RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Addendum to User Manual

Version 1.1 Patch 14
June 2015

Office of Information Technology
Albuquerque, New Mexico

Table of Contents

Preface

This manual provides information on the EHR Patch 14 additions and changes.

Recommended Users

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

Related Manuals

The VA also has multiple manuals for 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 *Electronic Health Record (EHR) Setup Guide, Version 1.1 Patch 14* for configuration instructions before using this User Guide.

1.0 Introduction

This manual is designed to inform the Clinical Application Coordinators (CACs) with the changes that have been implemented in the upgrade to EHR Patch 14, as well as new items that have been added for IHS.

2.0 Overview

2.1 What's New

The following components are new for Patch 14.

- Acute Myocardial Infarction (AMI) (Section 3.1 provides more information.)
- Stroke Tool (Section 3.2 provides more information.)

Note: Configuration is required for these components before utilization. Refer to the *P14 Setup Guide* for details.

2.2 What's Changed

The following components have been updated with functionality for Patch 14.

Note: Configuration might be required for these updates before utilization. Refer to the *P14 MU Setup Guide* for details.

2.2.1 Anticoagulation Goal

If No is selected for Warfarin indicated, the INR Goal drop-down menu defaults to N/A. The INR Goal field cannot be changed unless Yes is selected in Warfarin indicated.

2.2.2 Appointments and Visits

The Visit Detail shows the ICD-10 code when a visit dated after the implementation date is selected.

2.2.3 Clinical Information Reconciliation (CIR)

- If the selected SNOMED CT matches an existing entry in the problem file for the patient, an information message displays that a problem with the same SNOMED ConceptID already exists.
- If a dosing schedule is not defined when the Accept Order button is clicked on an Outpatient Medication, an error message appears.

2.2.4 Immunizations

Only Lot Numbers designated to the facility to which the user is logged on display for selection.

2.2.5 Integrated Problem List (IPL)

- Evaluation and Management (E&M) table containing all CPT codes defined to office visit per visit type as defined by the E&M has been added.
- A scroll tool has been added to the PickList dialog.
- The Provider Narrative column has been renamed to Alternate POV Provider Text on the POV dialog.
- The picklists the user can view and use when items from the Edit PickList dialog are defined has been added.
- If there is no existing primary POV, even though the Primary POV check box did not get checked, the problem is automatically a primary POV and not a secondary.
- The mouse pointer can be briefly rested over the code in the ICD column to view a popup of the map source advice, based on the SNOMED CT code.
- Right-click menu options order has been reorganized.
- A Pregnancy Issues and Problems (PIP) column has been added.
- The Treatment/Regimen dialog subsets have been reorganized.
- A visit must be selected for the Patient Education dialog to open.
- If the site is not licensed for ClinicalKey, the Web Reference Search dialog opens instead when the Clinical Decision Support button is clicked.

2.2.6 Items (Super-Bills)

- The Items (Super-Bills) application has been redesigned for a more user-friendly interface. In addition, the following functionality updates have been made:
    - If a visit prior to 10/01/2014 (ICD-10 Implementation) is selected, and an item with an ICD-10 association is selected, or a visit after 10/01/2014 is selected and an item with an ICD-9 association is selected, a warning message appears that a POV must be assigned from the IPL.
    - Lookup to Apelon tool added for SNOMED CT.

2.2.7 Lab

- A visit must be selected for the Patient Education dialog to open.
- If the site is not licensed for ClinicalKey, the Web Reference Search dialog opens instead when the Clinical Decision Support button is clicked.

2.2.8 Medications Management

- If a dosing schedule is not defined when the Accept Order button is clicked on an Outpatient Medication Complex Order, an error message appears.
- If a site is not licensed for ClinicalKey, the Web Reference Search dialog opens instead of ClinicalKey when the Clinical Decision Support button is clicked.
- If an active visit is not selected when the Education Information button is clicked, a Active Visit is Not Selected message appears.

2.2.9 Pharmacy Education

Purpose of Visit information may be added to Pharmacy education.

2.2.10 Reproductive Factors

Family planning method may be deleted.

2.2.11 Visits

On the Visit Detail, if a visit dated prior to the implementation date is selected, ICD-9 codes are shown. If a visit dated on or after the implementation date is selected, ICD-10 codes are shown.

2.2.12 Visit Services

When adding a visit service using ICD procedure code, if a visit dated prior to the implementation date is selected, ICD-9 codes are retrieved. If a visit dated on or after the implementation date is selected, ICD-10 codes are retrieved.

3.0 New Components

The components in the next sections are new for Patch 14.

3.1 Acute Myocardial Infarction (AMI) Events

The Acute Myocardial Infarction (AMI) tool captures specific SNOMED 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 was delivered DISABLED with the EHR P13 release. This component is enabled in the EHR P14 release.

3.1.1 Adding a New AMI Event

To add a new AMI event:

1. Select a patient and an unlocked visit.

> **Note:** A warning message displays if the user tries to add another AMI Protocol when one already exists for today's visit. The message also displays if the user creates a same day visit and adds a AMI Protocol record.

2. Select the AMI tab or component, or click the AMI button, depending on your site configuration. The AMI: Chest Pain/AMI Symptoms documentation tool opens.

> **Note:** Click the Details button () to expand or contract the AMI: Chest Pain/AMI Symptoms list. Use the scroll arrows to the right of the AMI Events list to view the full list.

3. Click the main Add button (
) in the top-right pane of the AMI tool, or right-click and select Add. The Add a New Record dialog opens.

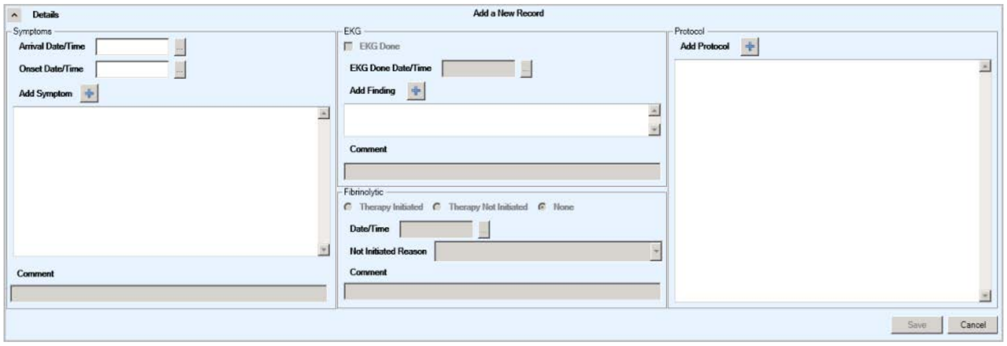


Figure 3-1: Add a New Record Dialog

Note:	The fields must be completed in order, from left to right, for the next set of fields to become active. For example, the Symptoms Arrival and Onset Date/Time must be completed before the Add Symptom button ( ) becomes active, and the Symptoms section must be completed before the EKG section becomes active. The Save button is only enabled if Arrival Onset and Date Onset is added. However if the Therapy Initiated, EKG Done, or Therapy Not Initiated buttons are selected, the Save button is not enabled until a Reason and Date/Time are selected.

