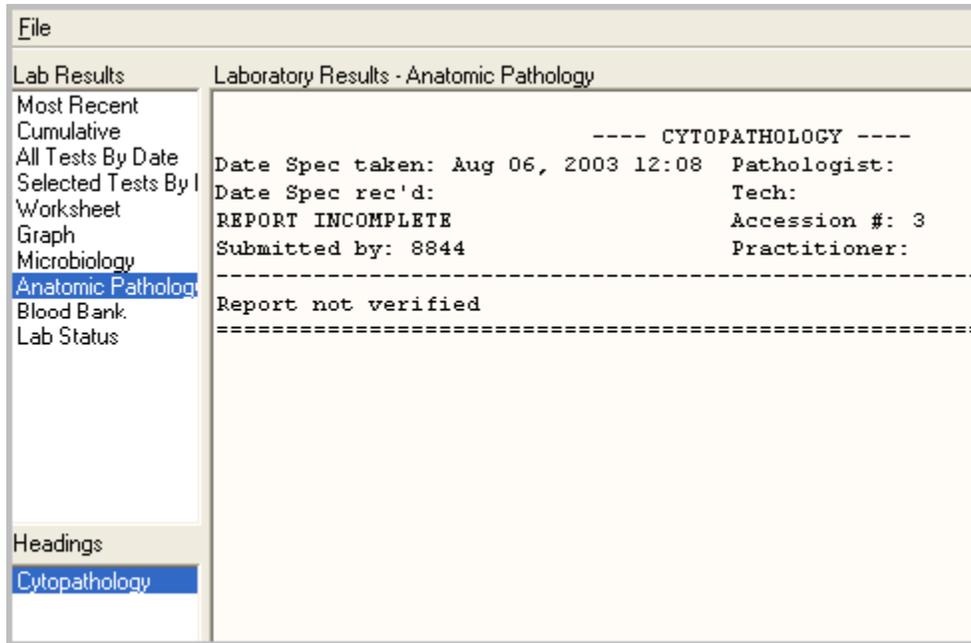


Figure 4-120: Anatomic Pathology Laboratory Results

4.7.5 Blood Bank

Blood Bank shows any blood that was requested. It also shows the results of any screening and if the patient has any blood products in the blood bank.

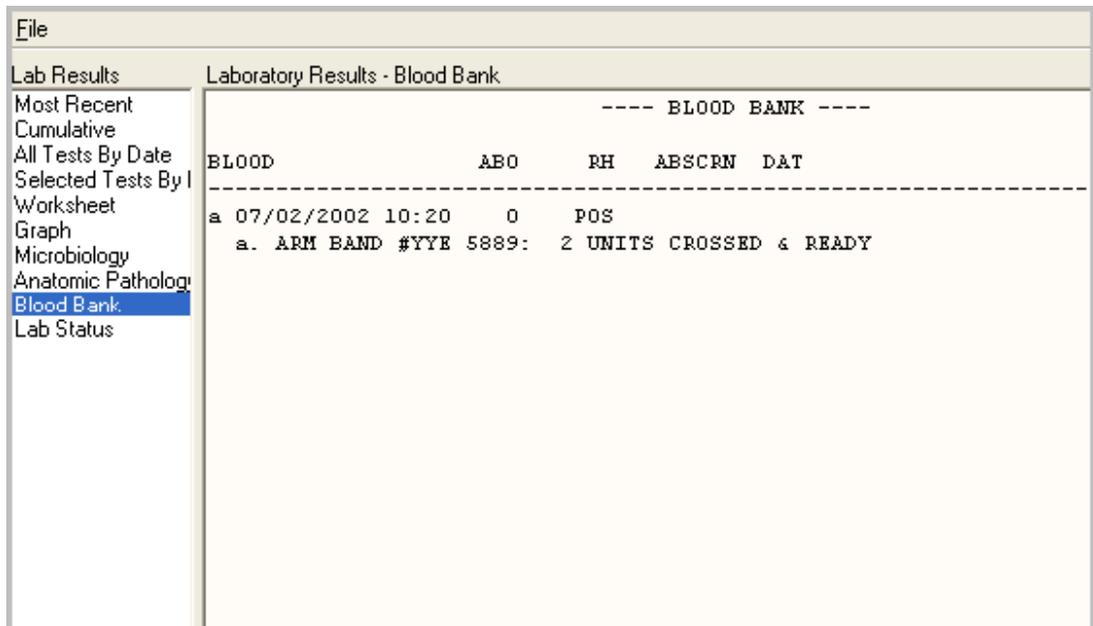


Figure 4-121: Blood Bank Laboratory Results

4.7.6 Lab Status

As the name implies, you can use this option to check on the status of labs that have been ordered for the selected patient. The orders are grouped by date and show the order number, the type of lab ordered, the provider, the urgency, and the status.

The screenshot shows a window titled "Laboratory Results - Lab Status - All Results". On the left is a navigation pane with options like "Lab Results", "Most Recent", "Cumulative", "All Tests By Date", "Selected Tests By I", "Worksheet", "Graph", "Microbiology", "Anatomic Pathology", "Blood Bank", "Lab Status", "Date Range", "Two Weeks", "One Month", "Six Months", "One Year", "Two Years", and "All Results". The main area displays lab orders grouped by date:

Test	Urgency	Status	Accession
Orders for date: 01/19/04			
Lab Order # 23439			Provider: MARTIN,DOUGLAS
BLOOD			
ANA TITER	ROUTINE	Test Complete	01/19/2004 11:14 LC 04 3
Lab Order # 23439			Provider: MARTIN,DOUGLAS
BLOOD			
SED RATE	ROUTINE	Test Complete	01/19/2004 11:15 HE 0119 1
Orders for date: 01/02/04			
Lab Order # 14421			Provider: MARTIN,DOUGLAS
BLOOD			
CBC	ROUTINE	Test Complete	01/02/2004 13:31 HE 0102 1
SED RATE	ROUTINE	Test Complete	01/02/2004 13:31 HE 0102 1
Orders for date: 11/13/03			
Lab Order # 116028			Provider: CARROLL,MARK F

Figure 4-122: Lab Status Laboratory Results

4.7.7 Graphing

Enhanced Graphing is incorporated in the Labs and Reports tabs. This Graphing requires the Clinical Indexes, which are part of PXR 1009. Once EHR 11 is installed, the site will build all the Clinical Indexes for Graphing to work appropriately.

Not all of the data sources that the VA graphs are available at this time in the EHR. This is mainly due to differences between the two systems, with different files and fields being utilized.

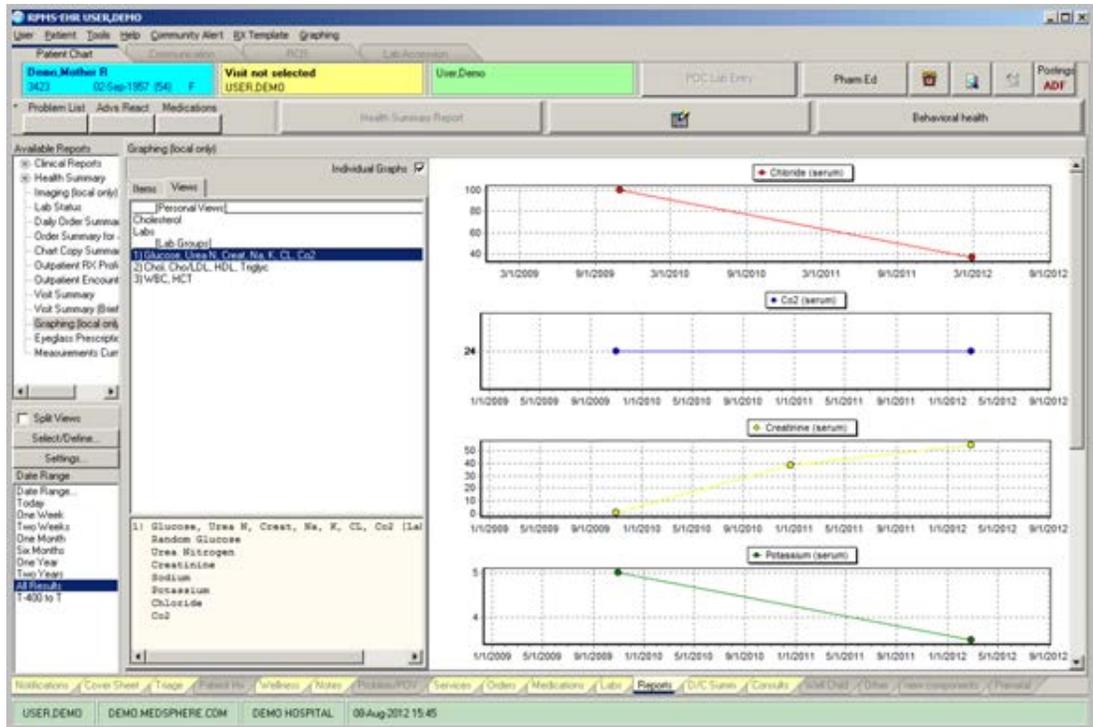


Figure 4-123: Graphing Tool

4.7.7.1 Types of Graphing

EHR Graphing displays all items that are not Laboratory tests, vitals, or medications (Inpatient, non-VA, or Outpatient) as single events. Representations for single events use only the horizontal axis. EHR Graphing uses triangle-shaped representations to mark these items.

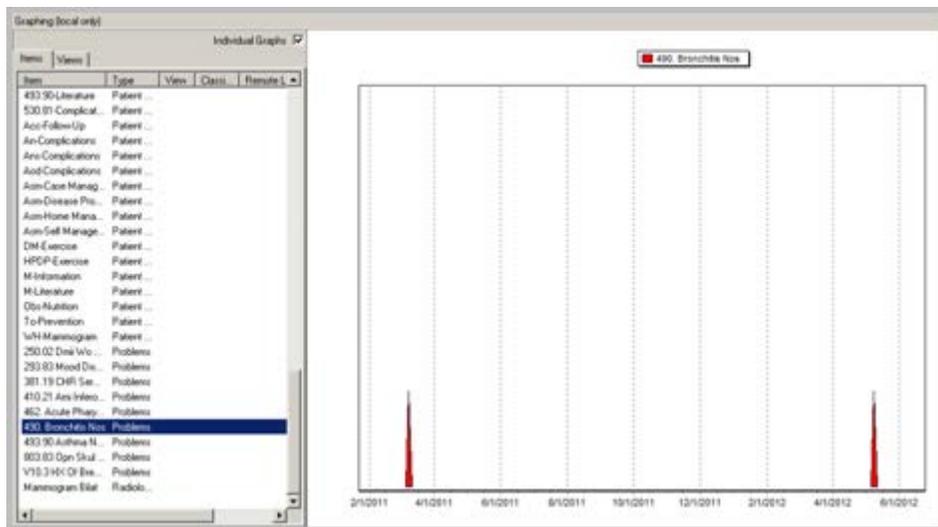


Figure 4-124: POV Graphing

4.7.7.1.1 Medication Graphing

EHR Graphing displays medications as bars that indicate a period of time. In the case of Outpatient medications, the bars begin on the horizontal axis at the release date of the medications. End dates are based on the following calculation:

medication release date + number of days supply = end date

For Inpatient and non-VA medications, the bars begin at medication Start Times and Dates, and end at medication Stop Times and Dates. In the case of non-VA medications, if no Stop Date exists, CPRS Graphing uses the Current Date as the Stop Date.

EHR Graphing differentiates multiple medications by color and vertically offsets them to ensure the visibility of overlapping bars.

Important: Healthcare professionals have no reliable way to determine whether patients do or do not take their Outpatient medications. Use caution when graphing relationships between Outpatient medications and other items.

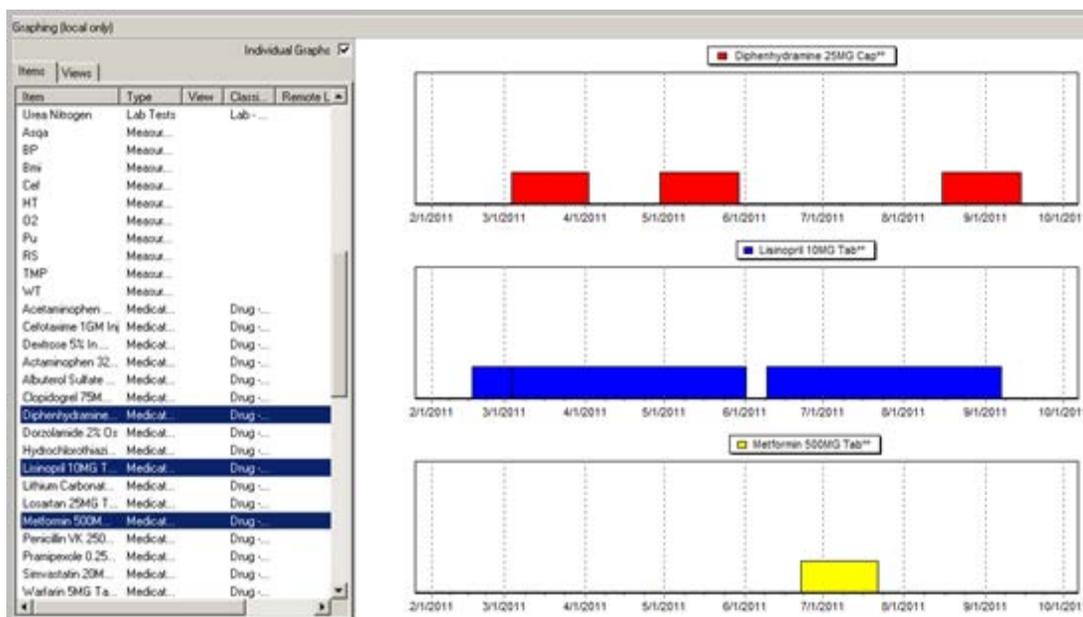


Figure 4-125: Graphing Multiple Medications

EHR Graphing displays Vitals Measurements as points on two axes. If more than one measurement exists for a given date and time, EHR Graphing connects measurements for like items with a line.

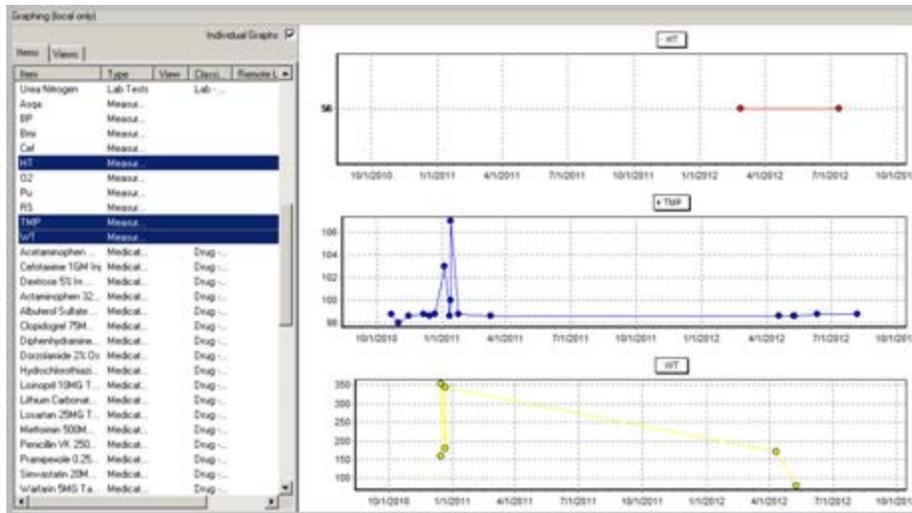


Figure 4-126: Vital Graphing

EHR Graphing also displays as points on two axes laboratory tests that have results with numerical values. Lines connect like items.

It displays Lab tests with non-numerical results (positive and negative results, for example) as points on the horizontal axis. It does not connect like items that have non-numerical results. To keep them out of the way of numerical data, EHR Graphing displays non-numerical results above or below the numerical values and line.

Values beginning with > are located at the top margin; others are graphed at the bottom margin. Free-text values display by default as do comments. To hide or show free-text values, click the Free-Text Values: label.

Comments are displayed in yellow boxes on the date axis, while the **comments label shows that there are comments. Clicking this label will show details of all items on the graph.

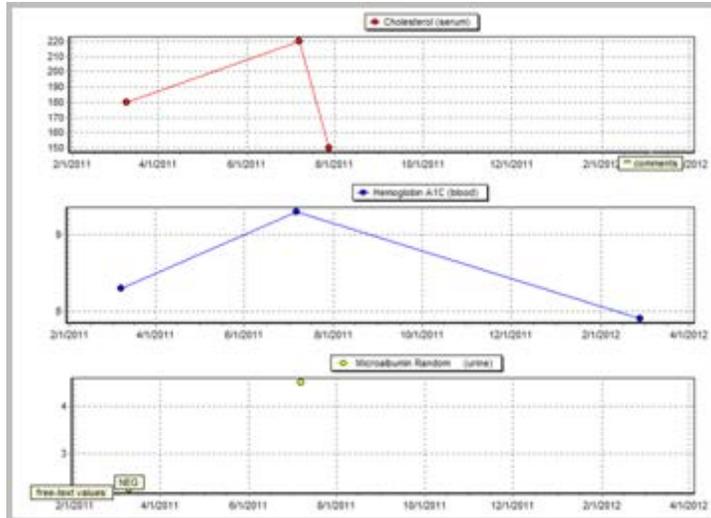


Figure 4-127: Lab Values

4.7.7.2 Viewing Graphs

Patients' information is listed on the left side of the graph. The time search can be changed in the bottom-left corner. Graphs can be viewed singly by selecting an item to view. The following is the TMP over the last year:

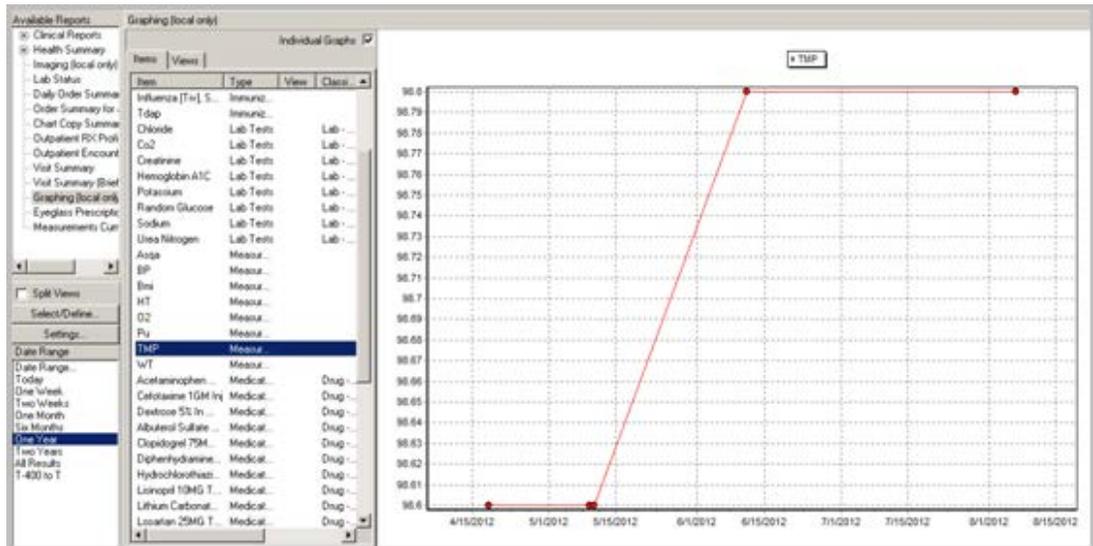


Figure 4-128: One Item

You can select multiple items to view by select an item in the selection box, holding the Ctrl key, and selecting other options. Next are the TMP, WT, and Pulse over one year.

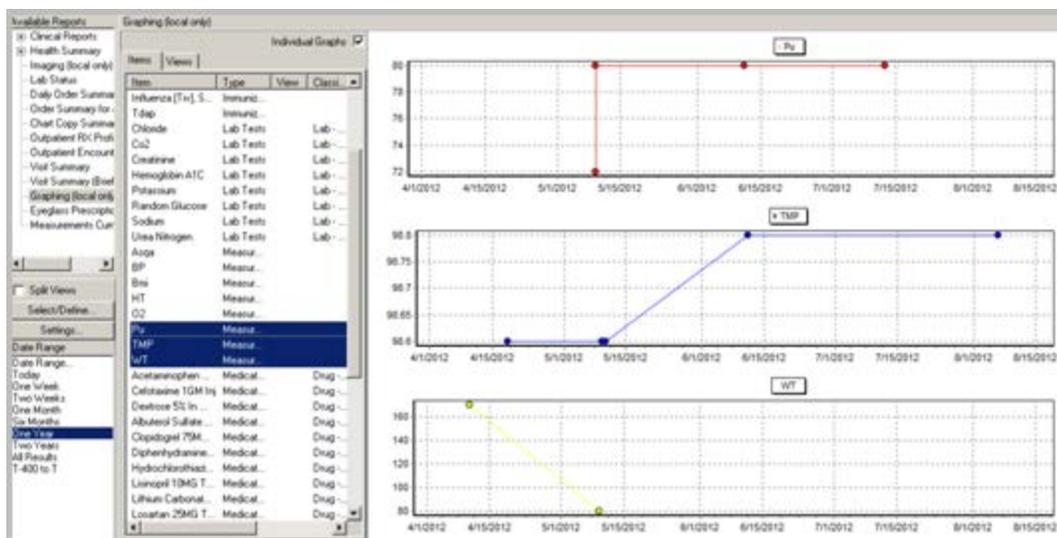


Figure 4-129: Multiple Items to Graph

You can also view them on the same graph by clearing the Individual Graphs check box at the top of the graph.

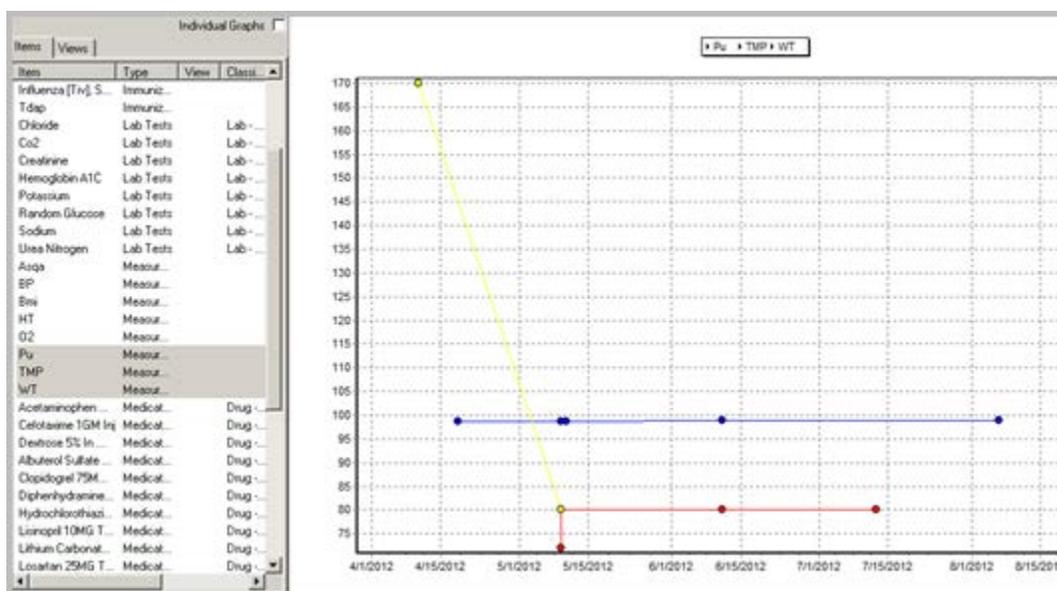


Figure 4-130: Multiple Items on the Same Graph

4.7.7.3 Setting up Graphing

You can set up graphing on the Labs tab, the Reports tab, or under Options on the tool bar.

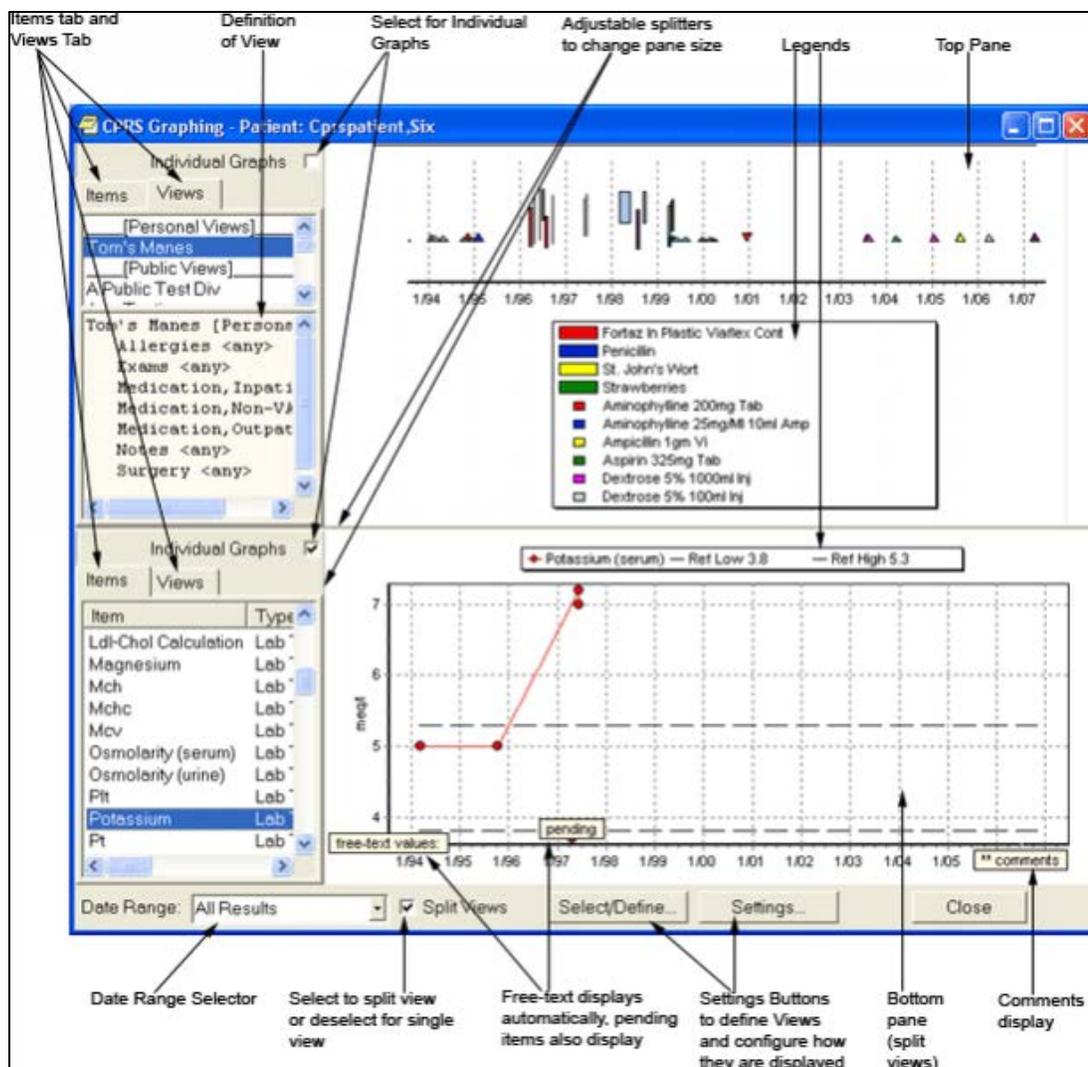


Figure 4-131: Setting Up Graphing Window

4.7.7.3.1 Settings

The Settings button enables you to view and change the different items you want to graph.

1. Select the Settings button from the left side of the Graphing dialog.



Figure 4-132: Settings Button

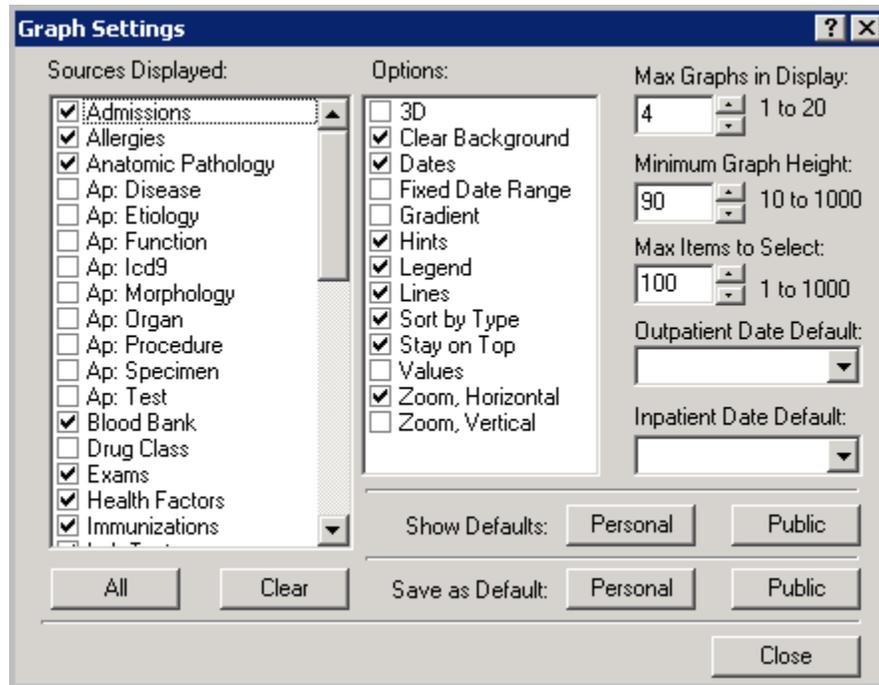


Figure 4-133: Settings dialog

2. Choose the sources, remembering that not all of them are available in IHS or at your site (for example, your facility may not do AP reports).
3. Select options. You can change the appearance of the graphs by selecting or clearing the items in the Options list. Users must review the items to determine which ones they prefer.
4. Select the maximum number of graphs and the height.
5. Select default dates if desired.
6. Users can save this as their default view. The Show Defaults field displays both the personal and public default. Only users with the correct keys can set up a public view.

4.7.7.3.2 Views

There are two tabs on the graphing tool, Items and Views.

The Items tab is information that the patient has in the time frame selected. All of the items appear in your setting for the chosen patient.

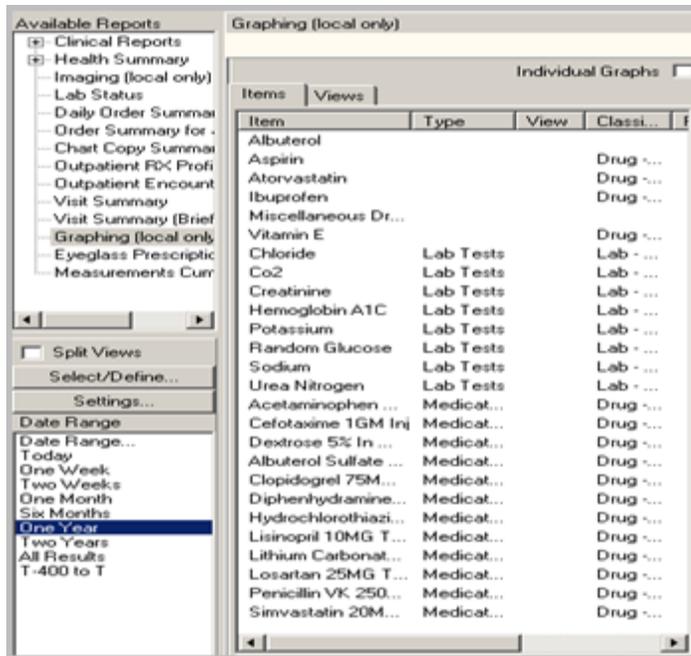


Figure 4-134:Items Tab

The Views tab includes your personal views and any laboratory worksheets that you have created and saved. There are two personal views and three Lab groups for the user logged on.

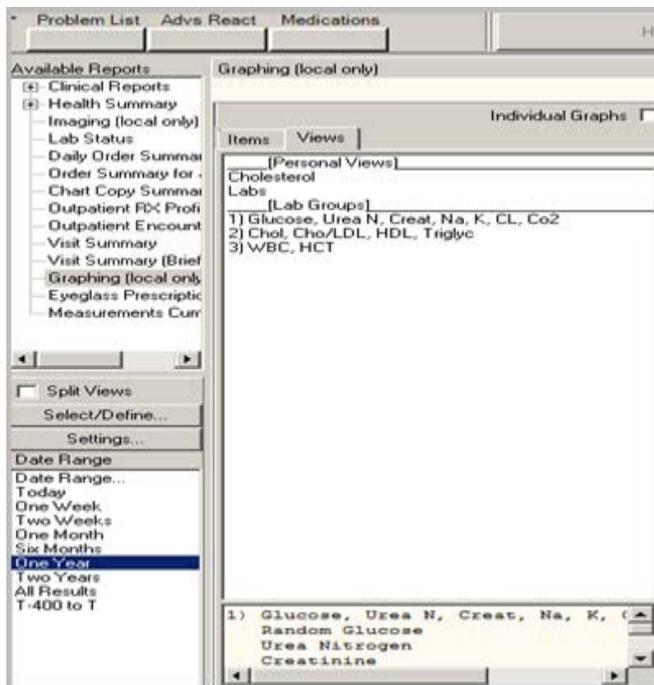


Figure 4-135:Views Tab

Users can create new views through Lab groups, but the user must log off and back on before it will appear in the Graph view.

1. To create a new View, click Select/Define. This brings up the dialog enabling you to create a new view and save it.



Figure 4-136: Select/Define Button

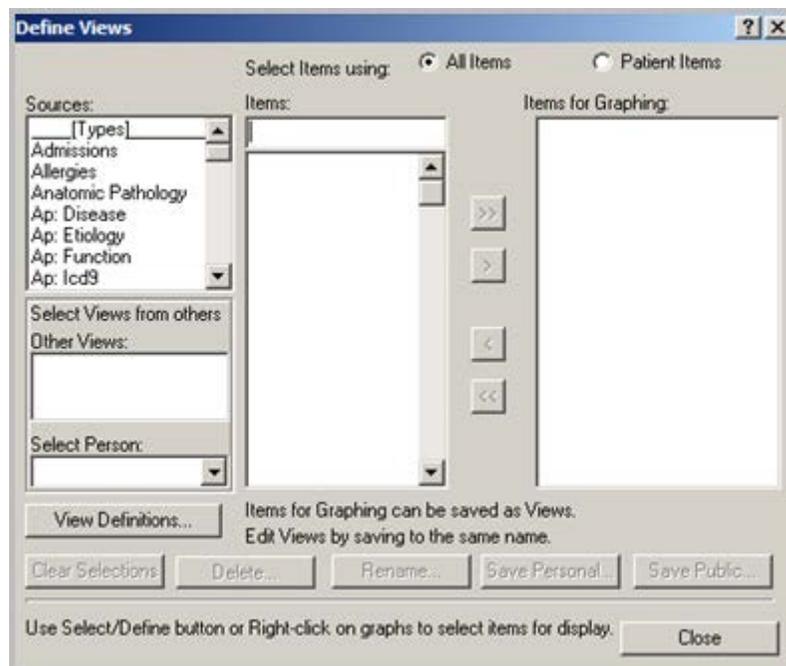


Figure 4-137: View Creation dialog

2. Select the sources for your view (for example, Measurements).
3. After you select a source, then select which items in that source you want to view. Add them by clicking the arrows.

You can select items from multiple sources

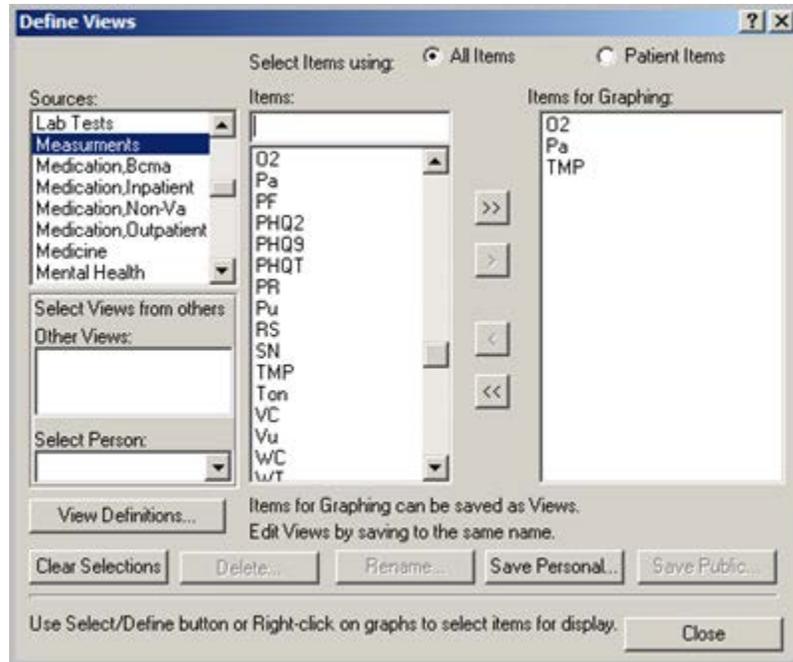


Figure 4-138: Personal View Defined

- When finished, you can save it as a personal view. However, If you have the correct security keys, it can be saved as a public view.

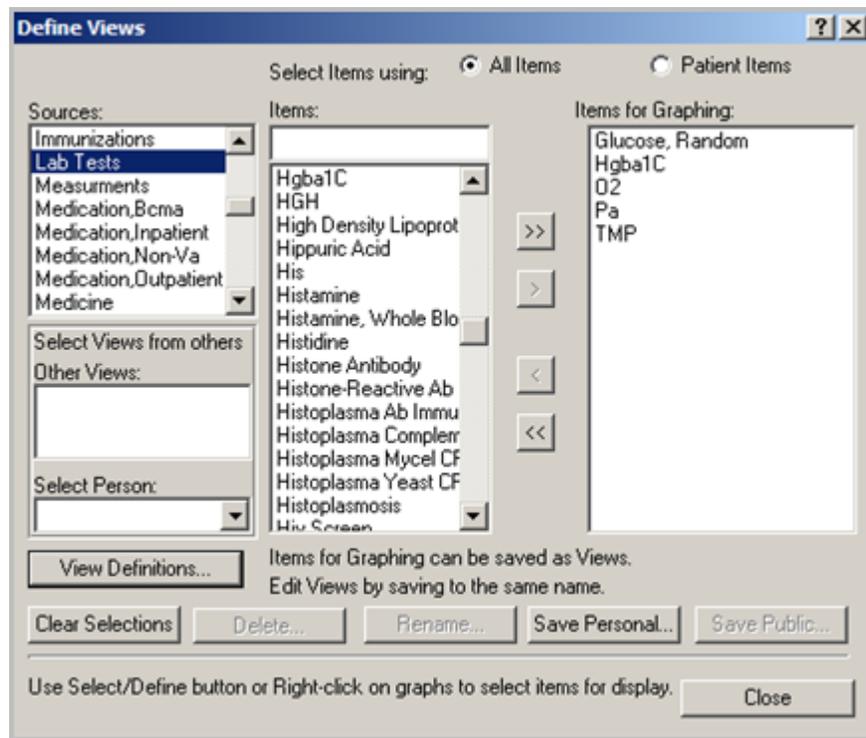


Figure 4-139: Ready to Save

5. Name the view to save it as a personal view.

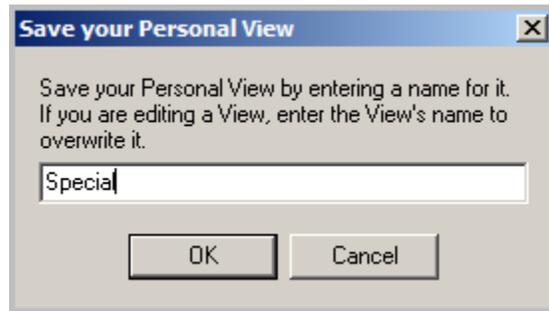


Figure 4-140: Personal View Name

6. You can click the View Definitions to get a listing of what is in all the views that are available.

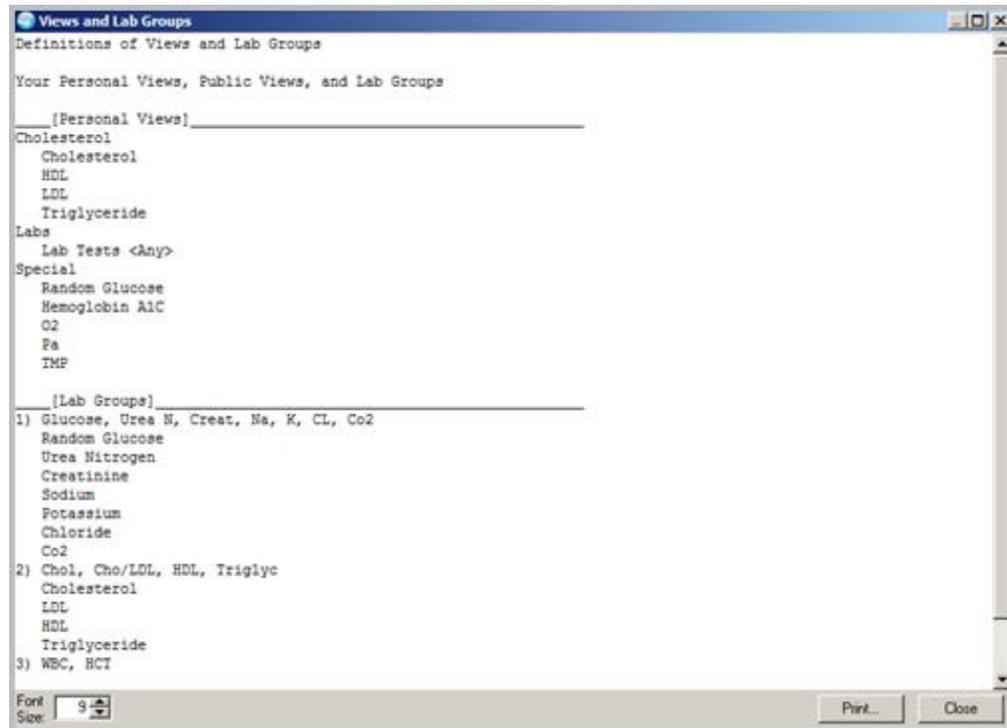


Figure 4-141:View Definitions

This view is then available to be selected

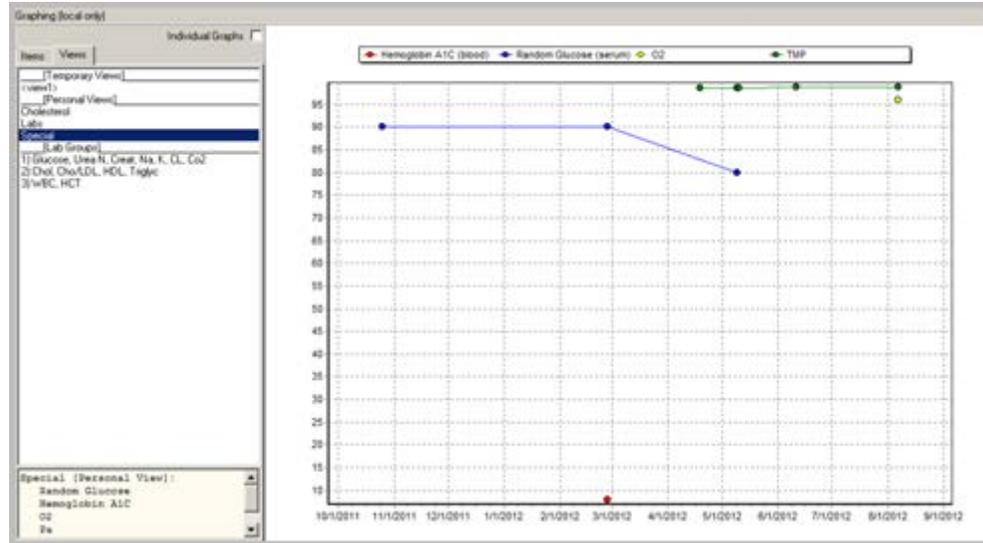


Figure 4-142:New View

Clicking the Split Views Box enables the user to see two different views at the same time.



Figure 4-143: Click Split Views

In the following case, the first view is a Cholesterol panel and the second view is the new one containing Labs and Vitals. In one case it is one graph and in the other individual graphs.

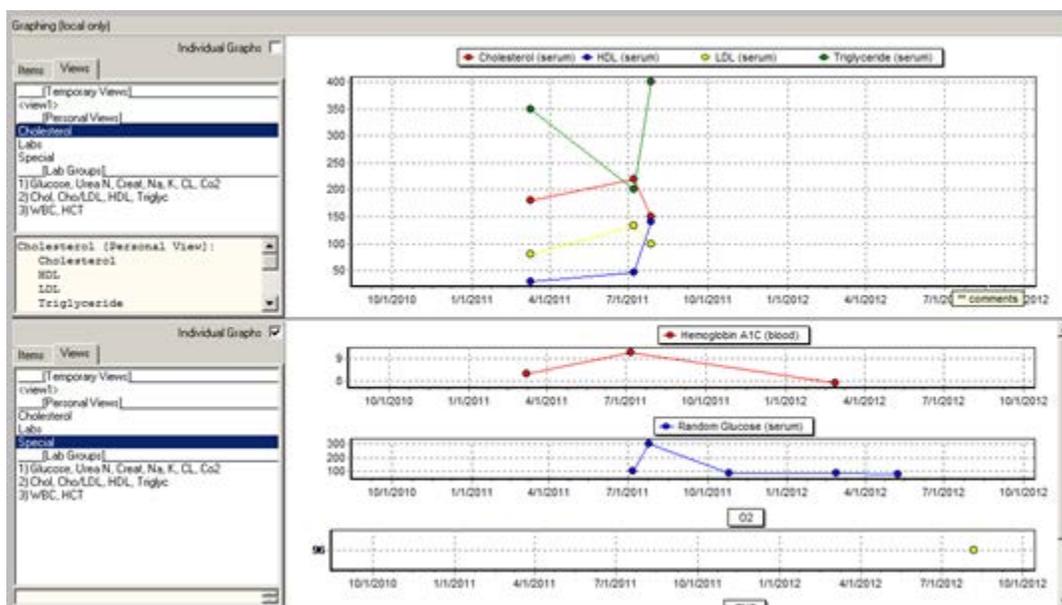


Figure 4-144: Split Views

4.7.8 Web Reference Search Function

4.7.8.1 Education Information Button

When a lab result is selected from the Most Recent list, click the Education Information button. This sends a call to the MedlinePlus Web site to provide information regarding the selected topic and the MedlinePlus Web site opens to the related page.

Note: The Add Patient Education Event dialog also opens when the Education Information button is clicked. Patient education is tracked for Meaningful Use, therefore, the Add Patient Education Event dialog should be completed. Refer to the Patient Education Online Help for details on completing this dialog.

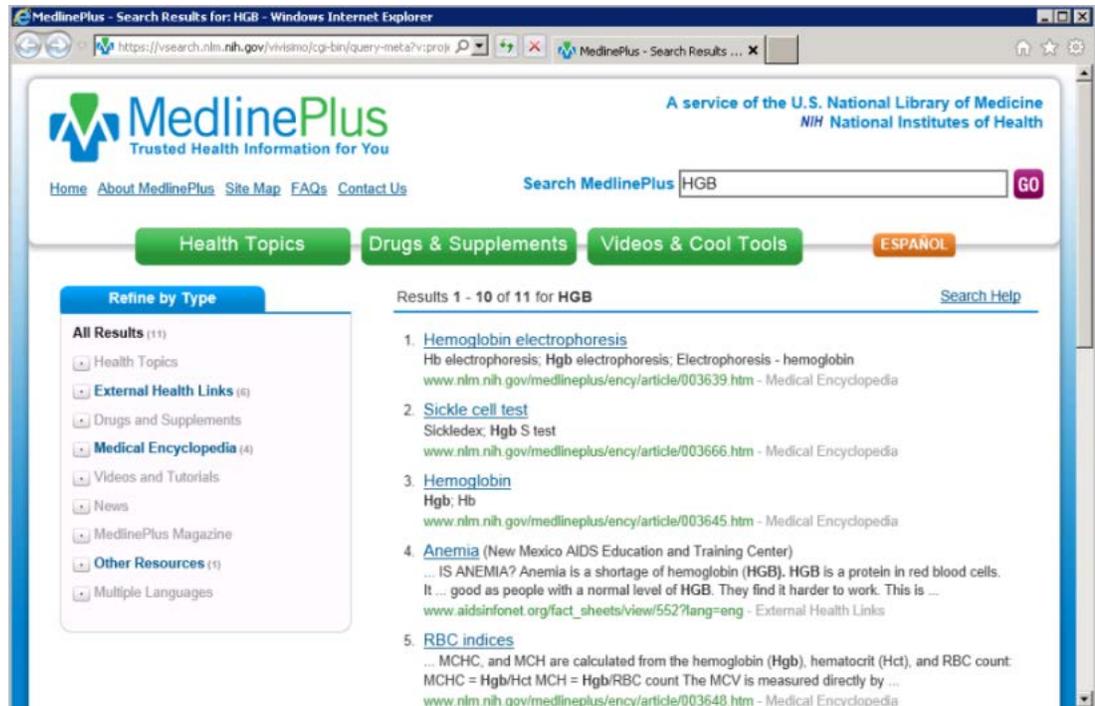


Figure 4-145:Medline Plus Web Site

4.7.8.2 Clinical Decision Support Button

When a lab result is selected from the Most Recent list, click the Clinical Decision Support button. This sends a call to the UpToDate Web site to provide information regarding the selected topic and the UpToDate Web site opens to the related page.

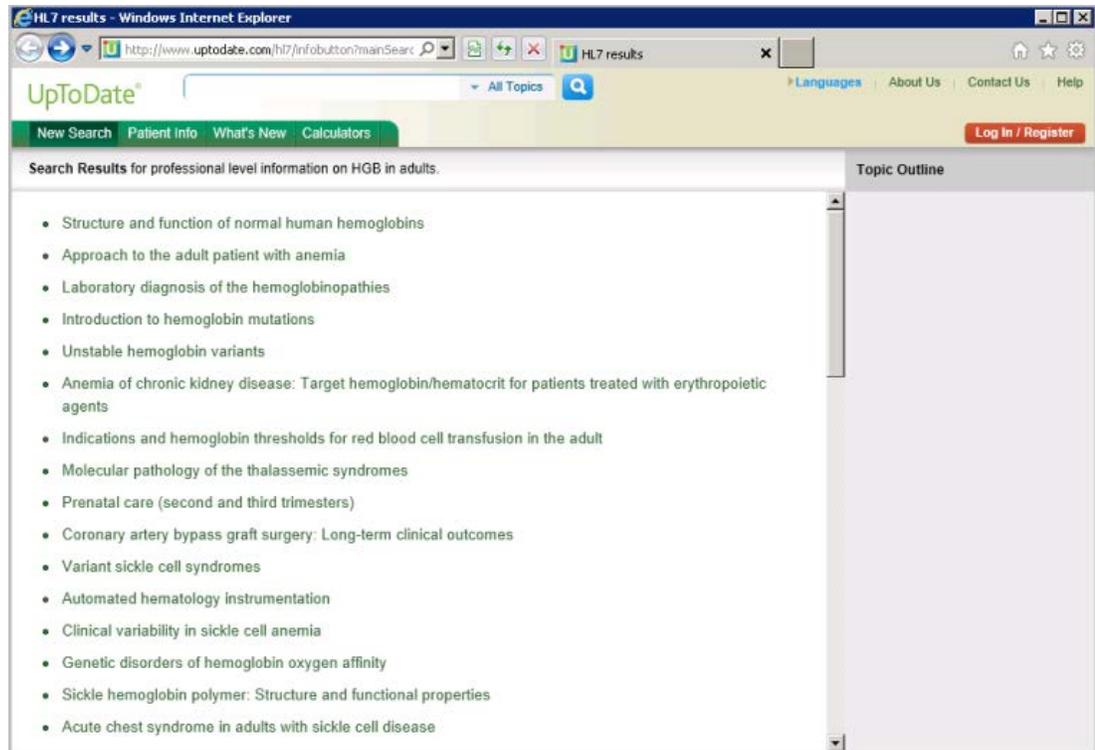


Figure 4-146: UpToDate Web Site

4.8 Lab POC Data Entry

The Lab Point of Care (POC) Data Entry component provides the user with the ability to capture Laboratory POC test results through the RPMS-EHR application.

The POC Lab Entry button requires that a visit and patient are selected before it becomes active. If this button does not exist, see your local CAC to have the button added.

4.8.1 Lab Point of Care Data Entry Form

Click the POV Lab Entry button to display the Lab Point of Care Data Entry Form.

Test Name	Result	Result Range	Units
HGB	16	12 to 16	g/dL

Figure 4-147: Lab Point of Care Entry Form

4.8.1.1 Form Features

The Lab Point of Care Data Entry Form has the following features.

- The Patient name is the same as the selected patient.
- The Hospital Location is the same as the location selected (visit).
- The Provider is the same as the visit provider (not the login user).
- The list of tests is in the control file (the BLR BEHO POC CONTROL file).
- The Collection Date and Time information is the same as the visit date and time.
- Test is a required field and displays in bold.
- Collection Date and Time information is required and displays in bold.
- Sign or Symptom information is required and displays in bold.
- Nature of Order/Change information is required and displays in bold.
- When you first access the form, Cancel is active and OK is inactive.

Once the form is open, the following happens:

- You cannot change the patient context and the visit.
- All buttons and tabs in the EHR are inactive.
- You cannot minimize or close the EHR main window.

Any user without initials on the new person file causes the No initials in file 200 warning message to display after clicking the POC Entry Form button.



Figure 4-148: No Initial in File 200 Warning Message

Click OK to close the message. You can assign yourself your initials using Tbox in RPMS, the same way that you assign yourself an Electronic Signature.

4.8.1.2 Fields on the Lab POC Entry Form

The following figure shows where the test has been selected and the form is ready for input.

Test Name	Result	Result Range	Units
COLOR		N/A	
CLARITY		N/A	
URINE GLUCOSE		NEG to 99	mg/dL
URINE BILIRUBIN		NEG	
URINE KETONES		NEG	mg/dL
SPECIFIC GRAVITY		N/A	
URINE BLOOD		NEG	
URINE PH		5 to 9	
URINE PROTEIN		NEG to 29	mg/dL
UROBILINOGEN		2 to 1	E.U./dL

Figure 4-149: Test Form for Selected Test

Note: All of the fields on the form (except for the Comment/Lab Description) must be completed in order for the Save button to become active.

The Test Results Grid displays the appropriate fields for Results.

The following fields are required in order to save the form:

- Ordering Provider – The name of the ordering provider of the particular test. You can change the name by selecting from the drop-down list.
- Test – The drop-down list contains the tests that are listed in the BLR BEHO POC CONTROL file. After you choose a test name, data populates the Test Results part of the form.
- Collection Date and Time – The default is the same as the visit date and time. You can change the data by selecting from the calendar (on the drop-down list).
- Nature of the Order – The default indicates the nature of the order. You can change this by selecting from the drop-down list.
- Sample Type – The system automatically populates this field (cannot be changed).
- Sign or Symptom – The drop-down list contains the active problems of the patient, plus an Other... option.
 - If you select Other... , the SNOMED CT dialog opens.

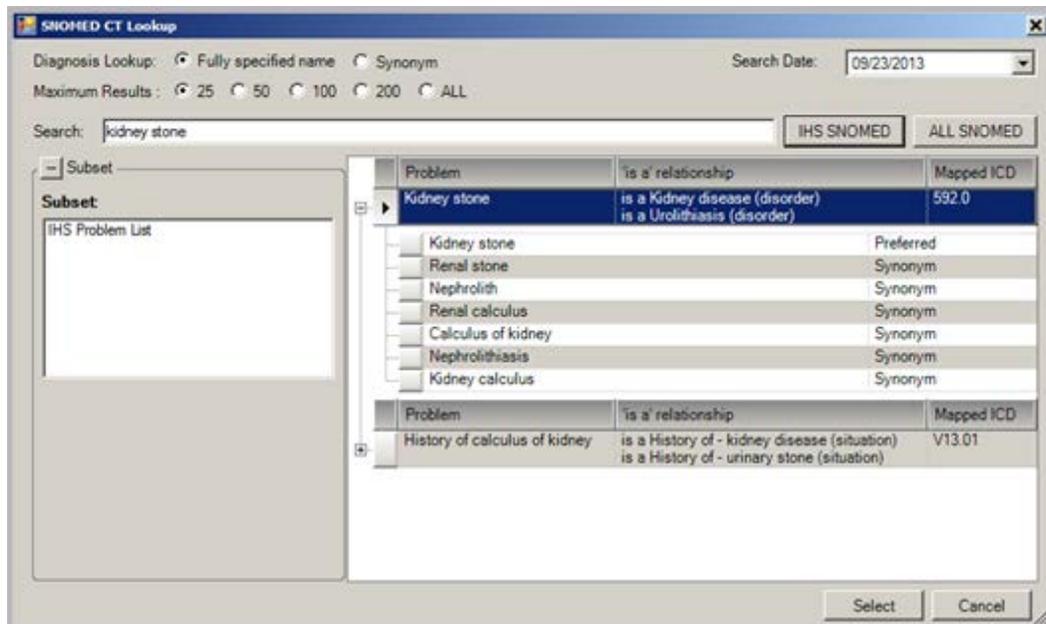


Figure 4-150: SNOMED CT Lookup dialog

- a. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the plus sign (+) next to the term to expand and view the child entries.

- Synonym returns the full list of SNOMED CT terms.
 - b. In Maximum Results, select one of the following to limit the number of returned results (or select ALL):
 - 25
 - 50
 - 100
 - 200
 - ALL
 - c. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
 - d. In Search, type the term by which you want to search.
 - e. In Subset, you can select a subset in which to search, if needed.
 - f. Click either the IHS SNOMED CT or the ALL SNOMED CT button. The list of SNOMED CT terms is populated.
 - g. Select and highlight a term, and then click the Select button. The Sign or Symptom field of the Lab Point of Care Data Entry Form refreshes with the selected SNOMED CT term you selected.
- In Comment/Lab Description (optional field), you can either:
 - Enter text, using up to 80 characters.

Note: If you enter more than 80 characters, the application truncates the text to 80 characters.

- Click the Add Canned Comment button. The Choose a Lab Comment dialog opens.
 - a. In the Choose a Lab Comment dialog, select a line item. These are defined in the control file.

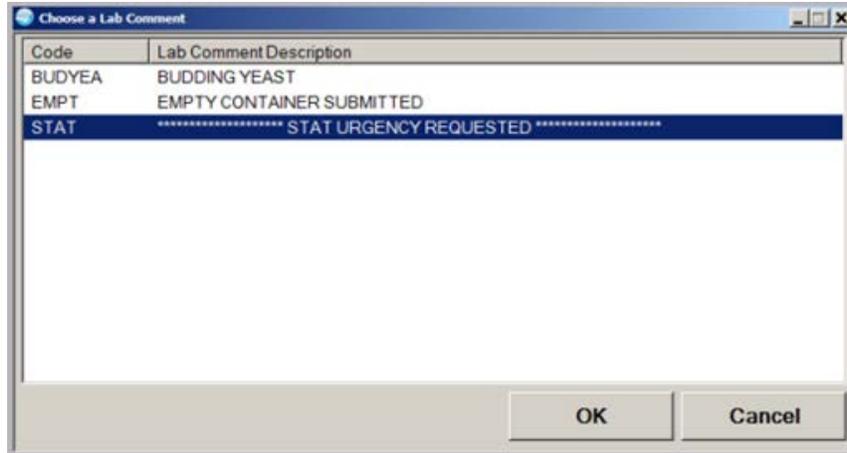


Figure 4-151: Choose a Lab Comment dialog

- b. The No Lab Comments Found warning message displays when the lab description is not defined in the control file. Click OK to exit the message.



Figure 4-152: No Lab Comments Found Message

- c. Click OK. The Comments/Lab Description field on the Lab Point of Care Data Entry Form is populated with your selection.

4.8.1.2.1 Test Results Grid

After you populate the Test field, the application automatically displays the appropriate fields for Results. The required fields depend upon how the test was setup in the Lab package.

TEST RESULTS				
Test Name	Result	Result Range	Units	
COLOR		N/A		
CLARITY		N/A		
URINE GLUCOSE		NEG to 99	mg/dL	
URINE BILIRUBIN		NEG		
URINE KETONES		NEG	mg/dL	
SPECIFIC GRAVITY		N/A		
URINE BLOOD		NEG		
URINE PH		5 to 9		
URINE PROTEIN		NEG to 29	mg/dL	
UROBILINOGEN		.2 to 1	E.U./dL	

Figure 4-153: Test Results Grid

1. Enter a test result for a particular test in the Result field.
 - If this is an acceptable result, you are allowed to go to another field.
 - If the entered value is not valid, the application displays the Invalid Entry warning message. Click OK to exit the message.



Figure 4-154: Invalid Entry Warning Message

- If you do not know the acceptable result for the particular field, type a question mark (?) in the field (on the form) and the application displays the Result Entry Help information message.



Figure 4-155: Result Entry Help Message

2. Click OK to return to the field where the ? is positioned.

4.8.2 Completing the Lab POC Data Entry Form

1. After all required fields on the Lab Point of Care Data Entry form are populated, click Save. The form closes and the data appears on the Labs window as the Most Recent Lab Results.

Note: You must click outside the Results grid for the Save button to be active.

If you do not want to save the data, you can exit this form at any time by clicking the Cancel button. If you click Cancel, the Confirm exit without save information message displays.

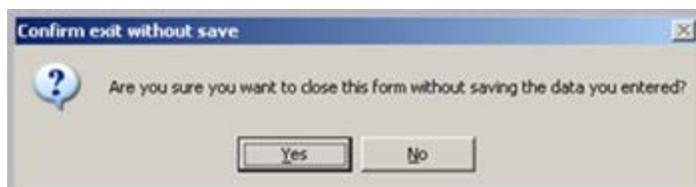


Figure 4-156: Confirm Exit Without Save Information Message

- Click Yes to exit the form without saving any data. Otherwise, click No to return to the form.

4.9 Medications

The Medications Management window lists the outpatient and inpatient medications that have been ordered for the current patient as well as any documented outside medications.

Action	Chronic	Outpatient Medications	Status	Process	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider
	<input checked="" type="checkbox"/>	CETIRIZINE 5MG TAB Qty: 30 Sig: TAKE ONE TABLET BY MOUTH DAILY	Pending							
		ACETAMINOPHEN/CODEINE-NO.3 TAB Qty: 5 for 2 days Sig: TAKE 1 TABLET BY MOUTH EVERY 6 HOURS IF NEEDED FOR PAIN. MAY CAUSE DROWSINESS	Active		24-Feb-2014	24-Feb-2014	25-Feb-2015	0	>9000	NIESEN MARY ANN
		NAPROXEN- 250MG TAB Qty: 20 for 10 days Sig: TAKE ONE (1) TABLET BY MOUTH TWICE A DAY WITH FOOD OR MILK	Active		24-Feb-2014	24-Feb-2014	25-Feb-2015	0	>9000	NIESEN MARY ANN

Action	Outside Medications	Status	Start Date

Action	Inpatient Medications	Status	Stop Date

Figure 4-157: Medications Window

The following are features of the Medications window:

- The label of the type of medication in the toolbar determines what actions you can take on this window. For example, if the label reads Inpatient Medications, then the Inpatient Medications group box on the window is the active one. Note that Inpatient Medications only displays for the inpatient visit.
- You can use the buttons at the top of the window to perform various functions in the active medication group box.
- There is the capability of indicating the Clinical Indication (when configured correctly) for the outpatient/inpatient medication order.

- The order of the Outpatient Medication columns can be configured in the RPMS.

4.9.1 Activating Medication Type

You can activate a medication type by clicking within the particular group box. Another way is to select from the drop-down list for the listed medication type (in the toolbar). The Inpatient Medications only appears for inpatient records only.

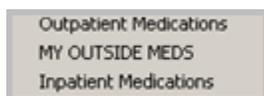


Figure 4-158: Drop-Down List for Medication Type

4.9.2 Outpatient Medications Group Box

The Outpatient Medication group box displays the outpatient medications that have been ordered for the current patient within the number of days shown in the Restrict Medications Activity button.

Action	Chronic	Outpatient Medications	Status	Process	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider
		PRAZOSIN 1MG CAP Qty: 60 for 30 days Sig: TAKE ONE (1) CAPSULE MOUTH TWICE A DAY THC BLOOD PRESSURE	Active		29-Jul-2011	29-Jul-2011	29-Jul-2012	11	X471	USER.DEMO
		HYDROCHLOROTHIAZIDE 25MG TAB Qty: 30 for 30 days Sig: TAKE ONE-HALF (1/2) TABLET MOUTH EVERY MORNING THC BLOOD PRESSURE	Active		25-Jan-2012	02-Feb-2012	25-Jan-2013	11	620	USER.DEMO
		VENLAFAXINE 75MG TAB Qty: 60 for 30 days Sig: TAKE TWO (2) TABLETS MOUTH EVERY DAY	Active		17-Jul-2012	17-Jul-2012	18-Jul-2013	0	X876	USER.DEMO
		RANITIDINE 150MG TAB Qty: 60 for 30 days Sig: TAKE ONE (1) TABLET MOUTH TWICE A DAY FOR STOMACH	Discontinued		25-Jan-2012	03-Feb-2012	25-Jan-2013	6	629	USER.DEMO
		CLOPIDOGREL 75MG TAB Qty: 30 for 30 days Sig: TAKE ONE (1) TABLET MOUTH EVERY DAY	Expired		03-Feb-2012	03-Feb-2012	04-Mar-2012	0	X827	USER.DEMO
		FLUOXETINE 10MG TAB Qty: 30 for 30 days Sig: TAKE ONE (1) TABLET MOUTH EVERY MORNING	Expired		03-Feb-2012	03-Feb-2012	04-Mar-2012	0	X822	USER.DEMO
		HYDROCODONE/ASAP 7.5/500MG TAB Qty: 20 for 10 days Sig: TAKE 1 TABLET MOUTH EVERY 8 HOURS IF NEEDED FOR PAIN - MCD	Expired		27-Jun-2012	27-Jun-2012	07-Jul-2012	0	670	USER.DEMO
		PRAMIPEXOLE 0.25MG TAB Qty: 180 for 30 days Sig: TAKE TWO (2) TABLETS MOUTH THREE TIMES A DAY	Discontinued		17-Jul-2012	17-Jul-2012	18-Jul-2013	0	X875	USER.DEMO

Figure 4-159: Outpatient Medications Group Box

4.9.2.1 Columns (Outpatient Medications)

You can sort any column by clicking the heading column.

The order of the columns in this group box can be configured in RPMS.

In addition, you can determine the columns that display in the Outpatient Medication group box by right-clicking any column heading. This feature assists those with smaller monitors to view only the needed information.



Figure 4-160: Column Heading Right-Click Menu

The top options on the right-click menu list the column's heading names that you can check or uncheck. Only the checked options display (along with the minimum Outpatient Medications data).

- **Show All:** If you currently have a special display and want to display all of the columns, highlight this option.
- **Hide All:** If you want to display only the minimum Outpatient Medications data, highlight this option. Only the Action, Chronic, Outpatient Medications, and Status columns display.
- **Restore Defaults:** This returns you to the default view of the Outpatient Medication (established when Save Settings was selected).
- **Save Settings:** This saves the current view of the Outpatient Medications as the default. Each time you access the Medications window, this (saved) view is the default view.

4.9.2.2 Action Menu (Outpatient Medications)

The options on the Action menu determine what actions you can take on the Outpatient Medications group box.

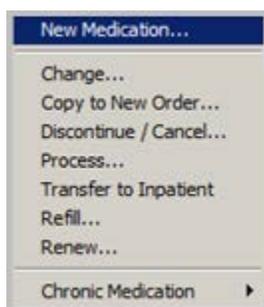


Figure 4-161: Options on Action Menu for Outpatient Medications Group Box

- **New Medication:** Use this option to order a new medication. See Outpatient and Inpatient Medication Orders for more information.

- **Change:** Enables you to change something pertaining to an already prescribed medication. See the Change section for more information.
- **Copy to New Order:** Use this option to copy the selected medication to a new order. See the Copy to New Order section for more information.
- **Discontinue/Cancel:** Use this option to discontinue or cancel a selected medication. See the Discontinue/Cancel Outside Medications section for more information.
- **Process:** Use this option to process the selected medication orders. See the Process section for more information.
- **Transfer to Inpatient:** Use this option to transfer a selected outpatient medication to inpatient. See the Transfer to Inpatient section for more information.
- **Refill:** Use this option to refill the selected medication. See the Refill section for more information.
- **Renew:** Use this option to renew the selected medication. See the Renew section for more information.
- **Chronic Medication:** Select Yes, No, or Select All from the menu. See the Chronic Medication section for more information.

4.9.2.3 Icons (Outpatient Medications)

The Process column has new icons indicating how the prescription was processed.

- The Printer icon () is used for prescriptions that are printed for the patient to take to an outside pharmacy. A check mark appears in front of the Printer icon () once the prescription has been printed.
- The Hospital icon () indicates prescriptions filled in-house.
- The Lightning Bolt icon () indicates prescriptions sent electronically.

Chronic	Outpatient Medications	Status	Process	Issued
	PRAZOSIN 1MG CAP Qty: 60 for 30 days Sig: TAKE ONE (1) CAPSULE MOUTH TWICE A DAY THC BLOOD PRESSURE	Active		29-Jul-2011
	HYDROCHLOROTHIAZIDE 25MG TAB** Qty: 30 for 30 days Sig: TAKE ONE-HALF (1/2) TABLET MOUTH EVERY MORNING THC BLOOD PRESSURE	Active		25-Jan-2012
	VENLAFAXINE 75MG TAB Qty: 60 for 30 days Sig: TAKE TWD (2) TABLETS MOUTH EVERY DAY	Active		17-Jul-2012
	RANITIDINE 150MG TAB** Qty: 60 for 30 days Sig: TAKE ONE (1) TABLET MOUTH TWICE A DAY FOR STOMACH	Discontinued		25-Jan-2012
	CLOPIDOGREL 75MG TAB** Qty: 30 for 30 days Sig: TAKE ONE (1) TABLET MOUTH EVERY DAY	Expired		03-Feb-2012
	FLUDOXETINE 10MG TAB** Qty: 30 for 30 days Sig: TAKE ONE (1) TABLET MOUTH EVERY MORNING	Expired		03-Feb-2012
	HYDROCODONE/acet 7.5/500MG TAB** Qty: 20 for 10 days Sig: TAKE 1 TABLET MOUTH EVERY 8 HOURS IF NEEDED FOR PAIN - MCD	Expired		27-Jun-2012
	PRAMIPEXOLE 0.25MG TAB Qty: 180 for 30 days Sig: TAKE TWD (2) TABLETS MOUTH THREE TIMES A DAY	Discontinued		17-Jul-2012

Figure 4-162: Example of Icons in Use

4.9.3 Inpatient Medications Group Box

The Inpatient Medication group box displays the outpatient medications that have been ordered for the current patient within the number of days shown in the Restrict Medications Activity button.

Action	Inpatient Medications	Status	Stop Date
	ACETAMINOPHEN/CODEINE 30MG TAB Give: 1-2 TABS PO Q4H PRN \PRN PAIN	Expired	15-Nov-2004
	ACETAMINOPHEN/OXYCODONE TAB Give: 1-2 tabs PO Q4H PRN \prn pain	Discontinued	07-Aug-2004
	ACETAMINOPHEN/OXYCODONE TAB Give: 2 TABLETS PO Q6H \WHILE AWAKE \PRN PAIN	Expired	08-Jul-2007
	ASPIRIN TAB EC Give: 325MG PO DAILY	Discontinued	25-Oct-2007
	DILTIAZEM 125 MG in SODIUM CHLORIDE 0.9% INJ. 100ML INFUSE AT PRESCRIBED RATE@1 \YIELDS FINAL CONCENTRATION OF 1MG/ML	Expired	17-Aug-2004
	DILTIAZEM TAB	Discontinued (EHR)	06-Aug-2004

Figure 4-163: Inpatient Medications Group Box

You sort any column in the Inpatient Medications group box by clicking the heading column.

4.9.3.1 Columns (Inpatient Medications)

The right-click menu for any column heading has the following options:

- **Restore Defaults:** Use this option when you change the column width and you want to restore the view to the default.
- **Saving Settings:** Use this option to save your settings for the column widths. When you access the Medications window, this will be the settings used for the Outside Medications group box.

4.9.3.2 Action Menu (Inpatient Medications)

The options on the Action menu determine what actions you can take on the Inpatient Medications group box.

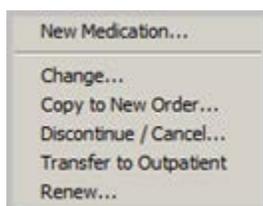


Figure 4-164: Options on Action Menu for Inpatient Medications Group Box

- **New Medication:** Use this option to order a new medication. See Outpatient and Inpatient Medication Orders for more information.
- **Change:** Enables you to change a detail pertaining to an already prescribed medication. See Change for more information.

- For a patient who has Inpatient status, but has an ambulatory visit, the list contains Inpatient Medications (because the patient still is an Inpatient, thus the medications would be given through the Inpatient Medications, then transferred to Outpatient Medications at discharge).

Note: You can determine the patient status by clicking the View Patient Detail () button in the toolbar, and looking for the STATUS field on the Detail dialog.

Find the appropriate item by scrolling the medication list. Otherwise, type enough letters of the medication's name in the top field to have the application search for the name. Be careful to choose the correct item because some lists can have similarly named items associated with the desired medication or medication quick order.

The application searches the quick orders first and then the medication list. Select the quick order or medication name and click OK.

Note: If the selected medication is a controlled substance that requires the signature of a provider with a DEA number, the DEA# Required warning message displays. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the Medication Order dialog, change the provider, and then reenter the Medication Order dialog.

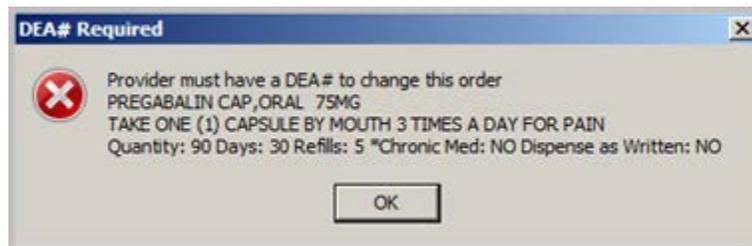


Figure 4-166: DEA# Required Warning Message

The ADRs button appears on many of the medication order dialogs. Click this button to show the Patient Postings information about the current patient (allergies as well as Crisis Notes, and so on).

4.9.4.1 Simple Dose Outpatient Medication Order

To create a simple dose Medication Order:

Figure 4-167: Outpatient Medication Order dialog (Simple Dose)

1. If necessary, you can change the type of medication by clicking Change.

Note: The patient's weight and the date of the last weighing is shown below the Change button.

2. Various Medication Order dialogs might have the Display Restrictions/Guidelines link. Click this link to view the Restrictions/Guidelines dialog.
 - a. You can print the text of the dialog by clicking Print.
 - b. Click Close to dismiss the dialog.
3. Highlight the dosage. (The associated cost is displayed to the right of the dosage.)
4. Select a route from the Route field.
5. Choose a schedule from the Schedule scroll list (select PRN, if desired).
 - The application completes the Days Supply field and calculates the Quantity field based on the formula: days supply x schedule = quantity.

- If you select OTHER for Inpatient Medications, the application displays the Order with a schedule OTHER dialog.

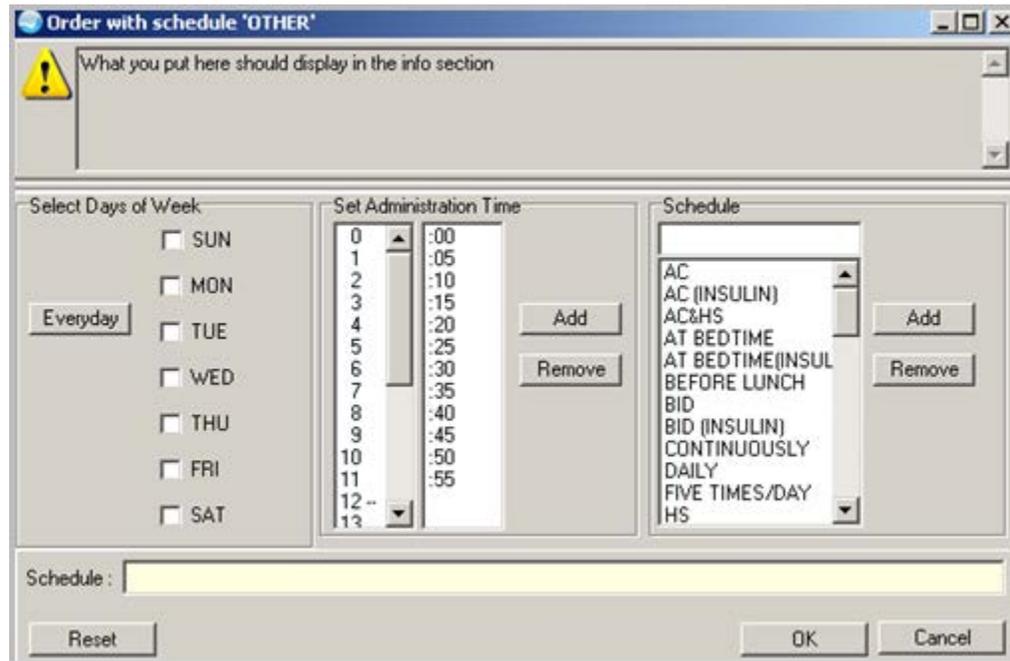


Figure 4-168: Other dialog

6. If necessary, highlight and change the numbers in these fields.

Note: If you change a number, the application attempts to recalculate the OTHER field. If you check PRN, be sure that the Quantity field is correct before accepting the order.

The maximum allowable days supply for the Days Supply field can be configured for your site (by using the Maximum Allowable Days Supply option in RPMS).

7. In the Patient Instructions field, type any directives for the patient. If the field is already populated, you can edit the instructions by typing over them.
8. Enter the number of refills.
9. Select a clinical indication from the drop-down list for the Clinical Indication field. The parameter BEHOORPA controls the display of this field. The drop-down list comes from the Problem List of the patient.
10. Select OTHER from the drop-down list and the application displays the SNOMED CT Lookup dialog.

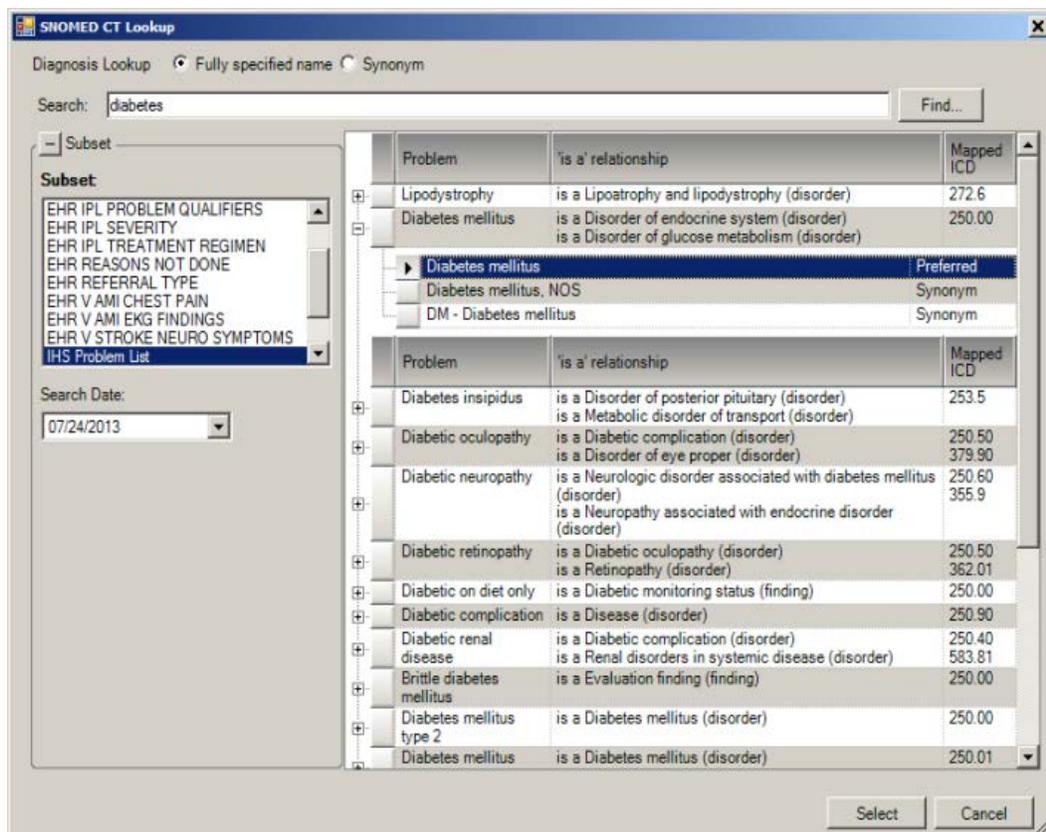


Figure 4-169: SNOMED CT Lookup dialog

11. In the Diagnosis Lookup section of the SNOMED CT Lookup dialog, select either the Fully specified name or the Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the plus sign (+) next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
12. In Search, type the term you want to search for.
13. In Subset, you can select a subset in which to search, if needed.
14. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
15. Click the Find button. The list of SNOMED CT terms is populated.
16. Select and highlight a term, and then click the Select button. The Clinical Indication field refreshes with the selected SNOMED CT term you selected.
17. Select the Chronic Med check box for medications that are ongoing for chronic medical issues (diabetes, hypertension, etc.).

18. Select the Dispense as Written check box indicating that the medication must be dispensed as written. For example, the pharmacy must dispense the brand name, exact tab size, etc. Most states require that the pharmacy substitute generic equivalents and/or tablet size (unless the provider checks the Dispense as Written check box).
19. Select the location where the patient should pick up the medication from the Pick Up group box.
20. Use the Outside Pharmacy Print button to generate a paper prescription.

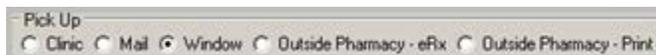


Figure 4-170: Print Option Buttons

After the prescription is signed, the Queue Print button becomes active and the flag icon is highlighted.

Action	Chronic	Outpatient Medications	Status	Process	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider
<input checked="" type="checkbox"/>		HYDROXYZINE 25MG TAB™ Qty: 30 for 30 days Sig. TAKE ONE (1) TABLET MOUTH EVERY 8 HOURS TR ITCHING -MCD	Active		13-Sep...	13-Sep...	14-Sep...	11	X943	USER,DEMO
<input checked="" type="checkbox"/>		NYSTATIN VAGINAL TAB Qty: 14 for 7 days Sig. INSERT ONE (1) TABLET VAGINA TWICE A DAY	Active		01-Aug...	01-Aug...	02-Aug...	3	X894	USER,DEMO
<input checked="" type="checkbox"/>		PREDNISOLONE 1% OPHTH SOLN Qty: 10 for 30 days Sig. PUT 1 DROP OPH EVERY 4 HOURS SHAKE WELL DO NOT TOUCH TIP TO EYE	Active		13-Sep...	13-Sep...	14-Sep...	1	X942	USER,DEMO
		DORZOLAMIDE SOLN OPH Qty: 1 Sig. PUT 2 DROPS 2% IN BOTH EYES. THIS IS THE COMMENT. THREE TIMES A DAY	Pending							
		GABAPENTIN 100MG CAP™ Qty: 1080 Sig. TAKE FOUR CAPSULES MOUTH THREE TIMES A DAY	Pending							
		ACETAMINOPHEN 325MG TAB Qty: 180 for 30 days Sig. TAKE ONE (1) TABLET MOUTH EVERY 4 HOURS TR PAIN OR FEVER	Active		31-Mar...	31-Mar...	01-Apr-2...	3	X1011	USER,DEMO
		ACETAMINOPHEN 325MG TAB Qty: 240 for 30 days Sig. TAKE ONE (1) TABLET MOUTH EVERY 3 HOURS TR PAIN OR FEVER	Active		31-Mar...	31-Mar...	01-Apr-2...	3	X1012	USER,DEMO

Figure 4-171: Queue Print

21. Click the Queue Print button to confirm that you are ready to print. A confirmation message appears.
22. Click Yes to select the template and printer for the prescription

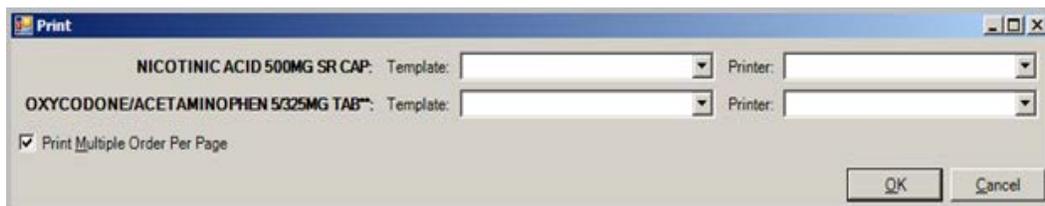


Figure 4-172: Prescription Print Template dialog

23. Sites can configure their own prescription formats. In the case , since one of them is a narcotic, a different prescription format may have been created at the site for that type of prescription.
24. For Outpatient Medications ONLY, you can transmit the prescription order electronically by selecting the Electronic option button (available when the APSP

AUTO RX parameter is set to YES). Once you select the Electronic option button, the Pharmacy field appears on the dialog.



Figure 4-173: Electronic Option Button and Pharmacy Field

25. Click the Ellipsis button by the Pharmacy field to display the Select a Pharmacy dialog. The parameter APSP ZIPCODE PROXIMITY RADIUS determines how far away to search for pharmacies.

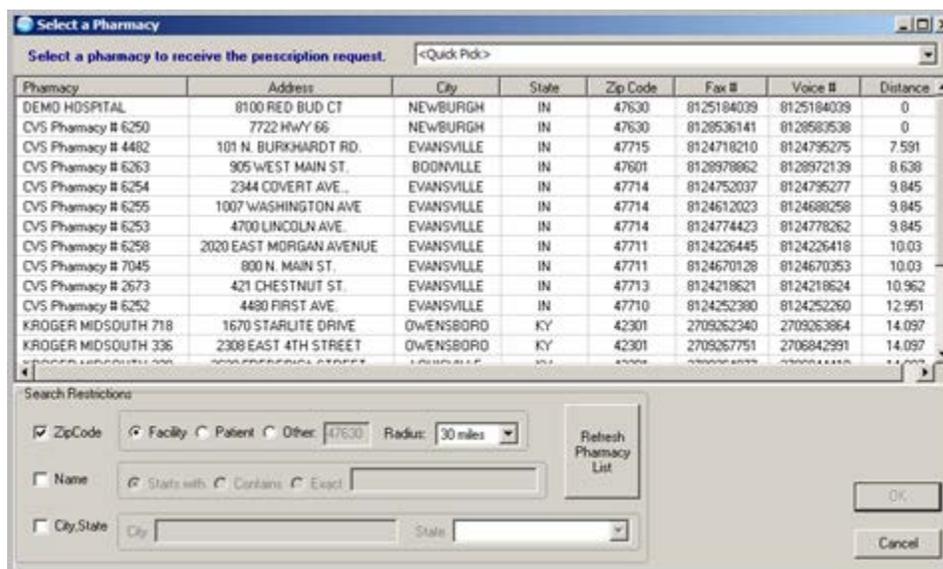


Figure 4-174: Select a Pharmacy dialog

This dialog pulls entries from the new APSP PHARMACY LIST file based on a reference zip code, which can be that of the originating facility, the patient, or a manually entered one, and a defined radius.

You can sort each column by selecting its corresponding header to ease the task of locating the correct pharmacy. Select the desired pharmacy from the list or from the quick pick list and click OK. This selection is retained for each additional medication order until the patient selection is changed or the session is terminated. In addition, the selection is added to the Quick-Pick list for that patient, which maintains the last three selected pharmacies for a patient in order of usage. Quick-Pick entries are retained across EHR sessions.

Note: If a patient has no quick pick entries, the list will not be visible.

The APSP PHARMACY LIST file is delivered unpopulated. It is populated dynamically from the SureScripts service, but currently must be populated manually.

After signing the order, the prescription is automatically finished and transmitted to the selected pharmacy. If the transmission is unsuccessful, the provider receives an alert and can then choose to either retransmit the message or print out the prescription:

Order Details - 2482:1

OXYMETAZOLINE SOLN,NASAL
 USE ONE (1) SPRAY PER NOSTRIL NASAL STAT Spray once into each nostril.
 Quantity: 1 Days: 6 Refills: 0 *Chronic Med: NO Dispense as Written: NO
 Indication: Eosinophilic asthma | developing into ac... Pharmacy: DEMO HOSPITAL
 Notes to Pharmacist: Sample note. *UNSIGNED*

Activity:
 08/01/2013 12:00 New Order entered by USER, DEMO
 Order Text: OXYMETAZOLINE SOLN,NASAL
 USE ONE (1) SPRAY PER NOSTRIL NASAL STAT Spray once into each
 nostril.
 Quantity: 1 Days: 6 Refills: 0 *Chronic Med: NO Dispense as
 Written: NO
 Indication: Eosinophilic asthma | developing into ac...
 Pharmacy: DEMO HOSPITAL
 Notes to Pharmacist: Sample note.
 Nature of Order: ELECTRONICALLY ENTERED
 Ordered by: USER, DEMO
 Signature: NOT SIGNED

Current Data:
 Current Primary Provider: USER, DEMO
 Current Attending Physician: USER, DEMO
 Treating Specialty: MEDICINE (ADULT)
 Ordering Location: GENERAL
 Start Date/Time:
 Stop Date/Time:
 Current Status: UNRELEASED
 Orders that have not been released to the service for action.
 Order #2482

Order:
 Medication: OXYMETAZOLINE SOLN,NASAL
 Instructions: 1 SPRAY PER NOSTRIL NASAL STAT
 Sig:
 USE ONE (1) SPRAY PER NOSTRIL NASAL STAT
 Patient Instructions:
 Spray once into each nostril.
 Days Supply: 6
 Quantity: 1
 Refills: 0
 Pick Up: ELECTRONIC
 Pharmacy: DEMO HOSPITAL
 Priority: ROUTINE
 Notes to Pharmacist:
 Sample note.
 Indication: Eosinophilic asthma | developing into acute
 state|
 SNOMED Descriptive ID: 492714018
 Discharge Medication: YES

Font Size: 8 Print... Close

Figure 4-175: Medication Details Showing Electronic Transfer

26. You can change the Priority by selecting from the drop-down list. The following are the options for selection:
- **ASAP:** Give as soon as possible
 - **Routine:** The default
 - **STAT:** Give immediately
 - **DONE:** Medication administration that is completed without order checks or reviewed by a pharmacist. Based on policies, this option is not recommended.
27. The Discharge Medication check box is checked if the patient is currently admitted or if the ordering location has a clinic stop code of 30. De-select, or select the check box, if needed.
28. Add comments in the Notes to Pharmacist field (if desired). What you add to this field is added to the lower-left field (for the sig). The Notes to Pharmacist field has a right-click menu to aid in editing the text. When the prescription is being transmitted to an outside pharmacy, the Comments field must be less than 210 characters. If more than 210 characters, when you click Save, the application displays the Unable to Save Order alert.



Figure 4-176: Unable to Save Order Warning Message

29. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is selected.
30. The Give Additional Dose Now check box may display for inpatient medications. The application displays when the first dose is expected to be given. When you click this check box, a new order is created and sent to Inpatient Medications. Make sure the new order and the original schedule you entered do not overmedicate the patient.
31. There may be other information for you to complete on the medication order.
32. Click Accept Order.
33. If you are finished ordering the medications, click Quit.

Note: The order must be signed before it can be forwarded to the Pharmacy service. You can either sign the order now or wait until later.

- If the Patient Status is Inpatient, the record displays in the Inpatient Medications group box.
- If the Patient Status is Outpatient, the record displays in the Outpatient Medications group box.

4.9.5 Complex Dose Medication Order

Make sure you are on the Complex tab of the Medication Order.

Dosage	Route	Schedule	Duration	then/and
325MG	ORAL	Q4-6H PRN		
650MG				

Figure 4-177: Outpatient Medication Order (Complex Dose)

Important: Once a complex medication order is started, remain on the Complex tab until the order is finished. If you switch tabs, the application displays a Warning message that states:
By switching to the Dosage tab, all data on this screen is lost. Click OK to continue to Cancel. Click OK to input information on the Dosage tab. Click OK to continue input on the Complex tab.

Use the instructions in the Simple Dose Outpatient Medication Order to complete the fields (except Dosage, Route, Schedule) on this type of order.

The following provides information about populating the fields in the grid at the top of the form.

Dosage	Route	Schedule	Duration	then/and
325MG	ORAL	Q4-H PRN		
650MG				

Figure 4-178: Grid at Top of Form

1. Click the Dosage field (to display the available dosages) and then select the appropriate dosage.
2. Click the Route field and select a route.
3. Select a schedule from the drop-down list for the Schedule field. (Select PRN if desired.)

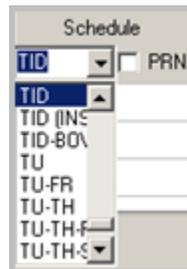


Figure 4-179: Available Selections for Schedule

4. Enter a duration in the Duration field. If you want to change the time units of measure (for example from Day to Week), select the units of measure first, then enter the duration number.



Figure 4-180: Available Selections for Duration

5. Select one of the following (appropriate) modifiers:
 - And
 - Then
 - Except (leave this cell blank for the final dose)

- Repeat Steps 1 through 5 until you have completed the complex dose. This process adds rows to the complex dosage instructions (in the grid).

The only addition for inpatient medications is a column that displays the administration times for the doses.

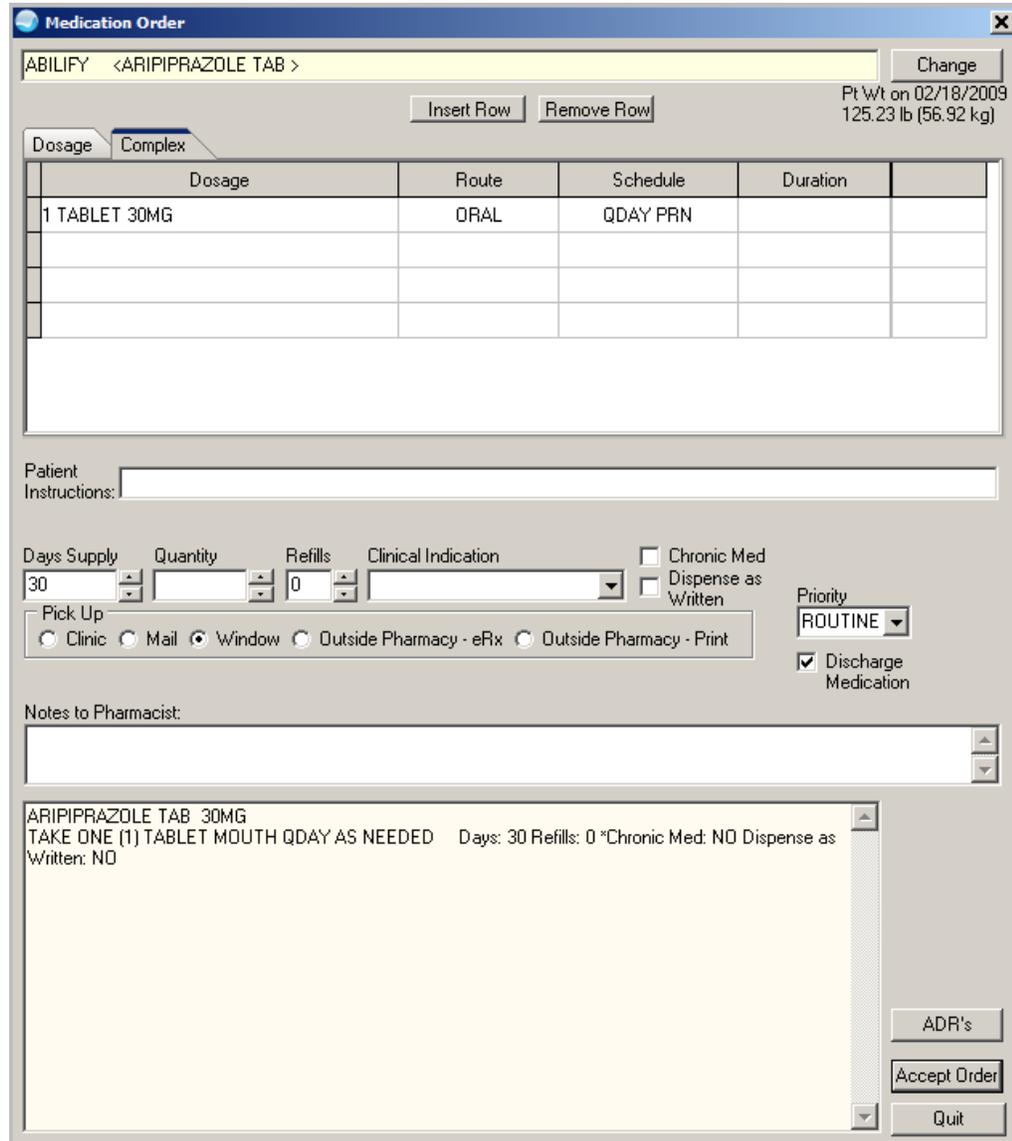


Figure 4-181: Inpatient Complex Dose

The parameter OR ADMIN TIME HELP TEXT displays information on how to change the administration times.

4.9.6 Simple Dose Inpatient Medication Order

To create a simple Inpatient-Medication order:

Figure 4-182: Inpatient Medication Order dialog

1. If necessary, you can change the type of medication by clicking Change.

Note: The patient's weight and the date of the last weighing is shown below the Change button.

2. Various medication order dialogs may have the Display Restrictions/Guidelines link on them. Click this link to view the Restrictions/Guidelines dialog.
 - a. You can print the text of the dialog by clicking Print.

- b. Click Close to dismiss the dialog.
3. Highlight the dosage.
4. Select a route from the Route field.
5. Select a schedule from the Schedule scroll list (select PRN, if desired). Inpatient Medications require a standard schedule.

If a non-standard schedule, it is created as follows:

The screenshot shows the 'Medication Order' dialog box for 'WARFARIN TAB'. The patient's weight is listed as 125.23 lb (56.92 kg). The 'Dosage' field is set to '2MG', the 'Route' is 'ORAL', and the 'Schedule' is 'TU-TH-SA@0800'. The 'Expected First Dose' is '27-Jul-2013@08:00 am'. The 'Priority' is set to 'ROUTINE'. The 'Comments' field contains 'Sample comments here.' The 'Admin. Time' is '0800'. The 'Give Additional Dose Now' checkbox is unchecked. The 'ADR's' button is visible. The 'Accept Order' button is highlighted. The 'Quit' button is also visible.

Dosage	Route	Schedule (Day-Of-Week)
2MG	ORAL	TU-TH-SA@0800 <input type="checkbox"/> PRN
1MG	ORAL	QAM
1MG	ORAL	QD
2MG	ORAL	QHS
2.5MG	ORAL	QID
3MG	ORAL	QOD
4MG	ORAL	STAT
5MG	ORAL	TID
	ORAL	OTHER
	ORAL	TU-TH-SA@0800

Figure 4-183: Non-Standard Schedule Selected

The following error appears:

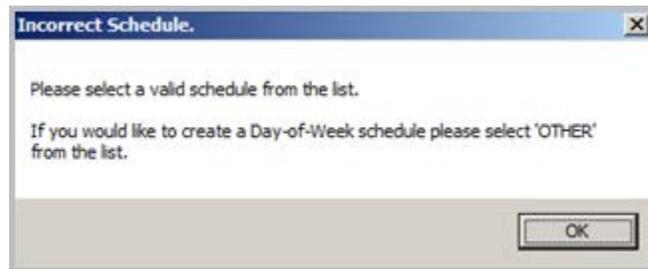


Figure 4-184: Non-Standard Error Message

6. Select OTHER from the schedule list.

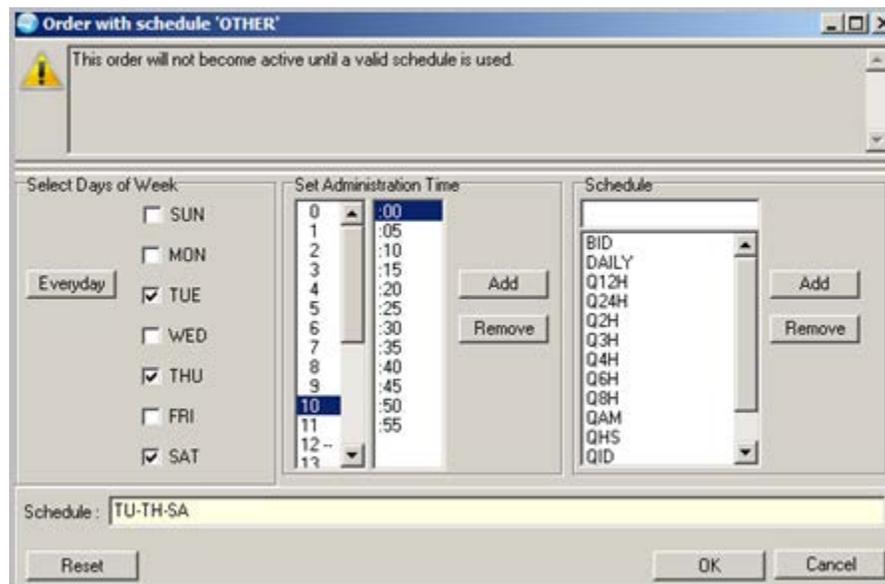


Figure 4-185: Creation a Schedule dialog

7. The provider selects which day of the week (or all) and the time, and then adds it to the standard schedule list. It can then be chosen once it has been added to the saved list.

4.9.6.1 Expected First Dose Information

The time of the expected first dose is displayed. The provider can then choose to give an additional dose NOW by clicking the check box if the expected first dose is too far into the future.

Medication Order

WARFARIN TAB Change

Pt Wt on 02/18/2009
125.23 lb (56.92 kg)

Dosage Complex

Dosage	Route	Schedule (Day-Of-Week)
2MG	ORAL	TU-TH-SA@0800 <input type="checkbox"/> PRN
1MG	ORAL	QAM
1MG		QD
1MG		QHS
1MG		QID
1MG		QOD
1MG		STAT
1MG		TID
1MG		OTHER
2MG		TU-TH-SA@0800
2.5MG		
3MG		
4MG		
5MG		

Expected First Dose: 27-Jul-2013@08:00 am

Give Additional Dose Now

Admin. Time: 0800 Priority: ROUTINE

Comments:
Sample comments here

WARFARIN TAB
2MG PO TU-TH-SA@0800 Sample comments here.

ADR's
Accept Order
Quit

Figure 4-186: Expected First Dose

4.9.6.2 Administrative Times

All schedules that have administration times set up in the Pharmacy files show those times displayed for the provider after the schedule is chosen. This appears in a text box below the Give Additional Dose Now check box.

Medication Order

WARFARIN TAB Change

Pt Wt on 02/18/2009
125.23 lb (56.92 kg)

Dosage Complex

Dosage	Route	Schedule (Day-Of-Week)
2MG	ORAL	TU-TH-SA@0800 <input type="checkbox"/> PRN
1MG	ORAL	QAM
1MG		QD
2MG		QHS
2.5MG		QID
3MG		QOD
4MG		STAT
5MG		TID
		OTHER
		TU-TH-SA@0800

Expected First Dose: 27-Jul-2013@08:00 am

Give Additional Dose Now

Admin. Time: 0800 Priority: ROUTINE

Comments:
Sample comments here.

WARFARIN TAB
2MG PO TU-TH-SA@0800 Sample comments here.

ADR's
Accept Order
Quit

Figure 4-187: Administrative Times

4.9.7 Outside Medications

4.9.7.1 Document Outside Medications

You can document outside medications for the current patient. This means that the prescription was sent to an outside Pharmacy (e-prescribing).

You can document Outside Medications for the current patient. Outside medications are those medications that the patient is taking that are over the counter, supplements, or medications prescribed by a physician not affiliated with the facility.

Action	Checked	Outpatient Medications	Status	Used	Call Filter	Expires	Filled	Recs	Provider
		TEFEDUTALINE 5MG TAB 15MG BY MOUTH EARLY ON TUESDAY THURSDAY SATURDAY AND SUNDAY Medication provided by another provider.	Active						
		DEGAMETHASONE 5MG TAB 0.5MG BY MOUTH EVERY MORNING Outside medication recommended by provider.	Active						

Figure 4-188: Active Outside Medications Group Box

The Outside Medication records normally appear on the Order window when the records have a status of Active. They can be removed by removing the NON-VA MEDS from the pharmacy display group in the file DISPLAY GROUP.

```
Select DISPLAY GROUP NAME:    PHARMACY
NAME: PHARMACY//
Select MEMBER: CLINIC ORDERS// ?
Answer with MEMBER, or SEQUENCE
Choose from:
1    INPATIENT MEDICATIONS
2    OUTPATIENT MEDICATIONS
3    NON-VA MEDICATIONS
4    CLINIC ORDERS
```

In certain cases, your local CAC can disable medication order enter/edit. In this case the user can only view the medications.

The label (name) of the Outside Medications is controlled by the BEHORX NONVA LABEL parameter. This means that Outside Medications might have a different name.

4.9.7.2 Columns (Outside Medications)

The right-click menu for any column heading has the following options:

- **Restore Defaults:** Use this option when you change the column width and you want to restore the view to the default.
- **Saving Settings:** Use this option to save your settings for the column widths. When you access the Medications window, these settings are used for the Outside Medications group box.

4.9.7.3 New Medication (Outside Medications)

Make sure that the Outside Medications group box is active. The Outside Medications option shows on the toolbar of the Medications window.

Make sure a visit is selected. Follow these steps to document an outside medication:

1. Select Action > New Medication (or select the New Medication option on the right-click menu or click the New button) to display the Document Herbal/OTC/Home Medications dialog (showing a list of available medications).

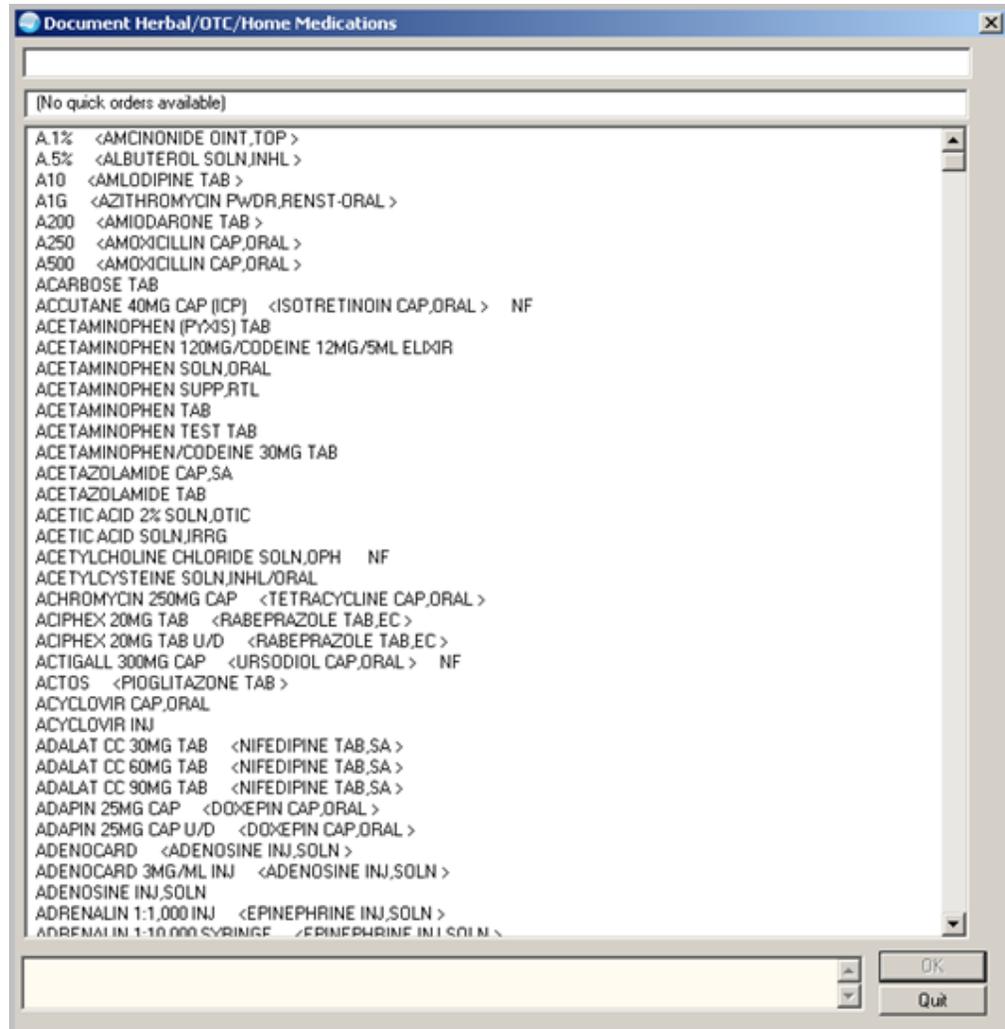


Figure 4-189: List of Drugs for Outside Medications Order

2. Find the appropriate item by scrolling the medication list. Otherwise, type enough letters of the medication's name in the top field to have the application search for the name. Be careful to choose the correct item because some lists can have similarly named items associated with the desired medication or medication quick order.
3. The application searches the quick orders first and then the medication list. Select the quick order or medication name and click OK. The application applies order checks on the selected medication.