4. In the Symptoms section:

Note:	Future dates/times are not allowed for any of the entries in AMI.

   a. The Arrival Date/Time field is the date and time the patient is admitted to the Emergency Department (ED). To enter it, type the date and time of the patient’s arrival in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog.

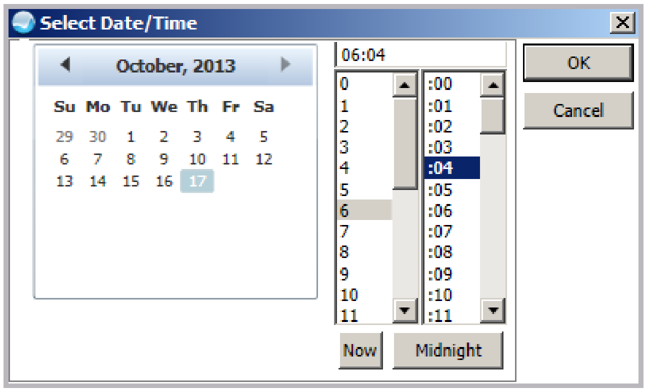
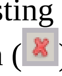


Figure 3-2: Select Date/Time Dialog

b. In Onset Date/Time, type the date and time of the onset of symptoms in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.

c. Click the Add Symptom button () to select symptoms. The Select Symptoms dialog opens. Click as many pre-filled symptoms as applicable, and then click Close. The selected symptoms appear in the Symptoms field.

- If there is an existing Symptoms entry you want to delete, click the Delete button (). Refer to the Editing an AMI Event topic for details.

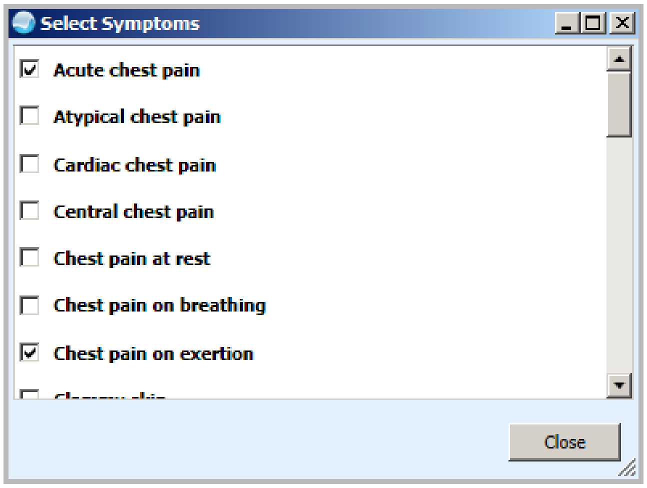


Figure 3-3.Select Symptoms Dialog

d. In the Comment field, type any comments, as needed.

5. In the EKG section:

a. If an EKG has been completed, click the EKG Done check box. The EKG fields activate.

> **Note:** If an EKG has not been completed and the EKG Done check box is not selected, the remaining fields in this section are inactive.
>
> Also, a date for the EKG is required to save the information.

b. In EKG Done Date/Time, type the date and time of the EKG in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.

c. Click the Add Finding button (). The Add EKG Finding dialog opens.

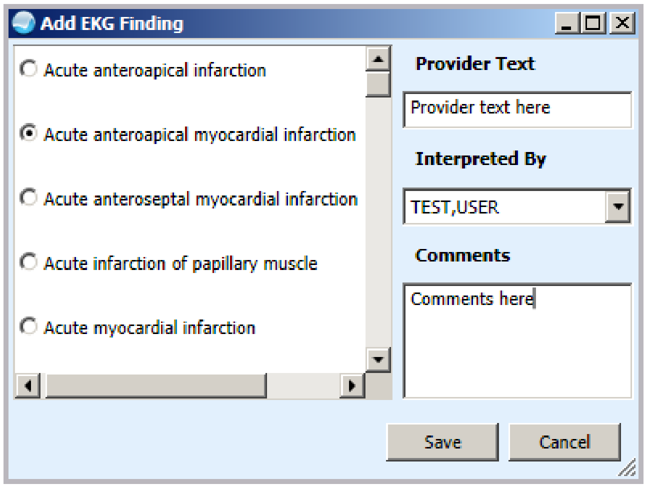


Figure 3-4.Add EKG Finding Dialog

- If there is an existing EKG findings entry you want to edit or delete, click the Modify button ( ) to edit, or click the Delete button ( ) to delete. Refer to the Editing an AMI Event topic for details.

d. Click an option button to select a finding. Acute anteroapical myocardial infarction, for example.

e. The Provider Text, you can type a more detailed explanation of the appended SNOMED Code text, if needed.

f. In Interpreted By, select a provider name.

g. In Comments, type any comments about the EKG findings, as applicable.

h. Click Save. The EKG entries appear in the EKG section.

6. In the Fibrinolytic section:

   a. Select one of the following applicable option buttons:

      - Therapy Initiated
      - Therapy Not Initiated
      - None

> **Note:** The None option button can also be used to clear previously input Fibrinolytic items.

b. In Date/Time, type the date and time of the therapy initiation or declination in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.

c. If therapy was declined by the patient, in the Not Initiated Reason, select a reason for the refusal from the drop-down menu.

Note:	The Not Initiated Reason field is only active if the Therapy Declined option button is selected.

d. In the Comment field, type any comments, as applicable.

7. In the Protocol section:

a. Click the Add Protocol button ( ). The Add Protocol/Standing Orders dialog opens.

- If there is an existing Protocol entry you want to edit or delete, click the Modify button ( ) to edit, or click the Delete button ( ) to delete. See the Editing an AMI Event topic for details.