- Document the outside medication on the Document Herbal/OTC/Home Medications dialog.

Figure 4-190: Document Herbal/OTC/Home Medications dialog

If UNKNOWN MED MISCELLANEOUS was selected on the medication selection window, then the Dosage, Route, and Schedule fields are not required.

- To change the medication, click the Change button and then select another medication.
- The check boxes in the Statement/Explanation group box can be configured and controlled by the ORWD NONVA REASON parameter.
- Complete the relevant sections and click Accept Order. After all outside medications are documented, click Quit.

The Outside Medication does NOT require the electronic signature.

Note: Outside medications cannot be selected when you sign orders for the patient. All outside medications with a status of New display on the electronic signature form.

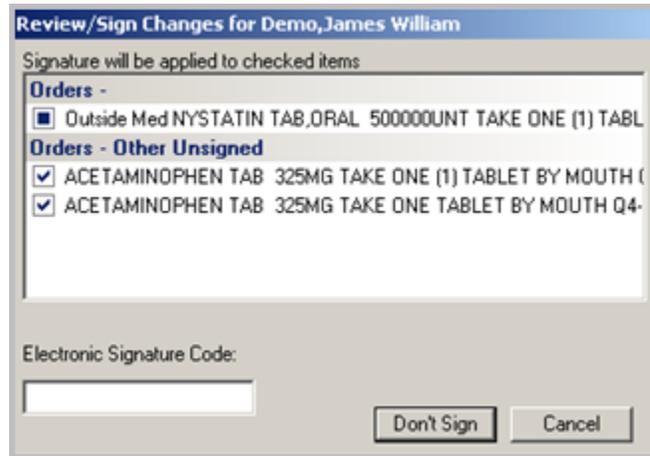


Figure 4-191: Electronic Signature Showing Outside Medications

4.9.7.4 Details for Outside Medications

You can view the details of a selected outside medication by selecting View > Details (or by selecting the Details option on the right-click menu) to display the Outside Medication Details dialog. See Details for more information about this dialog.

4.9.7.5 Unknown Outside Medications

Occasionally a patient tells a provider they take a daily medication and can describe it, but do not know what it is. This medication must be documented and later verified. To do this:

1. The site must define a dose form to use for these medications and enter it in the parameter BEHORX OUTSIDE MED DOSAGE FORM.
2. The site must create a drug tied to this dose form for unknown medication or something similar.

Figure 4-192: Miscellaneous Drug Dose Form

3. The medication and its description is then entered in the Dosage field.
4. Click Accept Order.

Action	THIS IS A TEST	Status	Start Date
	Acetaminophen TAB MOUTH EVERY DAY	Active	
	DANSIPAM 5MG TAB== 5MG MOUTH AT BEDTIME Outside medication not recommended by provider.	Active	
Validate	MISCELLANEOUS DRUG MISCELLANEOUS LITTLE PINK PILL EVERY DAY Outside medication recommended by provider.	Active	
Validate	MISCELLANEOUS DRUG MISCELLANEOUS YELLOW PILL EVERY DAY Outside medication not recommended by provider.	Active	
	ASPIRIN 325MG TAB 325MG MOUTH TWICE A DAY Outside medication not recommended by provider.	Discontinued	
	MISCELLANEOUS DRUG MISCELLANEOUS PINK PILL. Outside medication not recommended by provider.	Discontinued	

Figure 4-193: Unknown Medication for Validation

The medication now appears with an action of VALIDATE.

5. Once the medication is identified, the provider uses the Change action. Select the correct medication and accept the order.

The unknown medication is discontinued and the correct medication made active.

4.9.7.6 Discontinue/Cancel Outside Medication

You can cancel a selected outside medication by selecting Action > discontinue/Cancel (or by selecting the Discontinue/Cancel option on right-click menu). See Discontinue/Cancel for more information about this action.

4.9.7.7 Change Outside Medication

You can edit a selected outside medication by selecting Action > Change (or by selecting the Change option on right-click menu) to display the Document Outside Medication dialog.

Change the relevant sections and then click Accept Order. The Action column for the changed Outside Medication contains Change.

4.9.8 Buttons on Medications Window

These actions only apply to the active medication type group box. For example, if Outpatient Medications group box is active, then any action applies to that group box (only).

4.9.8.1 Active Only

The Active button appears on Outpatient, Inpatient, and Outside Medication group boxes.



Figure 4-194: Active Only Button

Click the Active Only button to display the medications for the current patient that have a status of 'active' in the Pharmacy package. These are the medications that the patient is actively taking.

4.9.8.2 Chronic Only

The Chronic Only button appears on Outpatient, Inpatient, and Outside Medication group boxes.



Figure 4-195: Chronic Only Button

Click the Chronic Only button to change the display to show only chronic medications for the current patient (applies to Outpatient medications only).

4.9.8.3 Restrict Medication Activity

The Restrict Medication Activity button appears on Outpatient, Inpatient, and Outside Medication group boxes.

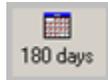


Figure 4-196: Restrict Medication Activity Button

Click the Restrict Medication Activity button to display the Restrict Medication Activity dialog.



Figure 4-197: Restrict Medication Activity dialog

You can change the number in the free text field, if needed, in the range 1 to 9999. After you click OK, the Medications window shows only medications that were active with the last specified days (for the current patient).

The default time can be configured in the RPMS.

4.9.8.4 Print

The Print button appears on Outpatient, Inpatient, and Outside Medication group boxes.



Figure 4-198: Print Button

Select one or more medication orders to print, and then click the Print button (or select File > Print) to display the Print Medications dialog.



Figure 4-199: Print Medications dialog

The Prescription option button displays only after being configured in RPMS. See your CAC about this configuration.

4.9.8.5 Report Format

This group box determines the format of the output.

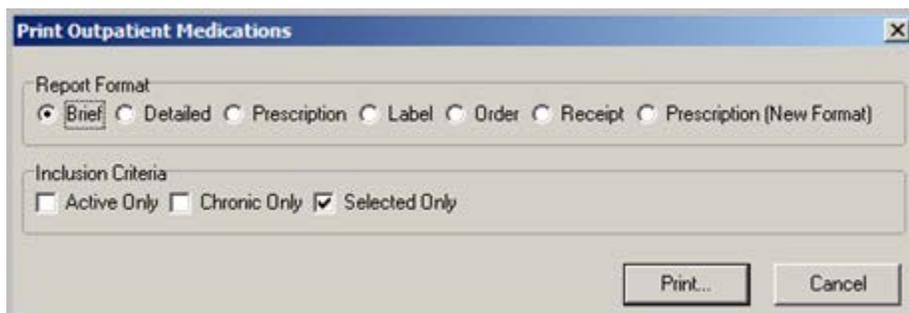


Figure 4-200: Report Format Group Box

- The **Brief** option outputs the information in the Medication, Prescriber, Status, and Refills Left columns (not just the ones in the current view).
- The **Detailed** option outputs the information in all of the columns (not just the ones in the current view).
- To print a **Prescription**, your local CAC can set the default printer for the medication report. Also, the CAC must set the Enable Printing of Prescription option to YES. Both of these options are accessed in RPMS.
- In order to use the **Label** option button, your site must be configured to print labels (using the Enable Printing of Sample Labels option in RPMS).
- **Prescription** (new format): If a site is printing prescriptions using the queue, there may be times when the prescription does not print. This requires a reprint of the prescription.
- The **Order** option prints the order from a pre-defined template. Refer to the Rx Print Format (Template) Editor – Export and Import Files book for additional information.

Users must select a reason for the reprint, and this data is tracked in the prescription.

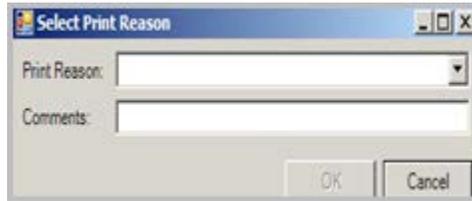


Figure 4-201: Select Reprint Reason dialog

4.9.8.5.1 Inclusion Criteria

1. This group box determines what is included on the output. Select one of the following:
 - Select the Active Only check box to include Active Only medication orders.
 - Select the Chronic Only check box to include the Chronic Only medication orders.
 - Select the Selected Only check box to include the selected medication orders.
2. Click Print on the Print Medications dialog to initiate the print process. The Print Setup dialog displays. This is where you select the printer and other settings.
3. Click OK on this dialog to output the information to the selected printer. (Otherwise, click Cancel to cancel the print process.)

4.9.8.5.2 Queue Print

The Queue Print icon is lit when there are items waiting to be printed. When clicked, the Prescription Template and Printer Selection dialog is displayed.



Figure 4-202: Queue Print Button

4.9.8.6 Process

The Process button appears on Outpatient group boxes. This function is NOT available for Outside Medications.

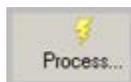


Figure 4-203: Process Button

The Process button enables you to select more than one medication order to process. The process enables you to change, refill, renew, and so, each medication in turn. Otherwise, you can choose the medication order individually and select the appropriate process (change, refill, and so on).

Select one or more medications and then select Action > Process or click the Process button to display the Medication Order dialog.

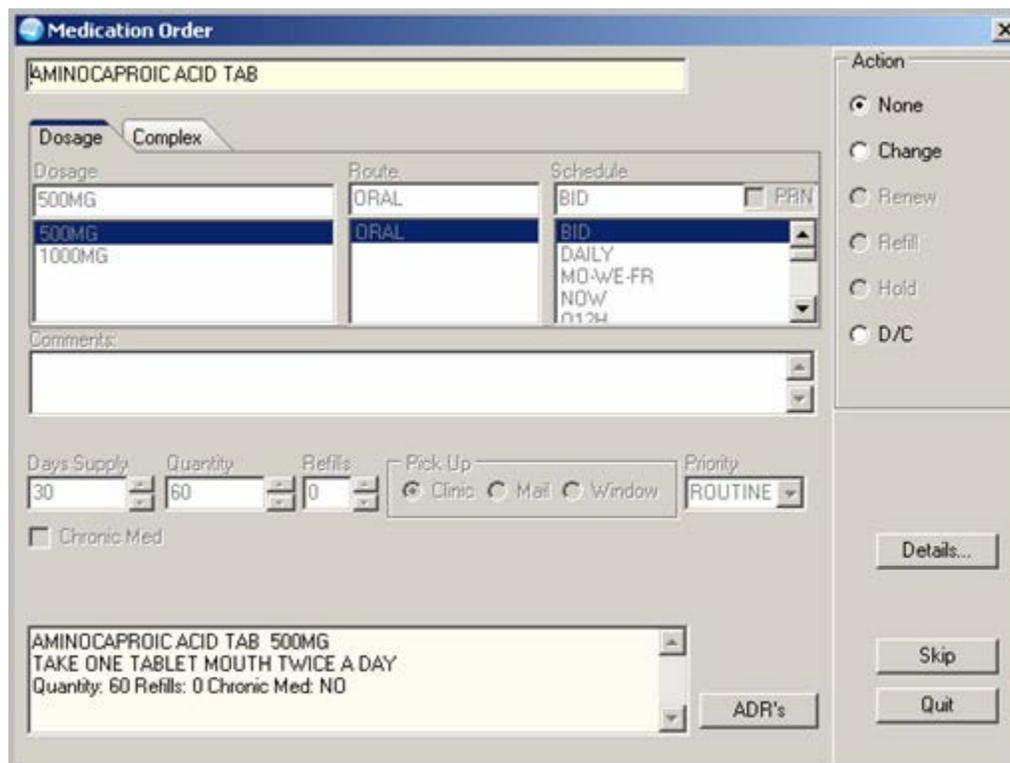


Figure 4-204: Medication Order Showing Process Actions

The Action you select determines the label on the button above the Quit button in the lower right corner of the dialog.

The Active Process Action option button determines the button label (the button above the Quit button). The following table provides information about that process and actions you can take.

Option Button	Button Label	Action on the Button
None	Skip	Skips to the next medication
Change	Change	Changes the medication.
Renew	Renew	Renews the medication order.
Refill	Refill	Orders a refill for the medication.
Hold	Hold	Puts the medication order on hold.
D/C	D/C	Cancels the medication order.

Click the ADRs button to display the Patient Postings information about the current patient.

If you click the Details button, the system displays the Medication Details dialog.

4.9.8.7 New

The New button appears on Outpatient, Inpatient, and Outside Medication group boxes.



Figure 4-205: New Button

Click the New button to display the Medication selection dialog. (This is the same as selecting the New Medication option on the Action menu.) After making a selection, the Medication Order dialog displays.

4.9.8.8 Check

The Check button appears on Outpatient, Inpatient, and Outside Medication group boxes.

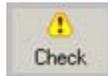


Figure 4-206: Check Button

Click the Check button to execute on-demand order checking. This causes the Order Checks dialog to display.

This performs order checks on all active and pending medications in the medication profile for both outpatient and outside medications and cites the source of the drug interaction information. You must dismiss the window in order to continue.

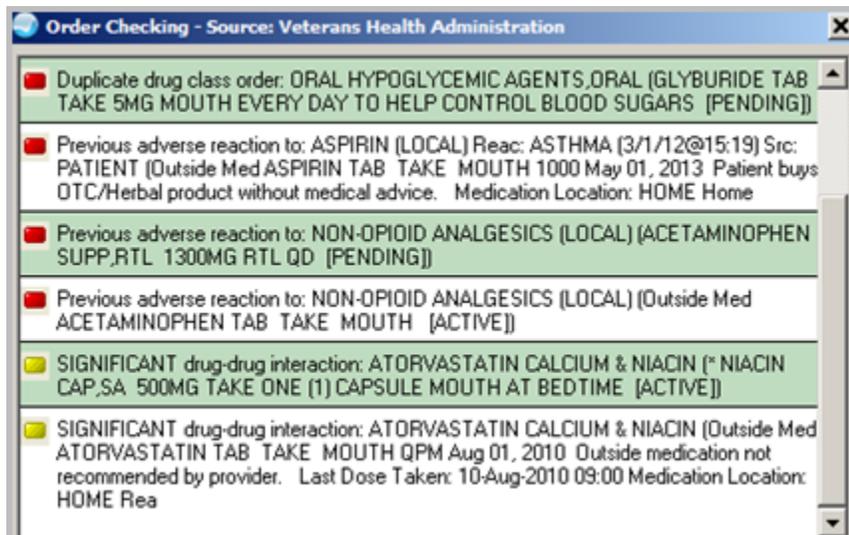


Figure 4-207: Order Checks

If no order checking transpired, the Order Checks information message displays informing you that there are no contraindications or warnings.

Click OK to dismiss the message.

4.9.8.9 Clinical Decision Support Button

The Clinical Decision Support button enables you to look up information on a highlighted medication order.



Figure 4-208: Information (Info) Button

It creates a search on UpToDate Web site for that medication and displays data for the provider.

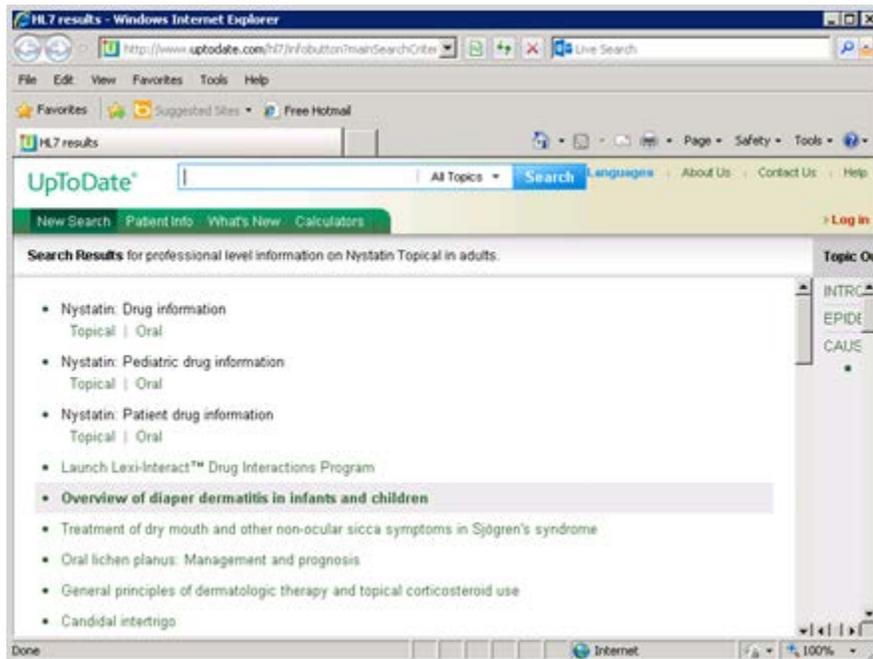


Figure 4-209: UpToDate Web Site

4.9.8.10 Education Information Button

The Education Information (formerly Information Ed) button enables you to look up information on a highlighted medication order.



Figure 4-210: Education Information (Ed) Button

It creates a search on MedlinePlus for that medication and displays data for the provider.

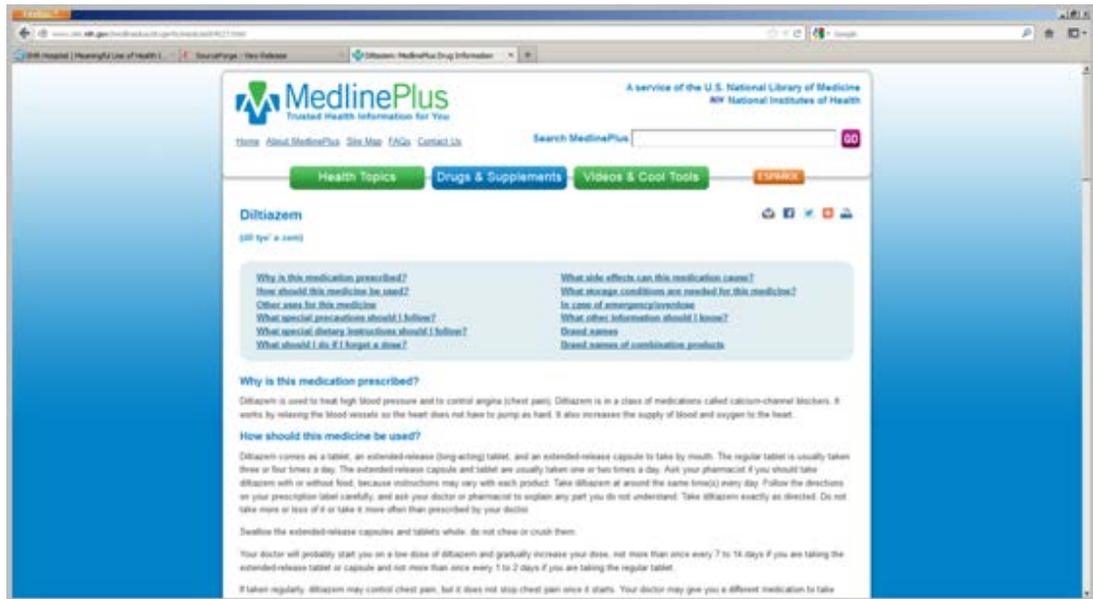


Figure 4-211: MedlinePlus Web Site

Note: The Add Patient Education Event dialog also opens, where you can add patient education information.

4.9.9 Options on Right-Click Menu

The following sections provide information about the options on the right-click menu.

4.9.9.1 Details

This option appears on the Outpatient, Inpatient, and Outside Medication group boxes. Use this option to display the Medication Details pop-up window.

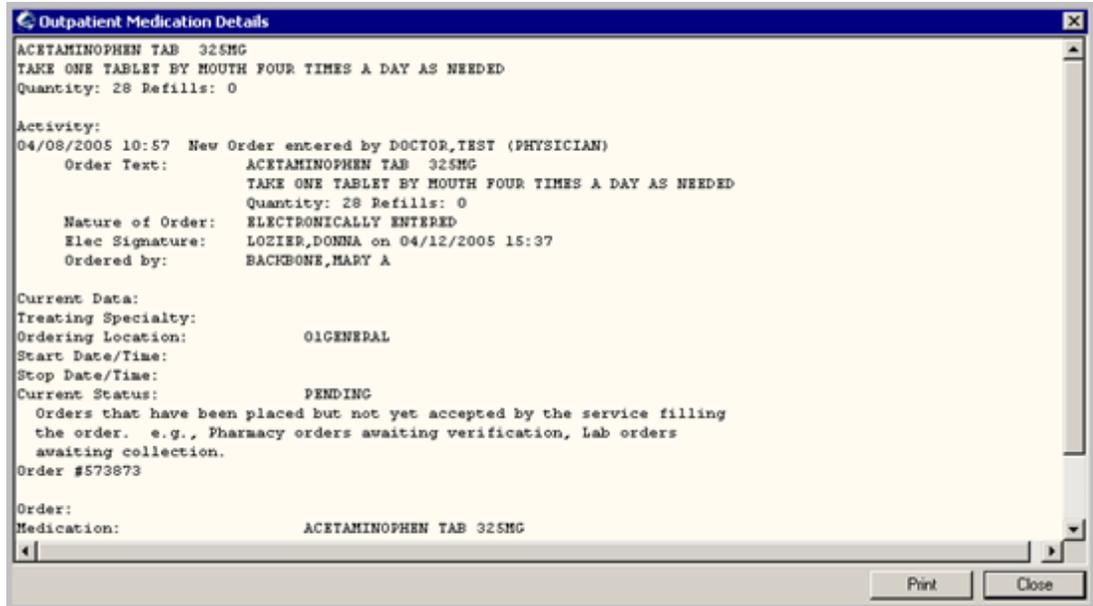


Figure 4-212: Medication Detail Window

4.9.9.2 Administration History

This option appears on the Outpatient and Inpatient group boxes. Use this option to display the administrative history of a selected medication (does not apply to IV Fluids). The Administrative History window displays.

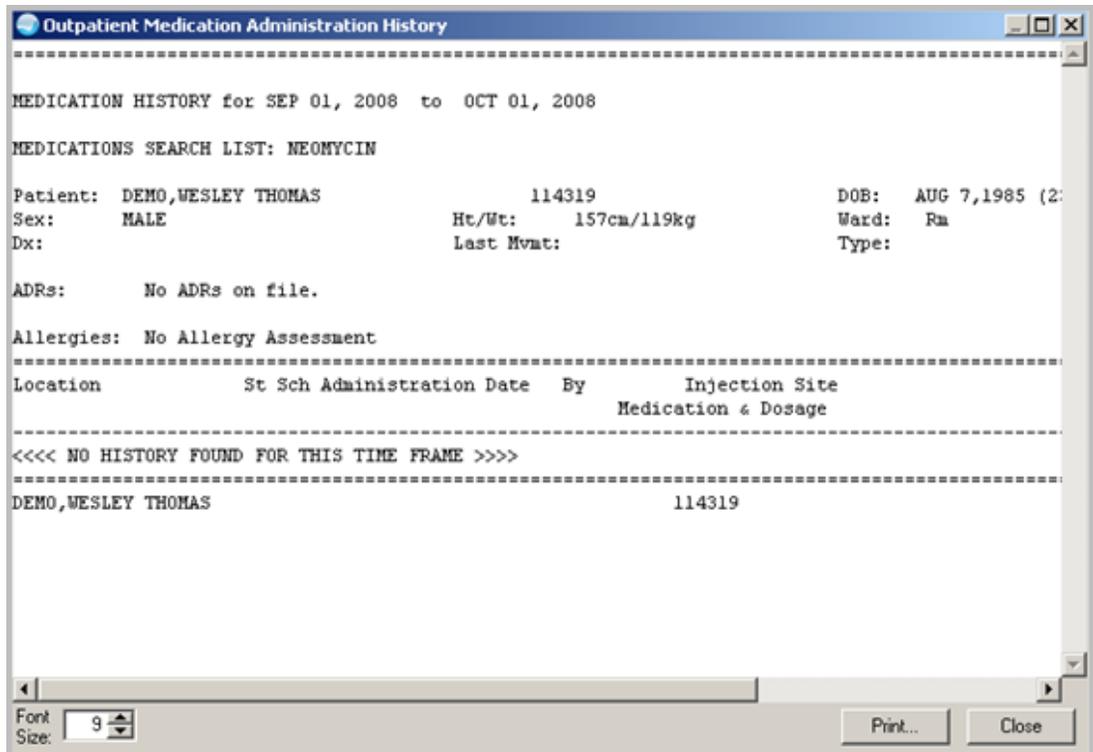


Figure 4-213: Administrative History dialog

Each window that displays by using the Details or Administration History option enables you to change the font size of the text displayed in this window by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows).

Note: This does not change the size of the text on the output (when you print).

Each window has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

1. Click Print to choose a printer and to output the (entire) contents of this window to the specified printer.

Note: The Print button may not appear. It is according to how your application is configured.

2. Click Close to dismiss the window.

4.9.9.3 Medication

This option appears on the Outpatient, Inpatient, and Outside Medication group boxes.

4.9.9.4 Change

This option appears on the Outpatient, Inpatient, and Outside Medication group boxes.

You can change the dosage, route, schedule, etc. of an existing medication order. This option does not allow you to change the medication itself (the Change button will not be active).

Follow these steps to change a medication order:

1. Select the medication you want to change (cannot be a cancelled order).
2. Select Action > Change (or select the Change option on the right-click menu) to display the Medication Order dialog. If you select an Outside Medication, the Document Outside Medication dialog displays with the Change button inactive.

Figure 4-214: Medication Order to Change

3. Complete the changes as appropriate on the Medication Order dialog. See Outpatient and Inpatient Medication Orders for more information about completing the Medication Order dialog or see Document Outside Medications for more information about completing the Document Outside Medications dialog.
4. Click Accept Order to change the medication order.

You can sign the changed order now or later.

4.9.9.5 Copy to New Order

This option appears on the Outpatient and Inpatient group boxes.

You might use this feature to create a new medication order from an expired one.

Make sure a visit is selected for the current patient. Follow these steps to copy an order to a new order.

1. Select the medication you want to copy to a new order.
2. Select Action > Copy to New Order (or select the Copy to New Order option on the right-click menu) to display the Copy Medication Order dialog.

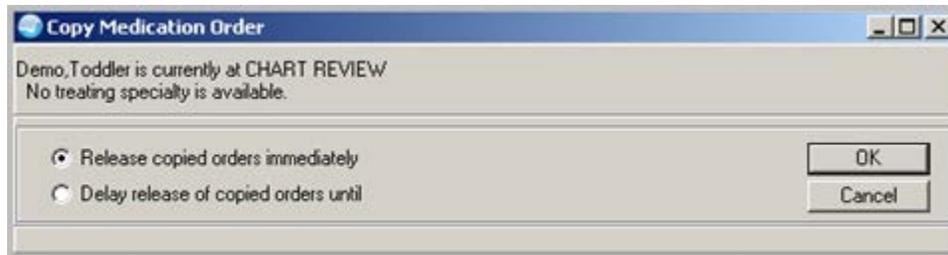


Figure 4-215: Copy Medication Order dialog

If the order does not have a Clinical Indication associated with it, the Unable to Save Order information message opens. A Clinical Indication must be added before proceeding. Refer to the appropriate Medication Orders topic based on the type of order you are copying, or the Using the SNOMED CT Lookup dialog if the Other option is selected in the Clinical Indication field.

3. Click the Release Copied Orders Immediately option button to create the same order over again.

The Delay release of copied orders until option requires that there has been the setup for delayed orders. You use the Delay option if the patient is being transferred and you have all of the orders set to auto-dc on the transfer. This option is not discussed in this topic.

4. Click OK to display the New Order dialog.

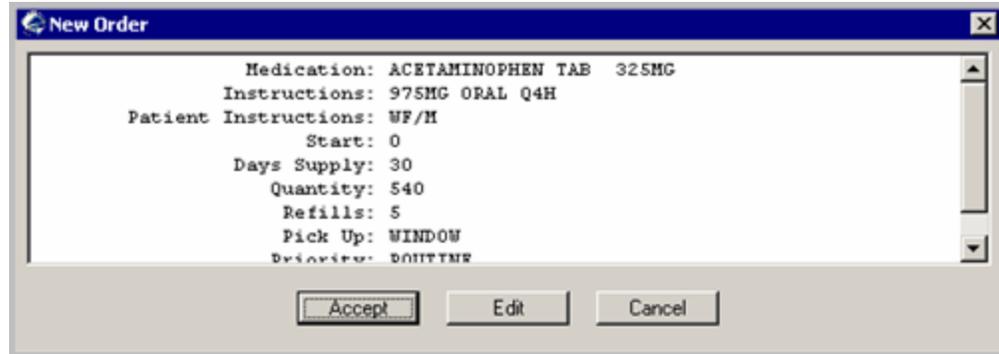


Figure 4-216: New Order dialog

- If you click Edit, you get the Medication Order dialog for the particular medication. See Outpatient and Inpatient Medication Orders for completing the dialog.
 - If you click Accept, a new order is created using the medication information displayed on the New Order dialog. (Otherwise, click Cancel.)
5. The specified medication has New in the Action column. You can sign the order now or later.

4.9.9.6 Discontinue/Cancel

This option appears on the Outpatient, Inpatient, and Outside Medication group boxes.

When an order is discontinued, the application changes the order's Stop Date/Time to the date/time the action is taken. Pending and Non-verified orders are deleted when the medication order is discontinued and no longer appears on the patient's profile. An entry is placed in the order's Activity Log recording who discontinued the order and when the action was taken.

Make sure a visit is selected for the current patient. Follow these steps to discontinue an order:

1. Select the medication orders you want to discontinue.
2. Select Action > Discontinue/Cancel (or select the Discontinue/Cancel option on the right-click menu) to display the Discontinue/Cancel Orders dialog.

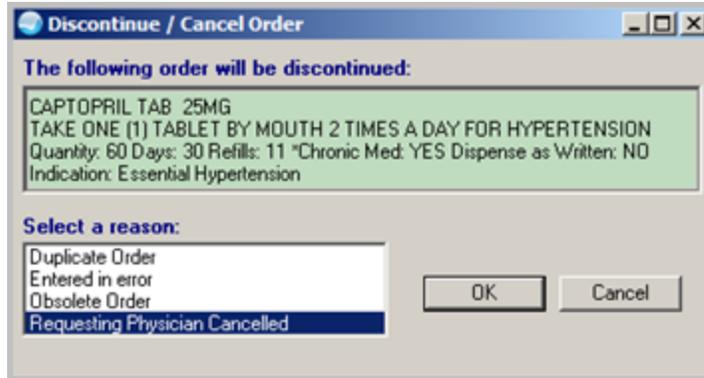


Figure 4-217: Discontinue/Cancel Orders dialog

3. Select the appropriate reason to discontinue from the Reason to Discontinue field and click OK. (Otherwise, click Cancel.)

The list of reasons to discontinue can be configured in RPMS (using the Edit DC Reasons option).

The specified medication displays DC in the Action column.

4.9.9.7 Hold

This option appears on the Outpatient and Inpatient group boxes.

Only active orders can be placed on hold. Orders placed on hold continue to show under the ACTIVE heading on the profiles until it is removed from hold. An entry is placed in the order's Activity Log recording the person who placed/removed the order from hold and when the action was taken.

The Hold/Unhold actions can be configured in RPMS. If the Disable Hold/Unhold Actions in EHR option is set to YES, this prevents orders from being placed on Hold.

Make sure a visit is selected for the current patient. Follow these steps to place a medication on hold:

1. Select the medication order you want to be placed on hold.
2. Select Action > Hold (or select the Hold option on the right-click menu) to display the Hold Order dialog.

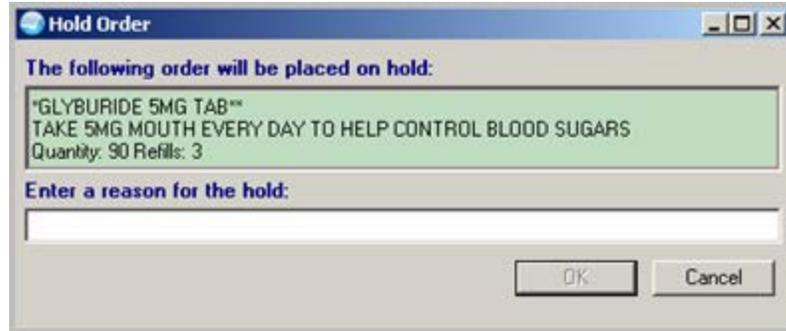


Figure 4-218: Hold Order dialog

3. Enter a reason in the free text field (required).
4. Click OK. The word Hold appears in the Order column for the selected order and the Status = Unreleased.
5. You must sign the Hold order now or later. After signing, the Status = Hold.

Once the medication is on Hold, you can remove it from Hold by selecting the medication and selecting Action > Release Hold to display the Release Order from Hold dialog.

This Hold is not a replacement for the Pharmacy Hold. It is designed to only be used on Inpatient Orders. The Hold Medication is normally done because the patient has a procedure scheduled and the medication cannot be given until after the procedure is finished. Outpatient pharmacy has their own hold action for medications given to patients to take home.

4.9.9.8 Process

This option appears on the Outpatient and Inpatient group boxes. See Process for more information about this option.

4.9.9.9 Refill

This option appears on the Outpatient Medications group box.

You can refill only outpatient medications that are active and have refills available (and NOT a medication that has been renewed).

You cannot refill a narcotic prescription.

Make sure a visit is selected for the current patient. Follow these steps:

1. Select the medication you want to refill.
2. Select Action > Refill (or select the Refill option on the right-click menu) to display the Refill Order dialog.

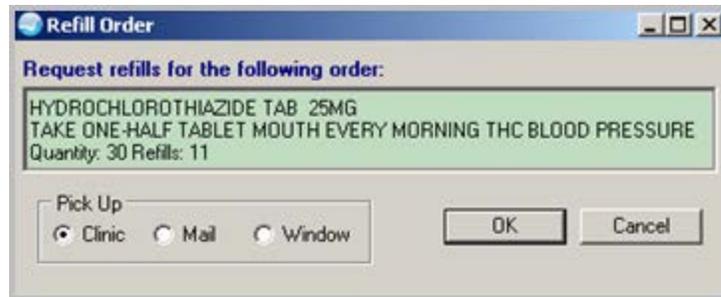


Figure 4-219: Change Refills for Outpatient Medication dialog

3. Click the appropriate option button in the Pick Up group box.
4. Click OK to have the medication refilled. (Otherwise click Cancel.)

The selected medication has Refill in the Action column.

4.9.9.10 Renew

This option appears on the Outpatient and Inpatient group boxes.

Only active orders or those that have been expired in a certain number of days can be renewed. The maximum number of days following the expiration can be configured for your site (using the Renewal Limit for Expired Meds option in RPMS). You must have Outpatient Pharmacy 7.0 loaded in order to renew a medication order.

After a renewed order is accepted, the Start Date/Time for the renewed order becomes the Stop Date/Time of the original order.

Once an order has been renewed, it cannot be renewed again or edited.

You cannot renew or refill narcotics. If you try to renew or refill, the application displays the Unable to Renew Order information message.

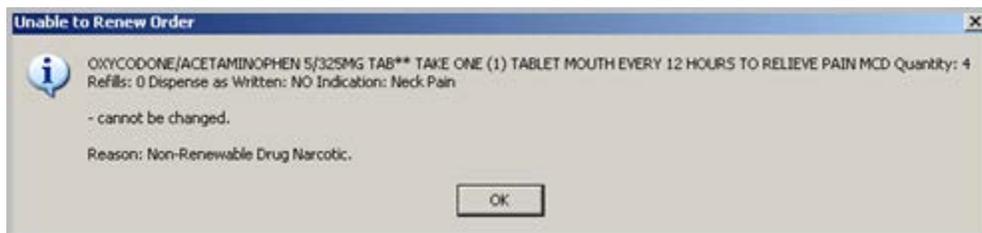


Figure 4-220: Unable to Renew Order Information Message

Make sure a visit is selected for the current patient. Follow these steps to renew a medication order:

1. Select the medication you want to renew.

2. Select Action > Renew (or select the Renew option on the right-click menu) to display the Renew Order dialog.



Figure 4-221: Renew Order dialog

3. If you need to change the Refill/Pick Up information, click inside the green box and the label on the button changes:



Figure 4-222: Renew Order dialog with Changed Button Label

- a. Click the Change Refill/Pick Up button to display the Change Refills dialog.



Figure 4-223: Change Refills dialog

- b. You can manually change the number of refills and change the Pick Up information by selecting from the drop-down list.
- c. When the Change Refills dialog is complete, click OK. You return to the Renew Order dialog. (Otherwise, click Cancel.)

If the order does not have a Clinical Indication associated with it, the Unable to Renew Order information message opens. A Clinical Indication must be added before proceeding. Refer to the appropriate Medication Orders topic based on the type of order you are renewing.

- Click OK on the Renew Order dialog. (Otherwise, click Cancel.)

The specified medication shows Status = Unreleased and Action = Renew. After signing the order, this changes the order to have Status = Pending.

4.9.9.11 Transfer to Inpatient

This action transfers a selected Outpatient Medication to an Inpatient Medication for a patient with the status of Outpatient. The application tells you if the medication cannot be changed to an Inpatient Medication. Follow these steps:

- Select the Outpatient Medication you want to transfer (you can select more than one, if needed).
- Select Action > Transfer to Inpatient (or select the Transfer to Inpatient option on the right-click menu). The application checks the status of the patient.

The Transfer Medication Order dialog displays.

If your patient is still an outpatient, then delaying the order until after admission is the only choice. The following dialog displays enabling you to enter delayed orders.

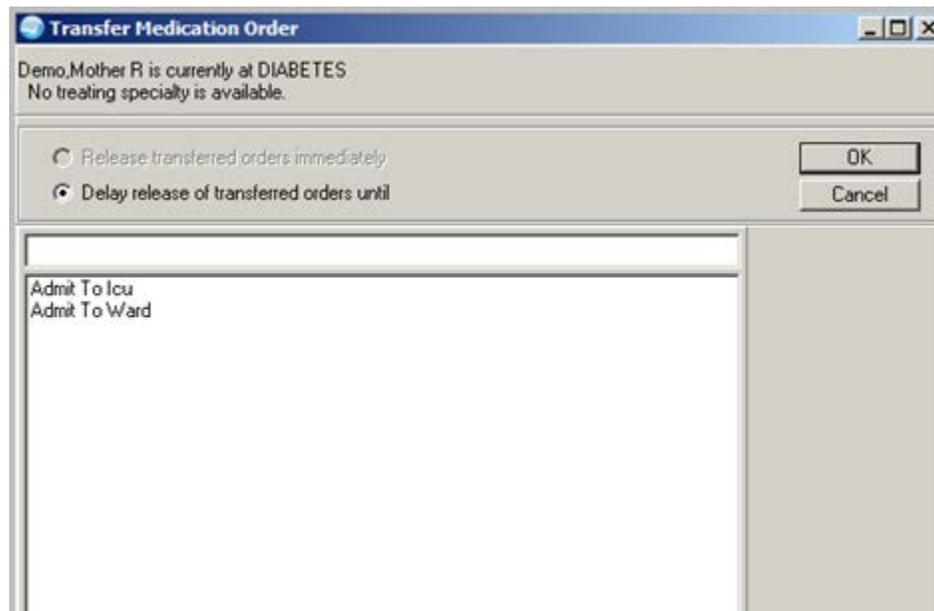


Figure 4-224: Transfer Medication Order dialog

- Select one of the options in the lower field, such as Admit to Ward.
- Click OK to display the Admit Patient dialog.

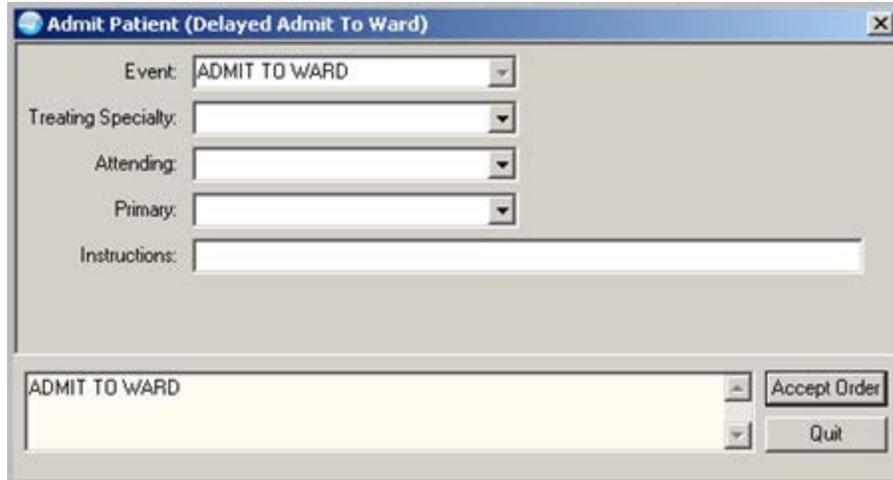


Figure 4-225: Admit Patient dialog

9. Complete the fields on this dialog by selecting from the drop-down lists. The Attending field is the only required field. The Instructions field is a free-text field.
10. Click Accept Order to display the Medication Order.

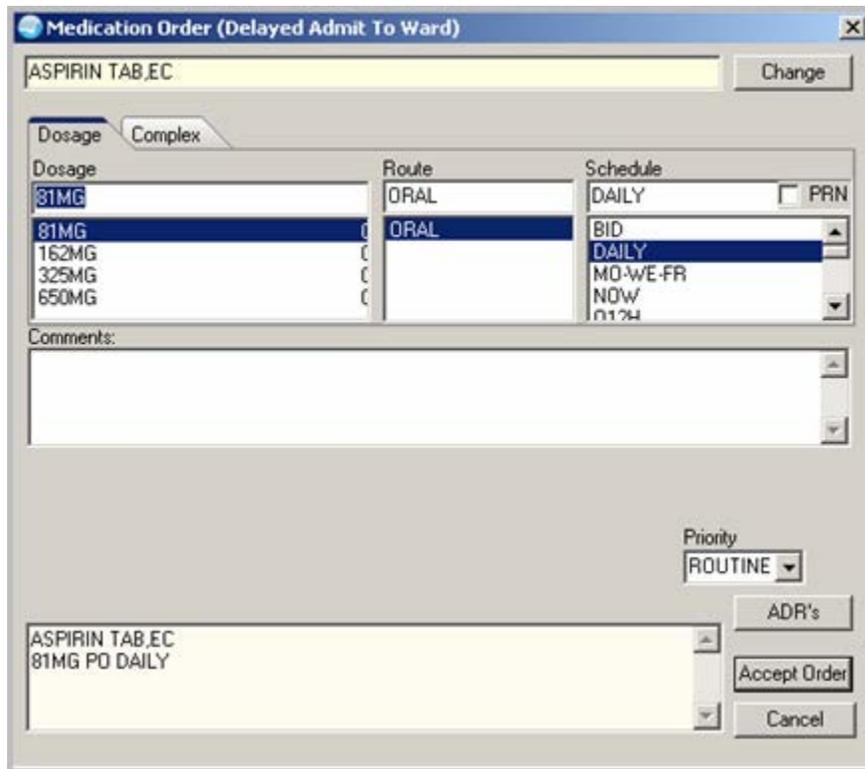


Figure 4-226: Outpatient Medication Order

11. Complete the medication order and click Accept Order. See Outpatient and Inpatient Medication Orders for more information about completing the dialog.

The selected medication appears in the Inpatient Medications group box with New in the Action column.

If your patient is already admitted, the Inpatient Order dialog opens for you to process. However, any med selected must have been setup to be an inpatient medication.

12. Sign the order. The Status becomes Pending.

4.9.9.12 Transfer to Outpatient

This action transfers a selected Inpatient Medication to an Outpatient Medication for a patient with the status of Inpatient. Follow these steps:

1. Select the medication from the Inpatient Medications panel that you want to transfer to outpatient (you can select more than one, if needed).
2. Select Action > Transfer to Outpatient (or select the Transfer to Outpatient option on the right-click menu). The application checks the status of the patient.

The Transfer Medication Orders dialog displays.

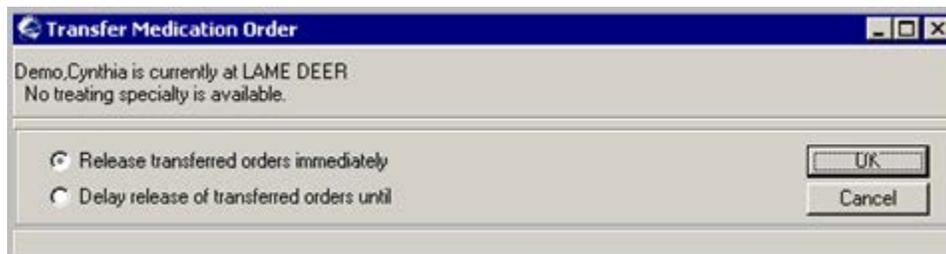


Figure 4-227: Transfer Medication Order dialog

3. Click OK. The Medication Order displays.
4. Complete the Medication Order dialog and click Accept Order. See Outpatient and Inpatient Medications Orders for more information about completing the dialog.

The selected medication order appears in the Outpatient Medications group box with New in the Action column.

5. Sign the order. The Status becomes Pending.

4.9.9.13 Chronic Medication

The Chronic Medication option/feature appears on the Outpatient Medication group box, and marks selected medications as chronic or as not chronic.

Chronic medications apply to outpatient medications only. They have a Chronic Medication check mark (✓) in the Chronic column. Once the medications are marked as chronic, you can sort the list by clicking on the Chronic column heading until all of the chronic medications are listed at the top.

Follow these steps to use the Chronic Medication features:

- To mark (outpatient) medications as chronic, select the medications.
 - To select all chronic medications, select Chronic Medication > Select All on the right-click menu (or on the Action menu).
 - Use the Shift or Ctrl key in combination with the left mouse button to select the medications.
- Select Chronic Medication > Yes on the right-click menu. The selected medications show a check mark (✓) in the Chronic column.
- To mark medications as not chronic, select the chronic medications.
 - To select all chronic medications, select Chronic Medication > Select All on the right-click menu (or on the Action menu).
 - Use the Shift or Ctrl key in combination with the left mouse button to select the medications.
- Select Chronic Medication > No on the right-click menu. The selected medications have no check mark (✓) in the Chronic column.

4.10 Orders

4.10.1 Orders Window

Orders are placed using options from the Write Orders field. You can place orders for a variety of items and procedures, such as medications, consults, lab tests, and so on.

File View Action Options									
Active Orders (includes Pending & Recent Activity) - ALL SERVICES									
View Orders	Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status	
Active Orders (includes)	Lab	MICROALBUMIN DEMO URINE SP ONCE Indication: TYPE 2 DIABETES MELLITUS LB #34	Start: -1	Hager,M				active	
Write Orders	Out. Meds	METFORMIN TAB DPAL 500MG TAKE ONE TABLET MOUTH TWICE A DAY THC BLOOD SUGAR - TWF Quantity: 180 Refills: 3	Start: 05/22/06 Stop: 05/23/07	Hager,M				active	
Delayed Orders	Out. Meds	HYDROCHLOROTHIAZIDE TAB 25MG TAKE ONE HALF TABLET MOUTH EVERY MORNING THC BLOOD PRESSURE Quantity: 30 Refills: 11	Start: 05/22/06 Stop: 05/23/07	Hager,M				active	
Allergy/Adverse Reacts	Out. Meds	ASPIRIN TAB EC 81MG TAKE ONE TABLET MOUTH EVERY DAY Quantity: 90 Refills: 3	Start: 05/22/06 Stop: 05/23/07	Hager,M				active	
Laboratory	Out. Meds	*GLYBURIDE 5MG TAB** TAKE 5MG MOUTH EVERY DAY TO HELP CONTROL BLOOD SUGARS Quantity: 90 Refills: 3	Start: 05/22/06 Stop: 05/23/07	Hager,M				active	
Imaging	Allergy	Reaction to PENICILLINS	Start: 12/17/04 11:02	Hager,M				active	
Outpatient Medications									
Inpatient Medications									
IV Fluids									
Text Only Order									
Lab Quick Orders									
Radiology Quick Orders									
Outpt Med Quick Orders									
Consults									
Admission Orders									

Figure 4-228: Orders Window

The Orders window displays information about each order. For example, which service the orders are associated with, the start and stop date of each order, the name of the provider who entered the order, and the status of the order.

The Orders window has the following features:

- The View Orders category field contains the name of the order category being viewed (in the right panel). In addition, it can contain the name of the order within that category.
- The Write Orders type field contains the list of order types that can be selected.
- The right-hand panel contains a list of the orders being viewed.
- Order checks are performed on all orders (after you click Accept Order and before you sign the order) to prevent errors (such as duplicate orders) from occurring.
- You can specify that an order become active immediately, or specify that an order be event delayed (inpatient only) and activated when the selected patient is admitted, transferred, or discharged.

Note: The orders listed in the Write Orders field vary from site to site. Because of this, some of the orders discussed in the following sections may not be available.

The Write Orders field is determined by one of two parameters, the ORWOR WRITE ORDERS LIST or the ORDWDX WRITE ORDERS LIST. The ORWDX WRITE ORDER LIST points to an order menu that can be used and if this parameter is set, it takes precedence.

4.10.2 Viewing Orders

You can control which orders appear on the Orders window by defining specific criteria. For example, you can specify that only unsigned orders associated with a specific service or section appear. Unsigned orders appear on the Orders window in bold, blue lettering.

To view orders:

1. On the View menu, select one of the following view options (in top of the menu):



Figure 4-229: View Menu Options

The appropriate orders appear in the right-hand panel.

2. Select the Refresh option if you want to update the current Orders window.
3. If you would like to filter the orders further, continue with Custom Order View.

4.10.2.1 Custom Order View

1. Select View > Custom Order View (or select Custom Order View on the right-click menu) to display the Custom Order View dialog.

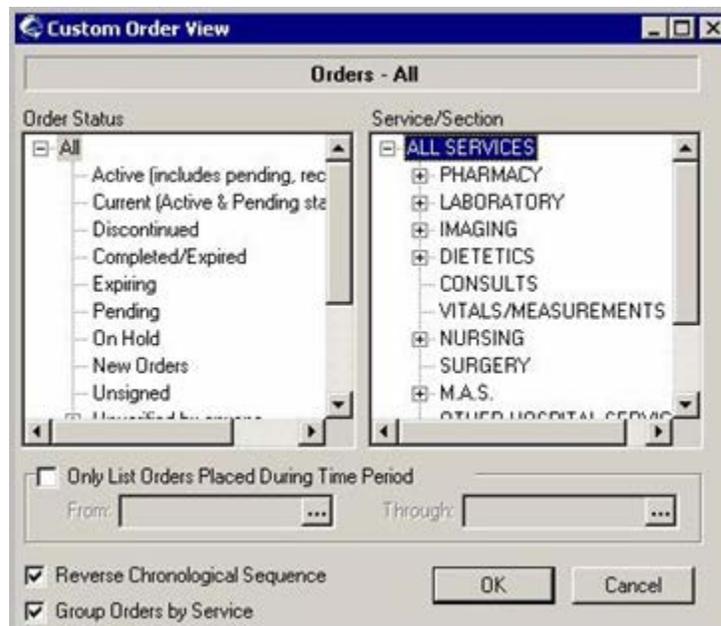


Figure 4-230: Custom Order View dialog

2. Select the criteria for the orders that you want to display on the Orders window by doing one or more of the following:

- a. Select an order status from the Order Status scroll list. (Click the  sign to expand a heading.)
 - b. Select a service or section from the Service/Section scroll list. (Click the  sign to expand a heading.)
 - c. If you would like to limit the orders to a specific date range, check the Only List Orders Placed During Time Period check box, and enter the From and Through dates.
 - d. Click the Ellipsis button to choose a date from a calendar.
 - e. Check the Reverse Chronological Sequence check box if you want the oldest orders to appear at the top of the orders list.
 - f. Check the Group Orders by Service check box if you want the orders to be sorted according to the service with which they are associated.
3. Click OK. The orders that meet the criteria you specified on the Custom Order View dialog display on the Orders window.

Criteria for the displayed orders appears above the Service column (in the right panel).

If all of the active orders are not displayed on the Orders window, the  icon appears above the last column on the right side of the screen.



Figure 4-231: Active Orders Not Displayed

If you choose Active Orders, you will see the Active and Pending orders that have had activity in the past number of hours that your site specifies in a parameter.

Note: Some sites use this to see all activity in the past 24, 48, or 72 hours. The CAC sets the number of hours.

4.10.2.2 Default View for Orders

A default view for your orders is one you particularly use the most and want it to be the view that displays when you enter the Orders window. To use the Default View for orders:

1. Establish the view that you want as your default view.
2. Select View > Save as Default View to display the Save Default Order View information message.

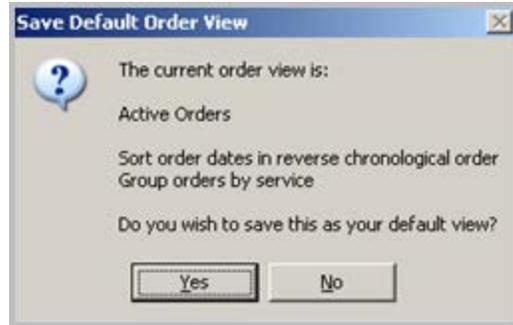


Figure 4-232: Save Default Order View Information Message

3. Click Yes to save the view as your default view. (Otherwise, click No.)

Note: If you are in another view on the Orders window, you can return to your default view by selecting View > Return to Default View.

4.10.3 Medication Orders

When ordering medications, you can order Outpatient or Inpatient Medications, including IV Fluids and Unit Doses. Outpatient medications and Inpatient medications are defined by Pharmacy.

Note: If a medication is preceded by an asterisk (*), the asterisk indicates that the order was changed by the pharmacy service.

If you would like to view additional information about a medication order, double-click the order or select a medication order and choose View > Details to display the Order Details dialog. See Order Details for more information.

To order outpatient medications, select the Outpatient Medications function on the Orders window. The ordering activities are the same ordering them on the Medications window. Refer to the online Help for the Medications window for more information.

To order inpatient medications, select the Inpatient Medications function on the Orders window. The ordering activities are the same ordering them on the Medications window.

4.10.3.1 ADRs Button

The ADRs button appears on many of the medication dialogs within the Orders menu. Click the ADRs button to show the Patient Postings information about the current patient (contains the patient's allergies as well as Crisis notes, and so on).

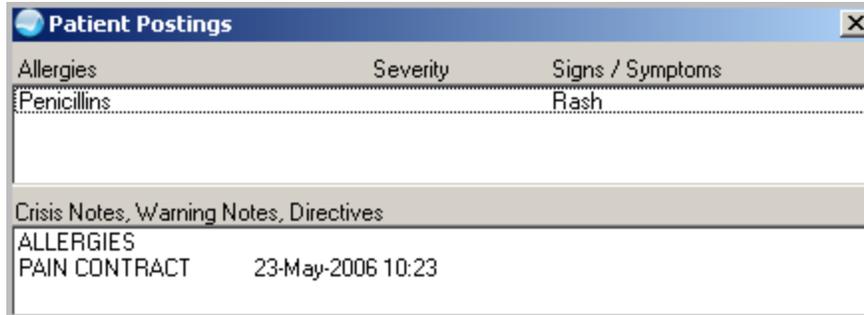


Figure 4-233: Patient Postings Information

4.10.3.2 Holding Pharmacy Orders

Only active pharmacy orders can be placed on hold. Orders placed on hold will continue to show under the ACTIVE heading on the profiles until they are removed from hold. An entry is placed in the order's Activity Log recording the person who placed/removed the order from hold and when the action was taken. The HOLD action in orders was designed to be for Inpatient orders such that the patient will not receive the medication because they are having a procedure done.

There is a pharmacy application to place outpatient medications on hold.

Note: The Hold option might not active on your system. This option is controlled by a parameter that must be turned on in the RPMS.

Make sure a visit is selected. To place an order on hold:

1. On the Orders window, select the pharmacy order you want to be placed on hold.
2. Select Action > Hold (or select Hold on the right-click menu) to display the Hold Order dialog.

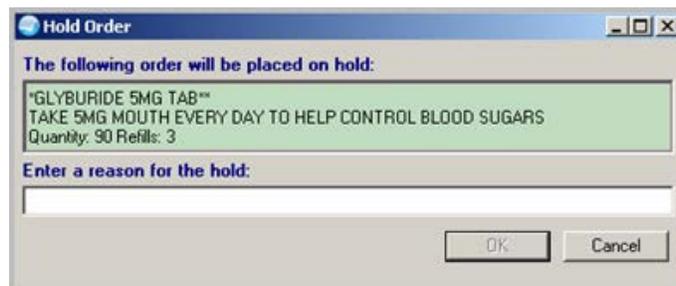


Figure 4-234: Hold Order dialog

3. The Enter a reason for the hold field is a required, free-text field.
4. Click OK.

The pharmacy order now has Status = Hold on the Orders window. You can sign the order now or later. See Sign Selected for more information.

4.10.3.3 Releasing a Pharmacy Order from Hold

The Release Hold option might not be available on your system. This option is controlled by a parameter that must be turned on in the RPMS.

Make sure a visit is selected. To release a pharmacy order from hold:

1. On the Orders window, select a pharmacy order with a Status = Hold.
2. Select Action > Release Hold to display the Release Order from Hold dialog.

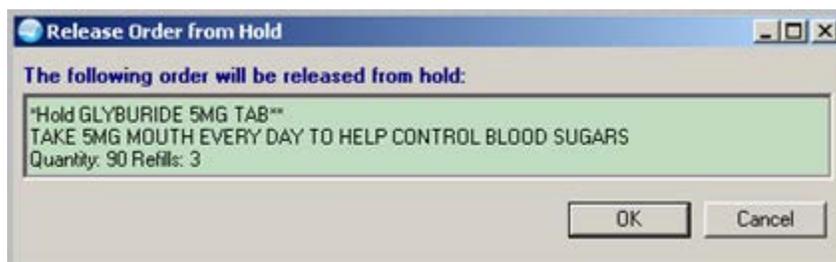


Figure 4-235: Release Order from Hold dialog

3. Click OK. (Otherwise, click Cancel.) The selected pharmacy order now has Status = Unreleased on the Orders window.
4. You can sign the order now or later. See Sign Selected for more information.

4.10.3.4 Renewing Medications

The CAC can set the renew limit for expired medication orders. This is the maximum number of days following the expiration of a prescription that it can still be renewed.

Only active orders or those that have been expired less than the renew limit (discussed previously) can be renewed. The Duration for the order (to renew) must have a Stop Date after the current visit date. You cannot renew narcotic medication orders.

After a renewed order is accepted, the Start Date/Time for the renewed order becomes the Start Date/Time of the original order. The original order's status is changed to Renewed (after signing the order).

Once an order has been renewed, it cannot be renewed again or edited.

Make sure a visit is selected. To renew a medication:

1. Select the pharmacy order to be renewed. You can select more than one order.

2. Select Action > Renew (or select Renew on the right-click menu) to display the Renew Orders dialog.

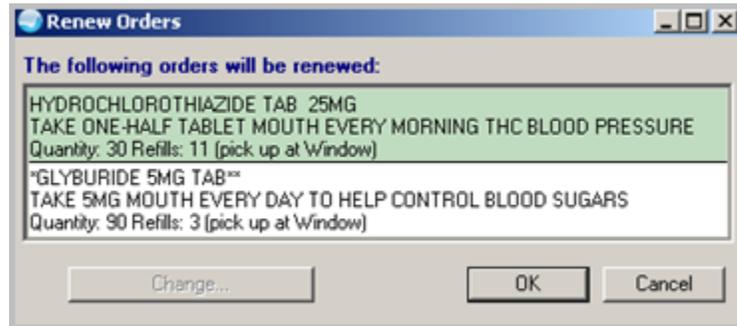


Figure 4-236: Renew Order dialog for Two Orders

3. If you need to change the Refill/Pick Up information, select the order's text in the Renew Orders dialog and the button label changes:

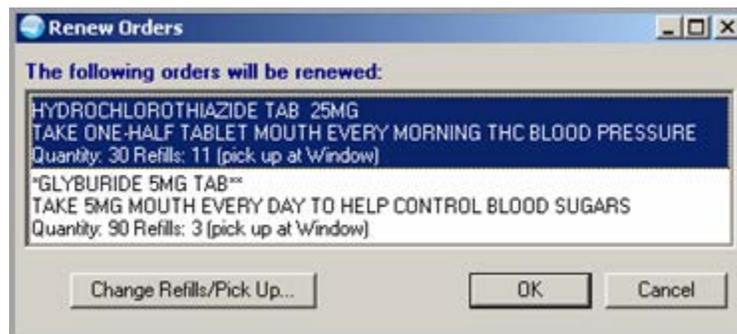


Figure 4-237: Renew Order with Change Refills/Pick Up Button

4. Click the Change Refills/Pick Up button to display the Change Refills dialog.

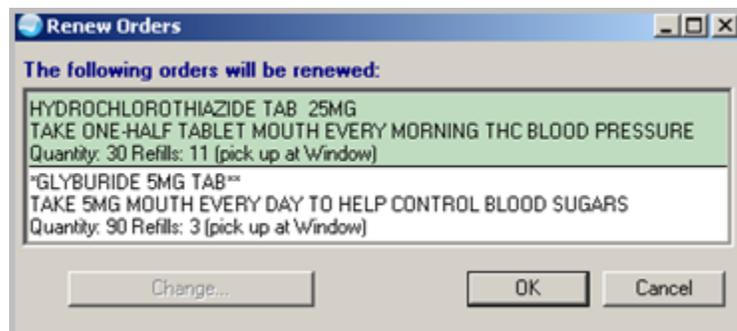


Figure 4-238: Change Refills dialog

5. You can manually change the number of refills and can change the Pick Up information by selecting from the drop-down list.
6. Click OK on the Change Refills dialog to return to the Review Orders dialog.

- You can repeat the previous process, if needed. Click OK on the Renew Orders dialog. (Otherwise, click Cancel.)

The renewed pharmacy order appears on the Orders window with Status = Unreleased.

If the order does not have a Clinical Indication associated with it, the Unable to Renew Order information message opens. A Clinical Indication must be added before proceeding. Refer to the appropriate Orders topic based on the type of order you are renewing, or Using the SNOMED CT Lookup dialog if the Other option is selected in the Clinical Indication field.

- You must either sign the order now or later. See Sign Selected for more information.

After signing the order, this changes the order to have Status

4.10.4 Ordering Infusions

IV infusions can only be ordered on the Orders tab.

Figure 4-239: Infusion dialog

- Select the solution to be administered from the list set up by pharmacy.

As soon as one is selected, it is moved to the Order dialog. Since the volume is normally part of the solution name, it is filled in automatically.

The screenshot shows the 'Infusion Order' dialog box with the following details:

- Tab:** Solutions
- Solution/Additive*:** DEXTROSE 5% IN 0.9% NS--1000 ML INJ,SOLN
- Volume/Strength*:** 1000 ML
- Route*:** INTRAVENOUS
- Priority*:** ROUTINE
- Buttons:** Accept Order, Quit

Figure 4-240: Solution Selected

2. Select any additives, as needed. The Additives tab automatically opens once a solution is selected. Multiple additives or solutions can be selected.
3. In the Volume/Strength fields, add the amount for the additives.
4. Select the applicable route from the Route drop-down list. If OTHER is chosen, a new dialog with a drop-down menu appears with all medication routines flagged as IV types.

The screenshot shows the 'Expanded Med Route List' dialog box with the following details:

- Routes:** INTRAVENOUS, INTRAVENOUS INTRATHECAL EF, IV PIGGYBACK, IV PUSH
- Buttons:** Cancel, OK

Figure 4-241: Other IV Med Routes

5. Select the type from the Type drop-down list.
 - If Continuous is selected, an Infusion Rate must be entered.

- If Intermittent is selected, an entry in the Schedule field is required. A time period to run the infusion can be entered, if needed.

The screenshot shows the 'Infusion Order' dialog box with the following configuration:

- Solutions/Addsives:** A list of solutions including CIPROFLOXACIN/DEXTROSE INJ.S, CLINDAMYCIN/DEXTROSE INJ.SOL, Dextrose 10% in Water INJ.SOLN, DEXTROSE 5% IN 0.225% NS--1000, DEXTROSE 5% IN 0.45% NS--1000, DEXTROSE 5% IN 0.45% NS--500 MI, DEXTROSE 5% IN 0.9% NS--1000 MI, DEXTROSE 5% IN LACTATED RING, DEXTROSE 5% IN NS WITH 20MEQ, DEXTROSE 5% IN WATER--100 ML, and DEXTROSE 5% IN WATER--1000 ML.
- Solution/Additive* Table:**

Solution/Additive*	Volume/Strength*
DEXTROSE 5% IN 0.9% NS--1000 ML INJ.SOLN	1000 ML
POTASSIUM CHLORIDE INJ.SOLN	20 MEQ
IRON DEXTRAN INJ.SOLN	10 MG
- Comments:** A text area with a 'Remove' button.
- Route*:** INTRAVENOUS
- Type*:** Continuous
- Schedule*:** (Empty)
- Infusion Rate (ml/hr)*:** (Empty)
- Priority*:** ROUTINE
- Duration or Total Volume (Optional):** 2 doses
- Buttons:** Accept Order, Cancel
- Summary:** POTASSIUM CHLORIDE INJ.SOLN 20 MEQ, IRON DEXTRAN INJ.SOLN 10 MG in DEXTROSE 5% IN 0.9% NS--1000 ML INJ.SOLN 1000 ml INTRAVENOUS Infuse Over 1 Q24H for a total of 2 doses

Figure 4-242: Continuous Type

- The Duration or Total Volume fields are optional.
- The Comments field is optional for comments to the pharmacist or nursing staff.

The screenshot shows the 'Infusion Order' dialog box with the following configuration:

- Solutions/Addsives:** Same list as Figure 4-242.
- Solution/Additive* Table:**

Solution/Additive*	Volume/Strength*
DEXTROSE 5% IN 0.9% NS--1000 ML INJ.SOLN	1000 ML
POTASSIUM CHLORIDE INJ.SOLN	20 MEQ
IRON DEXTRAN INJ.SOLN	10 MG
- Comments:** A text area with a 'Remove' button.
- Route*:** INTRAVENOUS
- Type*:** Intermittent
- Schedule* (Day-of-Week):** Q8H
- Infuse Over Time (Optional):** 1 Hours
- Priority*:** ROUTINE
- Duration or Total Volume (Optional):** 2 doses
- Buttons:** Accept Order, Cancel
- Summary:** POTASSIUM CHLORIDE INJ.SOLN 20 MEQ, IRON DEXTRAN INJ.SOLN 10 MG in DEXTROSE 5% IN 0.9% NS--1000 ML INJ.SOLN 1000 ml INTRAVENOUS Infuse Over 1 Q24H for a total of 2 doses
- Additional Info:** Admin. Time: 05-13-21, Expected First Dose: TODAY (Jul 27, 12) a:9:00 PM 21:00

Figure 4-243: Completed Infusion Order dialog

- Click Accept Order when finished.

4.10.5 Ordering Lab Tests

When ordering lab tests, a parameter in RPMS establishes the number of previous days to search for duplicate lab orders. This is part of the order checking process.

Make sure a visit is selected and that the current view is Active Orders. To place an order for a lab test (this is the generic lab order method):

- Select the Lab Tests function on the Orders window. The Order a Lab Test dialog displays.

Figure 4-244: Order a Lab Test dialog

Note: Lab test names in the upper part of the list are in numerical order, while the names in the lower part of the list are in alphabetical order.

- You can search for a lab test by entering a few characters in the free-text field below the Available Lab Tests label. In this case, the list scrolls to the first lab test containing those characters, if no quick orders begin with those characters. (Remember the system searches the quick orders first, then the list of available lab tests.)
- Select the desired lab test in the Available Lab Tests list box.
- The field in the lower part of the dialog shows information about the selected lab test. This field has a right-click menu for copying selected text. You can paste this text into another free-text field in the EHR or into another application (like MS Word).

Figure 4-245: Lab Order Showing Information in Lower Part of dialog

In some cases, a warning message displays in the lower part of the dialog. (Click outside the message to dismiss it.)



Figure 4-246: Warning Message for Lab Order

5. You can change the default values for the Collect Sample, Specimen, and/or Urgency fields. If you cannot change a field, the text label (to the left of the field) is not active.
6. You can change the collection type by selecting an option from the Collection Type drop-down list. Inpatients have the lab collect and possibly Intermediate Type if lab collections have been set up in the Laboratory files.
7. You can manually change the Collection Date/Time (cannot be earlier than the Current Date/Time). Otherwise, click the Ellipsis button to select from a calendar.
8. The How Often? field displays the lab administration scheduled. This is set up in the Laboratory application.
9. The How Long? field indicates a time. For example, 3 = 3 days, or occurrence 3X = 3 times.

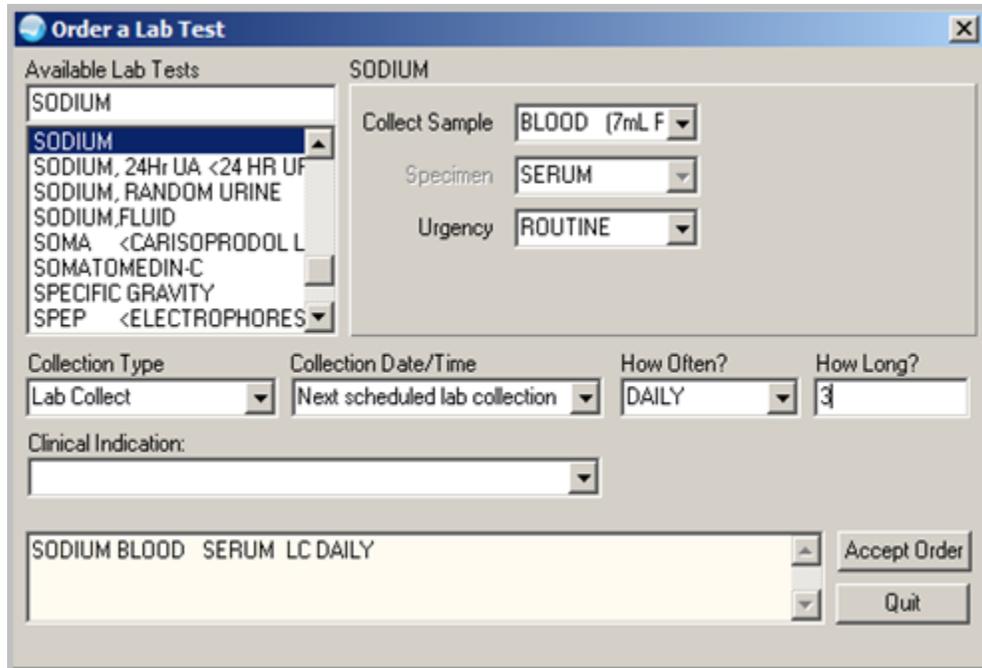


Figure 4-247: Lab Collect for Inpatients

- The Clinical Indication field is required (in order to save). Select an option from the drop-down list to populate this field. (You must have Lab Patch 22 loaded to have this field active.)

The default list is the patient’s problem list.

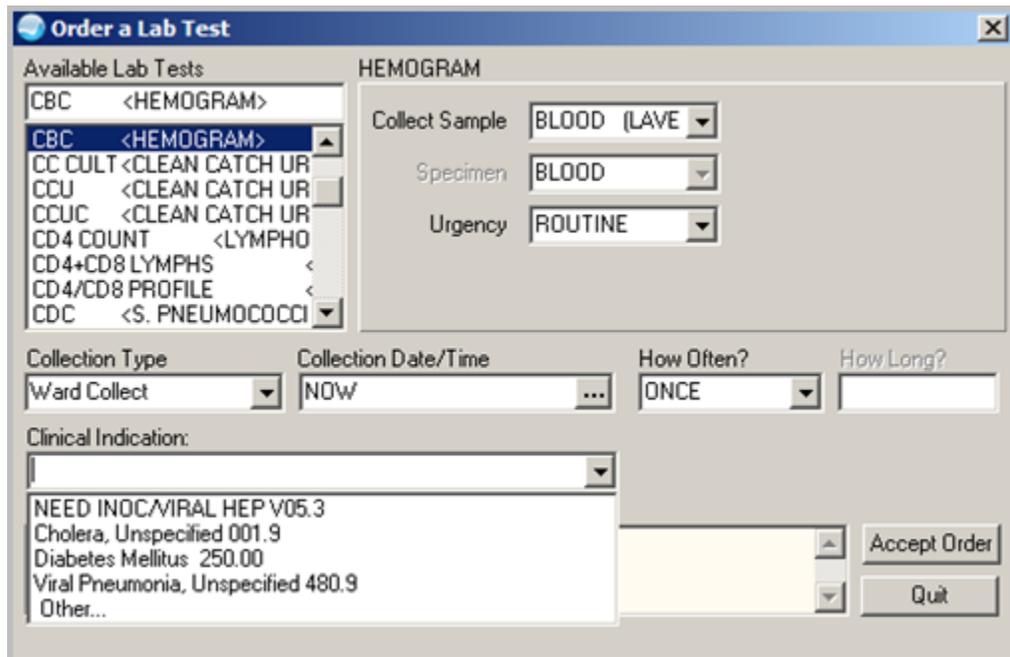


Figure 4-248: Problem List as Clinical Indication

If you select Other in the Clinical Indication field, the SNOMED CT Lookup dialog displays for you to select a problem. Refer to Using the SNOMED CT Lookup dialog for more information.

After selecting a SNOMED CT term, the Clinical Indication field becomes populated with the selected problem.

Figure 4-249: Clinical Indication Field

11. Click Accept Order.
12. When finished ordering lab tests, click Quit.

Note: The Lab Test order must be signed before it is sent. You can either sign the order now or wait until later.

4.10.6 Ordering Imaging/Radiology

Make sure a visit is selected and that the current view is Active Orders. To order any type of imaging or radiology (like nuclear medicine) order:

1. Select the Imaging function on the Orders window. The Order an Imaging Procedure dialog displays.

Figure 4-250: Order an Imaging Procedure dialog

2. Select the imaging type from the Imaging Type drop-down list (required field). Small sites may only have one imaging type and it is automatically selected.
3. Select a procedure from the Imaging Procedure scroll list (required field).
4. In the Reason for Study (REQUIRED) field, enter a reason.
5. In Clinical History, enter a clinical history to provide more data on the reason for study. This field has a right-click menu to aid in editing the text.
6. Select one or more modifiers from the Available Modifiers field, if needed.

The modifiers you select are displayed in the Selected Modifiers field.

Note: You can remove a modifier by selecting it and clicking Remove.

7. If necessary, change the Requested Date, Urgency, Transport, and Category fields.
8. Complete the Submit To field (if necessary).
9. Check the Isolation check box (if necessary).

10. If necessary, select the time that the PreOp Scheduled field by doing one of the following:
 - a. Enter a date (for example, 6/21/01 or June 21, 2001).
 - b. Enter a date formula (for example, T-2).
 - c. Click the Ellipsis button to select from a calendar.
11. Select an option button in the Pregnant group box (required).

Note: The Pregnant group box only displays for female patients of reproductive age (12 to 55 inclusive).

12. Click Accept Order.
13. When you are finished ordering imaging/radiology procedures, click Quit.
14. You can either sign the order now or wait until later. See Sign Selected for more information.

4.10.7 Text Orders

Text only orders such as Parameters, Activity, Patient Care, and Free Text orders are different kinds of orders that are placed for nursing and ward staff to take action on. They print only at the patient's ward/location, and are not transmitted electronically to other services.

Examples of text only orders include:

Order Type	Order
Parameters	Vital signs
Activity	Bed rest, ambulate, up in chair
Patient Care	Skin and wound care, drains, hemodynamics
Free Text	Immunizations

Predefined nursing orders (quick orders) might be available under various sub-menus.

4.10.7.1 Entering Text Orders

Make sure a visit is selected and that the current view is Active Orders. To place a text-only order:

1. Select the Text Only Order function on the Orders window. The Text Only Order dialog displays.

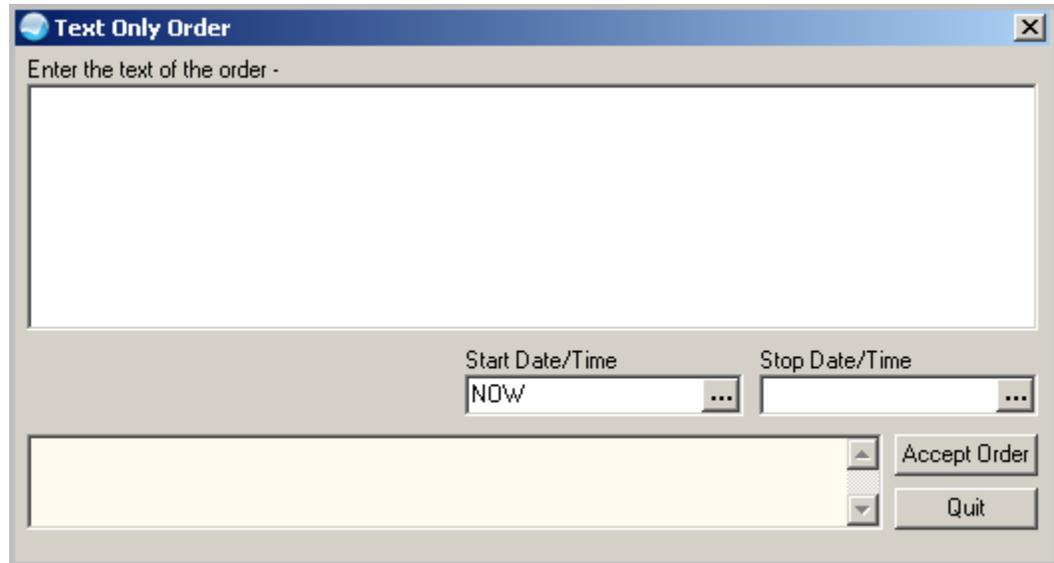


Figure 4-251: Text Only Order dialog

2. Complete the text for the order in the top field. The field has a right-click menu to aid in editing the text.
3. Enter a start date and time and a stop date and time by doing one of the following:
 - a. Enter a date (for example, 6/21/01 or June 21, 2001).
 - b. Enter a date formula (for example, T-2).
 - c. Click the Ellipsis button to select from a calendar.
4. Click Accept Order.
5. When finished ordering, click Quit.

Note: The Text Only order must be signed before it is sent. You can either sign the order now or wait until later. See Sign Selected for more information.

4.10.7.2 Complete Text Order

You can cause a (signed) text order to be dropped from the Active Order list. To complete a text order:

1. Select the signed Text Order.
2. Select Action > Complete to display the Complete Order dialog.

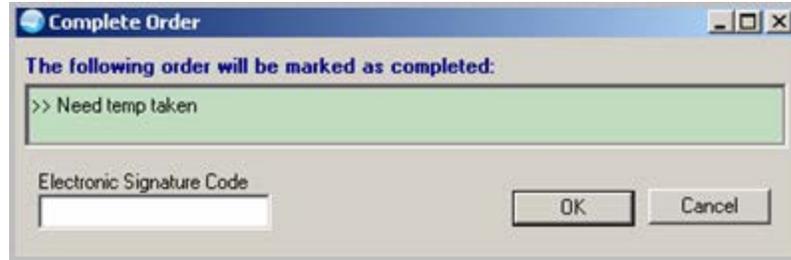


Figure 4-252: Complete Order dialog

3. Enter your electronic signature and click OK. The text order is dropped from the Active Order list. (Otherwise, click Cancel).

4.10.8 Generic Orders

Generic orders appear very similar to text orders, but they can have multiple specific fields for users to enter data. They are created by the CACs and may contain TIU objects and template fields.

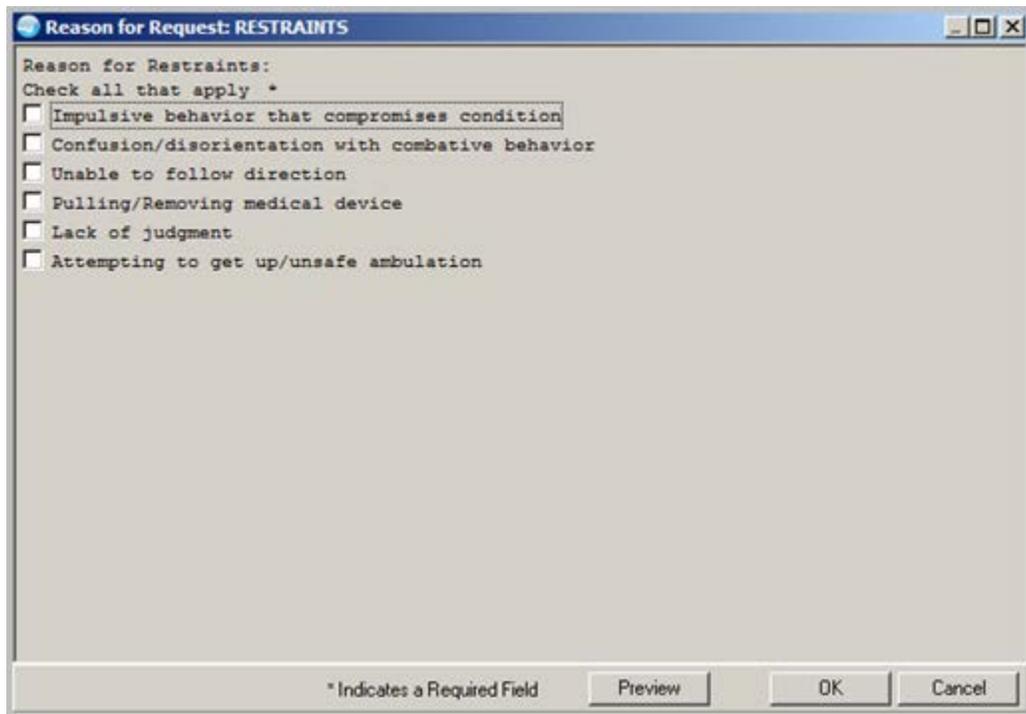


Figure 4-253: Generic Order with TIU Template Field

Generic orders may contain multiple fields, drop-down menus, and can even point to other files. Generic orders can provide a way to put together an order so that all the needed elements are present.

The screenshot shows a dialog box titled "RESTRAINTS". It contains the following fields and controls:

- Reason for Restraints:** A dropdown menu with the selected text: "Confusion/disorientation with combative behavior, Pulling/Removing medical".
- Type of Restraint:** A dropdown menu with the selected text: "Chest".
- Pt. Danger:** A dropdown menu.
- Family Informed?:** A dropdown menu.
- Start Date/Time:** A text field containing "NOW" and a calendar icon.
- Stop Date/Time:** A text field containing "NOW+12H" and a calendar icon.
- Preview:** A small window at the bottom left showing the current selection: "RESTRAINTS Reason for Restraints: Confusion/disorientation with combative behavior, Pulling/Removing medical device".
- Buttons:** "Accept Order" and "Quit" buttons are located at the bottom right.

Figure 4-254: Generic Order with Multiple Fields Including Drop-Downs

4.10.9 Quick Orders

Providers often need to order the same items for specific diseases or procedures. Therefore, it may be advantageous to bring up an order where all the fields and selections are already filled in using quick orders. Quick orders are created by the CAC and can be any type of order, such as Medication, Radiology, Laboratory, Nursing or Consult.

The common element is that the fields are already filled in, so the provider only needs to review and sign them. They can still be edited, if needed, as in the clinical indication for a lab order.

The CAC should make the name of the quick order clear enough so that the provider knows exactly what they are ordering when they select that order.

If you select Other in the Clinical Indication field, the SNOMED CT Lookup dialog displays for you to select a problem. Refer to the Using the SNOMED CT Lookup dialog topic for more information.

The following are some examples of quick orders.

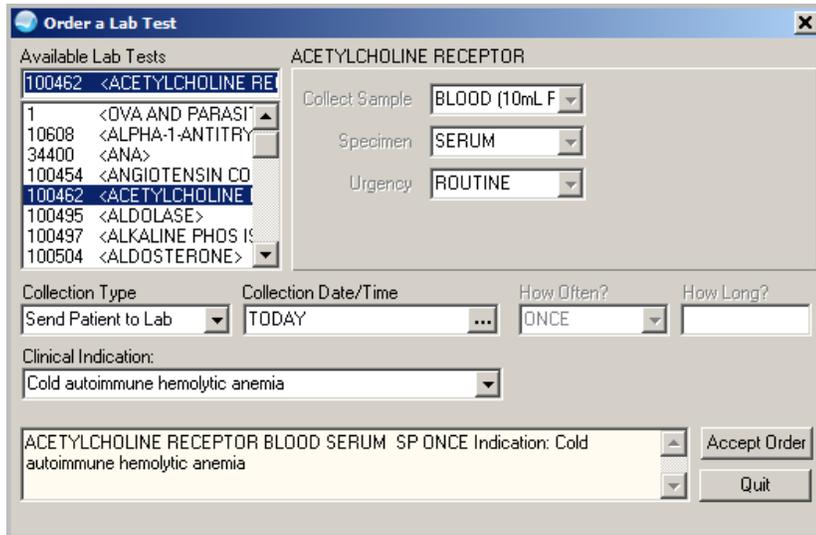


Figure 4-255: Lab Quick Order with Clinical Indication Completed

Medication Order

METFORMIN TAB,SA Change

Dosage Complex

Dosage	Route	Schedule
2000MG	ORAL	QDAY <input type="checkbox"/> PRN
500MG 0.286	ORAL	Q6H
1000MG 0.572		Q8H
		QAM
		QD
		QHS
		QID
		QOD
		STAT
		TID
		QDAY

Patient Instructions: THX BLOOD SUGAR - TWF

Days Supply: 90 Qty (TAB): 90 Refills: 3 Clinical Indication: Chronic Med Dispense as Written

Pick Up: Clinic Mail Window Outside Pharmacy - eRx Outside Pharmacy - Print Priority: ROUTINE

Pharmacy: TEST 8100 RED BUD CT NEWBURGH IN 47630

Notes to Pharmacist:

METFORMIN TAB,SA 500MG
 TAKE FOUR (4) TABLETS MOUTH QDAY THX BLOOD SUGAR - TWF
 Quantity: 90 Days: 90 Refills: 3 *Chronic Med: NO Dispense as Written: NO Pharmacy: TEST 8100 RED BUD CT NEWBURGH IN 47630

RECEIVING PHARMACY: TEST
 8100 RED BUD CT , NEWBURGH, IN 47630
 P:333.333.3333

PRESCRIBER:
 USER.DEMO
 DEMO HOSPITAL
 8100 RED BUD CT, NEWBURGH, INDIANA 47630
 P:555-330-2020

ADR's Accept Order Quit

Figure 4-256: Output Med Quick Order

4.10.10 Order Menus

Quick orders are normally placed on order menus that appear in the left column to select when ordering.

Menus can have sub-menus, as well.

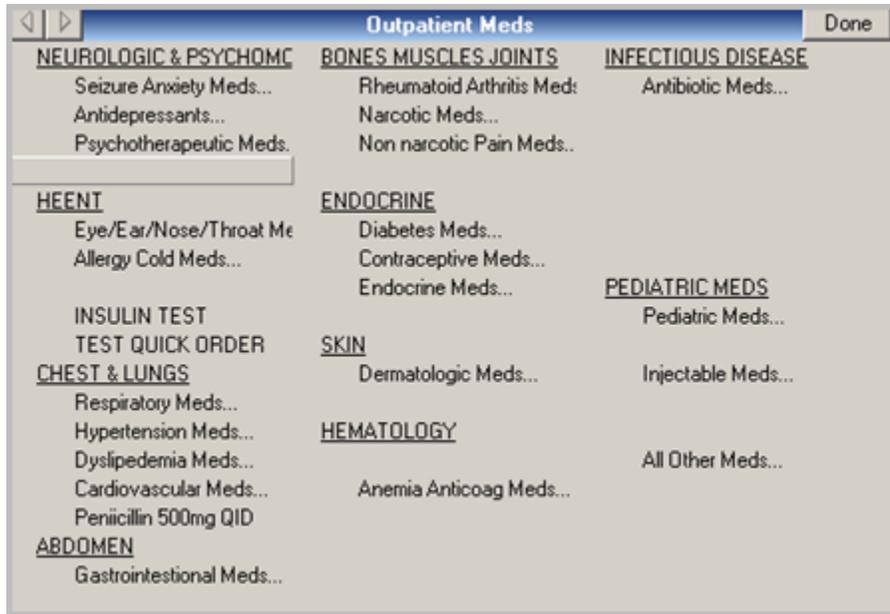


Figure 4-257: Menu with Sub-Menu

The user can select one or more items from a menu. To select multiple items, hold down the Ctrl key, and then select the items to be ordered. The items appear in blue.

After you release the Ctrl key, the first item appears, and the remaining items appear in a dialog.

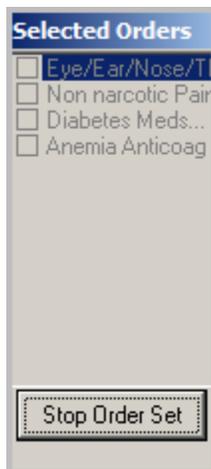


Figure 4-258: Start of Multiple Order Selection

The Stop Order Set button allows the user to quit ordering. Otherwise, it progresses through each item in the list until finished.

If the item(s) you selected contains a menu, you can then select items from that menu.

Clicking Next indicates you are moving on from that menu.

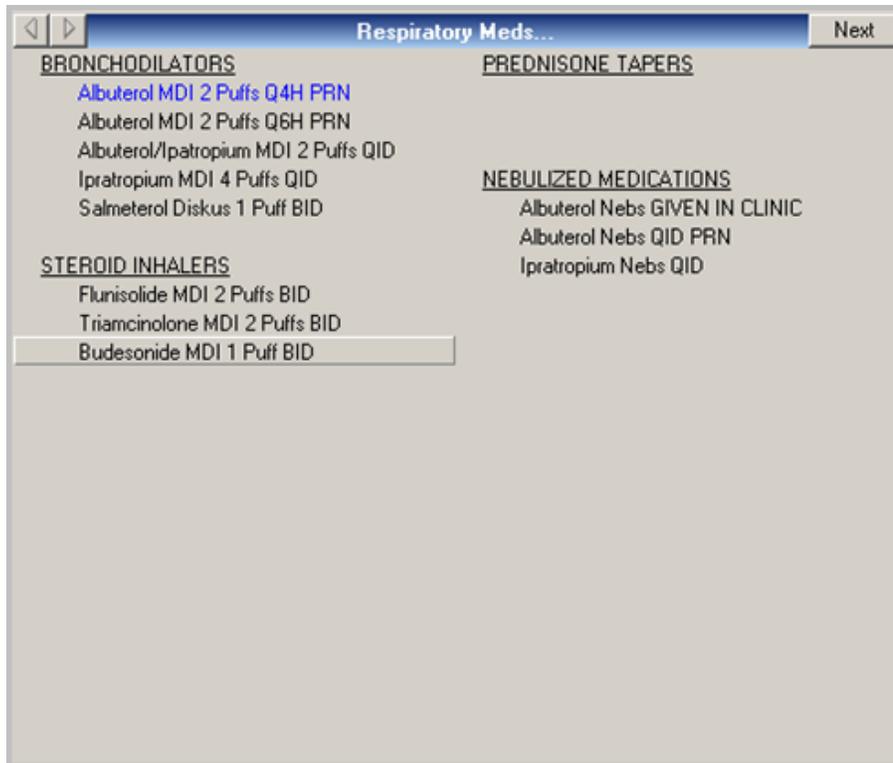


Figure 4-259: Next Button on Respiratory Meds dialog

As you progress through the items, the finished items contain a check box.

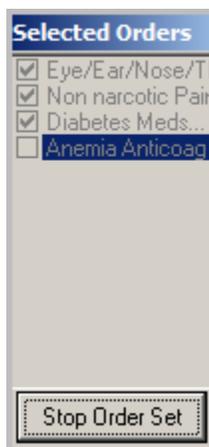


Figure 4-260: Order Selection in Progress

4.10.10.1 Personal Quick Orders

Providers can create personal Quick Orders. This is not recommended because then that particular individual is responsible for editing and changing the Quick Order if the medication goes off formulary or the Lab or Radiology test is inactivated.

Another problem is that the clinical indication may not be appropriate for the next selected patient or the pharmacy selected for an eRX may not be the one the next patient wants to use.

Also, the CAC does not have access to these Quick Orders and cannot fix them for the provider. Therefore, the provider needs to be extremely careful is using this option.

1. Complete the Order dialog.

Order a Lab Test

Available Lab Tests

GLUCOSE, RANDOM <R4

GLUCAGON

GLUCOSE, 24 HR URINE <

GLUCOSE, FLUID <FLUID GL

GLUCOSE, RANDOM <

GLUCOSE-6-PHOSPHATE DE

GLUTAMIC ACID DECARBOX

GLYCATED HEMOGLOBIN <

GLYCO <HEMOGLOBIN A1C

RANDOM GLUCOSE

Collect Sample BLOOD (7mL F)

Specimen SERUM

Urgency ROUTINE

Collection Type Lab Collect

Collection Date/Time Next scheduled lab collection

How Often? ONCE

How Long?

Clinical Indication:
Diabetes Mellitus 250.00

RANDOM GLUCOSE BLOOD SERUM LC ONCE Indication: Diabetes Mellitus

Accept Order

Quit

Figure 4-261: Making a Personal Quick Order

2. Select Options > Save as Quick Order.

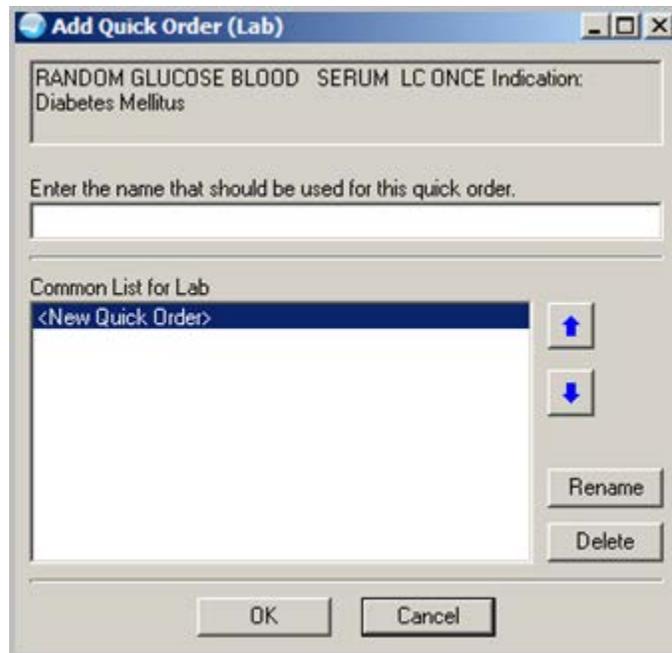


Figure 4-262. Add Quick Order (Lab) dialog

3. Enter a name for the Quick Order and arrange it in the list by moving it up and down with the arrow keys.

Note: A Quick Order can be renamed or deleted at a later time.

4. Click OK when finished.

When going into the generic dialog again, the Quick Orders are at the top of the list.

4.10.10.2 Editing the Common List

To make changes later to the personal Quick Order list, the provider needs to bring up an active dialog (Lab, Med, or Radiology). The easiest way is to select one of their Quick Orders.

1. Select Options > Edit Common List.

This brings up the list of personal Quick Orders of that ordering type.

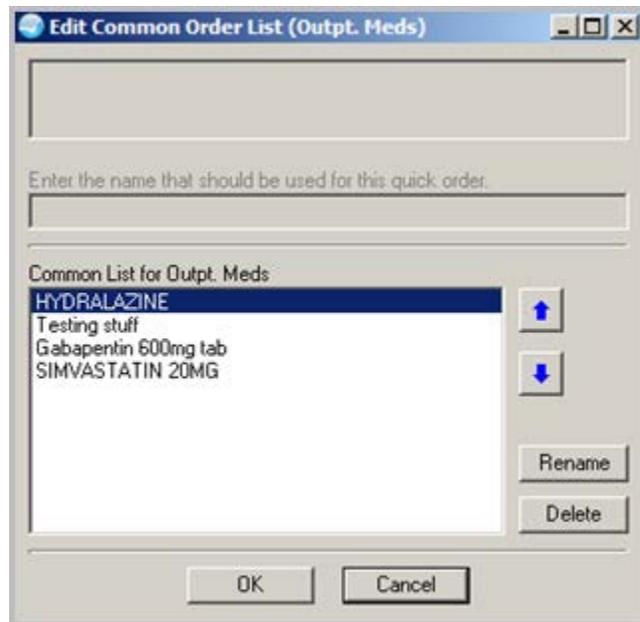


Figure 4-263: Editing Personal Quick Orders

The provider can move any Quick Orders up and down in the list using the arrow keys, and rename a Quick Order or delete one.

2. Click OK when finished.

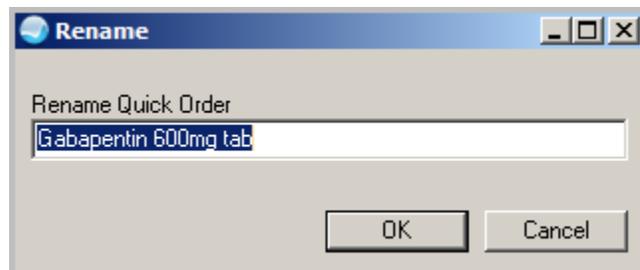


Figure 4-264: Renaming a Personal Quick Order

4.10.11 Change Orders

You can change the elements of an existing order. For example, you might need to change the dosage of a Pharmacy order. This function cannot be used for controlled substances.

An order that remains unsigned can be changed at any time. Once an order is signed, the change discontinues the old order and creates a new one.

Make sure a visit is selected and that the view is set to Active Orders. To change an order:

1. Select the order (cannot be a cancelled order) to change.

2. Select Action > Change (or select Change on the right-click menu) to display the order dialog for the selected record.
3. Complete the changes, as appropriate, on the Order dialog.
4. Click Accept Order.
5. You can sign the changed order now or later. See Sign Selected for more information.

4.10.12 Discontinue Order

When an order is discontinued, the application changes the order's Stop Date/Time to the date/time the action is taken. Pending and Non-verified orders are deleted when the medication order is discontinued and will no longer appear on the patient's profile. An entry is placed in the order's Activity Log recording who discontinued the order and when the action was taken.

The list in the Reason to Discontinue field is controlled by a parameter in the RPMS.

Make sure a visit is selected for the current patient. To discontinue an order:

1. Select the order you want to discontinue.
2. Select Action > Discontinue/Cancel (or select Discontinue on the right-click menu) to display the Discontinue/Cancel Orders dialog.

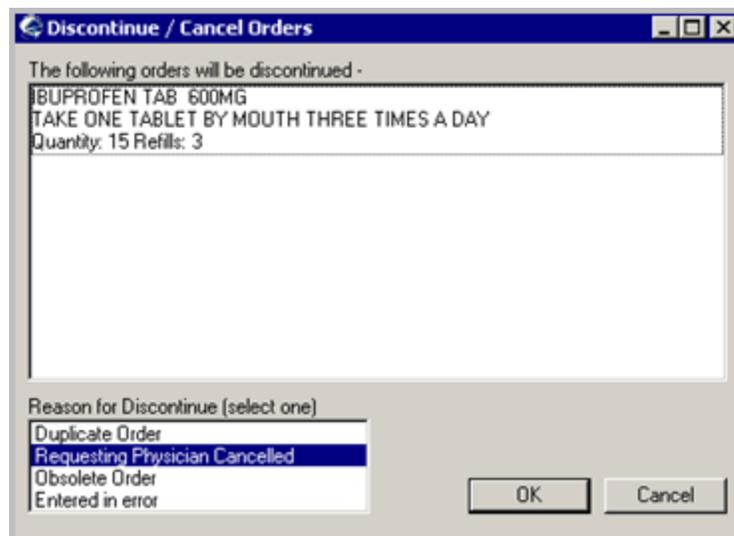


Figure 4-265: Discontinue/Cancel Orders dialog

3. Select the appropriate reason to discontinue from the Reason to Discontinue field and click OK.

The word Discontinue appears in the Order column for the selected order, and the Status = Unreleased on the Orders window (for medication orders).

Discontinue ERYTHROMYCIN SUSP 200MG/5ML TAKE 1 TEASPOONFUL BY MOUTH EVERY 6 HOURS Quantity: 200 Refills: 0 *UNSIGNED* <Requesting Physician Cancelled>	Stop: 10/31/04	Doctor, T					unreleased
--	----------------	-----------	--	--	--	--	------------

Figure 4-266: Discontinued Medication Order

Other types of orders, like imaging, have Status = Discontinue and the reason appears in the Order column.

Imaging	CLAVICLE <Entered in error>	Start: 03/14/07 Stop: 03/14/07 10:45	User, D				discontinued
---------	--------------------------------	--	---------	--	--	--	--------------

Figure 4-267: Discontinue Imaging Order

4.10.13 Event Delayed Orders

Providers may want to write orders either from the ER or the clinic before a patient is admitted. Or, they may want to write transfer orders before the transfer occurs. This can be done in the EHR using event delayed orders.

The CAC must set up event delayed orders and the rules that accompany them.

1. Click the delayed orders type in the Write Orders List box. This element is setup by a parameter so that clinic sites only do not have to display it.

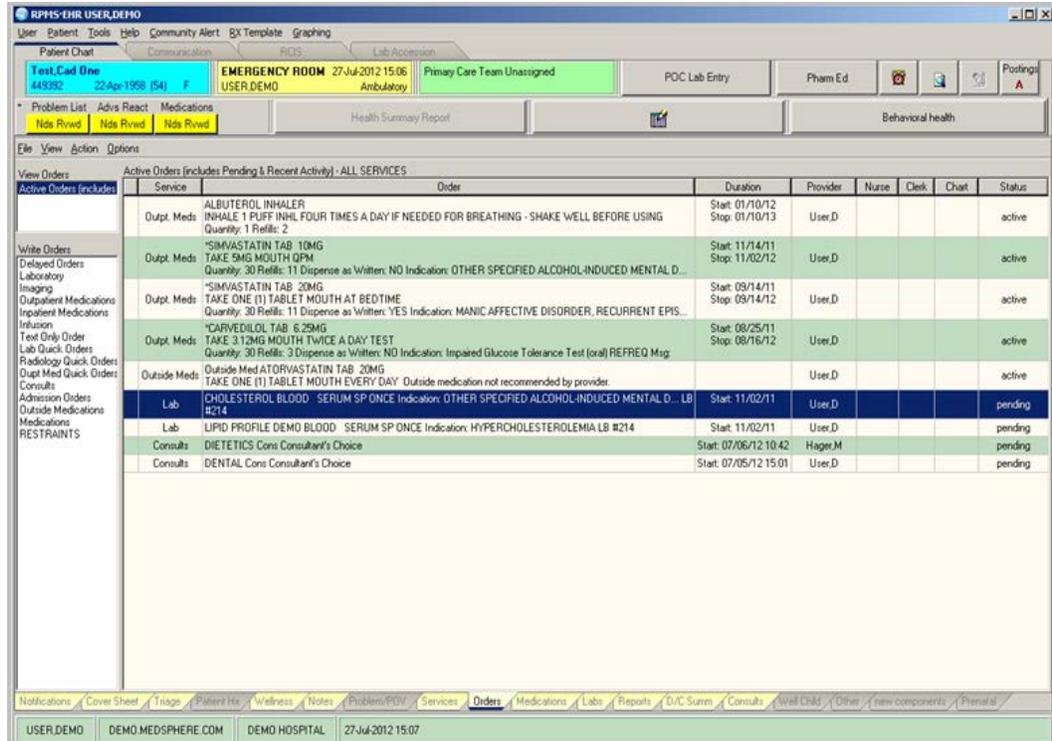


Figure 4-268: Delayed Orders in Write Orders Window

2. Determine the type of Delayed Order. Sites can set up various delayed orders for each location, as needed.
 - For Outpatients, only admission types display
 - For Inpatients, only transfer types display
3. Click OK. Admission order type is used in this example.

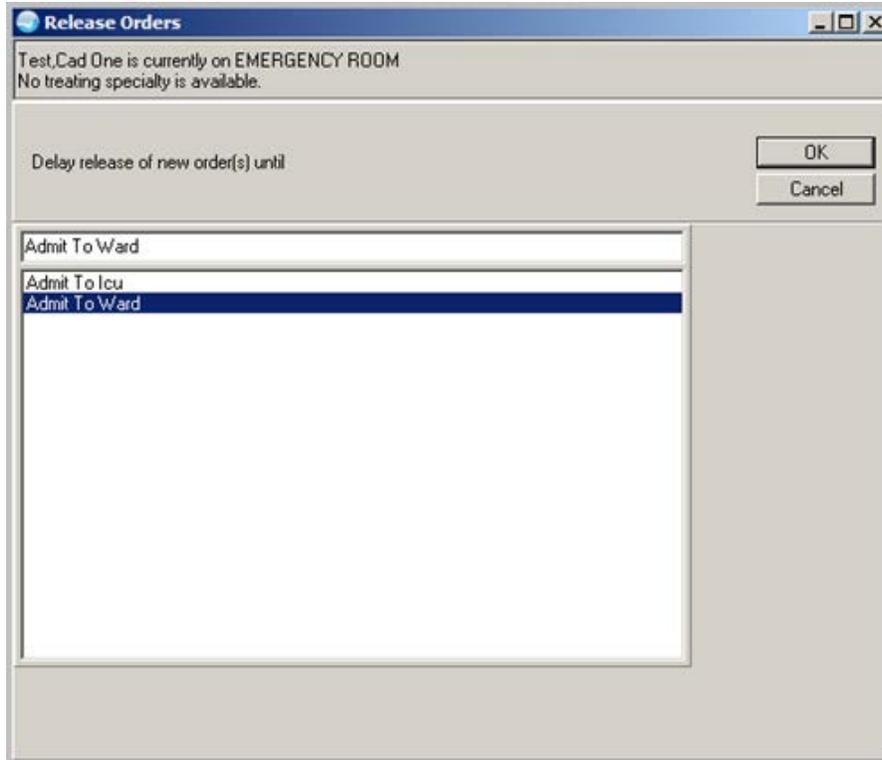


Figure 4-269: Admission Delayed Orders

4. The provider enters the admission order. The Treating Specialty field is especially important, as the admission clerk also enters this information and they must match. This order becomes active as soon as it is signed.