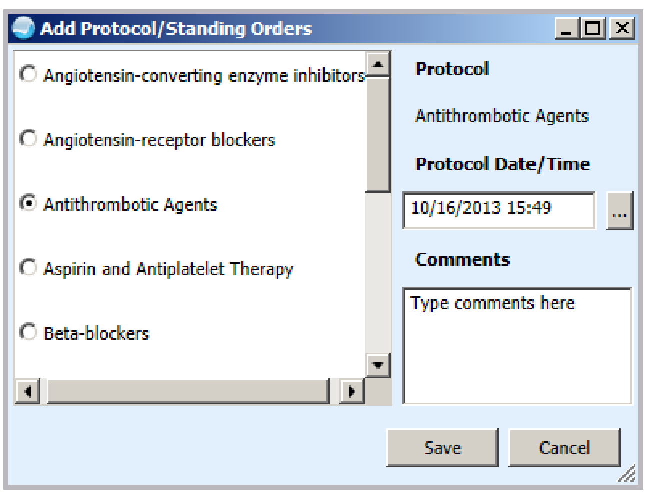


Figure 3-5: Protocol Dialog

b. Select a Protocol option button. The Protocol field populates with your selection.

c. In Protocol Event Date/Time, type the date and time of the protocol event in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.

d. In Comments, type any comments as applicable to the protocol.

e. Click Save. The selected protocol appears in the Protocol field.

8. Click Save in the bottom-right section in the Add a New Record dialog. Your AMI entries save and appear in the list of AMI events.

Note:	All of the applicable required fields must be completed for the Save button to become active.

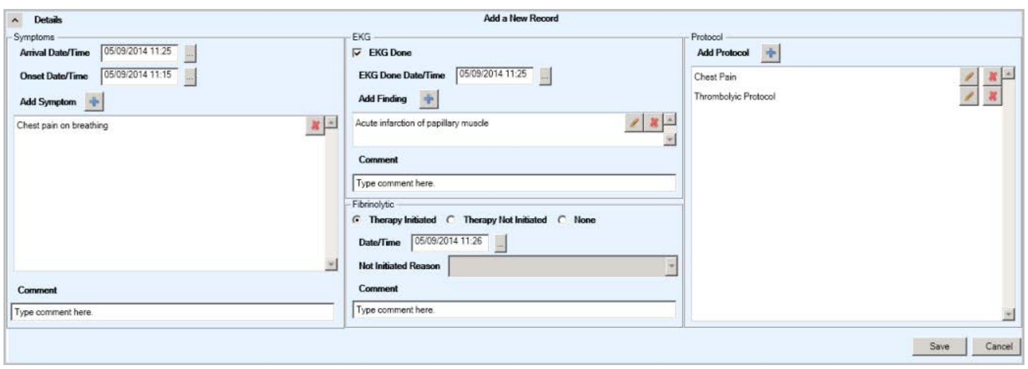


Figure 3-6: Completed AMI Event

3.1.2 Editing an AMI Event

To edit an AMI event, follow these steps:

1. From the list of AMI events, select an event to edit. The event opens.

Note:	The visit must be open and not locked.

2. Click the Edit button. The Editing a Record dialog opens.

Note: Alternatively, you can right-click an existing AMI event in the AMI Events list and select Edit. An AMI event must exist in order for the Edit function to be available.

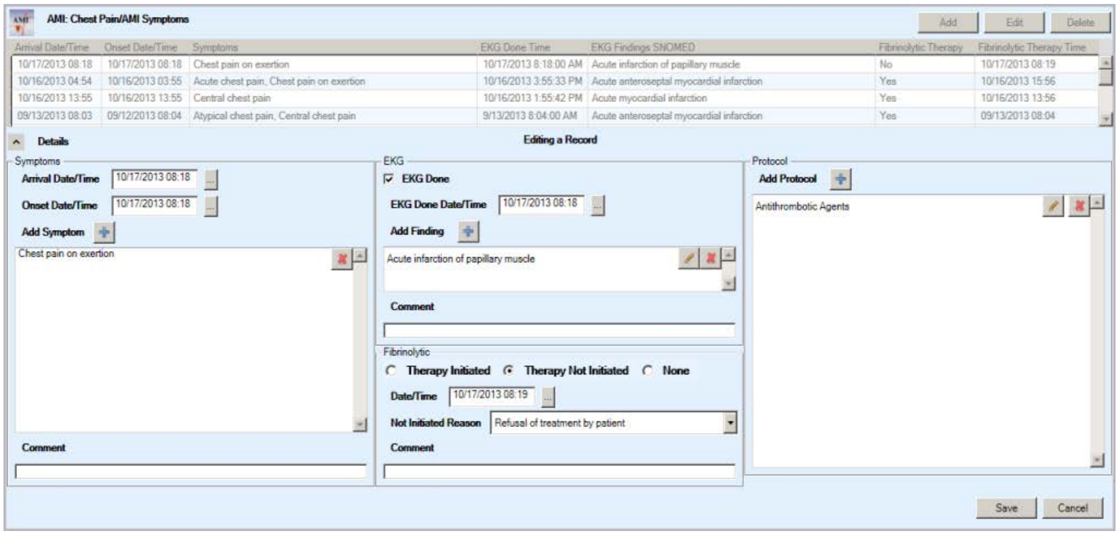


Figure 3-7: Event Edit

3. Make any changes, as applicable:

Note: Refer to the <u>Adding a New AMI Event</u> topic for additional details on completing these following fields, as needed.

- In the Symptoms section, complete any of the following actions:
    - Click the Add Symptom button ( ) to open the Select Symptoms dialog.
        a. Make any selections.
        b. Click Close to save changes.
    - Click the Delete button ( ) to delete a symptom.
    - In the text/numeric fields, you can type over or delete existing data.
- In the EKG section, complete any of the following actions:
    - Click the Add Finding button ( ) to open the Add EKG Finding dialog.

        a. Make your changes.

        b. Click Save.

    - Click the Modify button ( ) to open the Edit EKG Findings dialog.

        a. Make any changes.

        b. Click Save.

    - Click the Delete button ( ) to delete existing EKG findings.

    - In the text/numeric fields, you can type over or delete the existing data.

- In the Fibrinolytic section, complete any of the following actions:

    - Change the applicable option button, as needed.

> **Note:** The None option button can be used to clear previously input Fibrinolytic items.