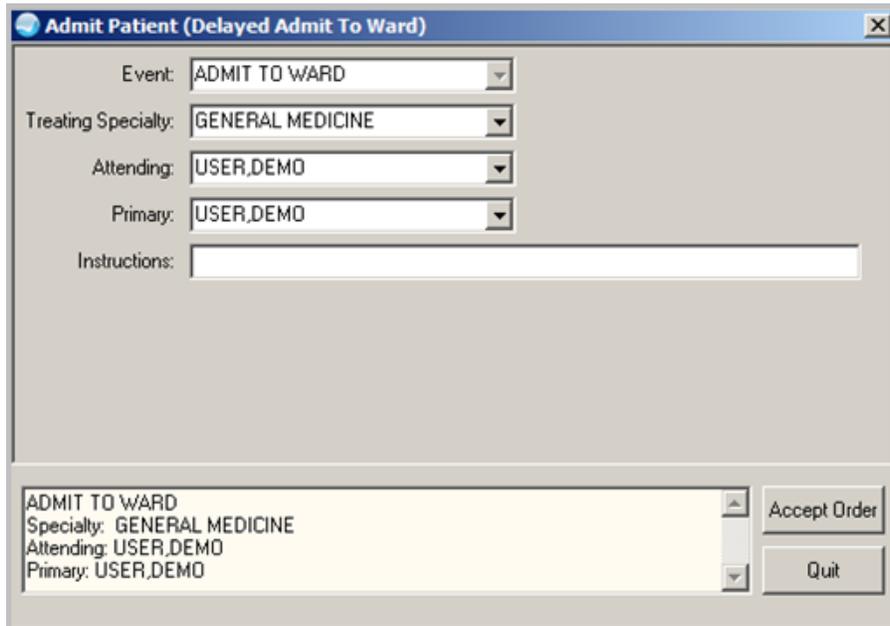


Figure 4-270: Admit Patient Delayed Admit to Ward

5. If the Delayed Order has an assigned admission menu, it appears. If not, the user must enter the order from the normal Write Orders list.

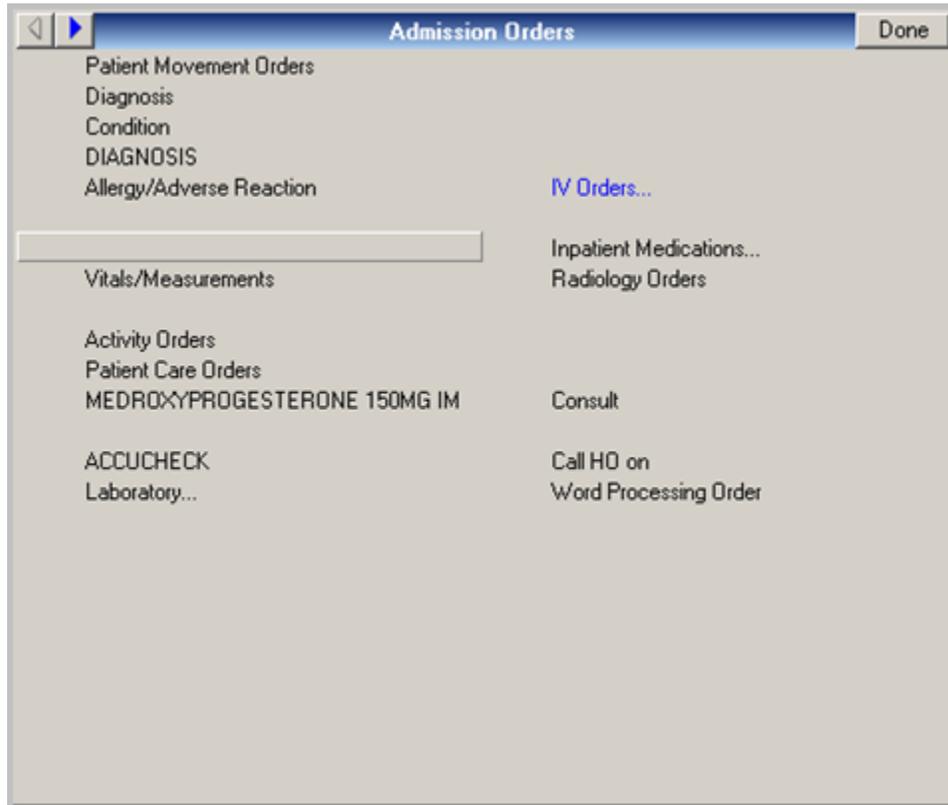


Figure 4-271: Delayed Order Done

The Event Delayed Orders are highlighted in the View Orders window.

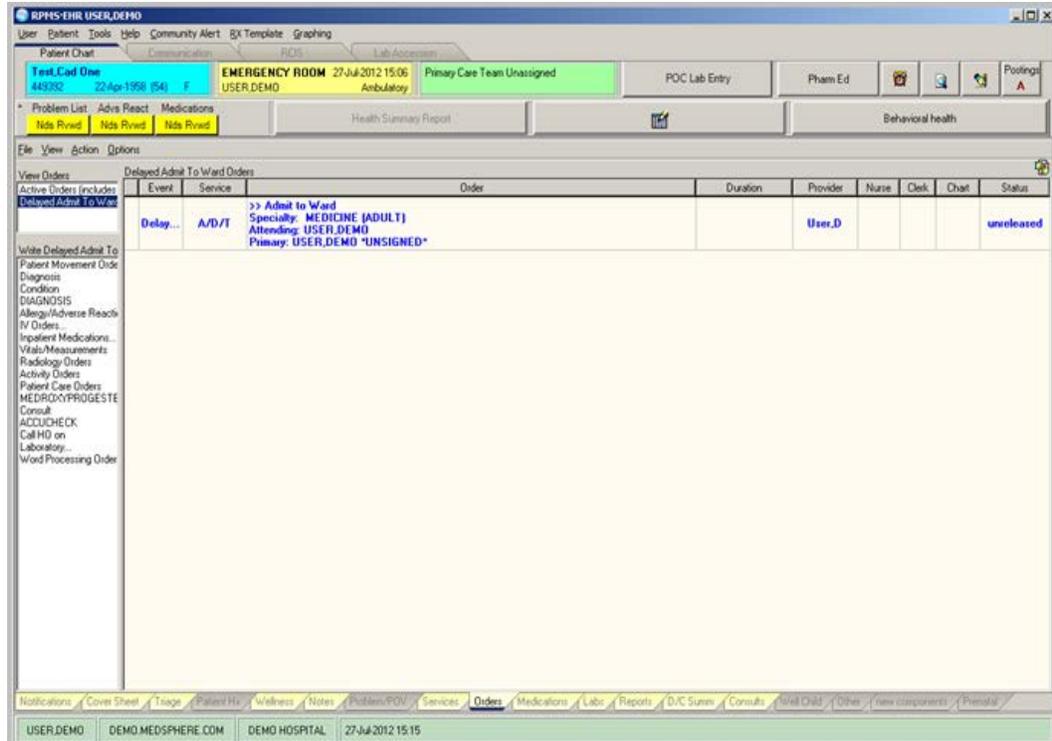


Figure 4-272: Event Delayed Order in View Orders Window

6. The provider is notified they are writing Delayed Orders.
Medication orders are for Inpatient medications. These orders appear as delayed.

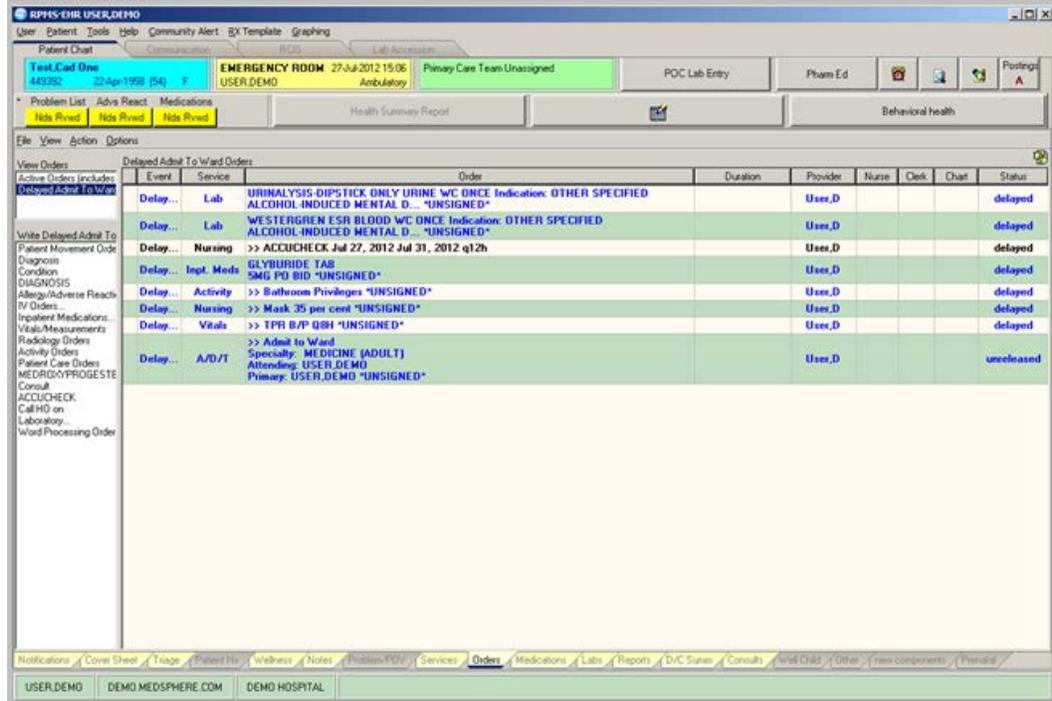


Figure 4-273: Unsigned Delayed Orders

Once signed, the Delayed Orders remain in delayed status until the patient is admitted to that location or treating specialty. Then the delayed orders go to pending or active status.

If the admission occurs to a different unit, the nursing staff can manually release the delayed orders.

7. Select Action and look for Release Delayed Orders. This option only appears if there are unreleased orders.



Figure 4-274: Manual Release

Under View, then Auto DC/Release Event, users can also review which orders were auto-DC'd or released in ADT action.

8. Selecting an action from the list displays all of the orders that were affected by that action.

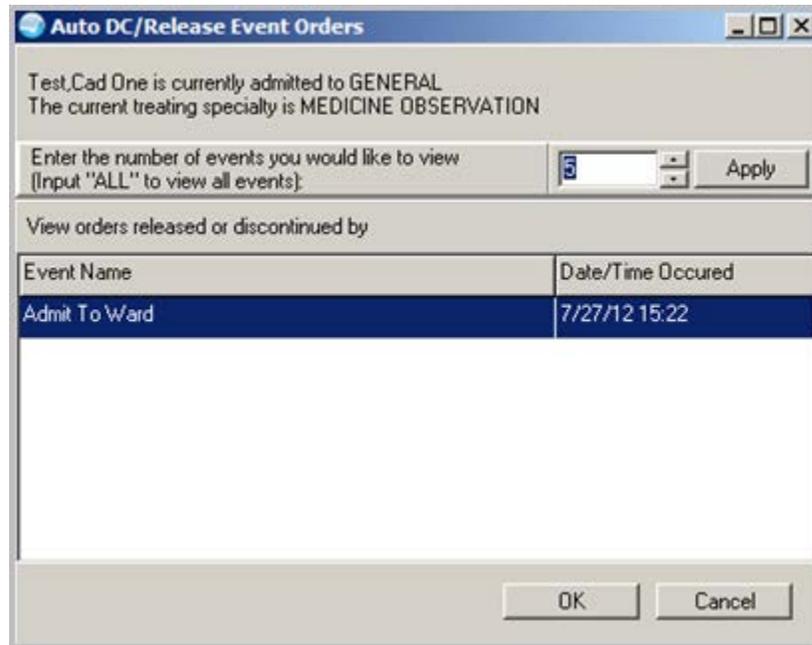


Figure 4-275: Auto DC/Release Event Orders

4.10.14 Copy to New Order

You can copy an existing order to a new order. This process lets you do one of the following:

- Copy the exact elements of the existing order to create a new order
- Change the order elements to create a new order

Note: Make sure a visit is selected.

To copy an order to a new order:

1. Select the order to be copied.
2. Select Action > Copy to New Order (or select Copy to New Order on the right-click menu) to display the Copy Orders dialog.

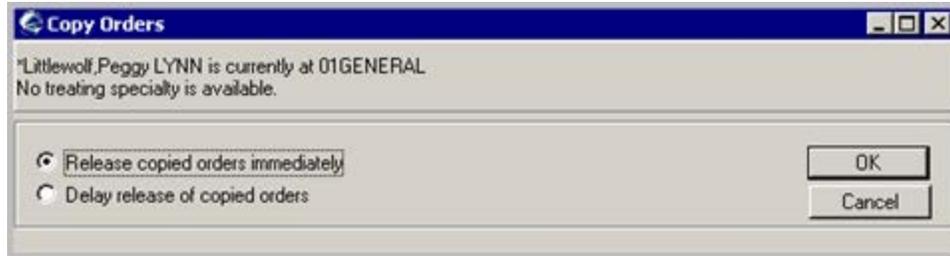


Figure 4-276: Copy Orders dialog

If the order does not have a Clinical Indication associated with it, the Unable to Save Order information message displays. A Clinical Indication must be added before proceeding. Refer to the appropriate Orders topic based on the type of order you are copying, or refer to Using the SNOMED CT Lookup dialog if the Other option is selected in the Clinical Indication field.

3. Make sure the Release copied orders immediately option button is selected. (The Delay release of copied orders option button is used for inpatients only.)
4. Click OK. The New Order dialog displays.

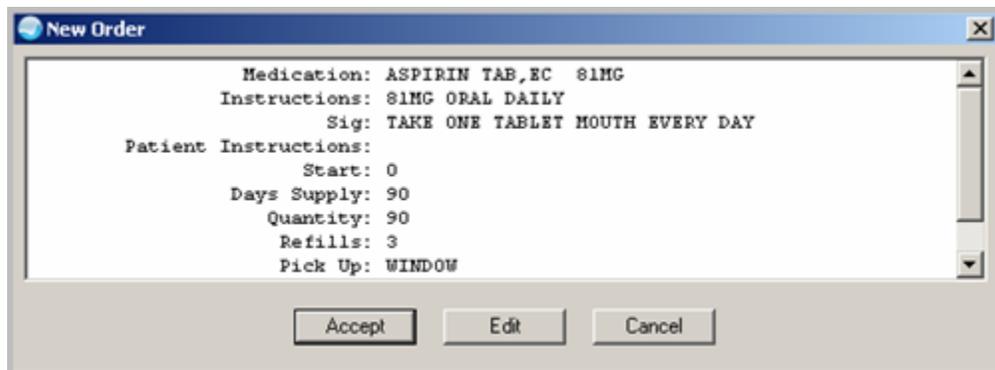


Figure 4-277: New Order dialog

You can do one of the following on this dialog:

- If you click Accept, this means the order elements are the ones you want to use.
 - If you click Cancel, this stops the Copy to New Order process.
 - If you click Edit, the order dialog displays. You can change the elements of the order on this dialog. After you complete the edit process, click Accept Order.
5. You can sign the order now or wait until later.

4.10.15 Order Comments

This function allows you to add comments to an order. The comments appear on the Order Details dialog.

Note: Make sure a patient is selected.

To add order comments:

1. Select the order to which you want to add comments.
2. Select Action > Order Comments to display the Comments for Order dialog.

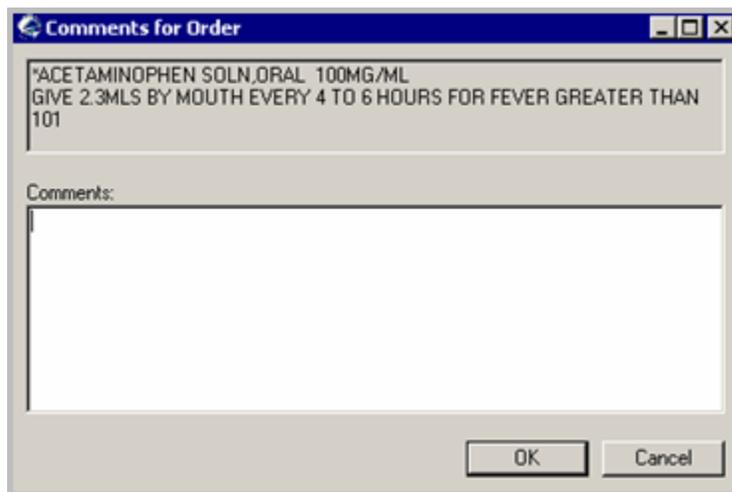


Figure 4-278: Comments for Order dialog

Note: Comments cannot be edited on active orders. If an active order is selected, the Unable to Edit Comments message appears. Click OK and select a different order on which to enter comments.

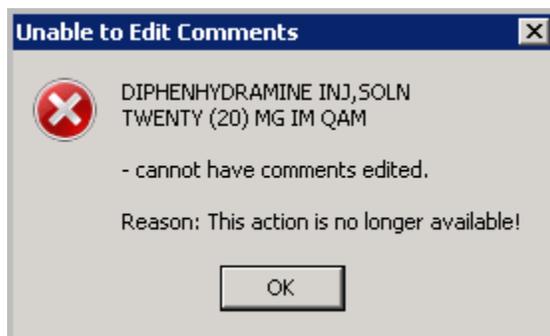


Figure 4-279: Unable to Edit Comments

3. Enter the comments in the Comments field.

Note: There is a right-click menu to aid in editing the text.

4. Click OK when the dialog is complete.

You can view the comments on the details for the order. (See Order Details for more information).

4.10.16 Order Details

You can view the details of an order that provides information about the order. To view the details of an order:

1. Select an order on the Orders window.
2. Select View > Details (or select Details on the right-click menu).

The Details dialog displays the following:

- Patient data, including height and weight at last measurement
- Whether the medication is a discharge medication
- Any comments

Order Details - 2482:1

Activity:
08/01/2013 12:00 New Order entered by USER, DEMO
Order Text: OXYMETAZOLINE SOLN, NASAL
USE ONE (1) SPRAY PER NOSTRIL NASAL STAT Spray once into each nostril.
Quantity: 1 Days: 6 Refills: 0 *Chronic Med: NO Dispense as Written: NO
Indication: Eosinophilic asthma | developing into ac...
Notes to Pharmacist: Sample note.
Nature of Order: ELECTRONICALLY ENTERED
Ordered by: USER, DEMO
Signature: NOT SIGNED

Current Data:
Current Primary Provider: USER, DEMO
Current Attending Physician: USER, DEMO
Treating Specialty: MEDICINE (ADULT)
Ordering Location: GENERAL
Start Date/Time:
Stop Date/Time:
Current Status: UNRELEASED
Orders that have not been released to the service for action.
Order #2482

Order:
Medication: OXYMETAZOLINE SOLN, NASAL
Instructions: 1 SPRAY PER NOSTRIL NASAL STAT
Sig:
USE ONE (1) SPRAY PER NOSTRIL NASAL STAT
Patient Instructions:
Spray once into each nostril.
Days Supply: 6
Quantity: 1
Refills: 0
Pick Up: WINDOW
Priority: ROUTINE
Notes to Pharmacist:
Sample note.
Indication: Eosinophilic asthma | developing into acute state|
SNOMED Descriptive ID: 492714018
Discharge Medication: YES

Font Size: 9

Print... Close

Figure 4-280: Order Details dialog

You can change the font size of the text displayed in this dialog by adjusting the size in the Font Size field (enter manually or use the up and down arrows).

Note: This does not change the size of the text on the output (when you print).

The dialog has a right-click menu enabling you to copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

3. Click Print to choose a printer and to output the (entire) contents of this dialog to the specified printer.

Note: The Print button may be available. It is according to how your application is configured.

4. Click Close to dismiss the dialog.

4.10.17 Results History

To view the results history of a Laboratory order:

1. Select an order with results you want to view.
2. Select View > Results History (or select Results History on the right-click menu). The Order Results History window displays.
3. You can print the text of the results by clicking Print.

4.10.18 Miscellaneous Ordering Features

Several convenience features described in this section are available to facilitate order entry and tracking.

4.10.18.1 Alerting User when Order Results are Available

You can select a recipient to receive a notification when order results are available.

Note: A recipient must have the Flag Order For Clarification alert set to ON to receive the alert. To set this, select Tools > Options. Use the Notification tab.

Follow these steps to notify a user when the results of an order are available:

1. Select an order.
2. Select Action > Alert when Results to display the Alert when Results Available dialog.

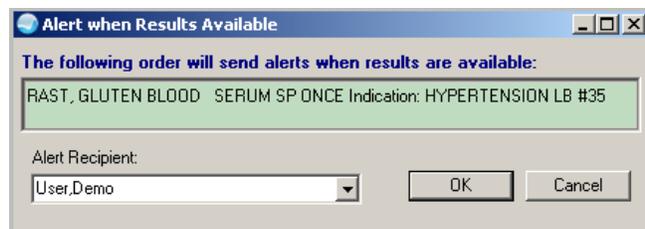


Figure 4-281: Alert when Results Available dialog

3. Choose an alert recipient from the Alert Recipient: drop-down list.
4. Click OK.

4.10.18.1.1 Flagging an Order

You can flag an order to draw attention to it. When an order is flagged, the order appears on the Orders window with a Red Flag (🚩) icon before the Service column. The application records the name of the person who flagged the order, and the date and time that it was flagged. The order remains flagged until it is unflagged by the user.

You can select an alert recipient to receive a notification about the flagged order.

Note: A recipient must have the Flag Order For Clarification alert set to ON in order to receive the alert. To set this, select Tools > Options. Use the Notification tab.

Follow these steps to flag an order:

1. Select the order that you would like to flag.
2. Select Action > Flag.

The Flag Order dialog displays.

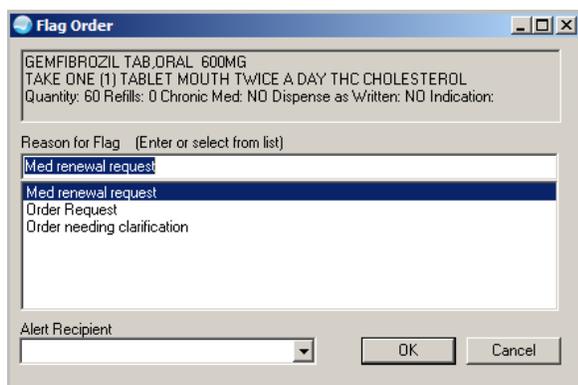


Figure 4-282: Flag Order dialog

3. Enter a reason for the flag in the Reason for Flag field. This field has a right-click menu to aid in editing the text.
4. Choose an alert recipient from the Alert Recipient drop-down list, if necessary.
5. Click OK to complete the flagging process. The corresponding order now has a flag indicator:

🚩	SIMVASTATIN TAB 20MG TAKE ONE TABLET BY MOUTH EVERY DAY Quantity: 30 Refills: 1	Start: 08/12/04 Stop: 08/11/05	Doctor,T				active
---	--	-----------------------------------	----------	--	--	--	--------

Figure 4-283: Flagged Order on Orders Window

4.10.18.1.2 Unflagging an Order

It is easy to remove the flag from an order. You can enter a reason for removing the flag, but this is not required.

In the Order Detail display for the unflagged order, the name of the person who removed the flag and the date and time that it was removed is recorded.

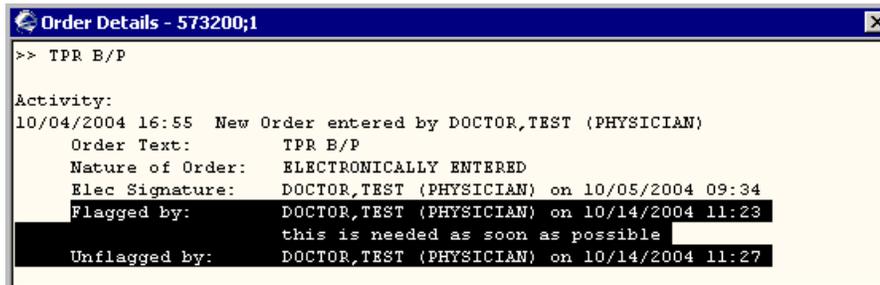


Figure 4-284: Order Detail Showing Flag and Unflag Information

Follow these steps to unflag an order:

1. Select the flagged order you want to unflag.
2. Select Action > Unflag to display the Unflag Order dialog.

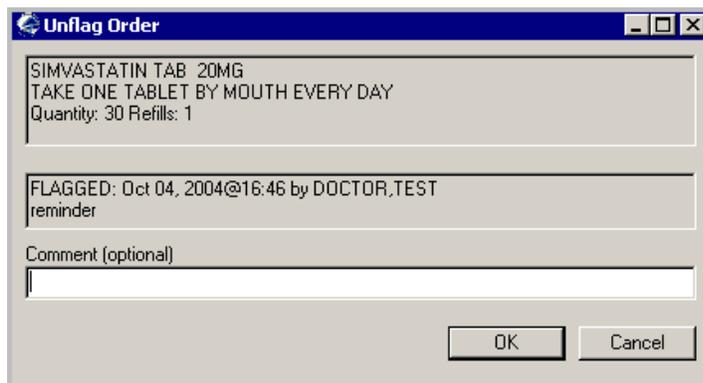


Figure 4-285: Unflag Order dialog

3. Enter a comment, if desired.
4. Click OK to complete the unflagging order process.

4.10.18.1.3 Quitting an Order

If you start an order (does not apply to Text Only order), complete the information, and then click Quit, the application displays the Unsaved Order information message.



Figure 4-286: Information Message After Clicking Quit

Click Yes to save the order and exit the Order dialog. (Otherwise click No to not save the order and exit the Order dialog.)

4.10.18.1.4 Sign Selected

When you have unsigned orders (appears in bold, blue lettering) on the Orders window, you can sign it. Follow these steps:

1. Select an unsigned order on the Orders window.
2. Select Action > Sign Selected (or select Sign Selected on the right-click menu) to display the Review/Sign Changes dialog.

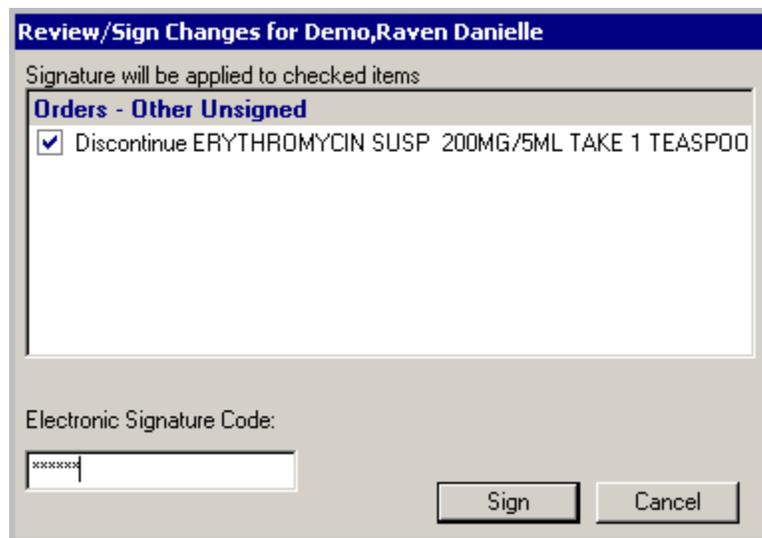


Figure 4-287: Review/Sign Changes dialog

3. Enter your electronic signature code. It applies to the checked orders listed on the dialog.
4. After entering the signature, click Sign. (Otherwise, click Cancel.)

Important: It is recommended that orders be signed using the Integrated Signature Tool, particularly for medications or contrast media. There is a safety mechanism built into the Integrated Signature

Tool that processes any allergies in the dialog and then does another allergy order check prior to processing the orders. This is bypassed when using the Sign Selected option.

4.10.18.1.5 Nurse and Clerk Verification

For Inpatient tracking of orders, clerks and nurses can initial that they have reviewed orders entered by providers.

Users need either the ORELSE (nurse) or ORMAS (clerk) security keys to view these options.

Double-click the order to open and review the Order Details dialog to confirm the patient and data is correct before verifying.

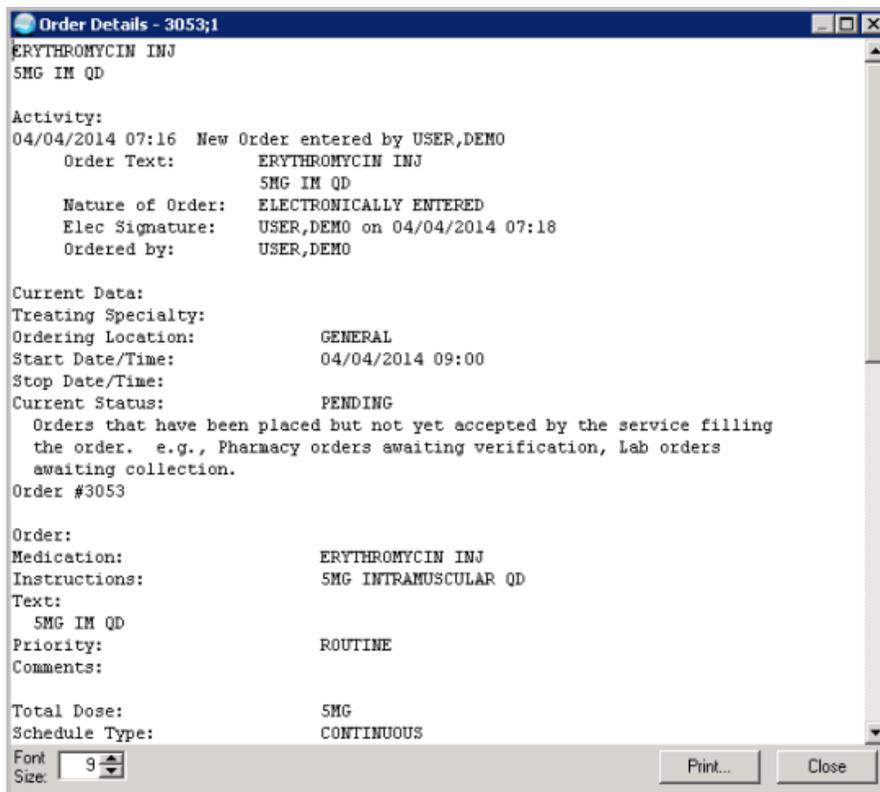


Figure 4-288: Inpatient Medication Order Details

After verifying the Order Details, from the Action drop-down menu (or by right-clicking an option), nurses can view Verify and Chart Review actions, and clerks can Verify an action.

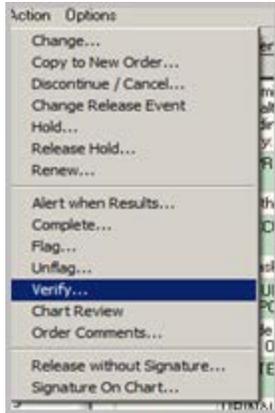


Figure 4-289: Verify Action

The nurse or clerk can select the orders they want to verify and then select the Verify action.

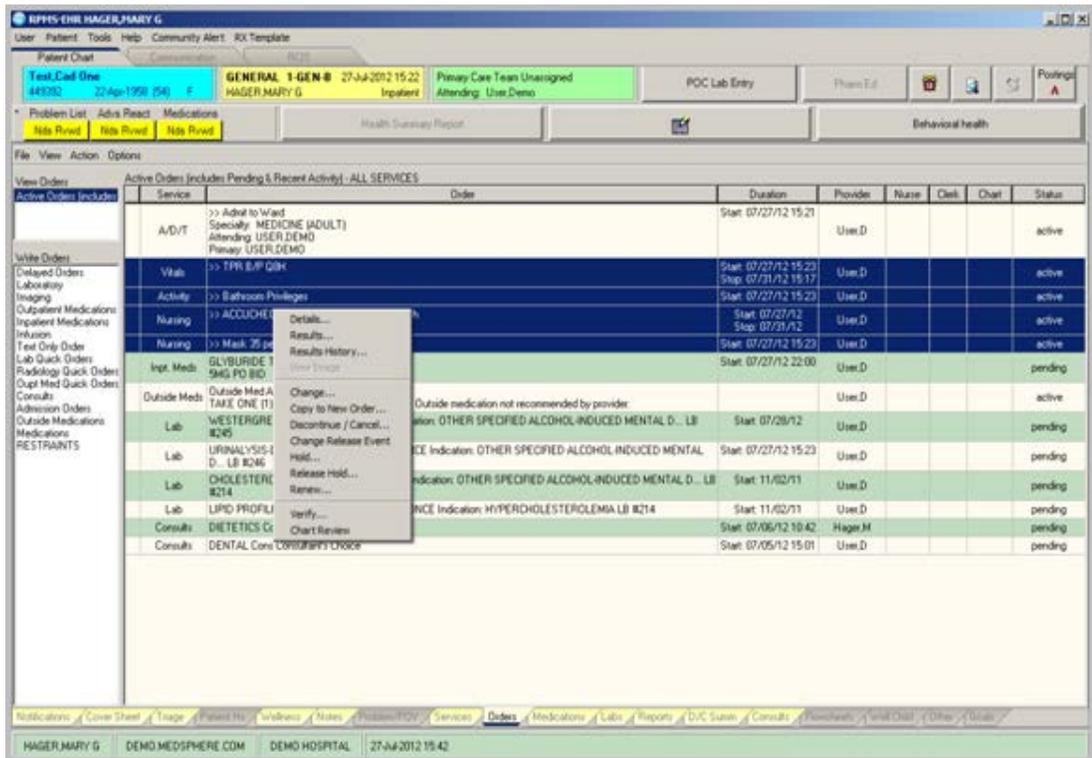


Figure 4-290: Nurse Verify Action

The action is then reviewed and signed.

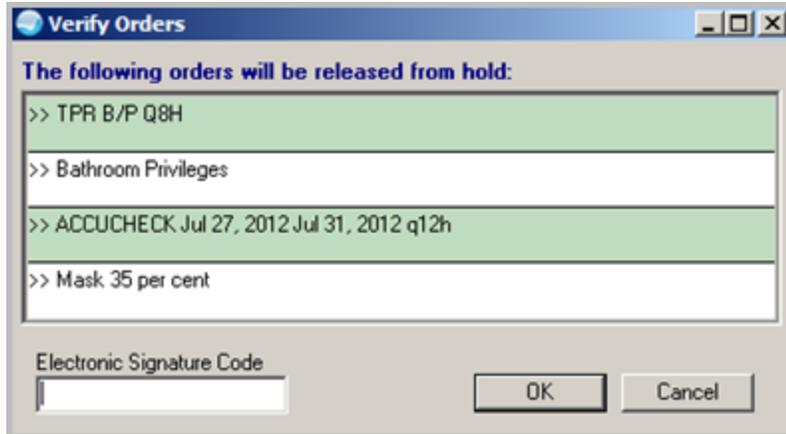


Figure 4-291: Review and Sign

The nurse's initials appear in the Nurse column.

Chart Reviews

A nurse can also select a group of orders and complete a chart review. In this instance, the nurse's initials appear in the Chart column.

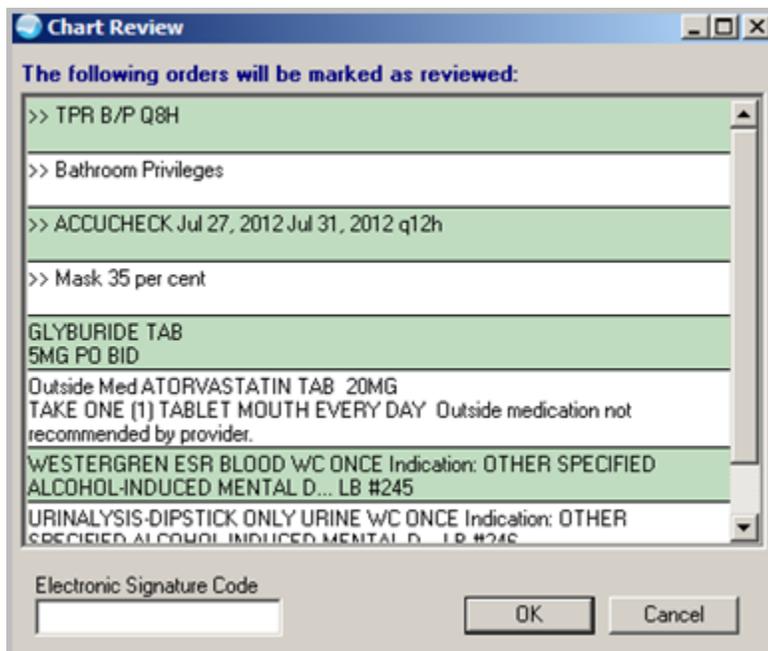


Figure 4-292: Chart Review dialog

4.10.18.2 Using the SNOMED CT Lookup dialog

To use the SNOMED CT Lookup dialog:

1. Click the Ellipsis button by the appropriate field to display the SNOMED CT Lookup dialog.

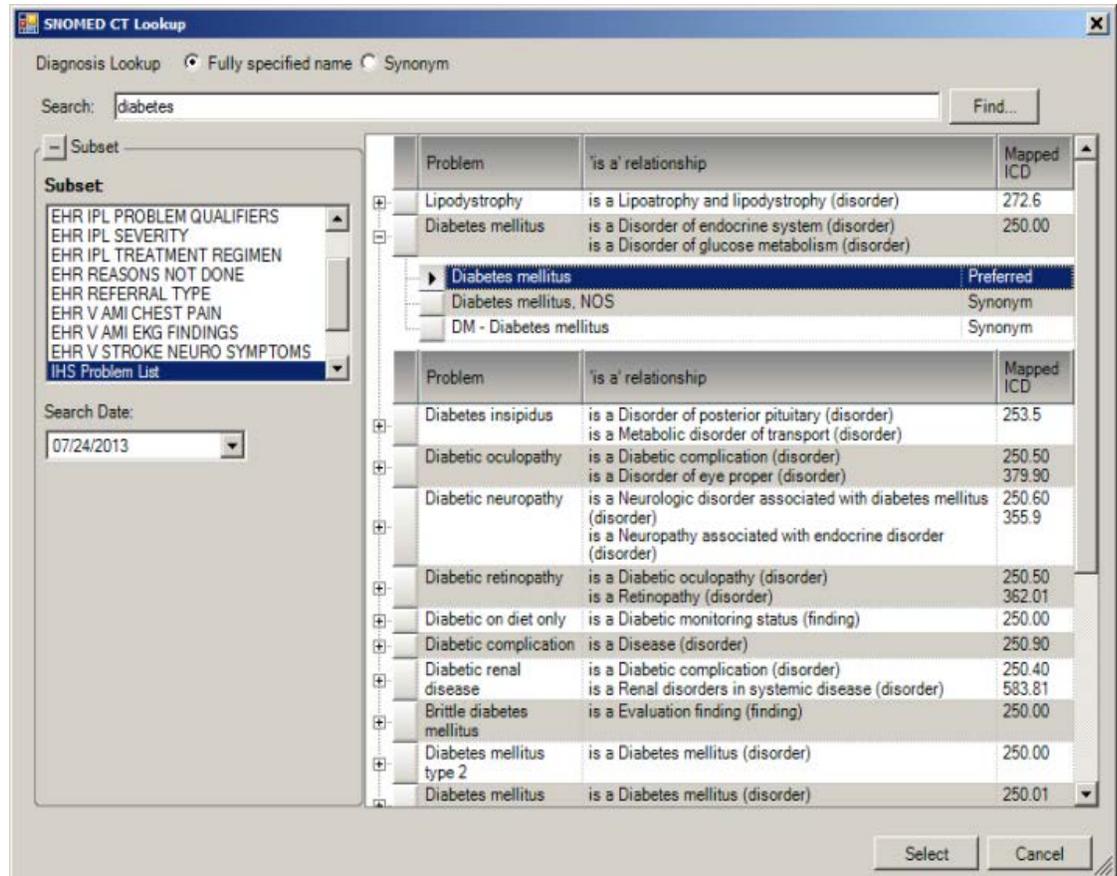


Figure 4-293: SNOMED CT Lookup dialog

2. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand sign (⊕) next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
3. In Search, type the term by which you want to search.
4. In Subset, you can select a subset in which to search, if needed.
5. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
6. Click the Find button. The list of SNOMED CT terms is populated.
7. Select and highlight a term, and then click the Select button. The Clinical Indication field refreshes with the selected SNOMED CT term you selected.

4.10.19 Order Checking

Order Checking is based on a system of rules that causes orders to be reviewed to determine whether they meet the defined criteria. If they do, an electronic message is sent to the ordering provider before the order is completed (such as duplicate order, drug-lab interaction, and so on). The provider can then choose to cancel the order or override the order check and place the order.

4.10.19.1 Severity Levels and Source of Information

Order Check dialogs cite the source of the drug interaction information and use colored icons to represent severity levels.

The colors are:

- Red – For High
- Yellow – For Moderate
- Green – For Low



Figure 4-294: Order Check

If the order is placed, a second order check appears after the order is signed. If the order check is moderate or high level, you are required to enter a reason why you are continuing with the order.

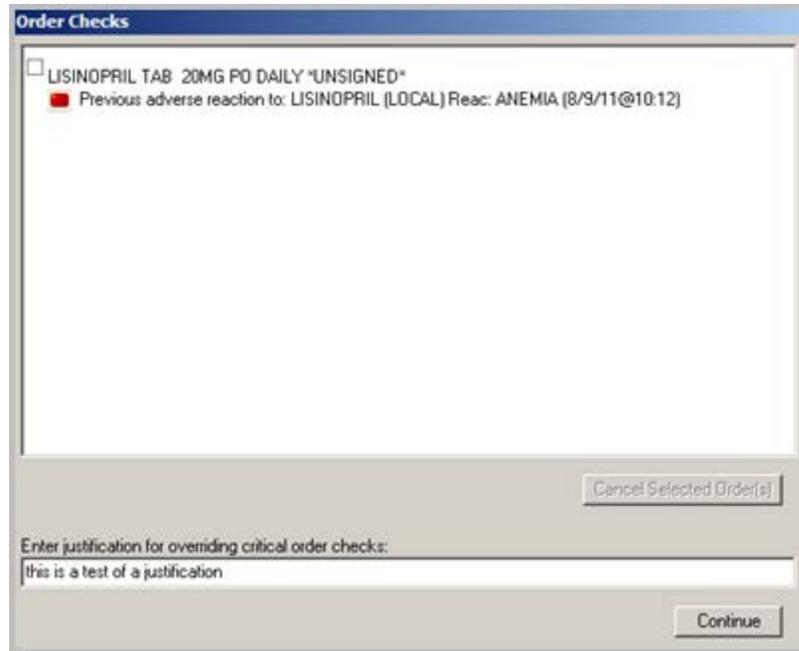


Figure 4-295: Order Check Justification

The justification remains with the order and is available in the Order Details.

4.10.19.2 Cancelling Orders in Order Checks

If an order is already signed and the user tries to sign a duplicate order, the application displays the Order Checks dialog. The user can choose the order to be deleted.

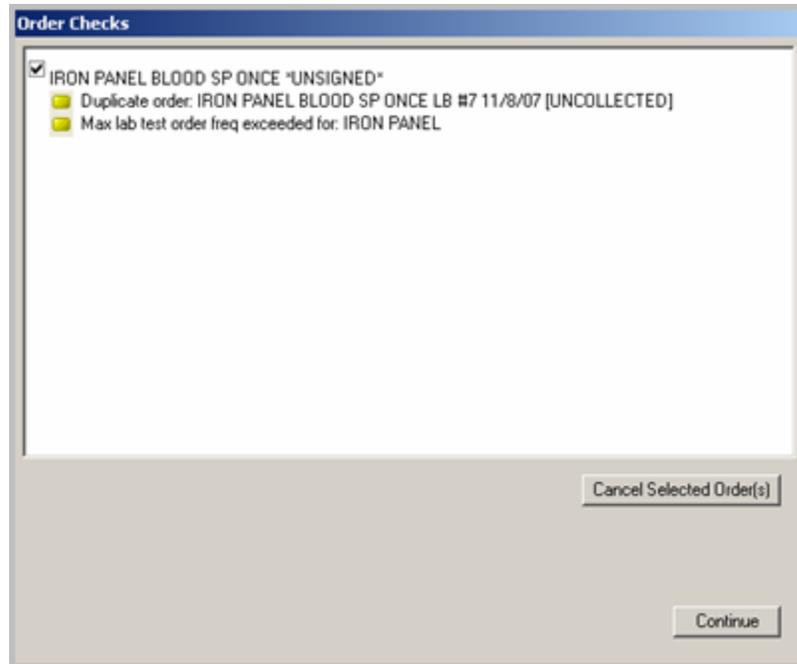


Figure 4-296: Order Checks dialog

1. If you check the order you want to delete and click the Cancel Selected Order(s) button, the application displays the Cancel Order information message:

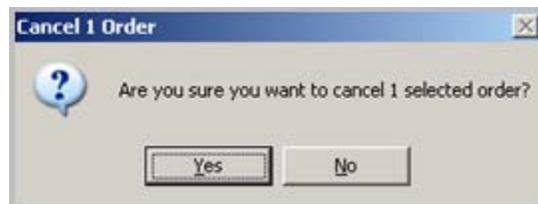


Figure 4-297: Cancel Order Information Message

2. Click Yes to cancel the selected order. The order then is removed from the Order window. (Otherwise, click No to not cancel the order.)
3. If you do not check the order and click the Continue button, you return to the Order window with both orders remaining on the list of orders.

4.10.19.3 Prepackaged Order Checks

The Order Checking application enables users to determine when order checks and notifications are sent. To accomplish this, the application includes several prepackaged order checks, as well as three menus for setting Order Checking parameters, such as enabling and disabling specific order checks.

Order checks can also be configured to be mandatory by the CAC or IRM. If this feature is enabled, individual order checks cannot be edited by the end users. Non-

mandatory order checks can be enabled or disabled through the Tools > Options menu.

Order checks exported with EHR:

Order Check	Value
ESTIMATED CREATININE CLEARANCE	Enabled
ORDER CHECKING NOT AVAILABLE	Enabled
ALLERGY-DRUG INTERACTION	Enabled
ALLERGY-CONTRAST MEDIA INTERACTION	Enabled
CT & MRI PHYSICAL LIMITATIONS	Enabled
BIOCHEM ABNORMALITY FOR CONTRAST MEDIA	Enabled
DUPLICATE ORDER	Enabled
RECENT BARIUM STUDY	Enabled
RECENT ORAL CHOLECYSTOGRAM	Enabled
DUPLICATE DRUG ORDER	Enabled
DUPLICATE DRUG CLASS ORDER	Enabled
CRITICAL DRUG INTERACTION	Enabled
CLOZAPINE APPROPRIATENESS	Enabled
AMINOGLYCOSIDE ORDERED	Enabled
RENAL FUNCTIONS OVER AGE 65	Enabled
MISSING LAB TESTS FOR ANGIOGRAM PROCEDURE	Enabled
GLUCOPHAGE-CONTRAST MEDIA	Enabled
LAB ORDER FREQ RESTRICTIONS	Enabled
ERROR MESSAGE	Enabled
POLYPHARMACY	Enabled
DISPENSE DRUG NOT SELECTED	Enabled
GLUCOPHAGE-LAB RESULTS	Enabled
SIGNIFICANT DRUG INTERACTION	Enabled
NO ALLERGY ASSESSMENT	Disabled
DUPLICATE OPIOID MEDICATIONS	Disabled
ALLERGIES UNASSESSIBLE	Disabled

Note: Most of these order checks are exported in the enabled state at the package level. Sites can then turn them on for individuals or teams, as determined by the site. CACs,

individuals, or services can also disable individual order checks, if they so choose. Package levels are only visible to those with programmer access and should NEVER be modified.

The list might not be up-to-date since it changes with EHR Patches. View order checks by using RPMS-EHR CONFIGURATION MASTER > ORD (Order Entry Configuration) > OCX (Order Check Configuration) > PAR (Order Check Parameters) > USR (Order Checks a User Can Receive) OR ENA (Enable/Disable an Order Check). Entering a question mark gives the user the list of order checks on the system.

4.10.19.4 Personal Preferences in Order Checks

Users can control what order checking is executed for orders. However, mandatory order checks cannot be turned off.

To turn order checks on or off:

1. Select Tools > Options to display the Options dialog. Then click the Order Checks tab.

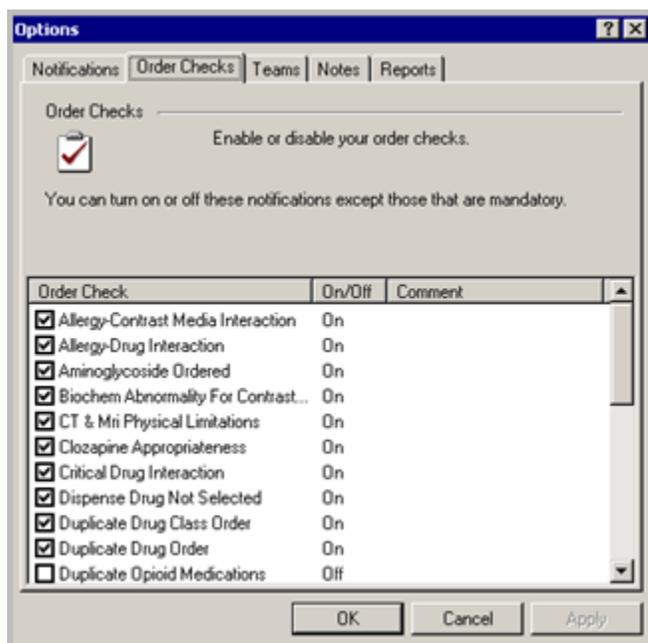


Figure 4-298: Order Checks Tab of Options dialog

The Order Check list comes from the Order Check file in RPMS. The CAC can turn any Order Check ON or OFF, as well as set any Order Check to Mandatory.

2. You can select or clear the various order checks, except for mandatory ones (the word Mandatory appears in the Comment column).

3. When the Options dialog is complete, click OK to dismiss it.

4.10.20 Printing an Order

You can print a selected order by selecting the Print option on the File menu. If necessary, you can set up the printer by selecting the Printer Setup option on the File menu.

Printing can also be set to occur automatically or the Print Orders dialog to print may appear automatically. This is controlled by parameters set up by the CAC.

To print a selected order:

1. Select File > Print to display the Print Orders dialog.

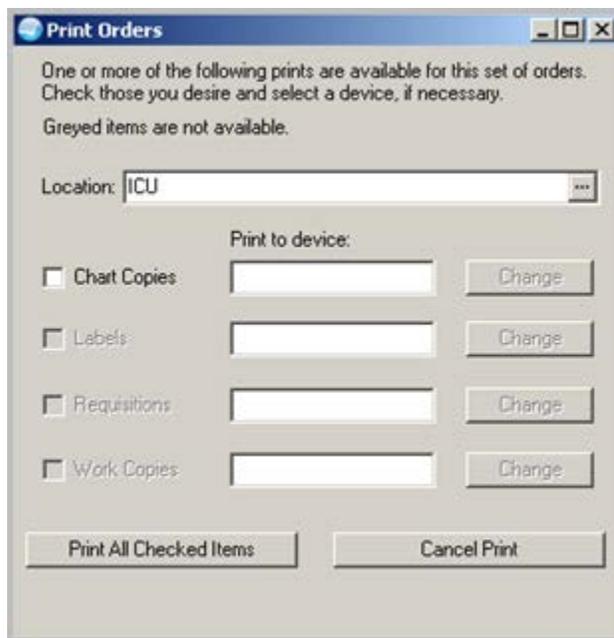


Figure 4-299: Print Orders dialog

2. The Location field displays where the orders will print. You can change the location by clicking the Ellipsis button and selecting an option on the drop-down list.
3. Select at least one check box to print.

Note: Parameters set up by your CAC control which items appear for printing, such as charts, labels, regs, work copies, and so on.

You can change the Print to Device field by clicking the Change button to display the Printer Selection dialog. The printers listed are the available printers in the selected location (in the Location field) on the Printer Orders dialog.

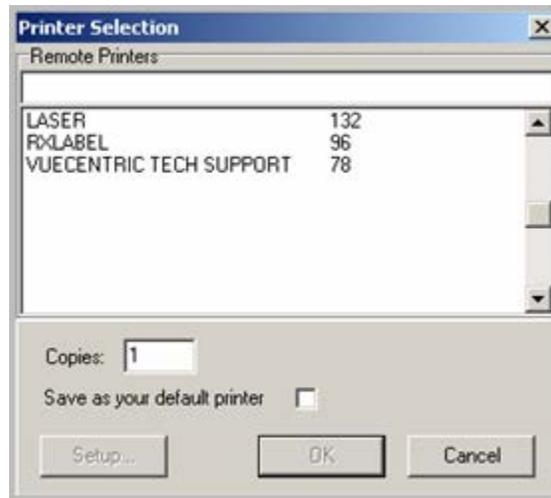


Figure 4-300: Printer Selection dialog

4. Select a printer. The number associated with the printer defines the page width (the number of characters across the page). This number comes from the RPMS device file.

Note: The selected printer can be made the default by clicking the Save as your default printer check box.

5. Change the number of copies by changing the value in the Copies field.
6. To review other setups (after selecting your printer), click the Setup button to display the Print Setup dialog. Here you can review the page width and page length dimensions. Although it appears you can change these numbers, you cannot because the application uses the values stored in the RPMS device file. The Page Length on a printer = number of lines on a page.
7. After the Printer Selection dialog is complete, click OK. (Otherwise, click Cancel).
8. Click the Print All Checked Items button on the Print Orders dialog. The contents of the (checked) orders output to the selected printer.

Note: The Cancel Print button only closes the Print Orders dialog.

4.11 Patient Education

The Education component displays the current patient's education events from the RPMS. This information appears on the grid below the Education label.

Visit Date	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location	Code
04/07/2006	Diabetes Mellitus Diet 2006	GOOD				USER,NURSE		Individual	DEMO HOSPITAL	NO CODE SELECTED
04/07/2006	Alcohol And Other Drugs Complications 2006	GOOD			COMMENT	USER,DEMO		Individual	DEMO HOSPITAL	NO CODE SELECTED
09/25/2000	Diabetes Mellitus Exercise 2006	GOOD				RJDD,MILES		Individual	DEMO HOSPITAL	NO CODE SELECTED
06/26/2000	Laboratory Tests 2006	GOOD		GOAL MET		MOORE,CATHERINE	2	Individual	DEMO HOSPITAL	NO CODE SELECTED
04/17/2000	Diabetes Mellitus Exercise 2006	GOOD				RJDD,MILES	3	Individual	DEMO HOSPITAL	NO CODE SELECTED
04/17/2000	Diabetes Mellitus Diet 2006	GOOD				RJDD,MILES	5	Individual	DEMO HOSPITAL	NO CODE SELECTED
04/17/2000	Diabetes Mellitus Information 2006	GOOD				RJDD,MILES	5	Individual	DEMO HOSPITAL	NO CODE SELECTED
04/16/2000	Laboratory/Phlebotomy 2006	GOOD		GOAL MET	KEEP PNESSURE	MOORE,CATHERINE	2	Individual	DEMO HOSPITAL	NO CODE SELECTED
09/24/2013	Complication Of Surgical Procedure Medication	Fair				USER,DEMO	30	Individual	DEMO HOSPITAL	06797001
09/30/2013	Eruption Due To Drug Disease Process	Fair				USER,DEMO	13	Individual	DEMO HOSPITAL	26320001
09/30/2013	Diabetes Mellitus Diet 2 Diabetes Mellitus Disease Process	Fair				USER,DEMO	3	Individual	DEMO HOSPITAL	42014003
09/30/2013	Disease Associated With Type 2 Diabetes Mellitus Medication	Fair				USER,DEMO	6	Individual	DEMO HOSPITAL	42014003
09/07/2013	Bites Of Arter With Infection Exercise	Fair				USER,DEMO	4	Individual	DEMO HOSPITAL	9977002

Figure 4-301: Education Component

You can sort the Patient Education information by selecting a column heading. If no Education information is present in the RPMS for a patient, the grid is empty.