    - In the text/numeric fields, you can type over or delete the existing data.

- In the Protocol section, complete any of the following actions:

    - Click the Add button ( ) to open the Add Protocol/Standing Orders dialog.

        a. Make any changes.

        b. Click Save.

    - Click the Modify button ( ) to open the Edit Protocol/Standing Orders dialog.

        a. Make any changes.

        b. Click Save.

    - Click the Delete button ( ) to delete existing Protocols, as applicable.

    - In the text/numeric fields, you can type over or delete the existing data.

4. Click Save.

3.1.3 Deleting an AMI Event

To delete and existing AMI event, follow these steps:

> **Note:** To delete findings from individual AMI events, refer to the Editing an AMI Event topic.

1. From the list of existing AMI events, select an event to delete.

   > **Note:** The visit must be open and not locked.

2. Click the Delete button.

   > **Note:** Alternatively, you can right-click an existing AMI event in the AMI Events list and select Delete. An AMI event must exist in order for the Delete function to be available

   a. In the Reason drop-down menu, select one of the following:

      - Duplicate
      - Entered in Error
      - Other

   b. If Other is selected, type a reason in the field.

      > **Note:** The comment field is only active if Other is selected.

3. Click Save. The AMI event is removed from the list of AMI Events.

3.2 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.

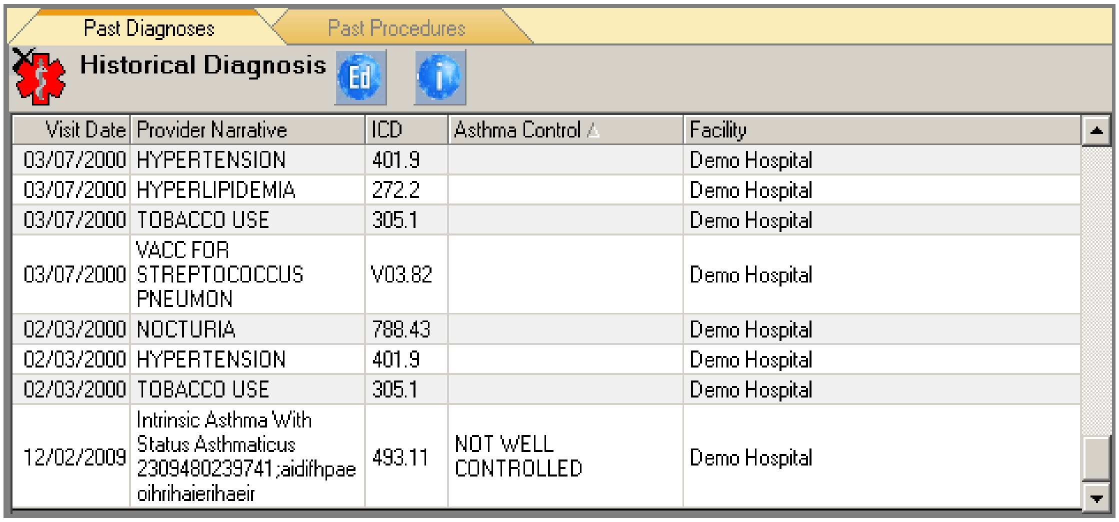
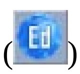
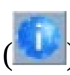


Figure 3-8: Historical Diagnosis Panel

View visit information by selecting a record and then selecting View Visit Detail on the right-click menu. The Visit Detail dialog opens.

3.2.1 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 Education Information or 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 ClinicalKey Web site is the default.

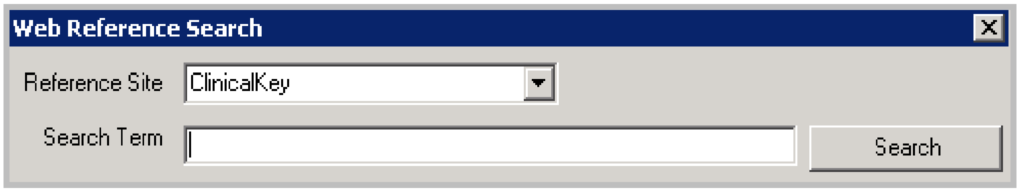


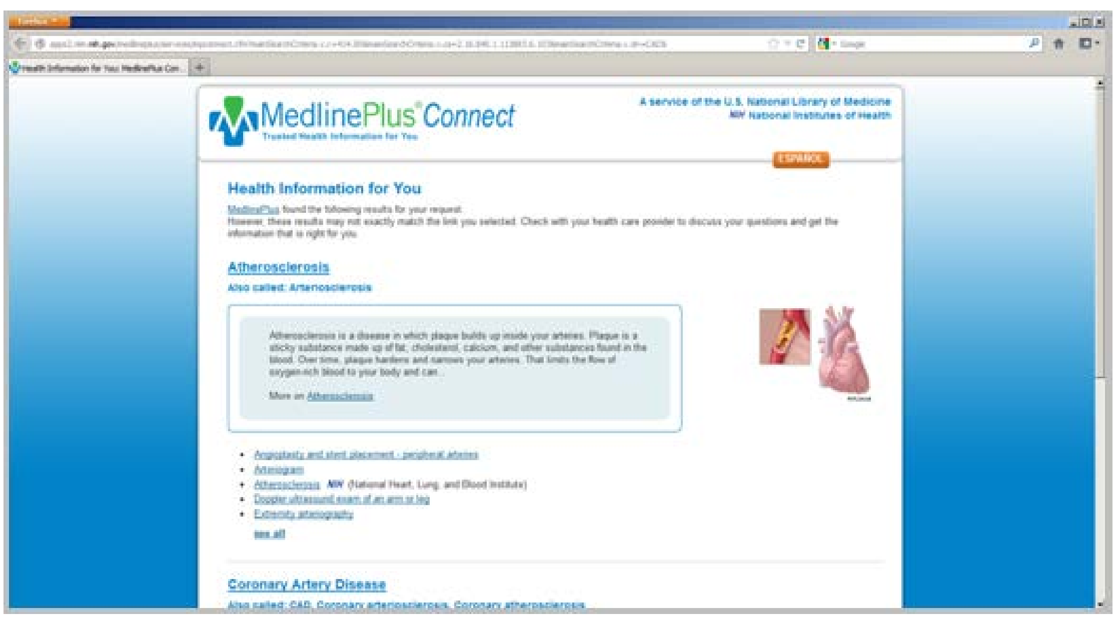
Figure 3-9: Web Reference Search Dialog

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.

3.2.2 Education Information Button

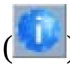
When a patient diagnosis is selected, click the Education Information button ( ). This sends a call to the MedlinePlus Web site to provide information regarding the selected topic and the MedlinePlus Web site opens to the related page.

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.



Medline Plus Web Site

3.2.3 Clinical Decision Support Button

When a patient diagnosis is selected, click the Clinical Decision Support button (). This sends a call to the ClinicalKey Web site to provide information regarding the selected topic and the ClinicalKey Web site opens to the related page.

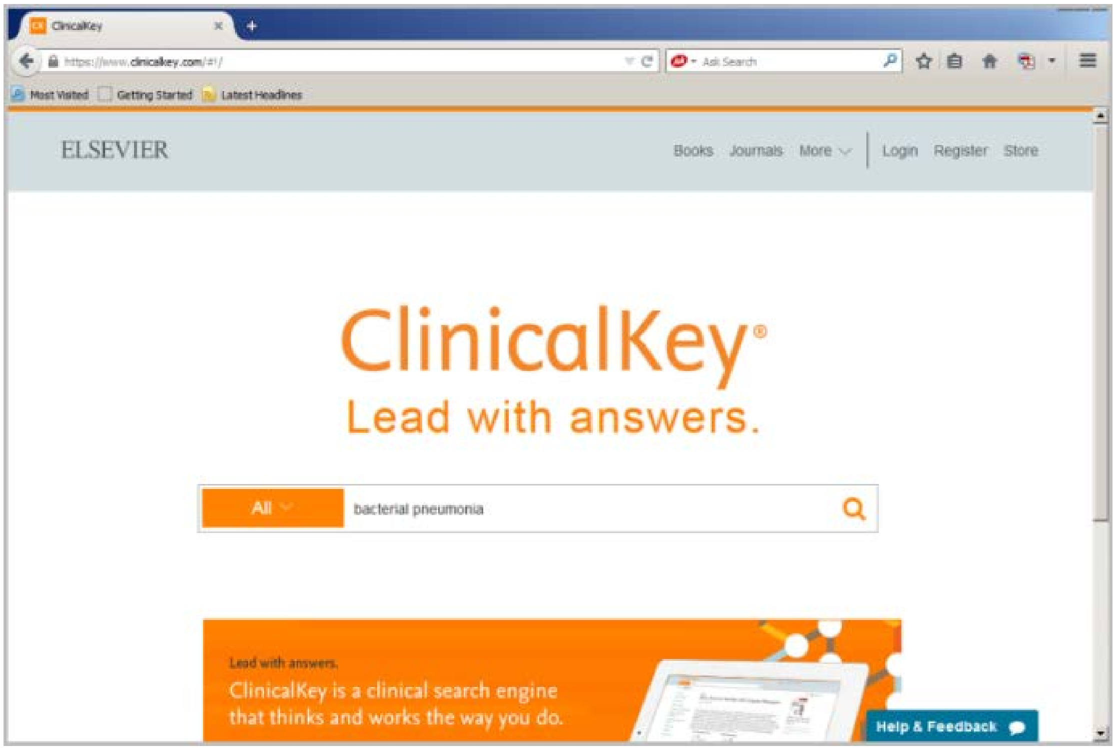


Figure 3-10: ClinicalKey Web Site

3.3 Stroke Tool

The Stroke tool captures specific SNOMED 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 was delivered DISABLED with the EHR P13 release. This component is enabled in the EHR P14 release.

3.3.1 Adding a New Stoke Event

To add a new stroke event:

1. Select a patient and an unlocked visit.

> **Note:** A warning message displays if the user tries to add another Stroke event when one already exists for today's visit. The message also displays if the user creates a same-day visit and adds a Stroke Event record.

2. Select the Stoke tab, drop-down menu, or component, or click the Stroke button, depending on your site configuration. The Stroke tool opens.

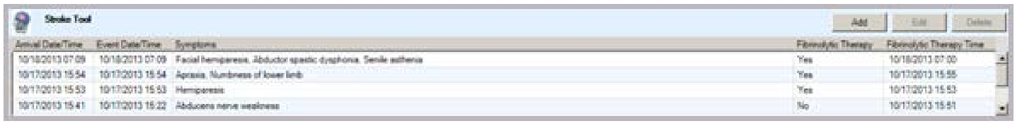


Figure 3-11: Stroke Tool Main Screen

> **Note:** Click the Details button ( ) to expand or contract the Stroke Tool. Use the Scroll arrow to the right of the Stroke events to view the full list.

3. Click the main Add button (Add) in the top-right pane of the Stroke tool, or right-click and select Add. The Add a New Record dialog opens.

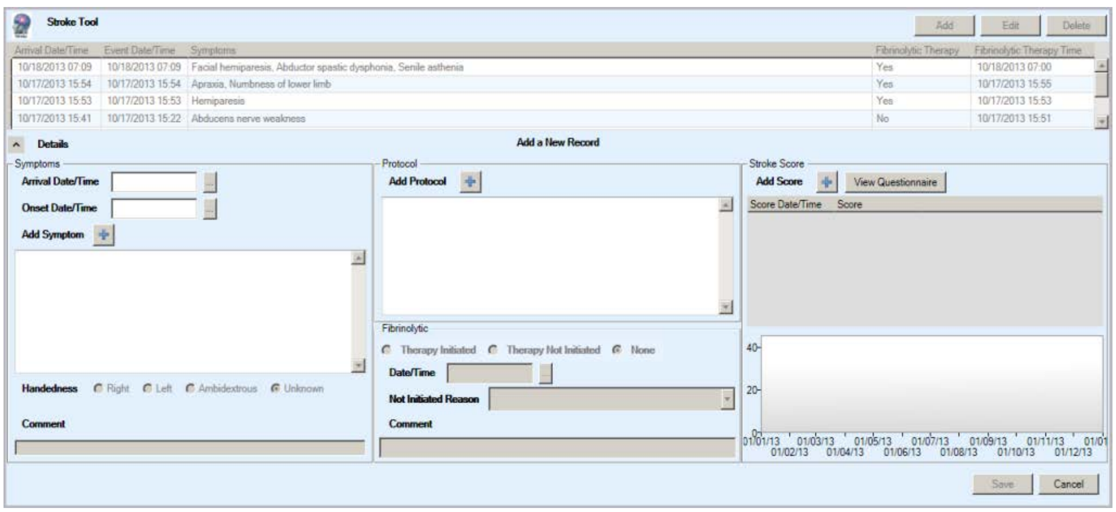


Figure 3-12: Add a New Record Dialog

Note:	The fields must be completed in order, from left to right, for the next set of fields to become active. For example, the Symptoms Arrival and Onset Date/Time must be completed before the Add button ( ) becomes active, and the Symptoms section must be completed before the Protocol section becomes active. The Save button is only enabled if Arrival Onset and Date Onset is added. However if the Therapy Initiated or Therapy Not Initiated buttons are selected, the Save button is not enabled until a Reason and Date/Time are selected.