The Patient Education component can be configured so that a user or class cannot add/edit information.

You can view Visit Detail information about a visit associated with a Patient Education record. Select the Display Visit Detail option on the right-click menu to display the Visit Detail dialog. See Section 4.11.1 for more information.

Note: Items for the current selected visit display in blue in the Patient Education component.

4.11.1 Visit Detail Information

The Patient education component has a Display Visit Detail option on the right-click menu.

1. Select an existing record within the component.
2. Right-click and then select the Display Visit Detail option. The Visit Detail window displays information from the visit file.

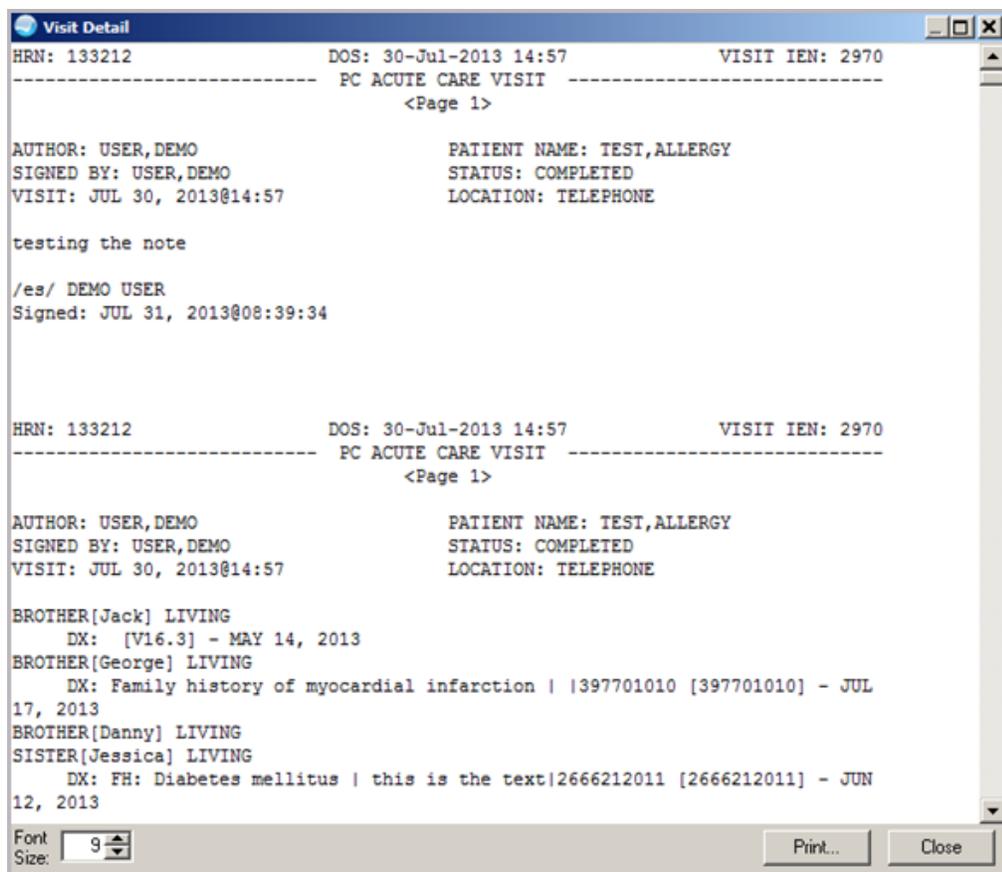


Figure 4-302: Visit Detail Information

- Click Close to dismiss the window.

You can change the font size of the text displayed in this window by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows).

Note: When printing, this does not change the size of the text on the output.

- Click Print to choose a printer and to output the (entire) contents of this window to the specified printer.

Note: The Print button appears according to how the component is configured.

The Detail window has a right-click menu where you can copy selected text and paste it into any free-text field within the HER or into another application (like MS Word).

4.11.2 Selecting an Education Topic

To add an Education event, you must first select an education topic. The selection utilizes one of five different selection dialogs by either clicking one of the icons or selecting one of the option buttons.

When you click Add (or select the Add Patient Education option on the right-click menu) within the Education component, the Education Topic Selection dialog displays.

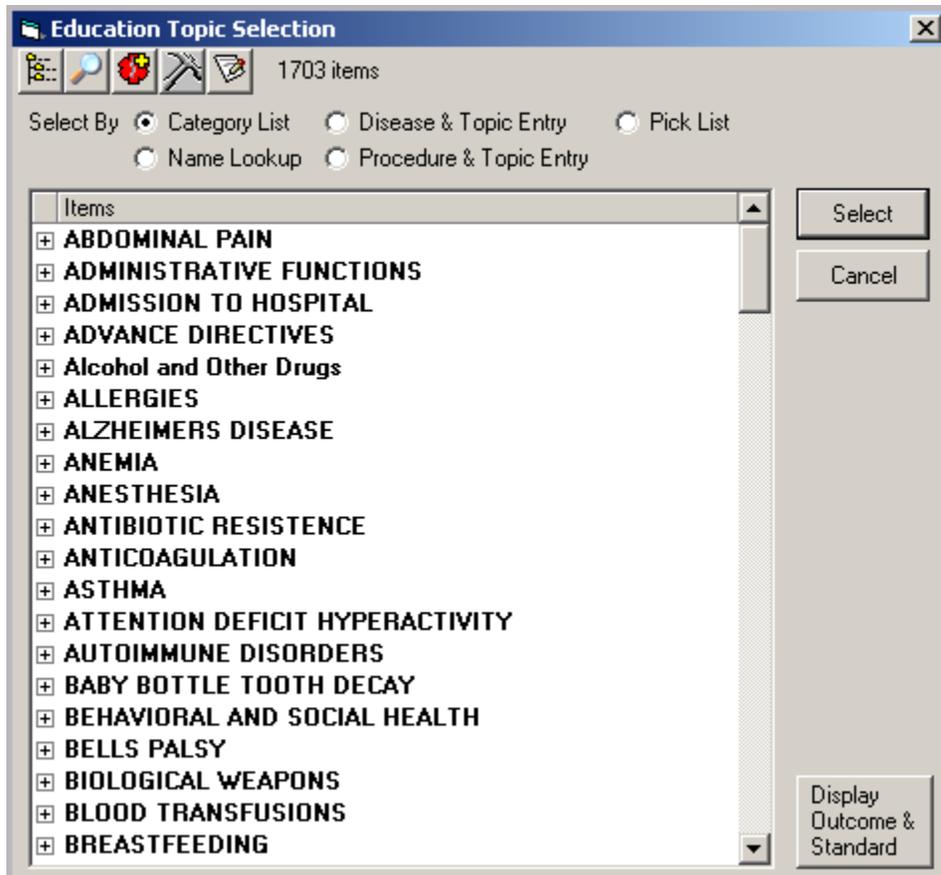


Figure 4-303: Education Topic Selection dialog

Many of the selection dialogs have the Display Outcome & Standard button. After selecting a topic and clicking the button, the Outcome and Standard for the selected education topic displays. See Outcome and Standard Statement for more information.

If you do not want to enter an education topic, click Cancel to dismiss the Education Topic Selection dialog.

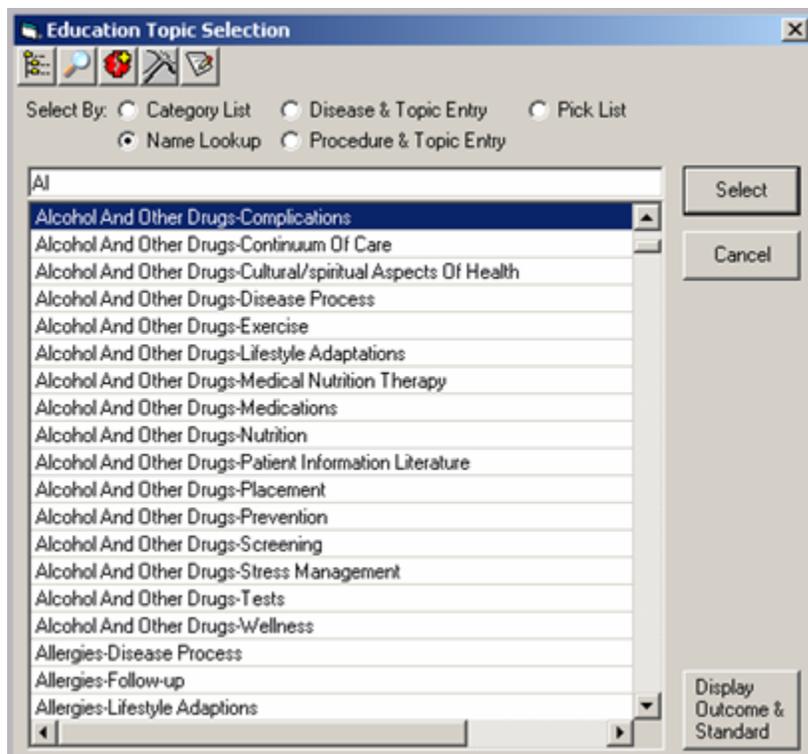


Figure 4-305: Selecting Education Topic by Name Lookup

After clicking Select, the Add Patient Education Event dialog displays with your selection in the Education Topic field.

4.11.2.3 Selection by Disease and Topic Entry

1. To select the Education Topic using the Disease and Topic Entry button () , you must select both a Diagnosis code and a corresponding topic, and then click OK. (Otherwise, click Cancel.)
2. Select the diagnosis from a SNOMED CT lookup or select the POV for the current encounter if it has already been entered.

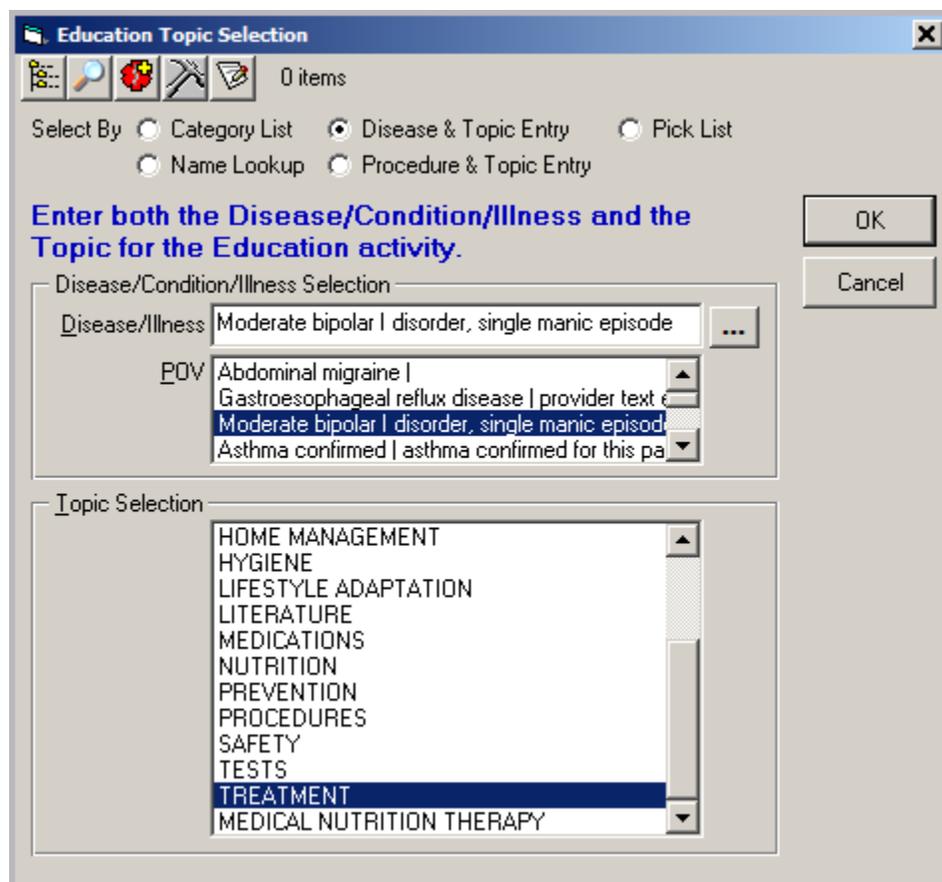


Figure 4-306: Selecting Education Topic by Diagnosis and Topic Entry

3. Populate the Disease/Illness field using one of two methods:
 - Method 1: If POV has already been entered, select the information in the POV field. The information populates the Disease/Illness field.
 - Method 2: Click the Ellipsis button next to the Disease/Illness field to open the SNOMED CT Lookup dialog.
 - a. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully specified name or Synonym option button.
 - Fully specified name returns a collapsed list of SNOMED CT terms. Click the Expand button (⊕) next to the term to expand and view the child entries.
 - Synonym returns the full list of SNOMED CT terms.
 - b. In Maximum Results

- o 25
 - o 50
 - o 100
 - o 200
 - o ALL
- c. In Search, type the term you want to search for.
- d. In Subset, you can select a subset to search, if needed.
- e. In Search Date, the field defaults to the current date. Click the drop-down arrow to open the calendar and select a different date to search, if needed.
- f. Click either the IHS SNOMED CT or ALL SNOMED CT button. The list of SNOMED CT terms and their mapped ICD code is populated.
- g. Select and highlight a term, and then click the Select button. The Disease/Illness field of the Education Topic Selection dialog refreshes with the selected SNOMED CT term you selected.
4. In the Education Topic Selection dialog, in the Topic Selection section, select a topic.
5. Click OK. The Add Patient Education Event dialog displays with the Education Topic field populated with your selection from the SNOMED CT Lookup.

Note: If you need to change the SNOMED CT code, click the Ellipsis button next to the Disease/Illness field.

4.11.2.4 Selection by Procedure and Topic Entry

To select the Education Topic using the Procedure & Topic Entry button () , you must enter both a CPT code and the corresponding topic.

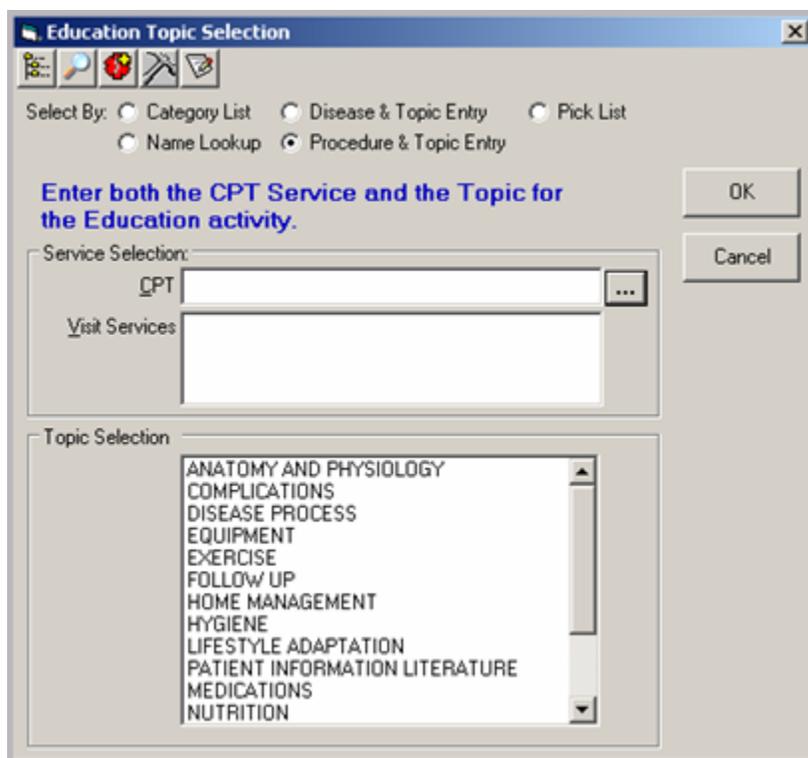


Figure 4-307: Selecting Education Topic by Procedure and Topic Entry

1. Populate the CPT field using one of two methods:
 - Method 1: Select the information in the Visit Services field. This information populates the CPT field.
 - Method 2: Click the Ellipsis button by the CPT field to display the Procedure Lookup dialog. See Using the Procedure Lookup dialog for more information.
2. Select one of the items on the Lookup dialog and click OK to have the selected item added to the CPT field on the Education Topic Selection dialog.
3. In the Topic Selection field, select a topic, and then click OK. The Add Patient Education Event dialog displays with your selection in the Education Topic field.

4.11.2.5 Selection by Pick List

To select the Education Topic using the Pick List button () , select one or more options from a Pick List.

One of two conditions is possible:

- The Pick List panel is populated
- The Pick List panel is empty (or you want to create a new Pick List).

4.11.2.5.1 Populated Pick List

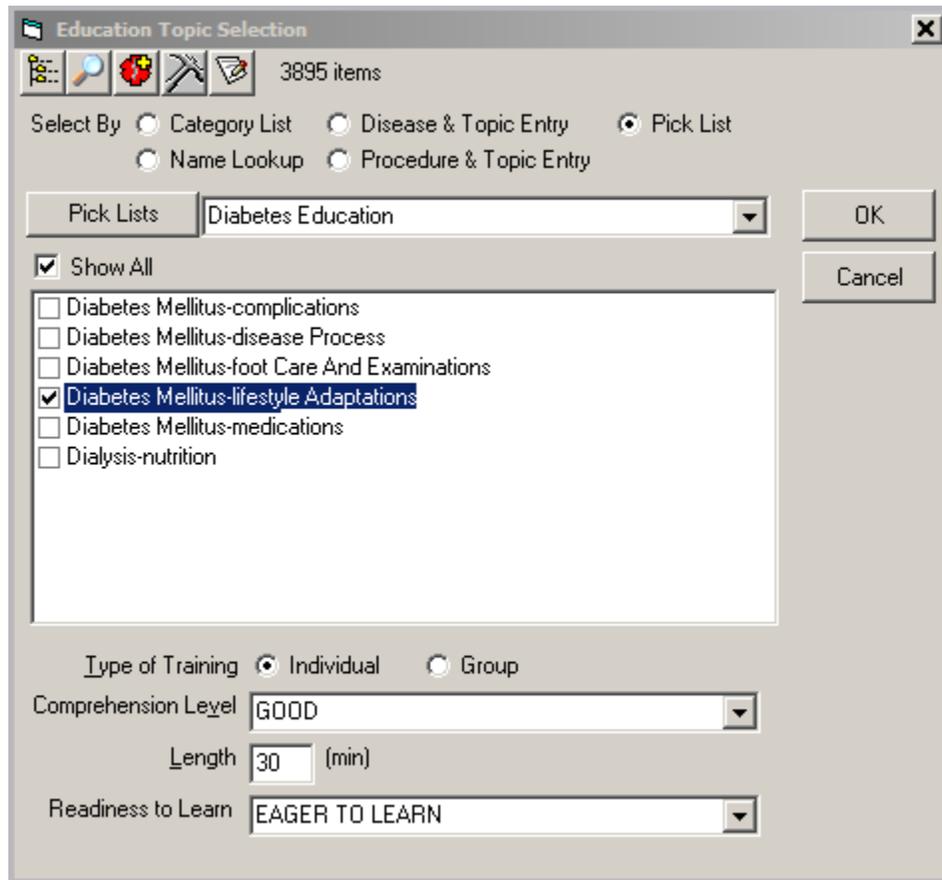


Figure 4-308: Populated Pick List Selection Menu

1. The education category is displayed in the drop-down list next to the Pick Lists button. If there is more than one category, select one. In the previous example, the education category is Diabetes Education.
2. You can check one or more items from the displayed Pick List.

Note: Click the Show All check box to show all Pick List items.

3. Select the Type of Training, Comprehension Level, Length (of time, in whole numbers) that specifies the number of minutes for the education, and Readiness to Learn.

Note: If you select more than one education topic, the Length of time is divided equally among the topics.

4. Click OK to add those items to the Education grid. (There is no Add Patient Education Event dialog in this instance.)

4.11.2.5.2 Empty Pick List

When the Selection dialog is empty, you need to create a pick list. This same method is used to create a new pick list.

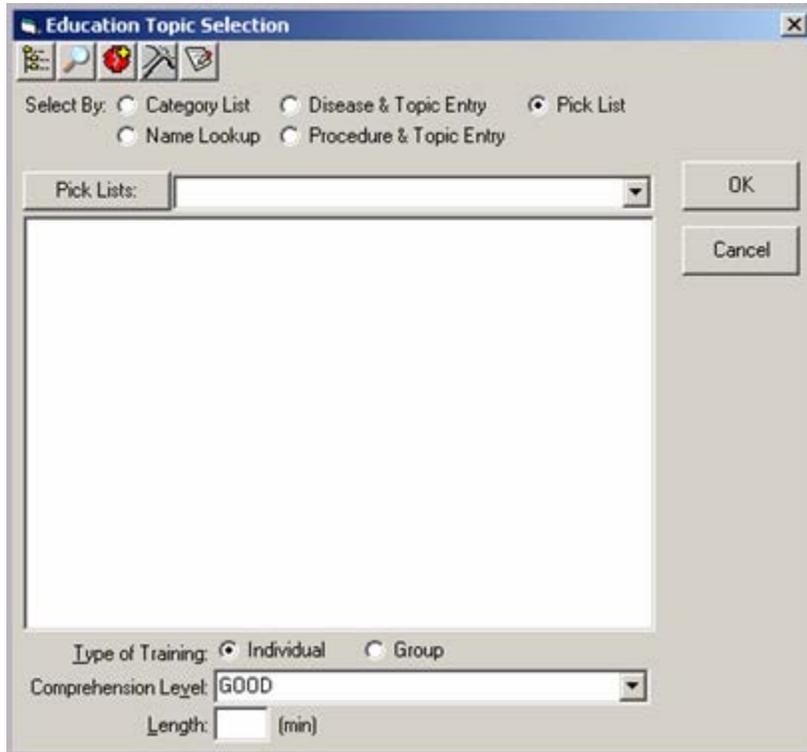


Figure 4-309: Selecting Education Topic by Pick List

Follow these steps to create a new Pick List:

1. Click the Pick Lists button to display the Manage Education Quick Picks dialog.

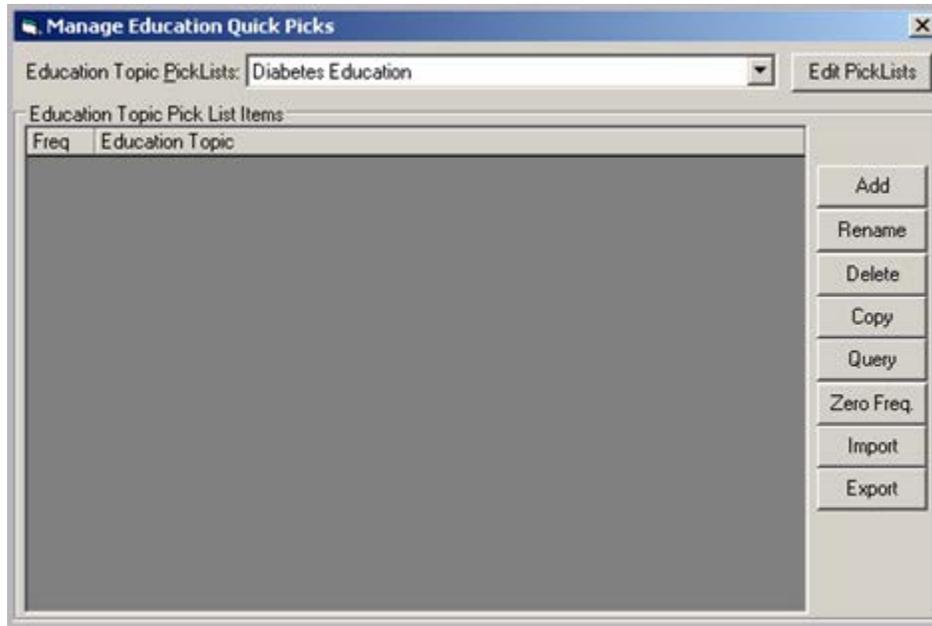


Figure 4-310: Manage Education Quick Picks

2. Click the Edit Pick Lists button to display the Manage Categories dialog.



Figure 4-311: Manage Categories dialog

3. Click the Add button to display the Add Category dialog.

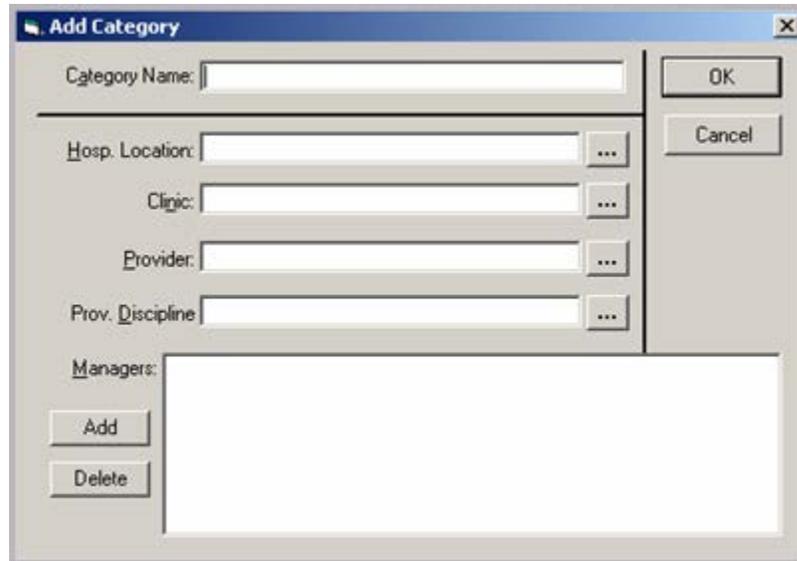


Figure 4-312: Add Category dialog

4. Type a name in the Category Name.
5. Choose how the pick list displays from the methods that follow. If you do not select a display method, the pick list is available to all users in all locations.
 - Hospital Location: The pick list is available to anyone who is in the selected hospital location.
 - Clinic: The pick list is available to anyone who is in the selected the clinic.
 - Provider: The pick list is available to the selected provider.
 - Provider Discipline: The pick list is available to anyone who is in the selected provider discipline.
6. To prevent other users from editing your pick list, add your name, and any other user allowed to edit your menu (in the Managers panel).
7. Click OK when complete.
8. Add education codes to the pick list category.
9. On the Manage Education Quick Pick dialog, select your pick list category from the Education Topic Pick Lists field.

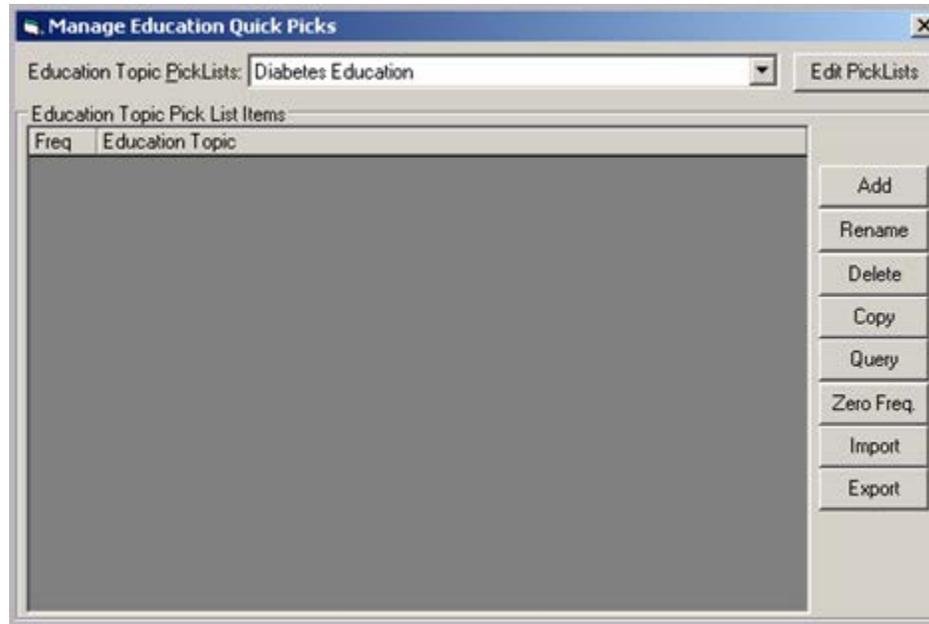


Figure 4-313: Manage Education Quick Picks dialog with no Pick Lists

10. Click the Add button and search for the code on the lookup utility. Select an education code you would like to add and click OK. The education codes are added to the pick list. Repeat this step as needed to add more codes.

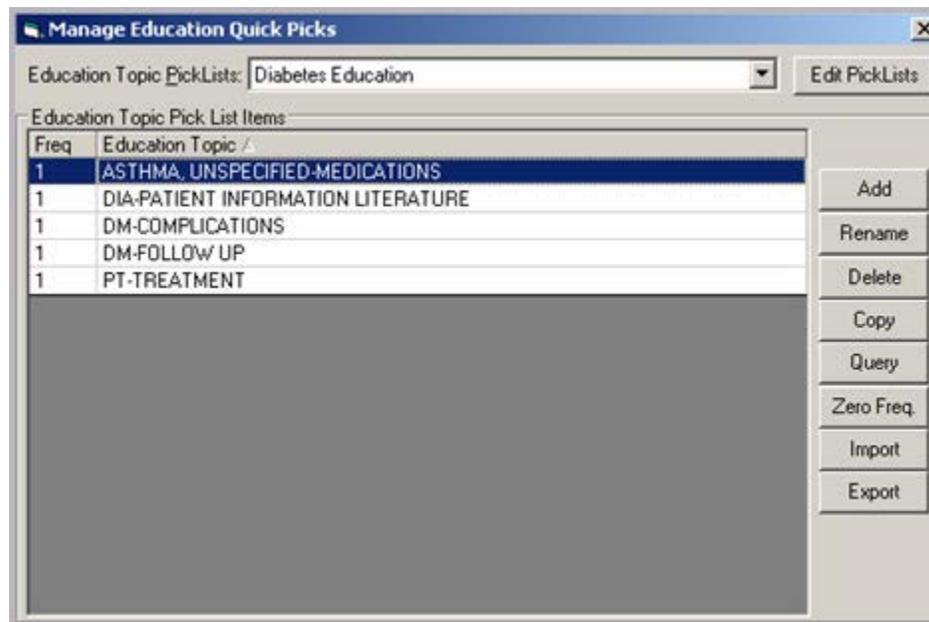


Figure 4-314: Manage Education Quick Picks with Pick Lists

Pick List Options

Additional options, as needed, to help you manage the pick list are as follows:

- **Rename:** Highlight the education code you want to rename and click the Rename button. A window opens and enables you to rename the education code. Remember that when a code is inactivated nationally, it remains in the pick list until manually removed by the pick list manager.
- **Note:** Renaming the code does not result in changing the way the education code is documented.
- **Delete:** Highlight the education code you want to remove from the pick list and click the Delete button.
- **Copy:** Click the Copy button to copy education codes from another menu to your new pick list.
- **Query:** Click the Query button to list the most commonly used patient education codes used by a provider or a clinic. Use caution when using this option, as education codes change on a very frequent basis and you do not want to include inactive codes in your pick list.

Note: To avoid selecting inactive patient education codes, use caution with the Query option since education codes change and become inactive frequently.

- **Zero Frequency:** Every time you use an education code, the frequency is recorded and displayed on the pick list. This function resets the frequency for all of the education codes.
 - **Import:** Use this button to import an education code pick list from another user.
 - **Export:** Use this button to export an education code pick list to your desktop computer. This file can be shared with other EHR users.
1. Complete the Education Topic Selection dialog:
 - a. Select one or more options in the panel below the Pick Lists button.
 - b. Select the Type of Training.
 - c. Select the Comprehension Level from the drop-down menu:
 - Poor
 - Fair
 - Good
 - Group – No Assessment
 - Refused
 - d. Type a length of time (in whole numbers) that specifies the number of minutes for the education.

Note: If you select more than one education topic, the length of time is divided equally among the topics.

- Click OK to populate the selected items in the Education panel. (There is no Add Patient Education Event dialog in this instance.)

4.11.2.6 Using the Procedure Lookup dialog

Follow these steps to use the Procedure Lookup dialog:

- Click the Ellipsis button at the end of the Procedure field to display the Procedure Lookup dialog.

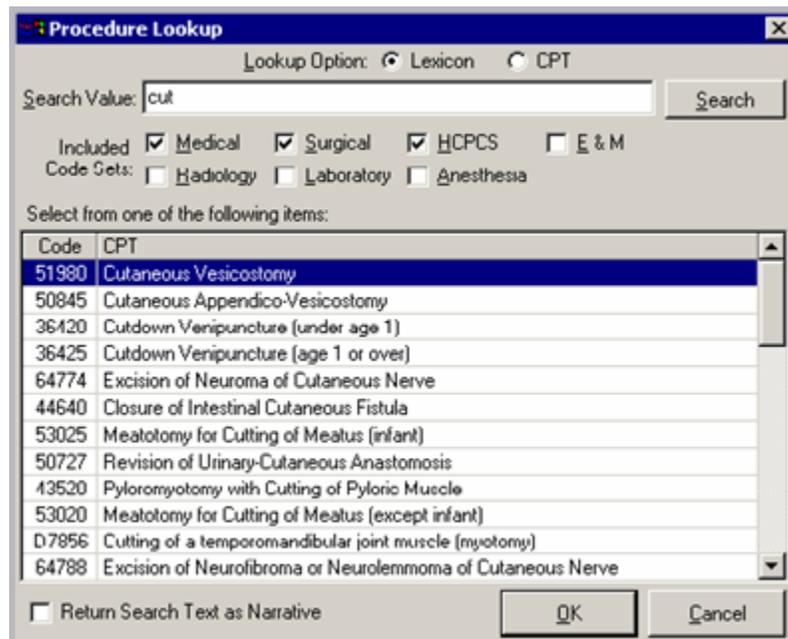


Figure 4-315: Initial Procedure Lookup dialog

- Select the Lexicon or CPT option button to determine where you want to search for the procedure.
- The Return Search Text as Narrative check box (when checked) enables the EHR to populate the Narrative field with whatever you enter in the Search Value field. Otherwise, the Narrative field is populated with whatever is selected for the Procedure field.
- Search for a procedure by entering a few characters in the Search Value field and clicking Search. The related procedures display in the lower part of the dialog.

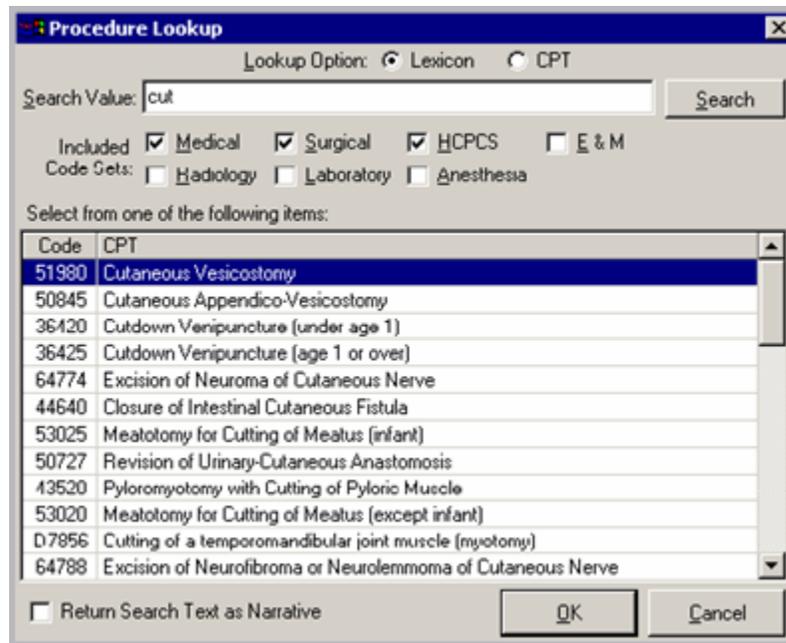


Figure 4-316: Procedure Lookup dialog After Clicking Search

5. If this is the wrong procedure, re-enter the characters in the Search Value field and click Search (repeat until you attain the correct procedure).
6. If needed, sort the Code or CPT column by selecting the column heading. Use the scroll bar to view the entire list. When you have found the correct procedure, select it and then click OK, or double-click the procedure. (Otherwise, click Cancel.)

The selected procedure populates the CPT field when selecting a CPT for a Procedure and Topic Entry in the Education Topic Selection dialog or if selecting a CPT for the Add Refusal tab when Completing the Health Factors and Refusal Information.

4.11.2.7 Using the Lookup Utility dialog for Location

Access the Lookup Utility by clicking the Ellipsis button at the end of the Location field. Use this dialog to search for and select a location for the Location field.



Figure 4-317: Initial Lookup Location dialog

Follow these steps to complete the Lookup Location dialog:

1. You can scroll the list to the location and select it. Otherwise you can search for a location.
2. To search for a location, type of few characters in the Search Value field and click Search.



Figure 4-318: Lookup Location dialog After Search

3. Select the appropriate record in the lower panel and click OK. The selected record populates the Location field. (Otherwise, click Cancel.)

4.11.3 Adding an Education Event

After selecting an education topic, you can add either new or historical Patient Education events:

- New Patient Education is for a current visit.
- Historical Patient Education is for past visits and typically for an outside facility or place.

It is important to note that for non-historic visits, the date and location of the Education must correspond to the currently selected encounter in the EHR (which can be for past dates).

Note: In order to add an Education record you must be assigned the PROVIDER key and cannot hold the BGOZ VIEW ONLY key.

In conjunction with adding education event information, you can add health factor information as well as a refusal for a selected topic.

The following information is divided into three parts:

- Completing the Patient Education Information
- Entering Historical Patient Education Information
- Completing the Health Factors and Refusal Information

4.11.3.1 Completing the Patient Education Information

The screenshot shows a dialog box titled "Add Patient Education Event". The "Education Topic" field contains "G0109-Home Management" with a subtitle "(Diab Manage Trn Ind/group)". The "Type of Training" section has "Individual" selected. The "Comprehension Level" dropdown is set to "REFUSED". The "Length" is "30 (min)". The "Comment" field is empty. The "Provided By" field contains "USER, DEMO". The "Readiness to Learn" dropdown is set to "UNRECEPTIVE". The "Status/Outcome" section has "Goal Not Met" selected. On the right side, there are buttons for "Add", "Cancel", "Historical", "Display Outcome & Standard", and "Patient's Learning Health Factors". Below the "Patient's Learning Health Factors" button, the text "Blind" is visible.

Figure 4-319: Add Patient Education Event dialog with Education Refusal Selected

Follow these steps to complete the Add Patient Education Event dialog for the current visit:

Note: If you need to change the Education Topic, click the Ellipsis button next to the Education Topic field. The Education Topic Selection dialog opens. Refer to Selecting an Education Topic for details on completing the dialog.

1. Select the type of training, if needed.
2. The default for the Comprehension Level is Good, and should be changed accordingly. The patient's Comprehension Level (also called Level of Understanding) can be classified as the following:
 - Good (examples: verbalizes understanding; able to return demonstration or teach-back correctly).
 - Fair (examples: verbalizes need for more education; incomplete return demonstration or teach-back indicates partial understanding).
 - Poor (examples: does not verbalize understanding; unable to return demonstration or teach-back).
 - Group – No Assessment (examples: education provided in group; unable to evaluate individual response).
 - Refused.

3. You can add a comment to the patient education code that provides further description of the encounter. Comments can be used for describing the name of a lesson plan or education material provided to the patient (limited to 100 characters).
4. If another provider is needed for the Provided By field, click the Ellipsis button to select from a lookup utility.
5. Select the appropriate Readiness to Learn document from the drop-down menu.
6. If needed, add goals. Goals are optional for the patient education documentation. Goals can be documented as Goal Set, Goal Met, or Goal Not Met. The free-text field in the Status/Outcome group box is limited to 20 characters (that describes something about the goal).
7. Click Display Outcome & Standard to display the Outcome and Standard statement for the displayed education topic, if needed.
8. When the Add Patient Education Event dialog is complete, click Add to add the education topic (or refusal) to the Education and Personal Health panels. (Otherwise, click Cancel.)

4.11.3.2 Entering Historic Patient Education

When you check the Historical check box on the Add Patient Education dialog, the Historical group box is added to the dialog.

Another way to enter the Historical Patient Education Event is to have no visit selected and click the Add button. The Add Patient Education Event with the Historical check box selected displays.

Figure 4-320: Historical Patient Education Event

- The Event Date and Location determine the date and location of the education event.
- The Event Date must be a past date. Either manually enter it or click the Ellipsis button to display a calendar from which to select a date.
- The Location can be either an IHS Facility or Other (at another facility or office).
- If you enable the IHS/Tribal Facility option button, you can enter a valid IHS Facility name or click the Ellipsis button to display a lookup utility from which to select one. If the manually-entered facility name is not a valid one, the EHR displays the lookup utility. See Using the Lookup Utility dialog for Location for more information.
- If you enable Other, you can enter the name of another place or office where the education event took place (like Dr. Brown's Office).
- If your site has been configured with a default outside location, type OTHER in the Location field. Then when you display the View Visit Detail window, the default outside location displays at the LOC. OF ENCOUNTER field.
- Complete the fields in the other parts of the dialog as when entering a non-historical education event.

4.11.3.3 Completing the Health Factors and Refusal Information

This part of the Patient Education dialog is optional. By clicking the Patient's Learning Health Factors button, you can add health factor information for the selected patient on the current visit. This information is divided into two parts:

- Completing the health factors information
- Completing the refusal information

Click the Patient's Learning Health Factors button on the Patient Education dialog to display the Add Health Factor and Add Refusal dialog. From this dialog, complete the following tabs.

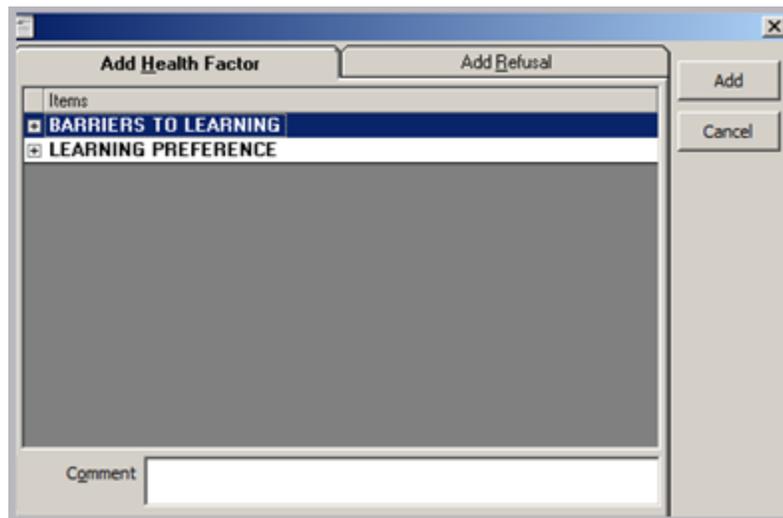


Figure 4-321: Add Health Factor and Add Refusal dialog

4.11.3.3.1 Add Health Factor Tab

Use the Health Factor tab to add specific learning factors which may help or hinder the patient's learning ability.

1. Click the Add Health Factor tab.
2. Expand one of the Items in order to select a health factor under that item.

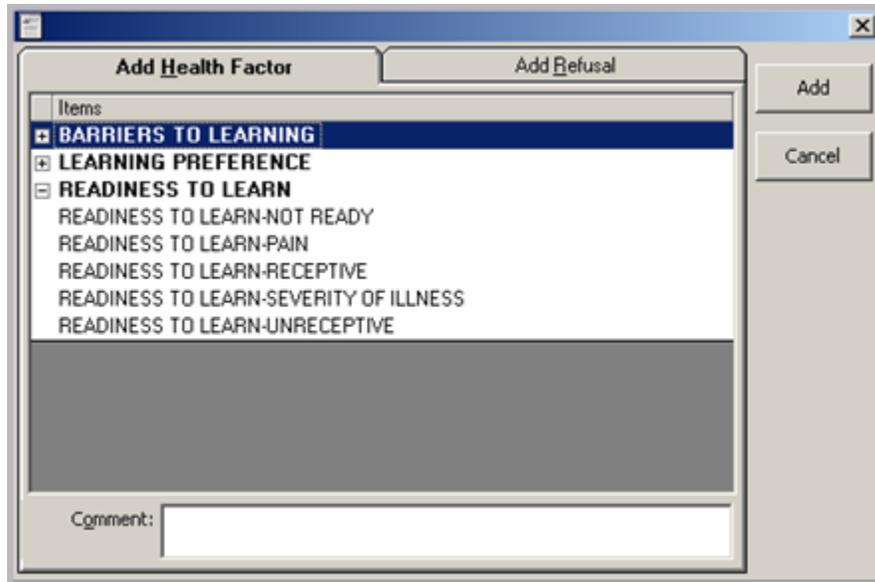


Figure 4-322: Expanded Item for Particular Health Factor

3. Highlight the particular health factor and click Add.

This adds the particular health factor to the Health Factor component and it displays in the Patient’s Learning Health Factors panel on the Add or Edit Education dialog.

4.11.3.3.2 Add Refusal Tab

Use the Add Refusal tab to add a refusal for a specified health factor learning refusal type.

1. Select the Add Refusal tab to add a refusal.

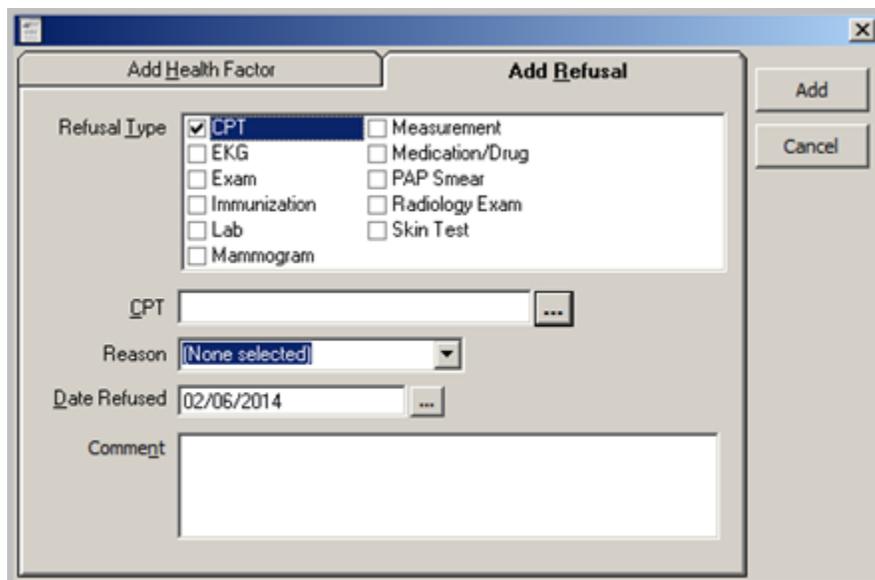


Figure 4-323: Add Refusal Tab

2. Select any one of the check boxes in the Refusal Type panel. The label for the field reflects what is selected in the Refusal Type panel.
3. Click the Ellipsis button next to the field below the Refusal Type. The Procedure Lookup dialog opens. Refer to the Using the Procedure Lookup dialog topic for details on completing the fields.
4. In Reason, select one of the following from the drop-down menu:
 - (None Selected)
 - Declined Service
 - Not medically indicated
 - No response to follow-up
 - Provider discontinued
 - Considered and not done
 - System reason
5. The Date Refused field defaults to the current date. Click the Ellipsis button to select a different (past) date.

Note: The Date Refused cannot be a future date.

6. The Comment field is a free-text field. Type a comment or notes, as needed.
7. After you complete this dialog, click Add to have the information added to the patient's learning refusal file, shown in the field below the Patient's Learning Health Factors button on the Add (or Edit) Patient Education Event dialog.

4.11.4 Editing an Education Event

In order to edit an Education record you must be assigned the PROVIDER key and cannot hold the BGOZ VIEW ONLY key. The visit the education topic was entered on cannot be locked.

See the Outcome and Standard topic for more information about the dialog that displays when you click the Display Outcome & Standard button.

Make sure a visit is selected. Follow these steps to edit an education event:

1. Select an Education Event you want to edit.
2. Click Edit (or select Edit Patient Education on the right-click menu) to display the Edit Patient Education Incident dialog.

Figure 4-324: Edit patient Education Incident dialog

See Selecting an Education Topic for information about how to select another education topic for the Education Topic field.

3. As needed, update any or all of the data fields of the original education event. See Adding an Education Event for completing the dialog.

Note: If the selected record is a historical patient education event, you cannot change the event date or place (in the Historical group box).

4. When the Edit Patient Education Event dialog is complete, click Save to update the education topic on the Education panel. (Otherwise, click Cancel.)

4.11.5 Deleting an Education Event

In order to delete an Education record you must be assigned the PROVIDER key and cannot hold the BGOZ VIEW ONLY key.

The education event must be on a visit that is not locked.

Note: Any Health Factor/Refusal information entered for the selected education event is NOT removed by the Delete function.

Make sure a visit is selected. Follow these steps to delete an education event:

1. Select an Education Event you want to delete.

- Click Delete (or select Delete Patient Education on the right-click menu) to display the Remove Patient Education? information message.

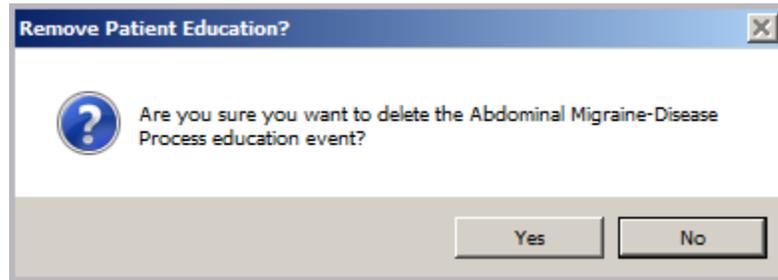


Figure 4-325: Delete an Education Event Information Message

- Click Yes to delete the selected record. (Otherwise, click No.)

4.11.6 Using the Web Reference Search

The Web Reference Search for the Patient Education component depends if any records are present. The Reference Site list can be configured.

- Condition 1: If there are records present, select one and click the Information button () , or select the Web Reference option on the right-click menu to go to the UpToDate Reference Web site for the topic associated with the selected record. You can change to another Web site by selecting from the Reference Site drop-down list (on the Web site).
- Condition 2: If there are no records present, click the Information button () , or select the Web Reference option on the right-click menu to display the Web Reference Search dialog.



Figure 4-326: Web Reference Search dialog

The Web Reference Search dialog to select a reference site only opens if you do not have a default set up and you have not selected any item in the education list. Once you have highlighted an item in the list, the Web Reference attempts to go to the default site and search on the topic you selected. If you chose a topic attached to a DX or procedure, you are presented with information on that particular topic.



Figure 4-327: Web Reference Topic

4.11.7 Outcome and Standard Statement

Users can display and print the Outcome and Standard Statement for a selected education event by clicking the Show Standard button (or by selecting Show Standard on the right-click menu) on the Education panel. The same thing happens when you click the Display Outcome & Standard button on the Education Topic Selection dialog and on the Add/Edit Patient Education dialogs.

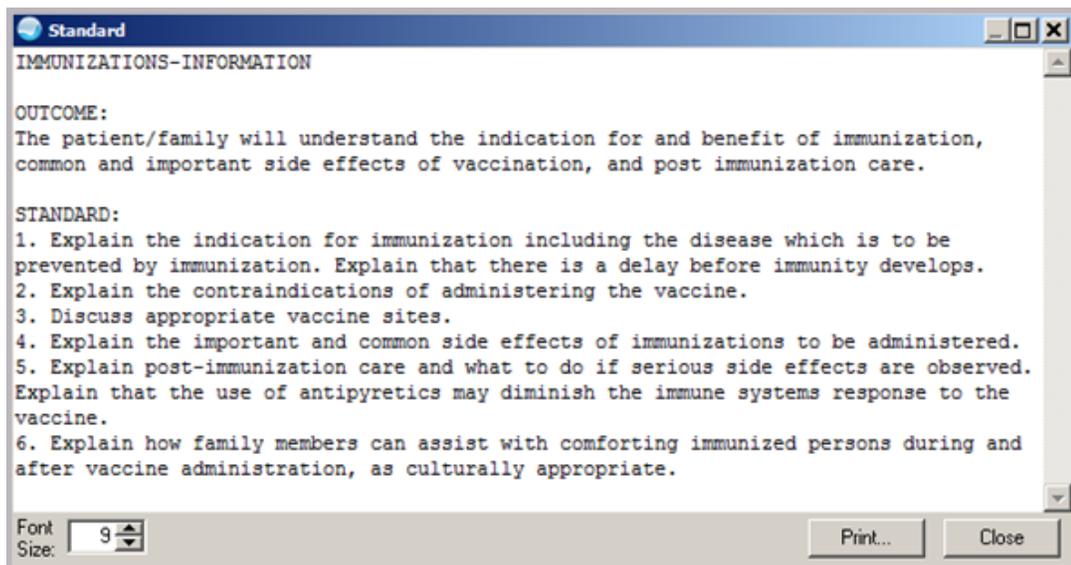


Figure 4-328: Example of Outcome and Standard Statement

The Standard window contains the outcome and standards for a selected education topic.

Click Close to dismiss the window.

You can change the font size of the text displayed in this window by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows).

Note: This does not change the size of the text on the output (when you print).

Click Print to choose a printer and to output the (entire) contents of this window to the specified printer.

Note: The Print button appears according to how your application is configured.

The Standard window has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word.)

4.12 Personal Health

The Personal Health component has features where you can record data regarding Functional Status, Birth Measurements, Refusal, and Treatment Contract.