4. In the Symptoms section:

Note:	Future dates/times are not allowed for any of the entries in the Stroke tool.

   a. In Arrival Date/Time, type the date and time of the patient's arrival in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog.

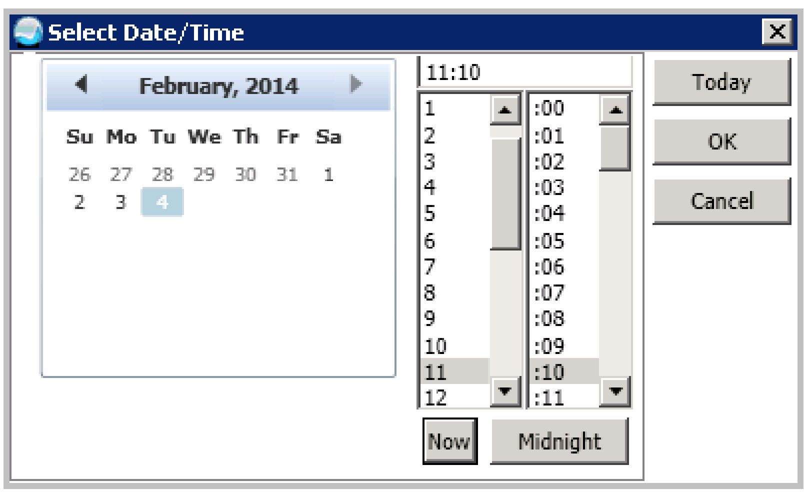


Figure 3-13: Select Date/Time Dialog

   b. In the Select Date/Time dialog, do one of the following:

      - 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.

- Click the Today button, and then click OK to set the date to today's date. The time remains at 00:00.

c. In Onset Date/Time, type the date and time of the stroke event in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.

- Click the Today button, and then click OK, to set the date to today's date. The time remains at 00:00.

d. Click the Add Symptom button ( ) to select symptoms. The Add Stroke Symptom dialog opens. Click as many pre-filled symptoms as applicable.

Note: The number of symptoms shown in each column in the Add Stroke Symptom dialog change based on the size of the window. The distance between each column is based on the longest name in the column. You can jump to a symptom on the list by clicking once in the list and then typing the first letter of the symptom.

- If there is an existing Symptom entry you want to edit or delete, click the Modify button ( ) to edit, or click the Delete button ( ) to delete it. Refer to the Editing a Stroke Event topic for details.

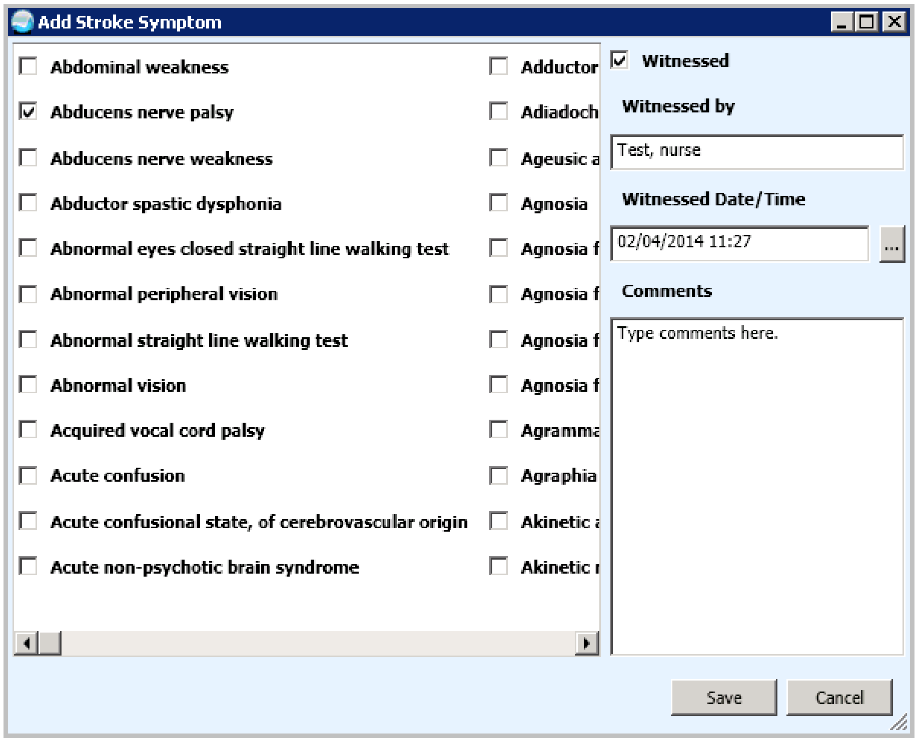


Figure 3-14: Add Stroke Symptom Dialog

e. If the stroke event was witnessed, select the Witnessed check box. The Witnessed by and Witnessed Date/Time fields become active.

f. If applicable, in Witnessed by, type the name of the person who witnessed the stoke event.

g. If applicable, in Witnessed Date/Time, type the date and time of the stroke event in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.
- Click the Today button, and then click OK to set the date to today's date. The time remains at 00:00.

h. In the Comment field, type any comments, as needed.

i. Click Save.

5. In the Handedness section, click the appropriate option button to select the patient's dominant hand, or select Ambidextrous or Unknown, as applicable.

6. In the Protocol section:

   a. Click the Add Protocol button ( ). The Add Protocol/Standing Orders dialog opens. If there is an existing Stroke Protocol entry you want to edit or delete, click the Modify button ( ) to edit, or click the Delete button ( ) to delete. Refer to the Editing a Stroke Event topic for details.