Various options are available for recording personal health data, depending on the selected patient. For example, the Birth Measurements option is only available when a patient less than 8-years old is selected.

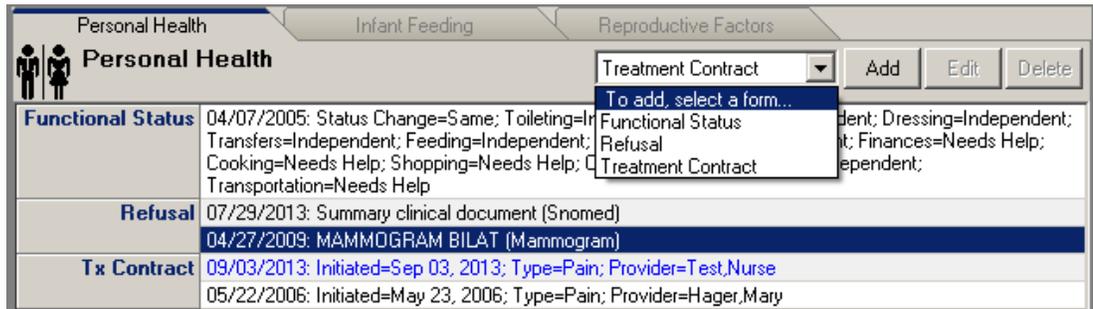


Figure 4-329: Personal Health Component

The choices available on the drop-down list depend on the appropriate BGOZ keys that are assigned. Contact your CAC about the available keys.

This component can be configured so that a particular user or class cannot add or edit reproductive history information.

The Personal Health component contains the Display Visit Detail option on the right-click menu. Selecting this option displays a dialog showing information about the visit where you can view or print the information.

4.12.1 Adding Personal Health Records

You can add several types of personal health records to the Personal Health component.

Important: You must select a patient and an unlocked visit to add PHR information.

4.12.2 Adding Functional Status

The Functional Status option is where you record the activities of daily living.

To add functional status to a record:

1. From the Personal Health component, select a line item, select the Functional Status option from the drop-down menu, and then click the Add button (or select Add on the right-click menu). The Enter Functional Status Record dialog opens.

Activities of Daily Living:	Instrumental Activities of Daily Living:
Toileting: Independent	Finances: Needs Help
Bathing: Needs Help	Cooking: Totally Dependent
Dressing: Needs Help	Shopping: Totally Dependent
Transfers: Totally Dependent	Housework: Needs Help
Feeding: Independent	Medications: Independent
Continence: Totally Dependent	Transportation: Totally Dependent
Change of Status: Decline	Patient is Caregiver: No

Figure 4-330: Enter Functional Status Record dialog

2. In the Activities of Daily Living or Instrumental Activities of Daily Living sections, select one of the following for any of the drop-down lists to record a functional status associated with those activities:
 - Independent
 - Needs Help
 - Totally Dependent
3. In Change of Status, if you are updating or adding a change in the patient's functional status, select one of the following from the drop-down menu:

- Same
 - Improvement
 - Decline
4. In Patient is Caregiver to Others, select one of the following from the drop-down menu:
 - Yes
 - No
 5. Click OK to add the Functional Status record to the Personal Health component. (Otherwise, click Cancel.)

4.12.3 Adding Birth Measurements

The Birth Measurements option is used to record birth measurement information about the current infant on the current visit. This option is only available when a patient less than 8-years old is selected.

To add birth measurements to a record:

1. From the Personal Health component, select the Birth Measurements option from the drop-down menu, and then click the Add button (or select Add on the right-click menu). The Update Birth Measurements dialog opens.

Figure 4-331: Update Birth Measurements dialog

Note: Follow the data formatting instructions on the Update Birth Measurements dialog.

2. In Birth Weight, type the patient's weight at birth. The unit of measure for birth weight is automatically changed for the following:
 - Changes to kilograms if k or K is typed
 - Changes to grams if g or G is typed
 - Changes to lbs.-oz. if a hyphen or space is typedThe resulting value is appropriately validated.
3. In Birth Order, type a numeric value to indicate the patient's birth order.
4. In the Feeding Choices section, type a value for the following fields:
 - Formula Started
 - Breast Feeding Stopped
 - Solids Started
5. In the Mother or Guardian field, click the Ellipsis button to open the Lookup Patient dialog and follow these steps:
 - a. In Search Value, type a name, and then click the Search button.



Figure 4-332: Initial Lookup Patient dialog

The Lookup Patient dialog refreshes with a list of matching names.

- b. Select a name, and then click Ok.

The Mother or Guardian field on the Update Birth Measurements dialog populates with your selection.

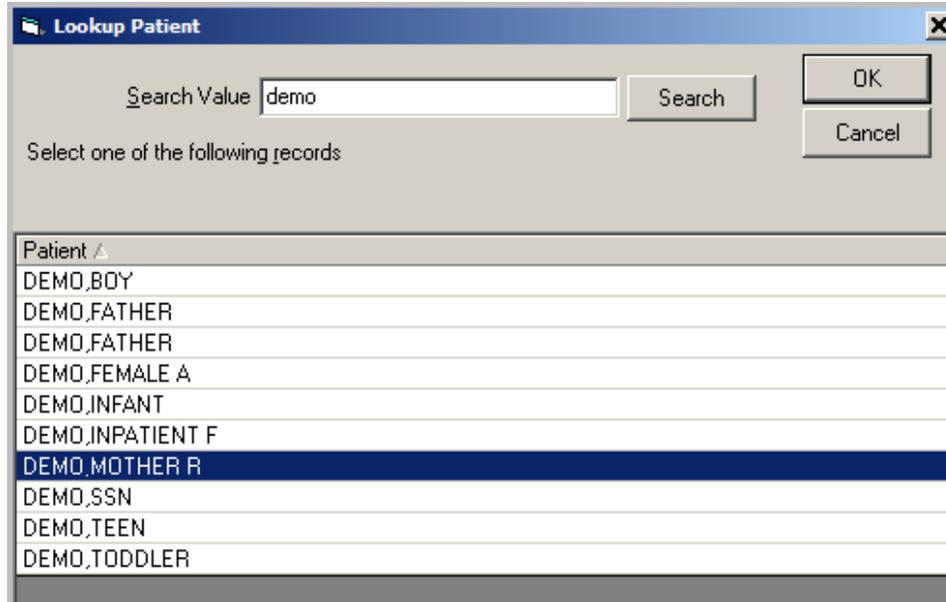


Figure 4-333: Lookup Patient dialog

6. Click OK to add the birth measurements record to the Personal Health component. (Otherwise, click Cancel.)

4.12.4 Adding Refusals

The Refusal option is where you record that the patient refused treatment or assessment on the current visit. A refusal demonstrates that an intention was attempted but the patient declined or stated not to perform the treatment or assessment.

1. From the Personal Health component, select Refusal from the drop-down menu, and then click Add (or select Add on the right-click menu). The Enter Service Not Provided/Refusal dialog opens.

Enter Service Not Provided / Refusal

Refusal Type

<input type="checkbox"/> CPT	<input type="checkbox"/> Measurement
<input checked="" type="checkbox"/> EKG	<input type="checkbox"/> Medication/Drug
<input type="checkbox"/> Exam	<input type="checkbox"/> PAP Smear
<input type="checkbox"/> Immunization	<input type="checkbox"/> Radiology Exam
<input type="checkbox"/> Lab	<input type="checkbox"/> Skin Test
<input type="checkbox"/> Mammogram	<input type="checkbox"/> SNOMED

EKG: ...

Reason: ▼

Date Refused: ...

Comment:

Add

Cancel

Figure 4-334: Enter Refusal dialog

- In Refusal Type, select the applicable refusal type: CPT, EKG, Exam, Immunization, Lab, Mammogram, Measurement, Medication/Drug, PAP Smear, Radiology Exam, Skin Test, and SNOMED CT.

4.12.4.1 CPT

- Select the CPT check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to CPT.

Enter Service Not Provided / Refusal

Refusal Type

<input checked="" type="checkbox"/> CPT	<input type="checkbox"/> Measurement
<input type="checkbox"/> EKG	<input type="checkbox"/> Medication/Drug
<input type="checkbox"/> Exam	<input type="checkbox"/> PAP Smear
<input type="checkbox"/> Immunization	<input type="checkbox"/> Radiology Exam
<input type="checkbox"/> Lab	<input type="checkbox"/> Skin Test
<input type="checkbox"/> Mammogram	<input type="checkbox"/> SNOMED

CPT: ...

Reason: ▼

Date Refused: ...

Comment:

Add

Cancel

Figure 4-335: Enter Refusal for CPT

- Click the Ellipsis button next to the CPT field to display Procedure Lookup dialog where you search for and select current procedural terminology.

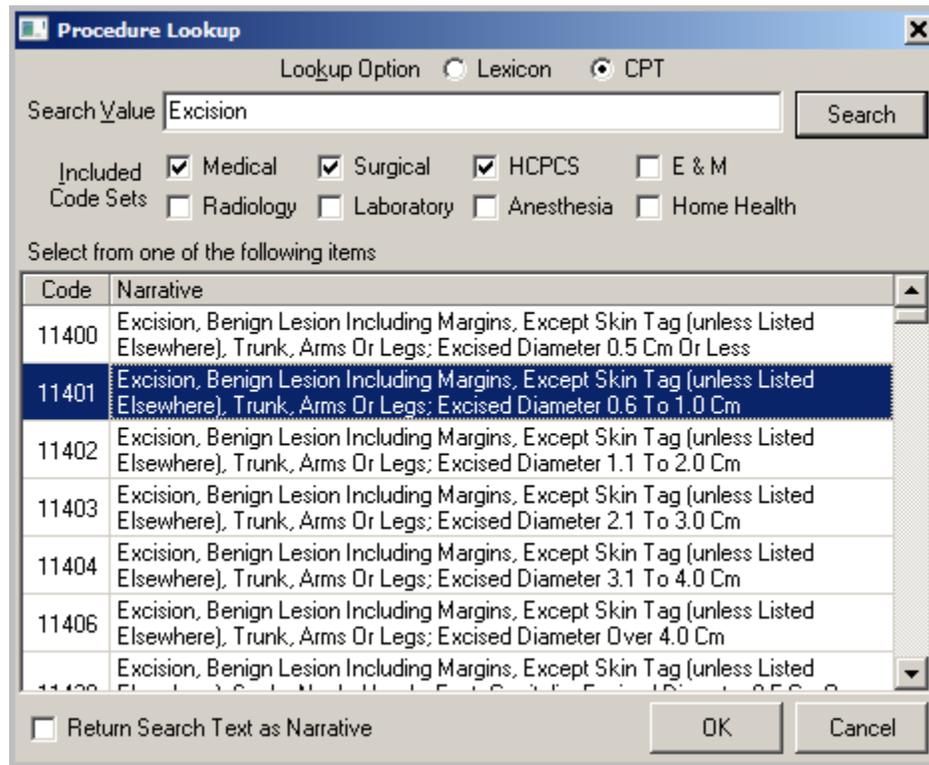


Figure 4-336: Procedure Lookup dialog

- In the Procedure Lookup dialog, in Lookup Option, select either the Lexicon or CPT option button.
- In Search Value, type a value for which to search.
- In Included Code sets, select a check box, as applicable:
 - Medical
 - Surgical
 - HCPCS
 - E&M
 - Radiology
 - Laboratory
 - Anesthesia
 - Home Health
- If needed, click the Return Search Text as Narrative check box.

7. Click the Search button. The search results show a list of procedures which includes the Code and Narrative.
8. Select a procedure from the list, and then click OK. Your selection populates in the CPT field of the Enter Service Not Provided/Refusal dialog.

4.12.4.2 EKG

1. Select the EKG check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to EKG.

The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains a "Refusal Type" section with a grid of checkboxes. The "EKG" checkbox is checked and highlighted. Other checkboxes include CPT, Measurement, Exam, Medication/Drug, Immunization, P&P Smear, Lab, Radiology Exam, Mammogram, Skin Test, and SNOMED. To the right of the grid are "Add" and "Cancel" buttons. Below the grid, there are three fields: "EKG" (text box containing "EKG" and an ellipsis button), "Reason" (dropdown menu containing "Finding related to health insurance issues"), and "Date Refused" (text box containing "09/03/2013" and an ellipsis button). At the bottom is a "Comment" text area with the placeholder text "Type comments here.".

Figure 4-337: Enter Refusal for EKG dialog

2. Click the Ellipsis button for the EKG field to display Lookup Diagnostic Procedure for EKG where you select a Diagnostic Procedure for EKG (if any).

Note: EKG is the default pre-populated entry for the EKG field.

3. In Search Value, type a term for which to search, or leave the field blank, and then click Search. The Diagnostic Procedure results show a list of procedures.

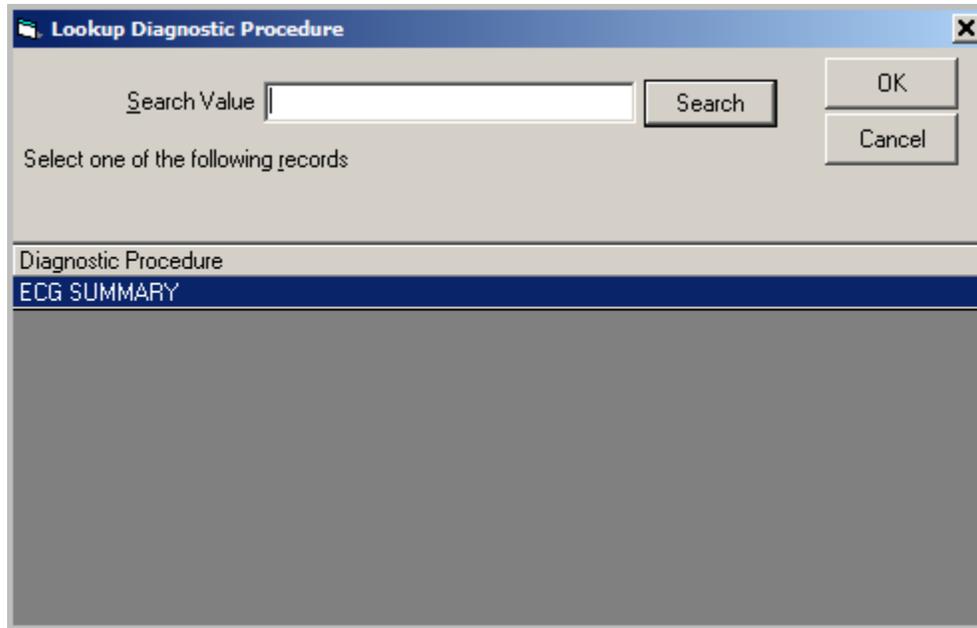


Figure 4-338: Lookup Diagnostic Procedure for EKG

4. Select a procedure from the list, and then click OK. Your selection populates in the EKG field of the Enter Service Not Provided/Refusal dialog.

4.12.4.3 Exam

1. Select the Exam check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Exam.

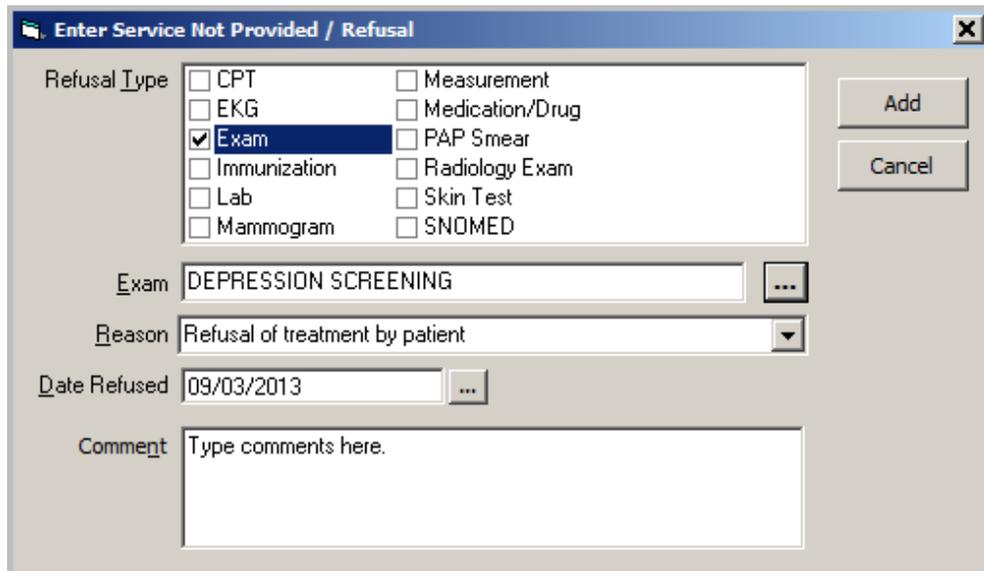


Figure 4-339: Enter Refusal for Exam

2. Click the Ellipsis button for the Exam field to display the Lookup Exam dialog where you select an exam name.

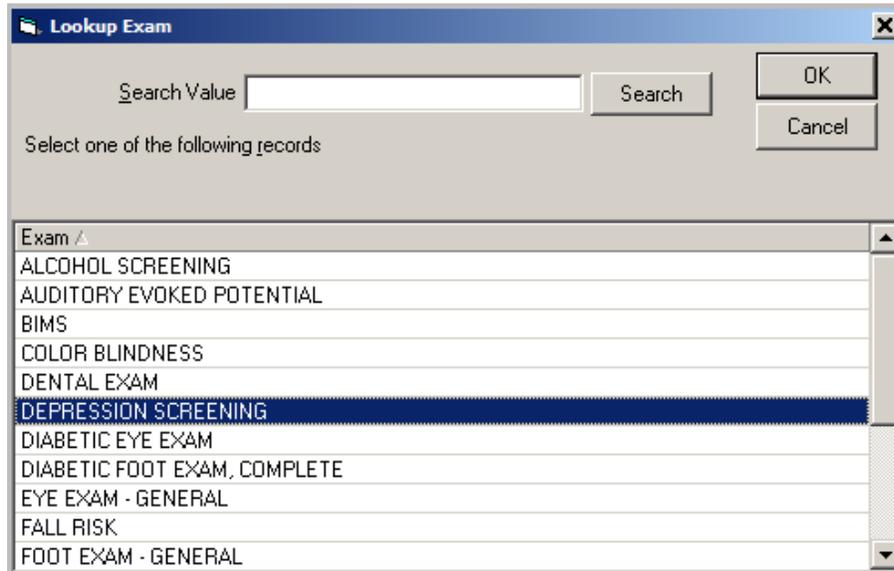


Figure 4-340: Lookup Exam dialog

3. In the Lookup Exam dialog, in Search Value, type a search term or leave the field blank to return all choices.
4. Click Search. The search results show a list of exams.
5. Select an exam from the list, and then click OK. Your selection populates in the Exam field of the Enter Service Not Provided/Refusal dialog.

4.12.4.4 Immunization

1. Select the Immunization check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Immunization.

Enter Service Not Provided / Refusal

Refusal Type

CPT Measurement
 EKG Medication/Drug
 Exam PAP Smear
 Immunization Radiology Exam
 Lab Skin Test
 Mammogram SNOMED

Add

Cancel

Immunization: DIPHTHERIA ANTITOXIN

Reason: Patient non-compliant - refused access to services

Date Refused: 09/03/2013

Comment: Type comments here.

Figure 4-341: Enter Refusal for Immunization

- Click the Ellipsis button for the Immunization field to display the Vaccine Selection dialog where you select a vaccine.

Vaccine Selection

Search Criteria

Search Value: Search

OK

Cancel

Show All Active Vaccines
 Show Only active Vaccines with a Lot Number
 Show All Vaccines

Select one of the following Records

Immunization	Description
ADENOVIRUS, NOS	Adenovirus vaccine, NOS
ADENOVIRUS, TYPE 4	Adenovirus vaccine, type 4, live, oral
ADENOVIRUS, TYPE 7	Adenovirus vaccine, type 7, live, oral
ADENOVIRUS, TYPES 4&7	Adenovirus, type 4 and type 7, live, oral
ANTHRAX	Anthrax vaccine
BCG	Bacillus Calmette-Guerin vaccine
BOTULINUM ANTITOXIN	Botulinum antitoxin
CHOLERA	Cholera vaccine, intramuscular
CMVIG	Cytomegalovirus immune globulin, intravenous
DENGUE FEVER	Dengue fever vaccine
DIPHTHERIA ANTITOXIN	Diphtheria antitoxin
DT (PEDIATRIC)	Diphtheria and tetanus toxoids adsorbed for ped
DTAP	Diphtheria, tetanus toxoids and acellular pertuss

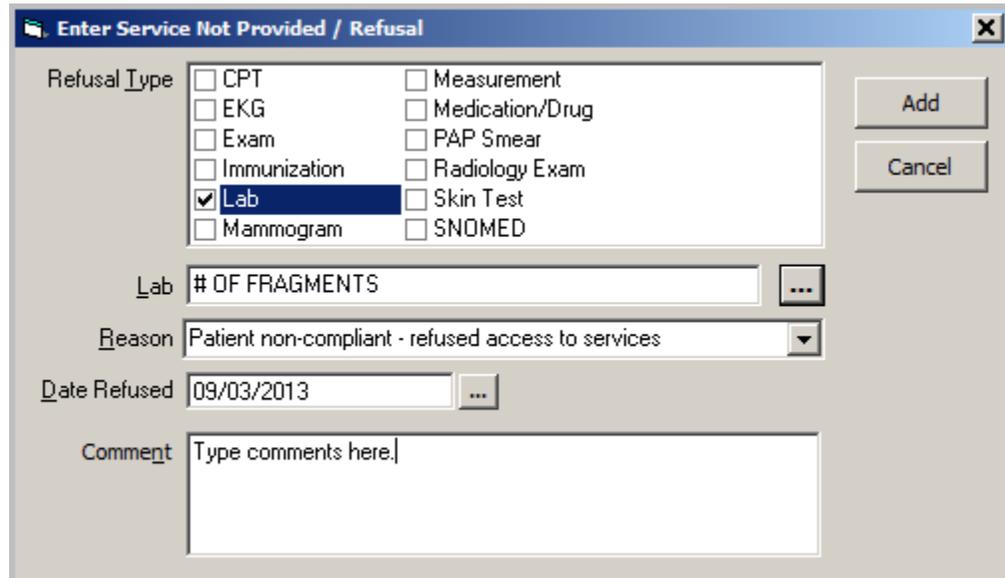
Figure 4-342: Vaccine Selection dialog

- In the Vaccine Selection dialog, in Search Value, type a search term or leave the field blank to return all choices.

4. Select one of the following option buttons:
 - Show All Active Vaccines
 - Show Only active Vaccines with a Lot Number
 - Show All Vaccines (default)
5. Click Search. The search results show a list of immunizations and their description.
6. Select an immunization from the list, and then click OK. Your selection populates in the Immunization field of the Enter Service Not Provided/Refusal dialog.

4.12.4.5 Lab

1. Select the Lab check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Lab.



The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains a "Refusal Type" section with a grid of checkboxes. The "Lab" checkbox is checked. Below this are fields for "Lab" (containing "# OF FRAGMENTS"), "Reason" (a dropdown menu), "Date Refused" (containing "09/03/2013"), and a "Comment" text area.

Figure 4-343: Enter Refusal for Lab

2. Click the Ellipsis button for the Lab field to display a lookup utility where you select a lab test name.

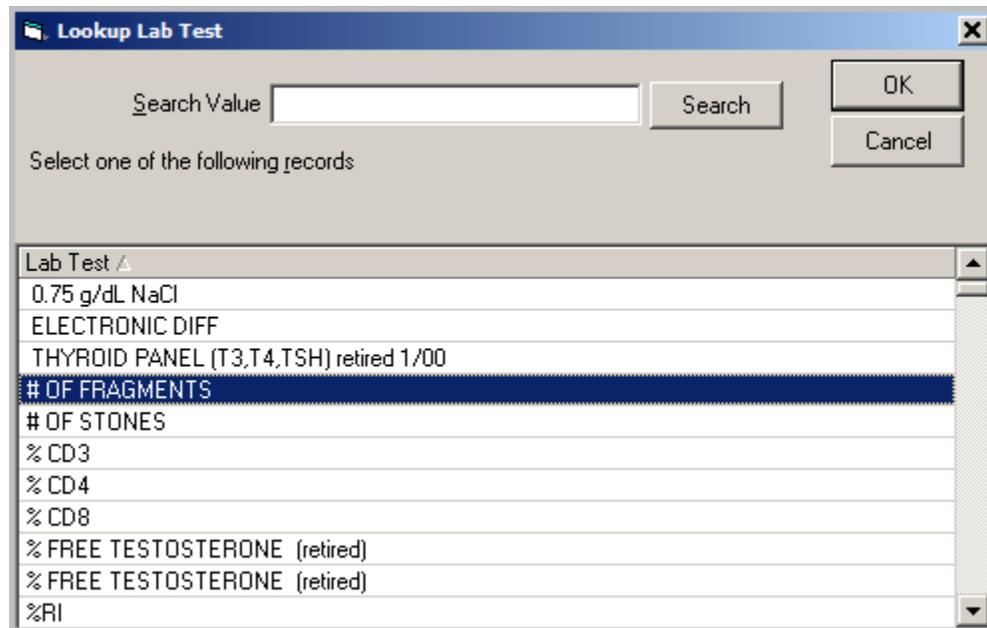


Figure 4-344: Lookup Lab Test dialog

3. In the Lookup Lab Test dialog, in Search Value, type a search term or leave the field blank to return all choices.
4. Click Search. The search results show a list of lab tests.
5. Select a lab test from the list, and then click OK. Your selection populates in the Lab field of the Enter Service Not Provided/Refusal dialog.

4.12.4.6 Mammogram

1. Select the Mammogram check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Mammogram.

Enter Service Not Provided / Refusal

Refusal Type

<input type="checkbox"/> CPT	<input type="checkbox"/> Measurement
<input type="checkbox"/> EKG	<input type="checkbox"/> Medication/Drug
<input type="checkbox"/> Exam	<input type="checkbox"/> PAP Smear
<input type="checkbox"/> Immunization	<input type="checkbox"/> Radiology Exam
<input type="checkbox"/> Lab	<input type="checkbox"/> Skin Test
<input checked="" type="checkbox"/> Mammogram	<input type="checkbox"/> SNOMED

Mammogram: MAMMOGRAM BILAT

Reason: (None selected)

Date Refused: 09/03/2013

Comment: Type comments here.

Figure 4-345: Enter Refusal for Mammogram

- Click the Ellipsis button for the Mammogram field to display the Lookup Radiology Exam dialog where you select a radiology exam for mammogram.

Lookup Radiology Exam

Search Value: MAMMOGRAM

Select one of the following records

Radiology Exam
MAMMOGRAM BILAT
MAMMOGRAM UNILAT

Figure 4-346: Lookup Mammogram dialog

- In the Lookup Radiology Exam dialog, in Search Value, type a search term or leave the field blank to return all choices.
- Click Search. The search results show a list of radiology exams.
- Select a radiology exam from the list, and then click OK. Your selection populates in the Mammogram field of the Enter Service Not Provided/Refusal dialog.

4.12.4.7 Measurement

1. Select the Measurement check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Measurement.

Figure 4-347: Enter Refusal for Measurement

2. Click the Ellipsis button for the Measurement field to display a lookup utility where you select a vital measurement.

Figure 4-348: Lookup Measurement dialog

3. In the Lookup Measurement dialog, in Search Value, type a search term or leave the field blank to return all choices.
4. Click Search. The search results show a list of measurement options.
5. Select a measurement from the list, and then click OK. Your selection populates in the Measurement field of the Enter Service Not Provided/Refusal dialog.

4.12.4.8 Medication/Drug

1. Select the Medication/Drug check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Medication/Drug.

The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains several fields and a list of refusal types. The "Refusal Type" list includes CPT, EKG, Exam, Immunization, Lab, Mammogram, Measurement, Medication/Drug (checked), PAP Smear, Radiology Exam, Skin Test, and SNOMED. The "Medication/Drug" field is populated with "ACETAZOLAMIDE 250MG TAB". The "Reason" dropdown menu shows "Patient non-compliant - refused access to services". The "Date Refused" field shows "09/03/2013". A "Comment" text area is at the bottom with the placeholder text "Type comments here.".

Figure 4-349: Enter Refusal for Medication/Drug

2. Click the Ellipsis button for the Medication/Drug field to display a lookup utility where you select a drug name.

The screenshot shows a dialog box titled "Lookup Drug". It features a "Search Value" input field and a "Search" button. Below the search field, it says "Select one of the following records". A list of drug names is displayed, with "ABACAVIR 300MG TAB" highlighted. Other drugs in the list include ACCUZYME PAPAINE/UREA OINT, ACEBUTOLOL, ACETAMINOPHEN 120MG SUPP, ACETAMINOPHEN 160MG/5ML SUSP, ACeTAMINOPHEN 325MG TAB, AceTaminOPhen 325mg Tab, ACETAMINOPHEN 325MG TAB, ACETAMINOPHEN 325MG TAB, ACETAMINOPHEN 325MG TAB UD, and ACETAMINOPHEN 650MG SUPP. "OK" and "Cancel" buttons are located at the top right.

Figure 4-350: Lookup Drug dialog

3. In the Lookup Drug dialog, in Search Value, type a search term or leave the field blank to return all choices.

4. Click Search. The search results show a list of drugs.
5. Select a drug from the list, and then click OK. Your selection populates in the Medication/Drug field of the Enter Service Not Provided/Refusal dialog.

4.12.5 PAP Smear

Select the PAP Smear check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to PAP Smear.

The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains a "Refusal Type" section with a grid of checkboxes: CPT, EKG, Exam, Immunization, Lab, Mammogram, Measurement, Medication/Drug, **PAP Smear** (checked), Radiology Exam, Skin Test, and SNOMED. To the right are "Add" and "Cancel" buttons. Below the checkboxes is a "PAP Smear" text field containing "PAP SMEAR" and an ellipsis button. Underneath is a "Reason" dropdown menu set to "Considered and not done". Below that is a "Date Refused" text field containing "09/04/2013" and an ellipsis button. At the bottom is a "Comment" text area with the placeholder "Type comment here.".

Figure 4-351: Refusal for PAP Smear

Note: When clicking the Ellipsis button, there are no other choices other than PAP SMEAR.

The Lookup Lab Test dialog opens, but defaults to PAP SMEAR.

The screenshot shows a dialog box titled "Lookup Lab Test". It has a "Search Value" text field containing "PAP SMEAR" and a "Search" button. To the right are "OK" and "Cancel" buttons. Below the search field is the text "Select one of the following records". Underneath is a list box with the heading "Lab Test" and one item, "PAP SMEAR", which is highlighted in blue.

Figure 4-352: Lookup Lab Test dialog

PAP SMEAR auto-populates in the Medication/Drug field of the Enter Service Not Provided/Refusal dialog.

4.12.6 Radiology Exam

1. Select the Radiology Exam check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Radiology Exam.

The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains a "Refusal Type" section with a grid of checkboxes: CPT, EKG, Exam, Immunization, Lab, Mammogram, Measurement, Medication/Drug, PAP Smear, Radiology Exam (checked), Skin Test, and SNOMED. To the right are "Add" and "Cancel" buttons. Below the grid is a "Radiology Exam" text field containing "ABDOMEN 1 VIEW" and an ellipsis button. Underneath is a "Reason" dropdown menu set to "Refusal of treatment by patient". Below that is a "Date Refused" text field containing "09/04/2013" and an ellipsis button. At the bottom is a "Comment" text area with the placeholder text "Type comment here."

Figure 4-353: Enter Refusal for Radiology Exam

2. Click the Ellipsis button for the Radiology Exam field to display the Lookup Radiology Exam dialog where you select a radiology exam.

The screenshot shows a dialog box titled "Lookup Radiology Exam". It features a "Search Value" text field, a "Search" button, and "OK" and "Cancel" buttons. Below the search area is a list box containing the following items: "Radiology Exam /", "ABDOMEN FOR FETAL AGE 1 VIEW", "ABDOMEN FOR FETAL AGE MULT VIEWS", "ABDOMEN MIN 3 VIEWS+CHEST", "ABDOMEN-KUB", "ACROMIOCLAVICULAR J BILAT", "ANGIO ADRENAL BILAT SELECT CP", "ANGIO ADRENAL BILAT SELECT S&I", "ANGIO ADRENAL UNILAT SELECT CP", "ANGIO ADRENAL UNILAT SELECT S&I", "ANGIO AORTOFEM CATH W/SERIAL FILMS CP", and "ANGIO AORTOFEMORAL CATH W/SERIAL FILMS S&I".

Figure 4-354: Lookup Radiology Exam dialog

3. In the Lookup Radiology Exam dialog, in Search Value, type a search term or leave the field blank to return all choices.
4. Click Search. The search results show a list of radiology exams.

5. Select a Radiology exam from the list, and then click OK. Your selection populates in the Radiology Exam field of the Enter Service Not Provided/Refusal dialog.

4.12.7 Skin Test

1. Select the Skin Test check box on the Enter Service Not Provided/Refusal dialog. The Refusal Item field changes to Skin Test.

The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains a "Refusal Type" section with a grid of checkboxes: CPT, EKG, Exam, Immunization, Lab, Mammogram, Measurement, Medication/Drug, PAP Smear, Radiology Exam, Skin Test (checked), and SNOMED. To the right of this grid are "Add" and "Cancel" buttons. Below the grid, there are three fields: "Skin Test" with the value "PPD" and an ellipsis button, "Reason" with a dropdown menu showing "(None selected)", and "Date Refused" with the value "09/03/2013" and an ellipsis button. At the bottom is a "Comment" text area with the placeholder text "Type comments here."

Figure 4-355: Enter Refusal for Skin Test

2. Click the Ellipsis button for the Skin Test field to display a lookup utility where you select a skin test.

The screenshot shows a dialog box titled "Lookup Skin Test". It features a "Search Value" text field, a "Search" button, and "OK" and "Cancel" buttons. Below the search area, it says "Select one of the following records". A list box contains the following items: "Skin Test", "PPD" (which is highlighted in blue), and "TETANUS".

Figure 4-356: Lookup Drug dialog

3. In the Lookup Drug dialog, in Search Value, type a search term or leave the field blank to return all choices.
4. Click Search. The search results show a list of skin tests.

5. Select a skin test from the list, and then click OK. Your selection populates in the Skin Test field of the Enter Service Not Provided/Refusal dialog.

4.12.8 SNOMED CT

1. Select the SNOMED CT check box on the Enter Service Not Provided/Refusal dialog. The SNOMED CT field changes to SNOMED CT.

The screenshot shows a dialog box titled "Enter Service Not Provided / Refusal". It contains a "Refusal Type" section with a grid of checkboxes. The checked option is "SNOMED". Below this, there are fields for "SNOMED" (with an ellipsis button), "Reason" (a dropdown menu), "Date Refused" (with a date and an ellipsis button), and a "Comment" text area. On the right side, there are "Add" and "Cancel" buttons.

Figure 4-357: Enter Refusal for SNOMED CT Test

2. Click the Ellipsis button for the SNOMED CT field to display the SNOMED CT Lookup utility where you select a SNOMED CT term.

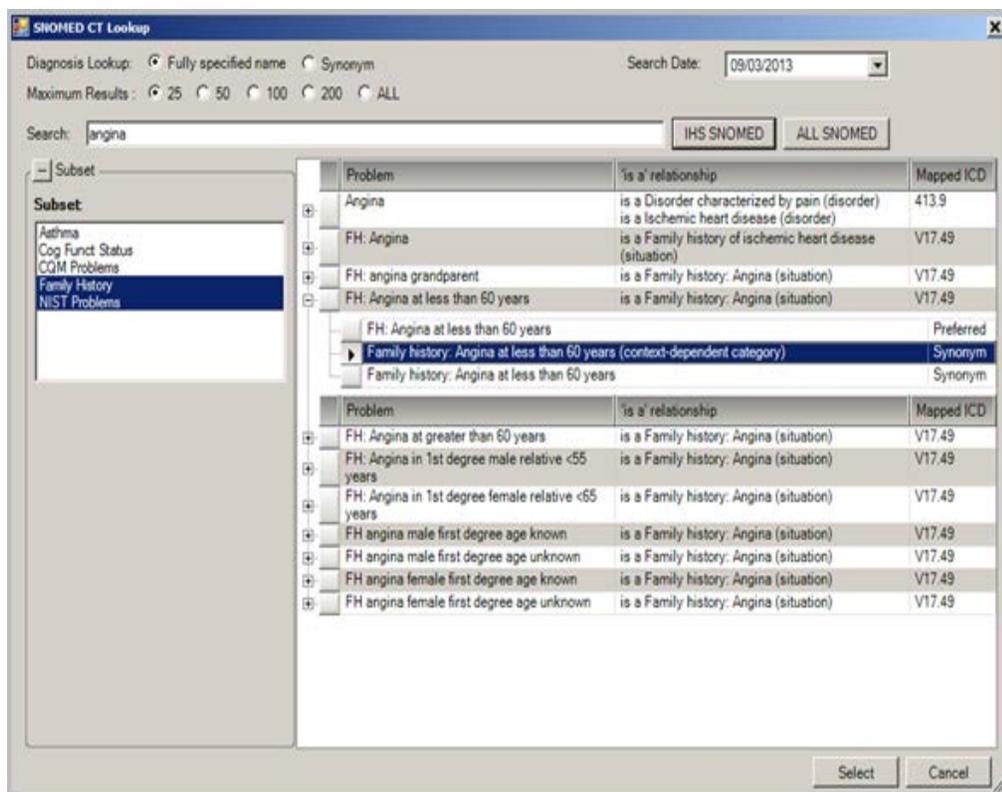


Figure 4-358: Lookup SNOMED CT dialog

3. In the Diagnosis Lookup, select one of the following option buttons:
 - Fully specified name (default)
 - Synonym
4. In Maximum Results, select one of the following option buttons:
 - 25
 - 50
 - 100
 - 200
 - ALL
5. In the Search field, type a search term.
6. In Subset, select one or more subsets to search.
7. Click again to clear a term.
8. Click either the IHS SNOMED CT or the ALL SNOMED CT button to search.
The search results show a list of applicable problems and the mapped ICD code.

9. Select a problem from the list, and then click Select. Your selection populates in the SNOMED CT field of the Enter Service Not Provided/Refusal dialog.
10. Complete the Enter Service Not Provided/Refusal dialog for all refusal types as follows:
 - a. In Reason, select a refusal reason from the drop-down menu.
 - b. The Date Refused field defaults to the current date. If needed, change the date by entering it manually or by clicking the Ellipsis button to select from a calendar. The date cannot be a future date.
 - c. If needed, enter comments about the refusal in the Comment field. This field is a free-text field that contains a right-click menu to help you in editing the entered text.
 - d. Click Add to add this record to the Personal Health component. (Otherwise, click Cancel.) The record shows in the Refusal section.

Birth Measurements	Refusal
Birth Weight=7 lbs 6 ozs (3.345241 kgs) ; Birth Order=1; Formula Started=12 M; Breast Stopped=18 M; Solids Started=18 M	09/03/2013: FH: Angina at less than 60 years (Snomed); Comment=Type comments here.
	07/29/2013: PPD (Skin Test); Comment=Test refusals
	07/29/2013: TETANUS (Skin Test); Comment=test refusal Snomed code
	04/25/2012: HIB (HBOC) (Immunization)

Figure 4-359: Completed Personal Health Refusal

4.12.9 Adding Treatment Contract Information

The Treatment Contract option is where you record that the treatment contract was made with the patient.

1. From the Personal Health component, select the Treatment Contract option and click Add (or select Add on the right-click menu) to display the Add Treatment Contract Record dialog.

Figure 4-360: Add Treatment Contract Record dialog

2. In the Type pane, select a type of contract from one of the following:
 - Pain
 - Mental Health
3. The Date Initiated field defaults to the current date. If needed, change the date by entering it manually or by clicking the Ellipsis button to select from a calendar. The date cannot be a future date.
4. If needed, the Provider field has a lookup utility where you can search for a name. See Using the Lookup Utility dialog for Provider.
5. Click OK to add the record to the Personal Health component. (Otherwise, click Cancel.)

4.12.10 Using the Lookup Utility dialog for Provider

You access the Lookup Utility by clicking the Ellipsis button at the end of the Provider field. You use this dialog to search for and select a name for the Provider field.

Follow these steps to complete the Lookup Provider dialog.

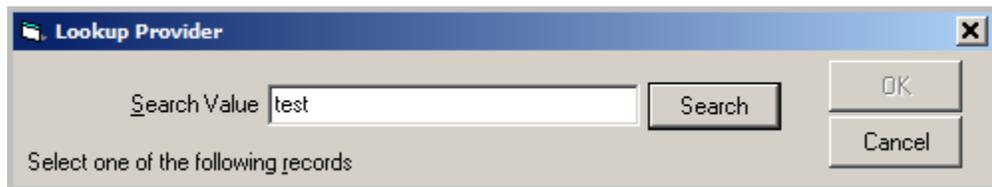


Figure 4-361: Initial Lookup Provider dialog

1. Type a few characters in the Search Value field and click Search. The appropriate names display in the lower panel of the dialog.
2. If this is not the correct data, repeat Step 1.

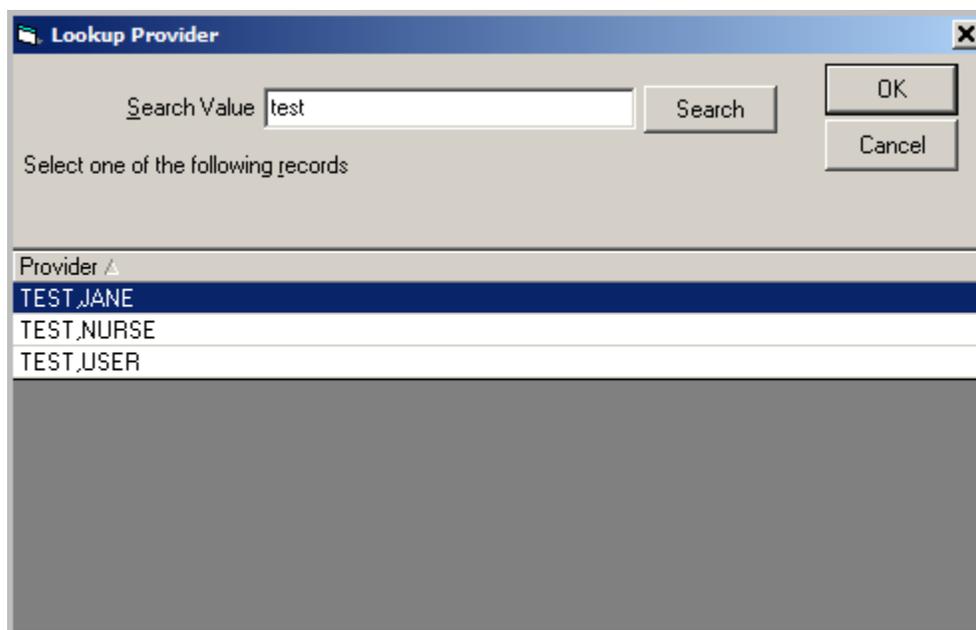


Figure 4-362: Lookup Provider dialog After Search

3. Highlight the appropriate name in the lower panel and click OK. The selected record populates the Provider field. (Otherwise, click Cancel.)

4.12.11 Editing Personal Health Records

The Personal Health panel may appear like this for a patient:

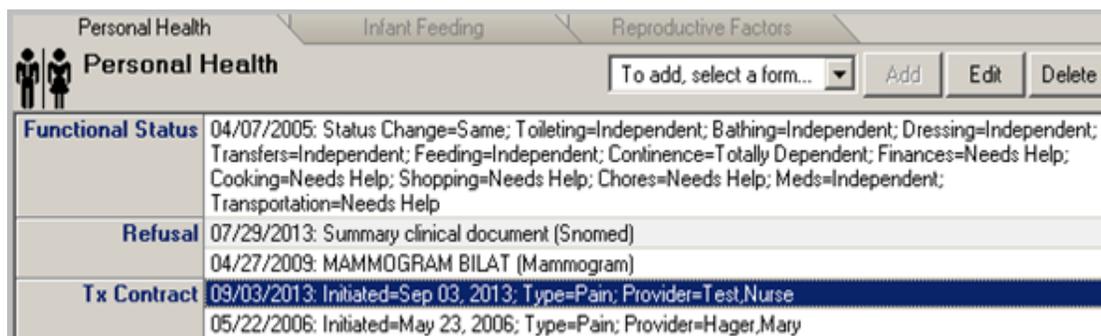


Figure 4-363: Editing Personal Health

There are two ways to edit Personal Health data:

- Edit by double-clicking the existing record in the grid. The appropriate dialog displays.
- Select an existing record and click Edit (or select Edit on the right-click menu). The appropriate dialog displays.

Make any changes, as applicable.

4.12.12 Deleting Personal Health Records

1. Select a record in the Personal Health panel that you want to delete and click Delete (or select Delete on the right-click menu). The Remove Record? information message displays.

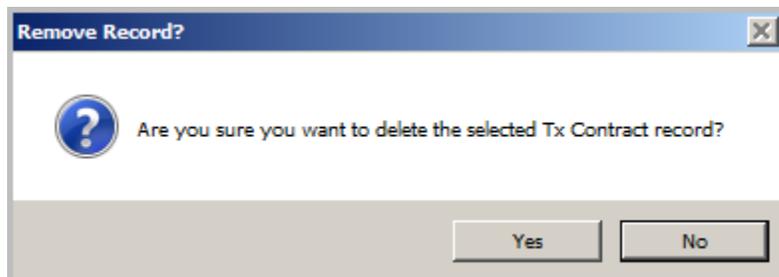


Figure 4-364: Remove Record Information Message

2. Click Yes to remove the selected record. (Otherwise, click No.)

4.13 Visit Diagnosis

The Visit Diagnosis is a view-only component that shows POV information for the current patient and information regarding the diagnosis for the visit.

SNOMED CT	Provider Narrative	Provider Text	ICD	Priority	Asthma Control	Cause	Injury Date	Injury Cause	Injury Place	Modifier	Onset Date
Gastroesophageal reflux disease	Gastroesophageal reflux disease provider text entry	provider text entry	530.81	Primary							
Reactive confusion	Reactive confusion this is the provider text	this is the provider text	290.2	Secondary							
Migraine without aura	Migraine without aura test	test	345.10	Secondary							

Figure 4-365: Visit Diagnosis Panel

View visit information by selecting a record, and then selecting View Visit Detail on the right-click menu. The Visit Detail dialog opens.

4.13.1 Web Reference Search Function

There are two Web Reference search options available from the Visit Diagnosis component that enables the user to look up information on a highlighted diagnosis from the Provider Narrative column on the Visit Diagnosis dialog:

- Education Information button ()
- Clinical Decision Support button ()

The Web Reference search depends on if any records are present or not when you click either button.

- **Condition 1:** If there are records present, select a record and click either the Ed Information or the Clinical Decision Support button.

Note: You can change to a different Web site, if desired, by selecting from the Reference Site drop-down list.

- **Condition 2:** If there are no records present or if no record is selected, click either the Education Information button or the Clinical Decision Support button to display the Web Reference Search dialog. The UpToDate Web site is the default.



Figure 4-366: Web Reference Search dialog

Select a different Reference Site from the drop-down menu, if needed. After entering a term and clicking Search, the selected Web site opens for the specified term.

4.13.1.1 Education Information Button

When a patient diagnosis is selected, click the Education Information button (). This sends a call to the MedlinePlus Web site to provide information regarding the selected topic and the MedlinePlus Web site opens to the related page.

Note: The Add Patient Education Event dialog also opens when the Education Information button is clicked. Patient education is tracked for Meaningful Use; therefore, the Add Patient Education Event dialog should be completed. Refer to the Patient Education Online Help for details on completing this dialog.



Figure 4-367: Medline Plus Web Site

4.13.1.2 Clinical Decision Support Button

When a patient diagnosis is selected, click the Clinical Decision Support button (). This sends a call to the UpToDate Web site to provide information regarding the selected topic and the UpToDate Web site opens to the related page.

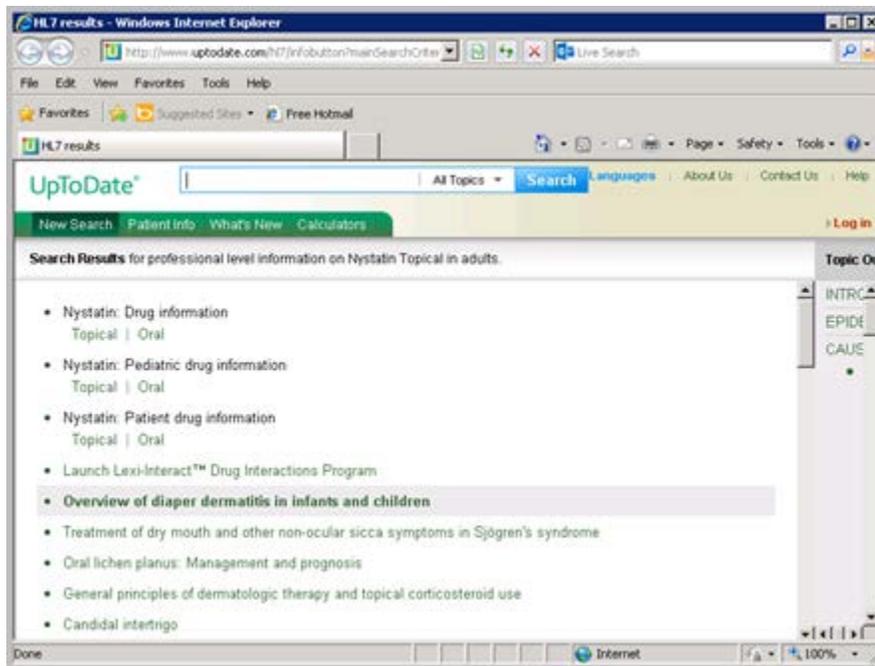


Figure 4-368: UpToDate Web Site

Appendix A: Image Viewer

The IHS Imaging Viewer object was developed to provide tight integration of images with reports in the IHS EHR application. To meet the requirements of Meaningful Use II, the context between images and reports must be maintained all times.

The EHR application is built on a flexible framework that allows the insertion of objects that communicate with the framework. The framework then handles all exchange of information with Resource and Patient Management System (RPMS).

VistA Imaging is used to attach images to Radiology Reports or Text Integration Utility (TIU) Progress Notes in RPMS. In the EHR application, Progress Notes and Radiology reports are displayed in tabs that are part of the patient's electronic medical chart. A user with access rights to Design Mode in the EHR application can add IHS Image Viewer objects to EHR templates. This allows users to easily display abstracts (thumbnail images) associated with a patient's Progress Note or Radiology Report. The IHS Image Viewer object also allows the user to open the full resolution viewer to further interact with the images.

The IHS Imaging Viewer has two distinct visual parts. The first visual part (which is inserted into the framework) communicates with the RPMS database, displays abstracts and launches the full resolution viewer when abstracts are selected for display. The second visual part is the full resolution viewer, which has no direct connection with the RPMS database. The full resolution viewer provides a rich set of tools to view and manipulate the images.

Additionally this document contains information about the setup and configuration of EHR application to support the Imaging Viewer.

A.1 Using the IHS Image Viewer

The workflow of the typical user is a search and display process. A particular patient becomes of interest for a clinical reason, a provider looks up the patient, examines the patient chart, discovers that the patient has documentation with attached images, and the provider accesses these images at will.

A.2 Client Configuration

A.2.1 Adding the IHS Imaging Abstract Viewer Object to a Template

3. To enter Design Mode, right-click the EHR title bar or press Ctrl/Alt/D on the keyboard.
4. Once in Design Mode, select the tab where you want to add the IHS Image Viewer object.

In a practical setting, the Notes and Reports tabs should have an IHS Image Viewer object inserted, since these are the only RPMS reports that have image indicators in the chart.

Note: CACs are generally the users given access to Design Mode.

5. Right-click in the area where you want to insert the IHS Image Viewer object into the EHR template.
6. Select Add Object from the Context menu.
7. Expand the Name item from the Object tree.
8. Scroll down the list of objects and select IHS Image Viewer.
9. Click Add.

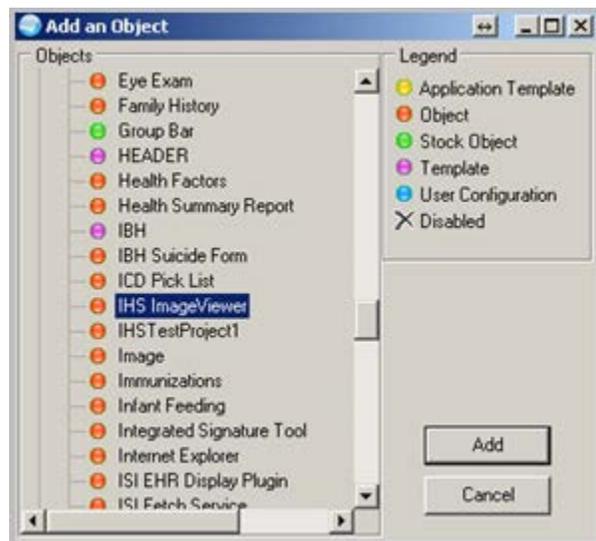


Figure A-1: Add an Object dialog

This inserts an IHS Image Viewer object into the selected area, which can be sized to fit the client area.

10. Access the properties by right-clicking the IHS Image Viewer object just inserted.
11. Select the Properties Context Menu.

A.2.1.1 Properties dialog

The Properties dialog contains the standard EHR object properties and additional custom properties. Two check boxes control what types of images are displayed in the IHS Image Viewer object, and another check box controls the object's appearance.

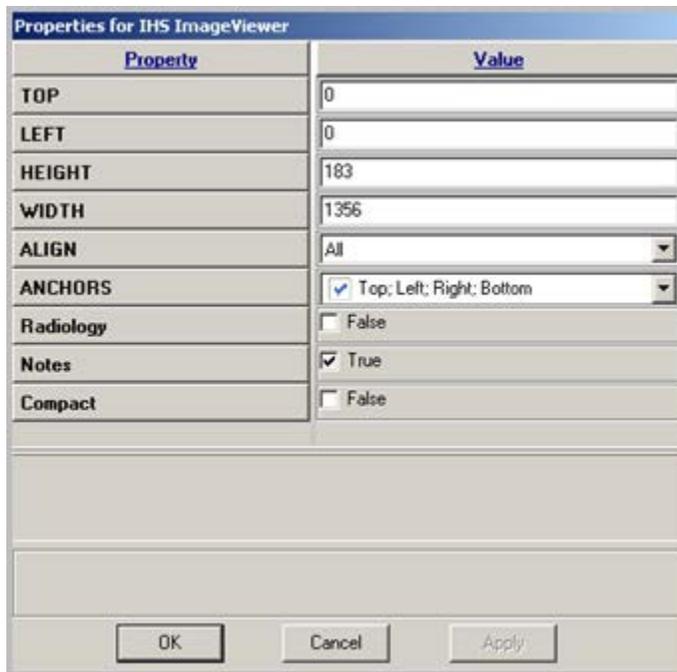


Figure A-2: Properties dialog

- When the Radiology check box is selected, the object displays Radiology images.
- When the Notes check box is selected, the IHS Image Viewer object displays images attached to progress notes. This enables the user to have IHS Image Viewer objects inserted into tabs that display radiology reports, progress notes or both.
- The Compact check box enables the IHS Image Viewer object to operate in compact mode. It is beneficial on very crowded tabs. In this mode the IHS Image Viewer object only shows the study information. When the user clicks an object, the abstracts are displayed in a popup window. Clicking outside of the pop up reverts the Abstract Viewer to its compact display. If the compact mode is not checked the abstracts and the study information is displayed within the object in detailed mode.

Clicking OK saves the settings for the selected IHS Image Viewer object.

1. Once the object is sized appropriately, click the Design menu.
2. Select the Save as Template menu item and click Save to save the current template. You can also select a different template from the list or create a new template.
3. Exit Design Mode by right-clicking the EHR title bar and selecting Design Mode from the context menu or press Ctrl/Alt/D on the keyboard.

The details of working with EHR templates can be found in the VueCentric EHR documentation, and are beyond the scope of this manual.

Once the IHS Image Viewer object is inserted and properly sized, the object properties must be set in order to view images.

Figure A-3 illustrates the IHS Image Viewer object inserted in Detailed Mode into the Notes tab:

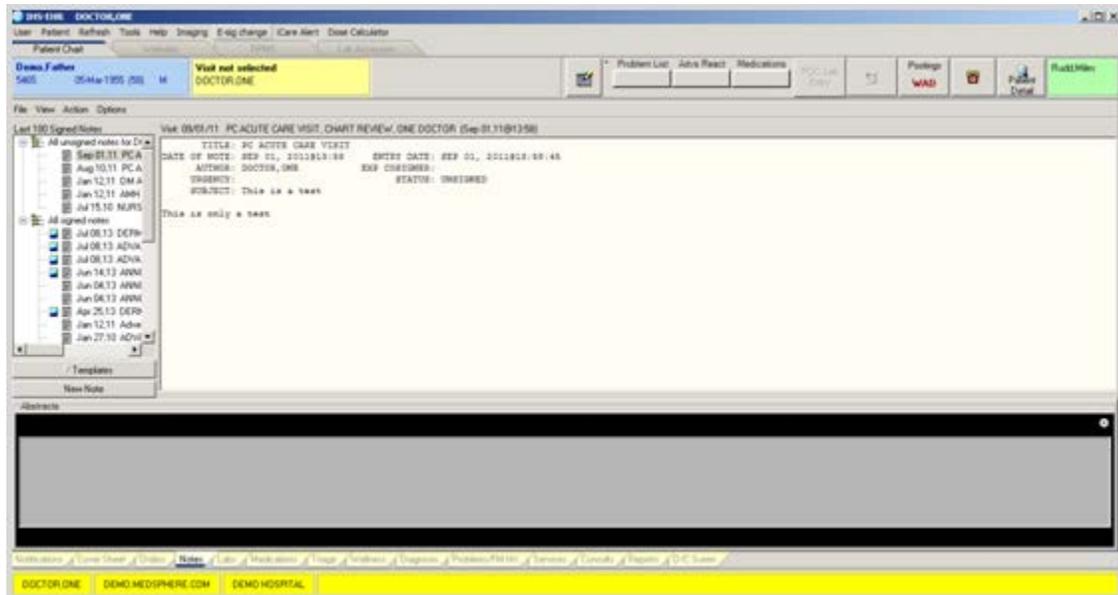


Figure A-3: IHS Image Viewer Object

A.2.1.2 IHS Image Viewer Property Settings

The user can access the Settings dialog for any of the inserted IHS Image Viewers by clicking the Settings (⚙️) icon on the upper-right corner of the IHS Image Viewer object. Figure A-4 displays the general settings.

General Tab

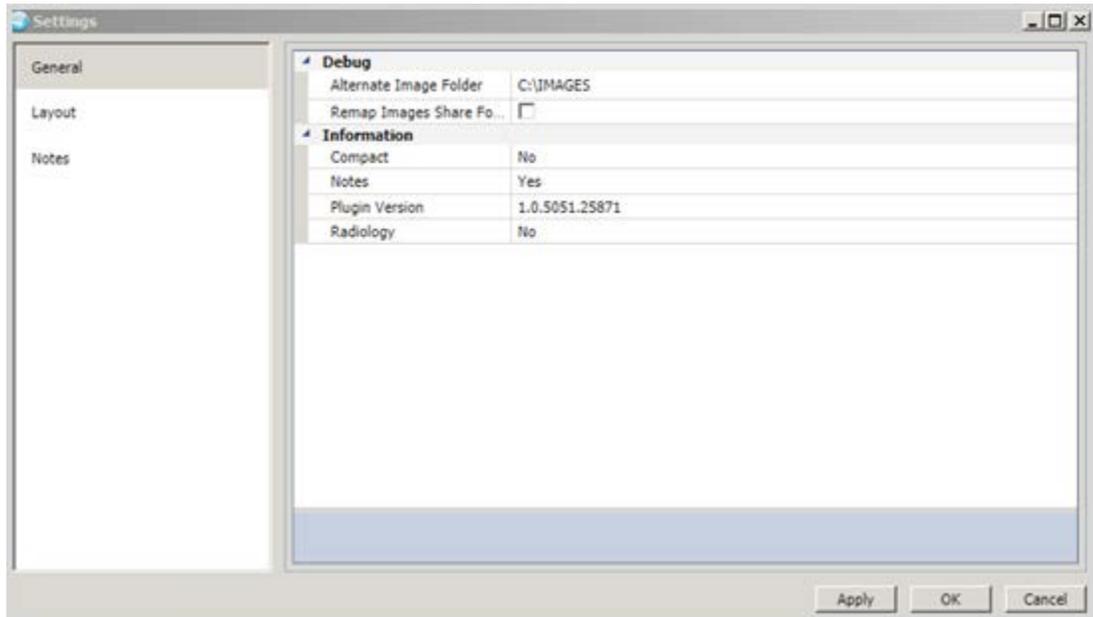


Figure A-4: Settings dialog – General Tab

On the General tab, the user may remap the image directory or force the install of the viewer component. These features are used for testing or troubleshooting.

Layout Tab

The Layout tab is used to control the appearance of radiology studies in the full resolution viewer.

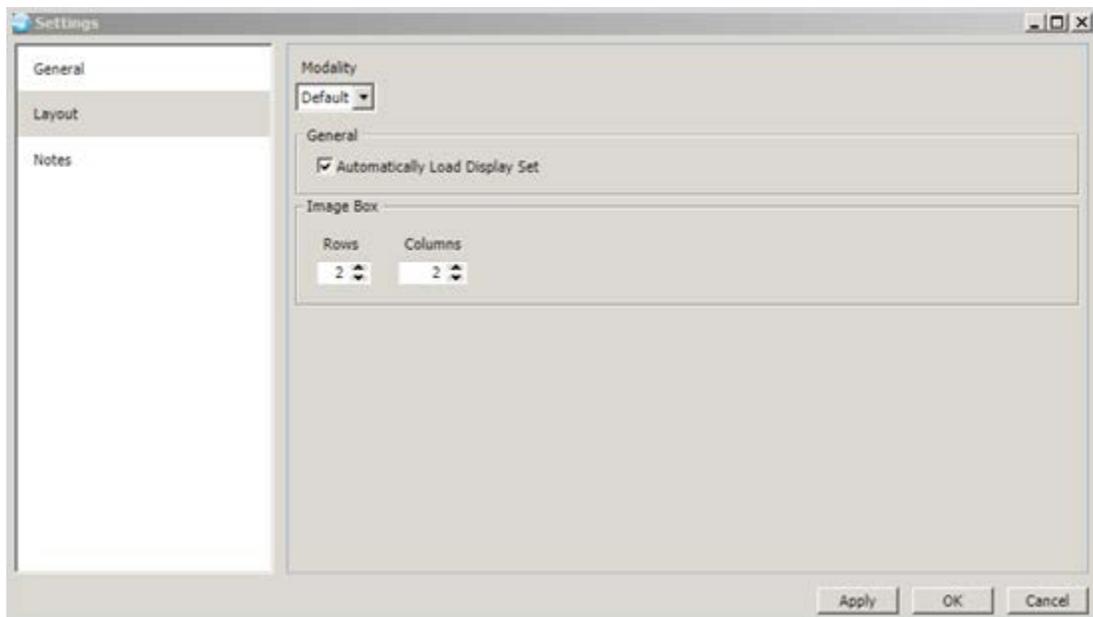


Figure A-5: Settings dialog – Layout Tab

The Layout tab provides the user with controls to select the full-resolution viewer layout based on the modality contained in the image headers. The default setting is used for the layout for modalities without specific layout definition.

The Automatically Load Display Set check box enables the loading of the entire study into the layout when the abstract is double clicked in the IHS Image Viewer object inserted into the Notes or Reports tab.

The expanded Modality drop-down list illustrates the currently supported Modality types.

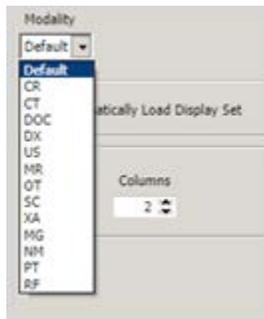


Figure A-6: Modality Drop-down List

The layout enables the user to select optimum configurations for the most common radiology procedures.

Notes Tab

The Notes tab controls the initial layout of the viewports on the notes tab of the full resolution viewer.

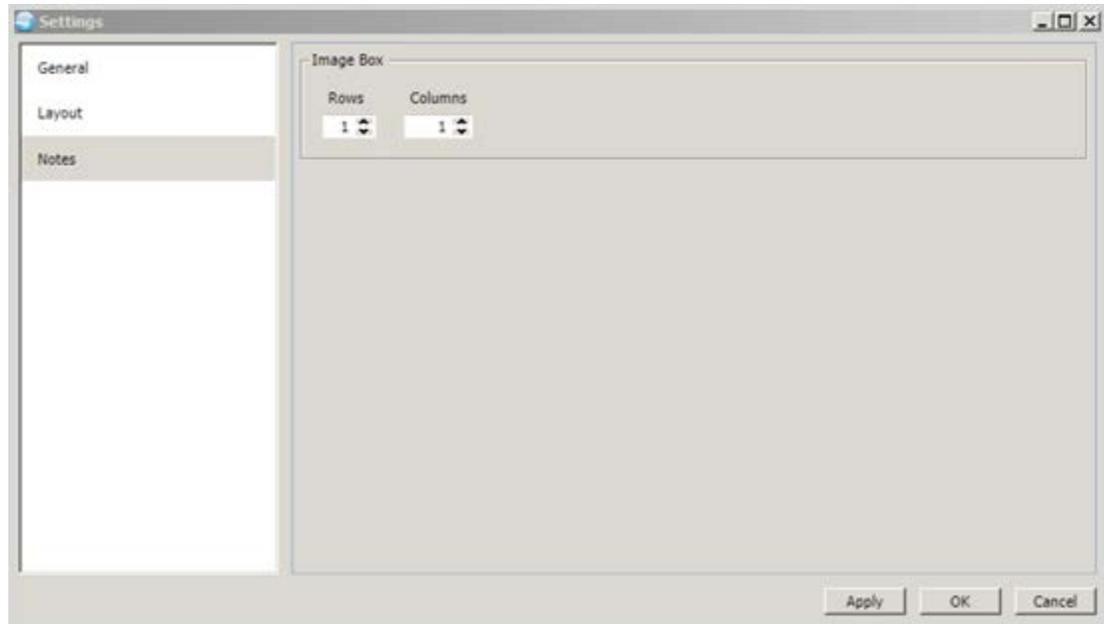


Figure A-7: Settings dialog – Notes Tab

The Image Box Row and Column selector controls the initial division of the full-resolution viewer into image boxes (also known as viewports).

A.3 Using the IHS Image Viewer

The workflow of the typical user is a search and display process. A particular patient is of interest for a clinical reason. The provider looks up the patient, examines the patient chart, discovers that the patient has documentation with attached images, and the provider can access these images at will.

A.3.1 Selecting a Patient

The top-left corner of a chart usually contains the patient pane.

Note: Sites may configure this area for their specific use, so there is no guarantee that the Patient Information pane will be in the same location.

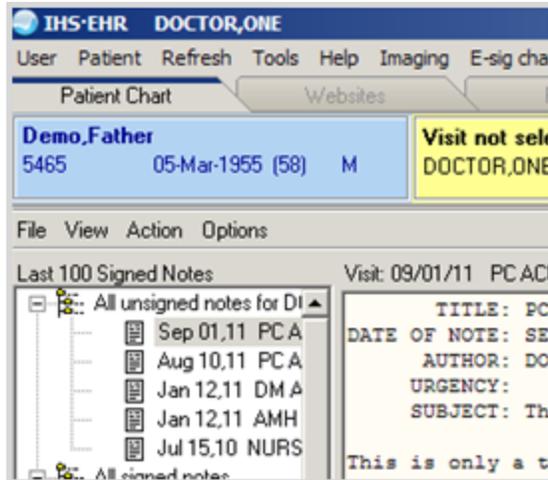


Figure A-8: Patient Chart

Selecting the Patient Information pane brings up the Patient Search tool.

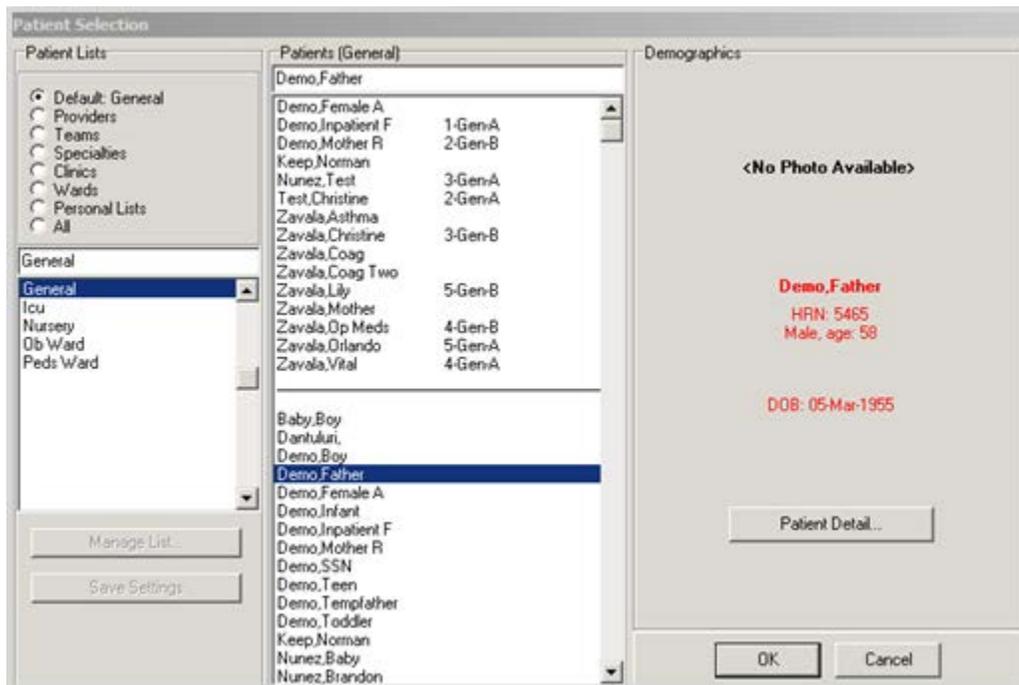


Figure A-9: Patient Search Tool dialog

A.3.2 IHS Image Viewer Object

Once a patient is selected, the user may interact with the IHS Image Viewer object inserted into one of the tabs. Figure A-10 shows a Detailed Abstract Viewer inserted into the Notes tab. When the Notes tab is selected and a note without images is selected, the Abstract Viewer is cleared.

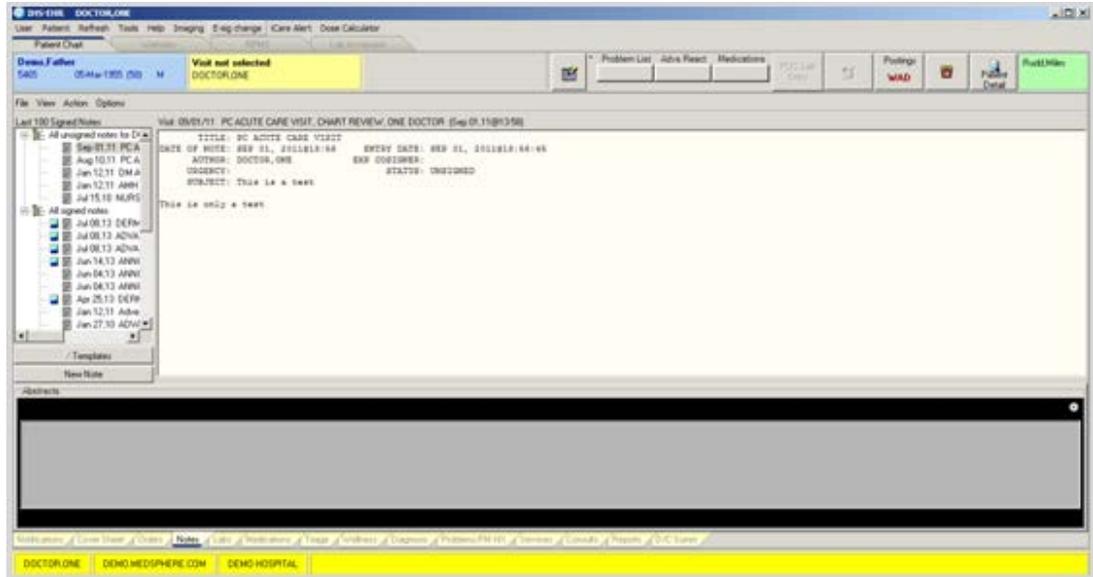


Figure A-10: Detailed Abstract Viewer

A.3.2.1 Notes

When a note with attached images is selected, the Abstract Viewer loads the images and displays an abstract for each series of images attached. In most cases, note images have a single image in each series. Therefore, each abstract usually represents a single image.

Some of the more advanced imaging modalities may generate DICOM series of images attached to TIU notes, in which case an abstract may represent multiple related images.

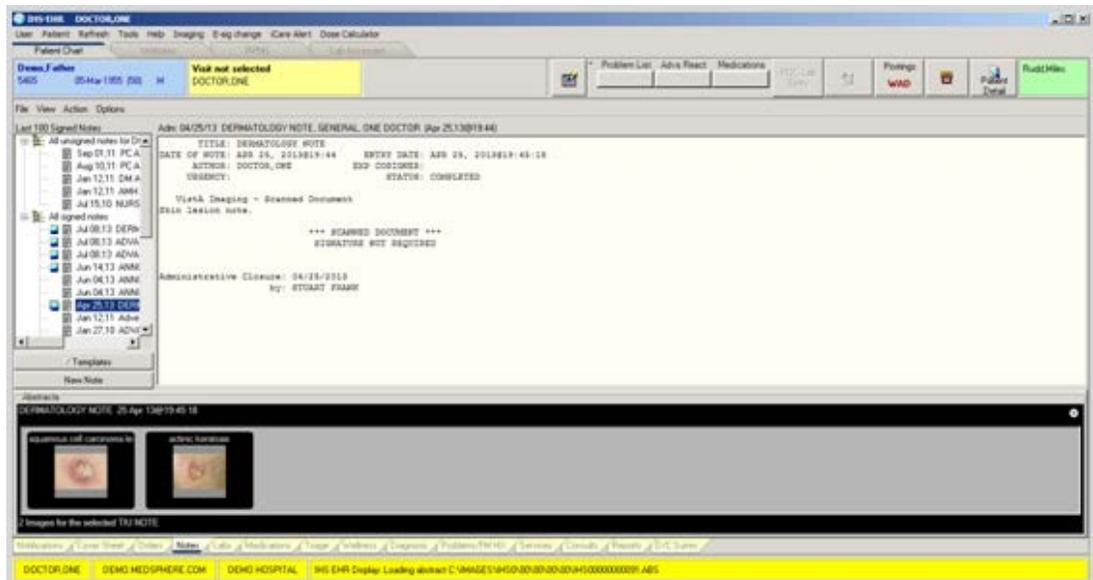


Figure A-11: DICOM Image Series Attached to Notes

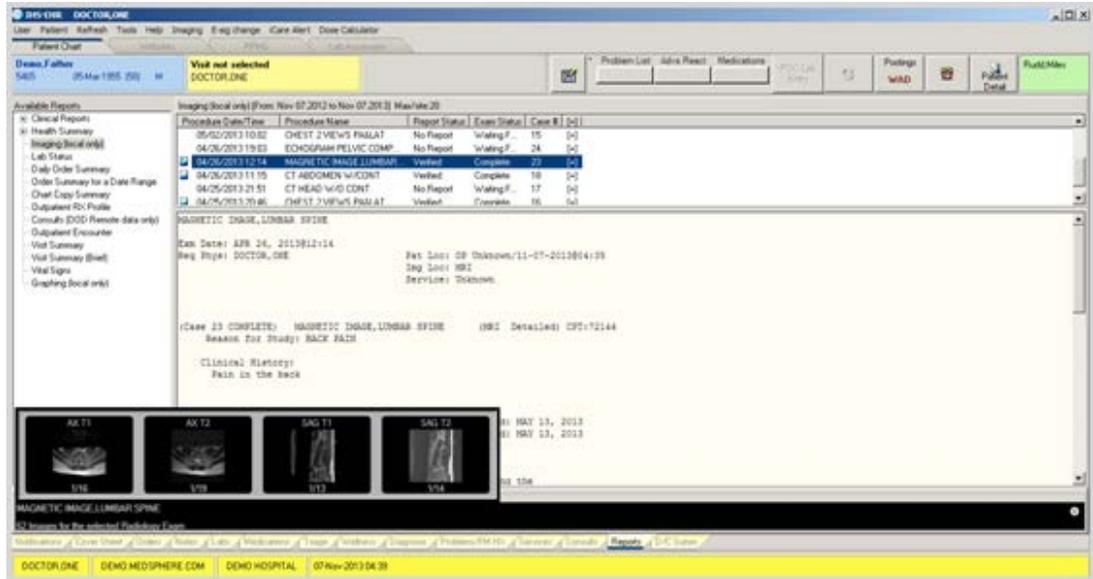


Figure A-14: Abstracts Loaded in the Abstract Viewer

A.3.3 Full Resolution Viewer

Selecting an abstract opens the full resolution viewer and loads the image into the viewports.

Figure A-15 displays the full resolution viewer for images attached to a Note.



Figure A-15: Image-Attached Notes

Selecting a Radiology abstract opens the full-resolution viewer and loads the images into viewports **if** the Autoload setting is selected in the object properties.

If the Autoload setting is not selected, the user can take one of two actions:

- Select an abstract and drag it to an unused viewport.
- Double-click an abstract, which causes all the images of the case loaded into memory and the series of the case to populate the viewports from the upper-left corner of the grid.

Figure A-16 represents a set of radiology images in the full resolution viewer:



Figure A-16: Radiology Images in Full Resolution Viewer

A.3.4 Working with Note Images

Once images associated with notes are loaded into the full-resolution viewer and automatically arranged into viewports, the user may start interacting with these images.

It is important to recognize that if a set of note images cannot fit into the configured number of viewports, the viewer allows paging through multiple sets of images. This is accomplished by using the viewer tools on the Notes tab. The number of images attached to the case and the number of viewports visible in the viewer, determine the number of pages occupied by images.

When there are more than one page of images, the viewer enables the Up and Down Arrow buttons as appropriate. Clicking the Down Arrow reveals the next page of images, while clicking the Up Arrow displays the previous page.

To dynamically change the layout click the Grid button () to launch the Layout Selection tool.

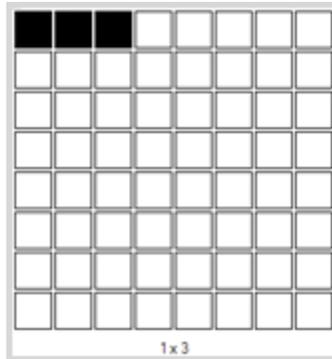


Figure A-17: Layout Selection Tool

The tool's shaded squares represent the grid layout to be applied to the viewer. Once the final selection is made, the viewer renders the case in the selected layout, where the top-left corner Viewport of the grid will be occupied by the image that is in the current layout's top-left Viewport.

The Viewport tools are used to manipulate image presentation.



Adjusts the image magnification to fit the width of the viewport. The operation preserves the Image's aspect ratio



Adjusts the image magnification to fit into the viewport in both vertical and horizontal direction while preserving the image's aspect ratio



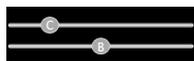
Magnifier tools can be used to increase or reduce the magnification of the image



Rotates the image 90 degrees to the left or to the right



Resets the image to the presentation that was used to when the image was loaded



Sliders adjust brightness and contrast

A.3.5 Working with Radiology Images

The loading of radiology images is controlled by the modality specific Layout settings. A radiology case may be auto loaded and laid out using all available Viewports, or may only load into the full resolution viewer's abstract strip. The user may, at any time, drag an abstract to an unused Viewport, or double-click an abstract to load the entire case into the available Viewports.

A.3.5.1 Viewports

The Viewer uses one or more Viewports for image display. A Viewport can contain a single image or a group of related images. How images are displayed is largely

dependent on the organization of the DICOM study. As a general guideline one can expect that:

- Images of a general radiology (CR or DX) exam are usually displayed one image per Viewport.
- Images of CT or MR exams are usually divided among several Viewports:
 - One viewport per series (or sequence)
 - Optionally one Viewport for scout (localizer) images

Images in a Viewport can be adjusted independently from images in other Viewports. Within a Viewport, all images can be adjusted at once or single images can be adjusted independently.

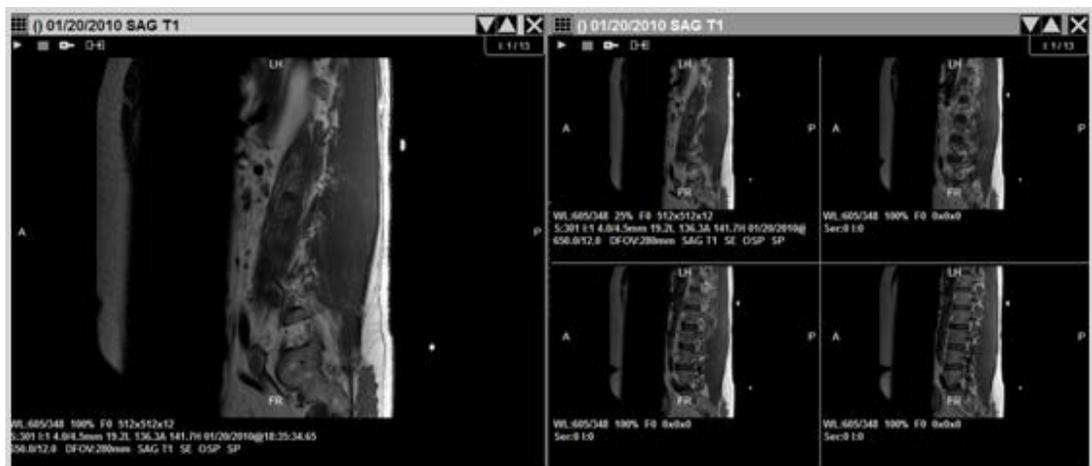


Figure A-18: Viewport Images

Viewports can display one image at a time (stacked view) or several images at once (tiled view). Users can switch between views without having to reload an exam.



Figure A-19: Viewport Display

The Title Bar

The Viewport Title bar displays the case ID, status and date of the exam. The Viewport Title bar may also display other information, such as the series ID.

If there is not enough space to display all the text in the Viewport Title bar, pause the mouse pointer over the title bar to make it expand and display all its contents.

The Contents Bar

The Contents bar is located in the upper-right corner of a viewport. It displays the number of exams, image sets (series), and images in the viewport.

Tick Marks

In viewports that contain multiple images, the relative position of the selected image in the stack is indicated by tick marks on the left side of the viewport. The I label in the Contents bar can also indicate the position of an image in the stack.

The Image Information Area

The information area at the bottom of a viewport displays such details about the selected image as image number, acquisition date/time, the image's current display properties (window/level, scale, and so on), and other acquisition data.

If there is not enough space to display all image information, you can pause the mouse pointer over the area to make it expand and display all its contents.

Clicking the information area opens the Image Detail window.

A.3.6 Manipulating Images

A.3.6.1 Changing Image Properties

The following changes can be made to images displayed in viewports:

- Scale
- Pan
- Window/Level
- Invert
- Orientation
- Sharpness
- Reset

Scaling Images

An image can be dynamically zoomed from 5% to 800%, or it can be scaled to a specific percentage of its original size. You can also expand an image in the Viewer window to the size of an entire screen.

As an image's scale is changed, the current scale percentage is shown in the image information area at the bottom of the viewport.

To Change Scale Dynamically

Select the image you want to scale and drag it with the right-mouse button while pressing the Ctrl key.

You can also turn on the Scale tool (). To do this, click the toolbar or right-click any image. Then click Scale and change scale by dragging with the left-mouse button.

When you have finished using the scale tool, turn it off by right-clicking once.

To scale an image to a specific size:

1. Click the Scale tool () in the toolbar or right-click any image.
2. Click Scale.
3. Point to the image you want to change and do any of the following:

To...	Do this...
Scale image to 100%	Point near the top-left corner of the viewport. When the mouse pointer changes to  , Click once.
Scale image to fit viewport	Point near the top middle part of the viewport. When the mouse pointer changes to  , click once.
Scale image to 50, 75, 125, 150, or 200%	Point near the top-right corner of the viewport. When the mouse pointer changes to  , click once. Then click a scale option in the menu that displays.

Note: While the Scale tool is turned on, you can also zoom in or out by dragging with the left-mouse button.

- Continue using the Scale tool, or disable it by right-clicking once or by choosing another tool.

To use full-screen view:

- In the Viewer window, double-click an image. The image expands to fill an entire screen.
- While the full-screen view is active, you can:
 - Adjust (window/level, flip/rotate, and so on) the current image.
 - Scroll to other images or use the Cine tool.
- When you have finished, double-click the image to restore it to its original size.

Panning images

To pan an image, point to the image you want to pan and drag using the left-mouse button. Images that are completely visible cannot be panned.

Note: If the image does not pan, right-click once to make sure that no other tools are active. (The mouse pointer looks like this when no tools are active: ).

Changing Window/Level

You can change an image's window/level using the mouse, the keyboard, or a combination of both. You can also use the Auto-Window/Level tool to base window/level values on a selected area in an image.

As an image's window/level is changed, the area under the image updates to show the current window/level values. Unless Apply To settings have been changed, window/level changes affect all images in the viewport.

To change window/level:

1. Point to the image you want to adjust and drag it using the right-mouse button.
 - Drag up or down to change window (window width) values.
 - Drag left or right to change level (window center) values.
2. You can also click the Window/Level tool () in the toolbar and change window/level by dragging it with the left-mouse button.
3. When you have finished using the Window/Level tool, turn it off by right-clicking once.

To use the auto-window/level tool:

1. Click the Auto-Window/Level tool () in the toolbar.
2. In the image you want to adjust, drag the mouse pointer to define a rectangular area that includes the tissue you want to base the window/level on.
3. When the drag/highlight is completed, the new window/level values are applied to the entire image.
4. Continue using the Auto-Window/Level tool, or disable it by right-clicking once or by choosing another tool.

Inverting Grayscale Values

You can invert grayscale values to create a Negative view of an image.

To invert an image:

1. Click the Invert tool () in the toolbar, or right-click any image and click Invert.
2. Click the image you want to invert.
3. Continue using the Invert tool, or disable it by right-clicking once or by choosing another tool.

Reorienting Images

You can change an image's orientation by rotating it 90 degrees or by flipping it front-to-back. As changes are made, any positional indicators displayed near the edges of the image are updated to reflect the new orientation. (This does not include markers that are burned into the image itself.)

To rotate images 90 degrees:

1. Click the Rotation tool () in the toolbar.
2. Point to the image you want to rotate.
 - To rotate the image counterclockwise, click on the left side of the image.
 - To rotate the image clockwise, click on the right side of the image.
3. Continue using the Rotate tool or disable it by right-clicking once or by choosing another tool.

To flip images:

1. Click the Flip tool () in the toolbar.
2. Point to the image you want to flip.
 - To flip the image vertically, click the top part of the image.
 - To flip the image horizontally, click the bottom part of the image.

Changing Layout

You can specify the layout (number of rows and columns) in a window and in each viewport. The layout of each viewport or window can be set independently.

To use full-screen view:

- In the Viewer window, you can double-click an image to expand it to fit the current screen.
- While you are in full-screen view, you can adjust the image or scroll to other images.
- When you have finished, double-click again to return to the original screen layout

To change layout in a viewport:

1. In the upper-left corner of a viewport, click the Layout tool () and drag it down using the mouse.
2. In the grid that displays, move the mouse until the desired number of rows and columns are highlighted.
3. Click the left-mouse button.

Note: Layout cannot be changed if the viewport contains only one image.

To change layout in the Viewer:

1. In the toolbar, click the Viewer Layout tool () and drag down using the mouse.
2. In the grid that displays, move the mouse until the desired number of rows and columns are highlighted.
3. Click the left-mouse button.

Copying Properties

You can copy properties, such as window/level, scale, position (pan), and orientation, from one viewport to another. You can copy several properties at once, or copy a single property only.

To control which properties are copied:

1. In any occupied viewport, click the Copy tool () and drag down to display the drop-down menu.
 - A check mark indicates properties to be copied
 - The absence of a check mark indicates properties that will not be copied
2. Select a property to add or remove a checkmark. The settings you choose affect all viewports in all windows, and will be retained for the duration of your session.

To copy properties (Copy icon):

1. Select the image with the properties you want to copy.
2. Click the Copy tool () in the source viewport.
3. Click an image in the target viewport.
4. Continue using the Copy tool, or disable it by right-clicking once or by choosing another tool.

To set initial copy settings:

1. In the Viewer or Manager toolbar, click View | Settings.
2. Click the Viewport tab.
3. In the Copy Options area, select each property to be copied when the Copy Properties feature is used.
4. Click OK.

Linking Viewports

Viewports in the Viewer can be linked. When viewports are linked, scrolling and paging changes made in one viewport affect all linked viewports. Changes to scale,

orientation, and so on, performed in one viewport can affect all linked viewports as well.

When viewports are linked, the Link icon located near the top of the viewport appears as follows:



When viewports are not linked, the Link icon changes appearance:



To link viewports:

If the viewports being linked contain images from different exams, select anatomically equivalent areas in each viewport before creating the link.

1. In one of the viewports you want to link, click this Link tool ().
2. Click each viewport you want to link. As the link is established, the Link icon will change (.
3. When you have finished, right-click once to turn off the link function. Links are retained until the exam is closed or until the link is explicitly removed.
4. Scroll or adjust the contents of one of the linked viewports as desired. Changes are reflected in all linked viewports.

Important: If the linked viewports contain images from the same exam (for example, all images have the same Frame of Reference UID), each viewport shows the same anatomy as you scroll or page through images in the linked viewports.

To unlink viewports:

1. Use either of the following methods:
 - Point to the viewport you want to unlink, press the Ctrl key, then click the Link tool (.
 - In the viewport you want to unlink, click the Link tool () and drag-down a short distance with the mouse.
2. Click Unlink.

To control which properties are linked:

1. In a linked viewport, click the Link tool () and drag-down to open the drop-down menu.

- A check mark indicates that changes for a particular property have been applied across all linked viewports.
 - The absence of a check mark indicates that changes for a particular property have been applied to the current viewport only.
2. Select a property to add or remove a checkmark.

The settings you choose affect all linked viewports until the viewports are cleared. If there are multiple links active, settings for each link group can be set independently.

Moving Image Sets

Images can be moved from one viewport to another.

To move images:

1. Locate the viewport you want to use as the target viewport.
 - The target viewport can be empty, or it can contain a single image set.
 - The target viewport cannot contain more than one image set. The Contents bar in the upper-right corner indicates how many image sets (series) are present.
2. Drag the title bar of the viewport that contains the images you want to move into the target viewport.
 - If the source viewport contains any hidden image sets, the next hidden image set is displayed when the move is completed.
 - If the target viewport was previously occupied, your current drag and drop settings determine if the contents of the target viewport are swapped or replaced.

Sorting Image Sets

Images in a viewport are automatically sorted based on information from the acquisition modality. If necessary, you can override the default sorting used and set your own sort order.

A.3.6.2 Using the Cine Tool

Starting and Stopping the Cine Tool

1. If there are multiple images visible in the viewport (tiled view), click the image that you want to use as a starting point.
2. Click the Arrow () located in the upper-left corner a viewport.
3. When you have finished, click Halt () to stop the Cine tool.

To Set Cine Speed

1. Open the Cine drop-down menu by clicking the Arrow () or Halt () and dragging-down with the mouse.
2. Point to Speed, then click Low, Medium, or High.

Note: To set the default cine speed, click View | Settings | Viewport, then choose an option from the Cine Speed box.

To Set Cine Direction

1. Open the Cine drop-down menu by clicking the Arrow () or Halt () and dragging-down with the mouse.
2. Point to Direction and click Loop Forward, Loop Reverse, or Yoyo.
 - The direction you choose takes effect immediately, including any currently running Cines.
 - All viewports are affected by the change.

Note: To set the default Cine direction, click View | Settings | Viewport, then choose an option from the Cine Direction box.

To Set the Cine Range

1. If the Cine tool is running, stop it by clicking Halt (.
2. Display the image to be the first image in the Cine range.
3. Open the Cine drop-down menu by clicking the Arrow () and dragging-down with the mouse.
4. Point to Range, then click First Cine Image.
5. Display the image to be the last image in the range.
6. Open the Cine drop-down menu by clicking the Arrow () and dragging a short distance with the mouse.
7. Point to Range, then click Last Cine Image.

To Reset the Cine Range

1. Open the Cine drop-down menu by clicking the Arrow () or Halt () and dragging-down with the mouse.
2. Point to Range, then click Reset.

Using Sharpen/Smooth

You can apply sharpen/smooth filters to an image. Unless Apply To settings have been changed, sharpen/smooth changes affect all images in the viewport.

The info area at the bottom of each viewport displays which filter is used, where F+N indicates a sharpen filter, and where F-N indicates a smooth filter.

Sharpening or Smoothing an Image

1. Click the Sharpen tool () in the toolbar; or right-click any image and then click Sharpen.
2. Point to the image you want to adjust and drag the mouse using the left-mouse button.
 - To increase sharpness, drag up or left.
 - To decrease sharpness, drag down or right.
3. Continue using the Sharpen/smooth tool, or disable it by right-clicking once or by choosing another tool.

A.3.6.3 Mensurated Scale

When an image is displayed, a mensurated scale is displayed on the left side of the image's viewport. The scale uses pixel size data in the image header. If there is no pixel size data available for the image, you can use the Calibrate tool to establish a pixel size. See Using Calibrate for addition information.

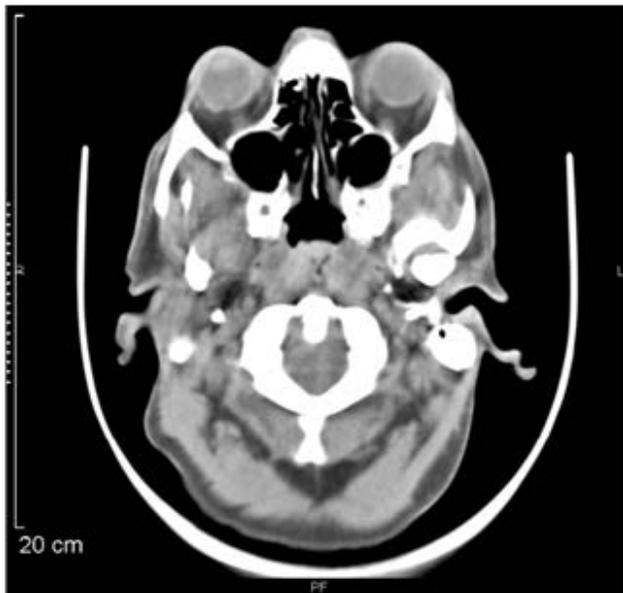


Figure A-20: Mensurated Scale

To display the mensurated scale:

1. With an image in the viewport, right-click to display the Context menu.
2. Click the Mensurated scale option from the menu. The scale displays to the left of the image.

To remove the mensurated scale from view:

- Right-click the image to display the Image Context menu,

A.3.6.4 Annotations**Annotation Basics**

You can use annotations to call attention to areas of interest in an image. You can also add text labels or measure image features. Annotations that are added during a session are not saved with the image and will be discarded when the Image Viewer is closed.

Adding Shapes and Labels

You can add lines, shapes, and text to an image.

Note: Any hidden annotations in an image are displayed when you select an annotation-related tool.

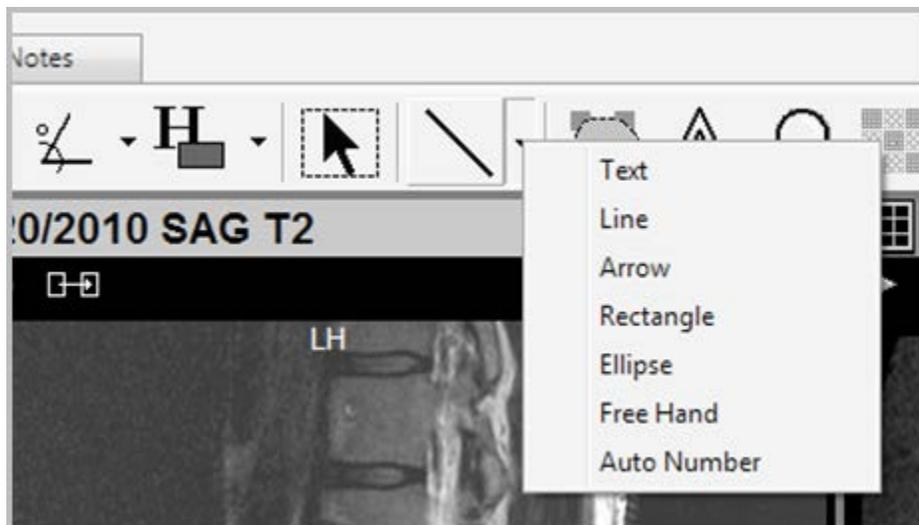


Figure A-21: Annotation Tools

To add lines and arrows:

1. Use the Annotation button in the toolbar to turn on the Line or Arrow tool.
2. Set the start point of the line, drag the mouse, and release the mouse button when the line or arrow is the desired length.

3. You can add additional annotations, select a different tool, or right-click once to turn off the active tool.

To add rectangles and ellipses:

1. Use the Annotation button in the toolbar to turn on the Rectangle or Ellipse tool.
2. Drag the mouse to draw the line or shape. An outline displays as you drag the mouse.
3. Release the left-mouse button when the outlined area is the desired size.
4. You can add additional annotations, select a different tool, or right-click once to turn off the active tool.

To add freehand shapes:

1. Use the Annotation button in the toolbar to turn on the Free Hand tool.
2. Outline the area of interest by clicking three or more spots around its area.
3. Right-click once to stop adding handles.
4. Continue adding a new freehand shape, or right-click a second time to turn off the tool.
5. To make adjustments to the freehand shape, enable edit mode, then drag the handles as needed. See *To edit annotations* for additional information.

To add text labels:

1. Turn on the Text tool by doing one of the following:
 - Use the Annotation button in the toolbar to turn on the Text tool.
 - If the button noted previously is not visible, click the arrow next to the Annotation button () , then click Text.
2. In the image you want to annotate, drag the mouse to define a box that contains the text. When you complete the drag, a blinking cursor is displayed in the box.
3. Type the text that you want to appear in the box.
 - The text you enter wraps, based on the width of the box.
 - You can copy text to and from the text box using Ctrl+C and Ctrl+V.
 - To add a line break, use the Enter key.
4. Click once outside of the box to finalize your edits.
5. You can add additional annotations, select a different tool, or right-click once to turn off the active tool.

To add auto numbers:

1. Turn on the Auto Number tool by doing one of the following:
 - If the button noted previously is not visible, click the arrow next to the Annotation button, then click Auto Number.
 - In the Auto Number dialog that displays, click the buttons that correspond to the numbering style and starting point you want to use.
2. Click each point in the image where you want a number to appear.
3. Add additional numbers, select a different tool, or right-click once to turn off the active tool.

Note: Spinal labels are incremented from C1 to L6. After L6 is used, auto-numbering is turned off automatically.

A.3.6.5 Adding Measurements

You can measure lengths, areas, angles, and Hounsfield values in an image. If you want measurements to be saved, make sure the exam is locked before adding measurements.

Note: Before measuring a small image feature, increase the scale of the image to improve the placement of the measurement.

To measure lines:

1. Click the Measure | Length tool () in the toolbar, or right-click an image and choose Measure | Length.

Note: If the mouse pointer changes, you must use the Calibrate tool before proceeding.

2. Point to the part of the image from which you want to begin measuring.
3. Drag the mouse to create the measurement line. Once you have finished dragging, a label appears next to the line, displaying the measurement.
4. Drag the text results to reposition as needed.

Note: If the measurement label includes a (c) or a (c*) label, the measurement is based on a manual calibration, rather than on a modality-defined pixel size.

5. Continue adding measurement lines or right-click once to turn off the tool.

To measure angles:

1. Click the Measure | Angle tool () in the toolbar, or right-click an image and choose Measure | Angle.
2. Drag the mouse to draw the first line of the angle. The second line of the angle is automatically created.
3. Drag either or both lines by their handles to adjust the angle.
4. Drag the text results to reposition as needed.
5. Continue adding angles, or right-click once to turn off the tool.

To measure Cobb angles:

1. Click the Measure | Cobb Angle tool () in the toolbar, or right-click an image and choose Measure | Cobb Angle.
2. Starting with the top-most line to be drawn, drag the mouse to create the line. The program automatically creates the second line.
3. Reposition the lines as needed by dragging the handles. Drag the text results to reposition as needed.
4. Continue adding angles or right-click once to turn off the tool.

A.3.6.6 Using the Hounsfield Tool

The Hounsfield tool offers the capabilities to measure areas captured in ellipse or freehand shape, as well as rectangles.

To measure rectangular or elliptical areas:

1. Select the area to be measured.
2. Set the start point of the rectangle or ellipse.
3. Drag the mouse and release the mouse button when the ellipse covers the desired area.
4. Drag the end-points of the perpendicular lines as needed to adjust.
5. Drag the text results to reposition as needed.
6. Continue adding Hounsfield measurements, or right-click once to turn off the tool.

To measure freehand areas:

1. Outline the area to be measured by clicking three or more spots around its area.

2. Right-click once to stop adding handles.
3. Continue adding a new freehand measurement, or right-click a second time to turn off the tool.
4. To make adjustments to the measurement, enable the Edit mode.
5. Reposition the text results or drag the handles as needed. See To edit annotations for additional information.

A.3.6.7 Working with Annotations

To move annotations:

1. Click the Select tool () in the toolbar.
2. Click the Lock tool () near the annotation you want to move. Or right-click the annotation, and choose Edit Annotation.
3. Once you have finished, you can resize, move, or edit other annotations, or you can right-click once to turn off the tool.

To resize annotations:

1. Click the Select tool () in the toolbar.
2. Click the Lock tool () near the annotation you want to resize. Or right-click the annotation, and choose Edit Annotation.
3. Drag any of the sizing handles to change the size of the annotation.

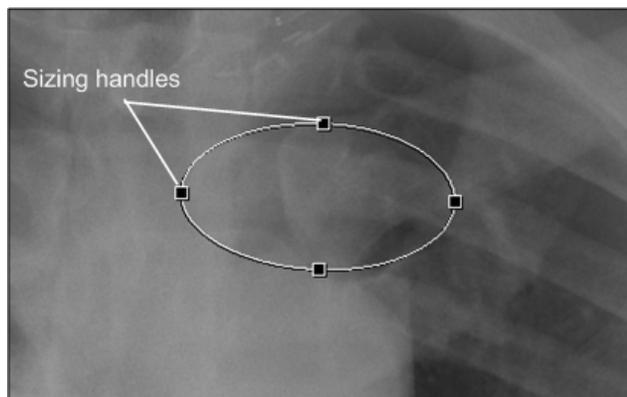


Figure A-22: Sizing Handles

4. Once you have finished, you can resize, move, or edit other annotations, or you can right-click once to turn off the tool.

To edit annotations:

1. Click the Lock tool () near the annotation you want to edit. Or right-click the annotation, and choose Edit Annotation.

Note: Only one annotation at a time in an image can be unlocked for editing. Clicking the Lock tool () on an annotation releases only that particular annotation from its locked state.

2. Make the changes you want to the annotation by clicking and dragging handles in a drawing tool, or clicking and dragging endpoints in a line.

Note: While in Editing mode, the Arrow drawing tool has handles to drag for repositioning and re-sizing. However, to facilitate precise measurement, the Length-Measurement tool does not. When the cursor hovers at the line's endpoint, crosshairs display to show the cursor is in the correct position for clicking and dragging the line.

3. Right-click once to turn off the tool.

To edit text labels:

1. Click the Select tool () in the toolbar to turn on the Select Annotation tool, or right-click the text annotation you want to edit.
2. Double-click the text annotation.
3. Edit the text.
4. Click once outside the text annotation to finalize your edits.
5. Once you have finished, you can resize, move, or edit other annotations, or you can right-click once to turn off the tool.

A.3.6.8 Using Calibrate

The Calibrate tool displays automatically if you try to measure an image that does not have a modality-defined pixel size. If the image in question has an embedded measurement scale, you can use the embedded scale and the Calibrate tool to set a pixel size manually.

If the Calibrate tool has been used, measurement values display one of the following:

- A (c) label indicates that pixel size was set manually.
- A (c*) label indicates that a manually defined pixel size has been used to override a modality-defined pixel size.

To use the Calibrate tool:

1. If the Calibrate tool is not already turned on, click the  tool in the viewport and drag-down to open the drop-down menu.
2. Click Calibrate.
3. While the mouse pointer appears in this mode () , draw a line between the two points that you want to use to establish a measurement standard.
 - a. The Calibrate Image dialog displays as you start drawing the line.
 - b. If the line is not ideally placed, you can re-draw the line.
4. In the Calibrate Image dialog, enter the length of the line that you drew, and then choose the unit length (centimeters, millimeters, or inches).
5. Check the Apply to Image Set check box if you want this calibration to be used for all images in the image set. Otherwise, the calibration applies to the individual image only.
6. Click OK.

Note: To remove calibration settings for a viewport, clear and reload the image in the viewport.

Using the Image Detail Window:

The Image Detail window is opened by clicking the information area at the bottom of an occupied viewport. Opening this window causes three tabs to display:

- The Full Header tab displays the entire DICOM header except for private elements and Look Up Tables.
- The Display Data tab lists acquisition data for the selected image.
- The Image Data tab lists DICOM header data.

Information in the Image Detail window is updated if you select a different image in the same viewport.

To close the Image Detail window, click the Exit icon () , or click the information area that the window was opened from.

You can click the Information icon () in the toolbar to open an instance of this window for each occupied viewport. Clicking the Information icon again closes all windows.

A.4 RPCs

The Image Viewer code calls the following existing RPCs to acquire contextual information upon the receipt of a windows message. All RPC calls are made from the Abstract View component, and the results are communicated to the Full-Resolution Viewer component. This allows the Full-Resolution Viewer component to be independent of EHR.

The KIDS package automatically assigns them to the proper menu options to make them accessible to the EHR client.

Table A-1: RPC Contextual Information Table

RPC	Required
MAGJ USER2	Yes
<p>RPC: MAGG CPRS RAD EXAM INPUT PARAMETER: CPRSMMSG</p> <p>String from the CPRS Windows Message Sample CPRSMMSG: RPT^CPRS^20^RA^i6918775.83 69-1^39</p> <p>RETURN PARAMETER: Array of Image data</p>	Yes
<p>NAME: MAG3 CPRS TIU NOTE</p> <p>RETURN VALUE TYPE: ARRAY Returns a list of all images for a TIU document</p> <p>INPUT PARAMETER: TIUDA DESCRIPTION: internal entry number of the TIU document</p> <p>RETURN PARAMETER DESCRIPTION: Array of “^” delimited Image information in the format</p>	Yes

Appendix B: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: <http://security.ihs.gov/>.

The ROB listed in the following sections are specific to RPMS.

B.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

B.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.

- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

B.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

B.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

B.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

B.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

B.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.

- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

B.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

B.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

B.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

B.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

B.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

B.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

B.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

B.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

B.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Acronym List

AMI	Acute Myocardial Infarction
CAC	Clinical Application Coordinator
CCDA	Consolidated Clinical Document Architecture
CCR	Continuity of Care Record
CIR	Clinical Information Reconciliation
CPRS	Computerized Patient Record System
EHR	Electronic Health Record
ICD	International Classification of Diseases
IHS	Indian Health Service
IPL	Integrated Problem List
LOINC	Logical Observation Identifiers Names and Codes
OP	Outpatient
PDF	Portable Document Format
PHN	Public Health Nurse
PHR	Personal Health Record
POV	Purpose of Visit
RPMS	Resource and Patient Management System
SNOMED CT	Systematized Nomenclature of Medicine-Clinical Terms
TOC	Transitions of Care
VA	Department of Veterans Affairs

Contact Information

If you have any questions or comments regarding this distribution, contact the OIT User Support (IHS) by:

Phone: (888) 830-7280

Web: <http://www.ihs.gov/helpdesk/>

Email: <mailto:support@ihs.gov>