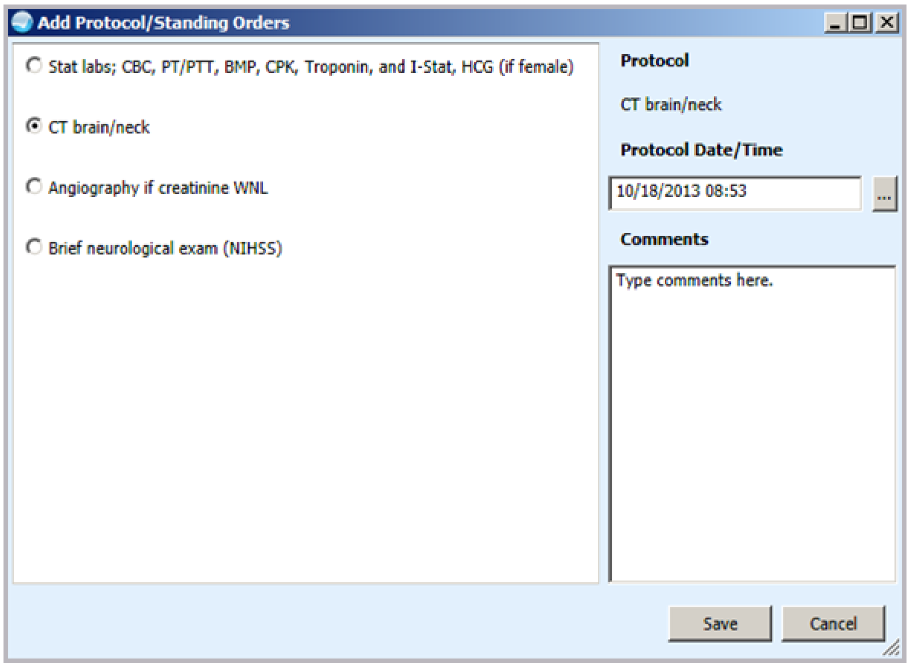


Figure 3-15: Protocol Dialog

   b. Select a protocol option button. The Protocol populates with your selection.

   c. In Protocol Date/Time, type the date and time of the protocol event in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

      - 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.

- Click the Today button, and then click OK to set the date to today's date. The time remains at 00:00.

d. In Comments, type any comments as applicable to the protocol.

e. Click Save. The selected protocol appears in the Protocol field.

7. In the Fibrinolytic section:

a. Select one of the following applicable option buttons:

- Therapy Initiated
- Therapy Not Initiated
- None

> **Note:** The None option button may also be used to clear previously input Fibrinolytic items.

b. In Date/Time, type the date and time of the therapy initiation or declination in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog. Do one of the following:

- 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.
- Click the Today button, and then click OK to set the date to today's date. The time remains at 00:00.

c. If therapy was declined by the patient, in the Not Initiated Reason, select a reason for the decline from the drop-down menu.

d. In the Comment field, type any comments, as applicable.

8. In the Stroke Score section:

a. Click the Add Score button ( ). The Add Stroke Score dialog opens.

- If there is an existing Stroke Score entry you want to edit, click the Modify button ( ). Make the changes in the Edit Stroke

Score dialog, and then click Save. Refer to the Editing a Stroke Event topic for details.

b. Click an option button to select a score for the following:

Note:	You can pause your cursor over the item to view an explanation or over the Score option button to view a NIH Stroke Scale explanation of the score. Click the View Questionnaire button to view the Stroke Scale explanations (read-only) in a list form.

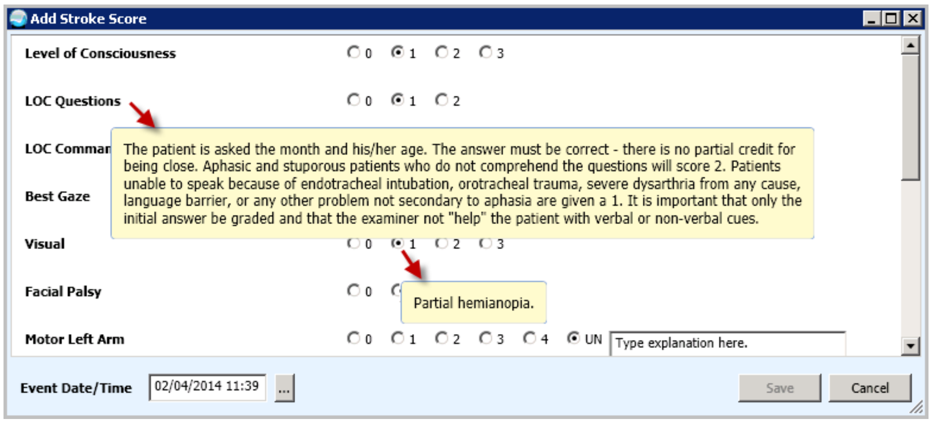


Figure 3-16: Add Stroke Score with Pause Over

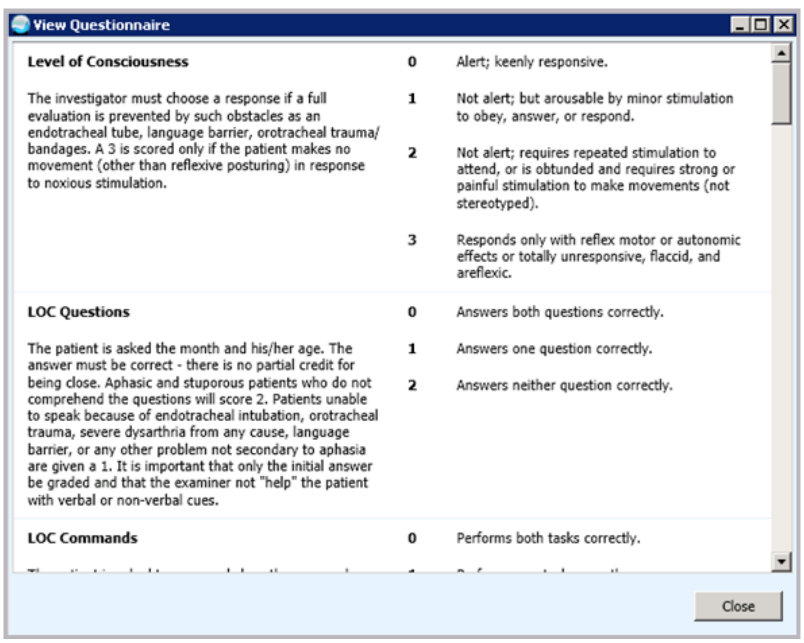


Figure 3-17: View Questionnaire

- Level of Consciousness – Select 0-3

- LOC Questions – Select 0-2
- LOC Commands – Select 0-2
- Best Gaze – Select 0-2
- Visual – Select 0-3
- Facial Palsy – Select 0-3
- Motor Left Arm – Select 0-4 or UN. If UN is selected, type a comment in the field
- Motor Right Arm – Select 0-4 or UN. If UN is selected, type a comment in the field
- Motor Right Leg – Select 0-4 or UN. If UN is selected, type a comment in the field
- Motor Left Leg – Select 0-4 or UN. If UN is selected, type a comment in the field
- Limb Ataxia – Select 0-2 or UN. If UN is selected, type a comment in the field
- Sensory – Select 0-2
- Best Language – Select 0-3
- Dysarthria – Select 0-2
- Extinction and Inattention (formerly Neglect) – Select 0-2

c. The Event Date/Time defaults to the current day and time. To change it, type the stroke score date and time in xx/xx/xxxx 00:00 or N-X (now minus X minutes) format, or click the Ellipsis button to select a date and time from the Select Date/Time dialog, if applicable. Do one of the following:

  - 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.
  - Click the Today button, and then click OK, to set the date to today's date. The time remains at 00:00.

d. Click Save. Your score trend entries appear in the graph section.

Note:	You must select an option button for every Stroke Score item. If UN is selected, a comment must be typed in the field for the Save button to become active. Each time you add a Stroke Score, the entry plot on the graph after you click Save.

9. Click Save in the bottom-right section in the Stroke Tool. Your entries appear in the list of stroke events.

Note:	All of the applicable required fields must be completed for the Save button to become active.

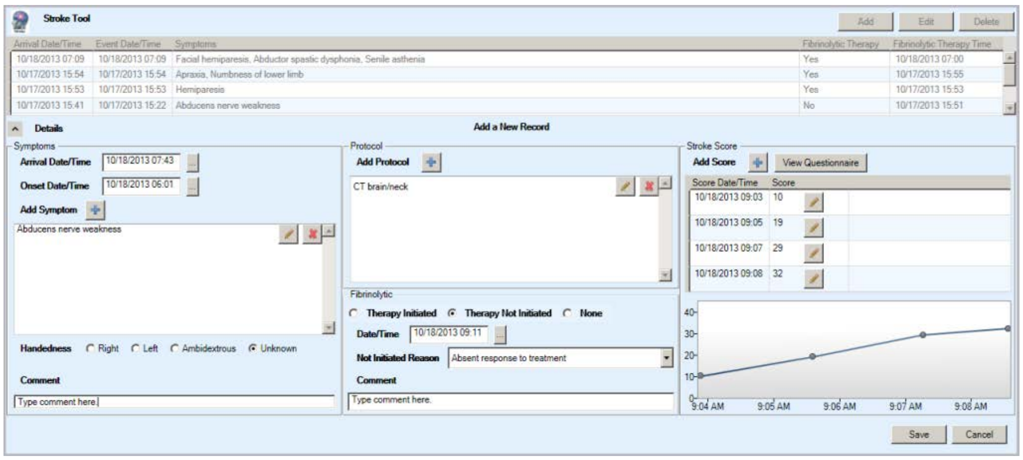


Figure 3-18: Completed Stroke Record

Note:	Stroke scores can now be deleted.

3.3.2 Editing a Stroke Event

To edit an existing stroke event, follow these steps:

1. From the Stroke Tool existing event list, select the event you want to edit. The event (read-only) shows below the list.

Note:	The visit must be open and not locked. Click the Details button (˅) to expand or contract the Stroke event fields. Use the scroll arrows to the right of the Stroke events list to view the full list.

2. Click the Edit button, or right-click and select Edit. The Editing a Record event fields become active.

Note:	A Stroke event must exist for the Edit function to be available.

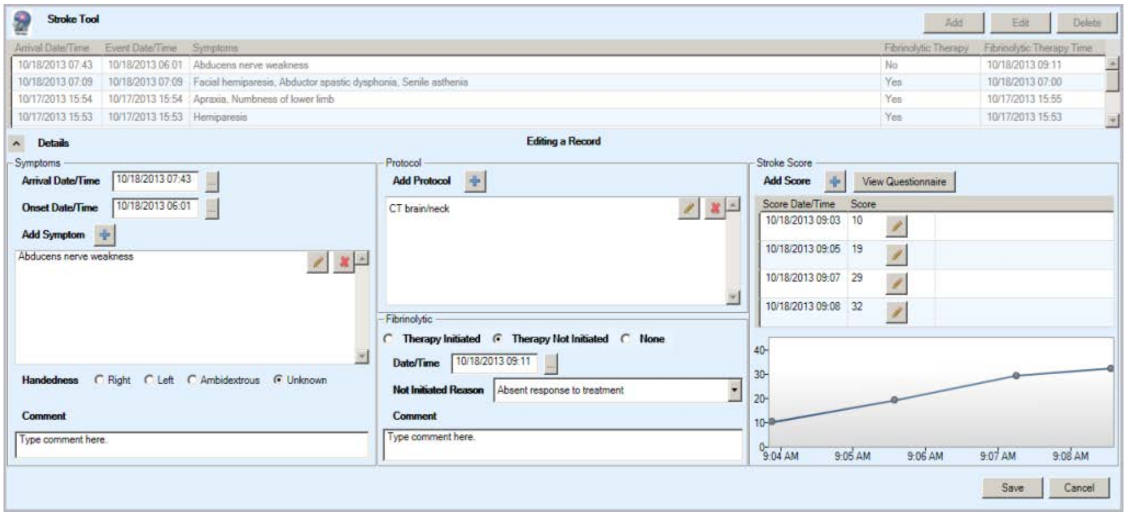


Figure 3-19: Stroke Event Edit

3. Make any changes, as applicable:

Note:	Refer to the Adding a New Stroke Event topic for additional details on completing the following fields, as needed.

- In the Symptoms section, complete any of the following actions:
  - o Click the Add Symptom button ( ) to add a Symptom. The Add Stroke Symptom dialog opens.
    a. Make any selections.
    b. Click Save.
  - o Click the Modify button ( ) to open the Edit Stroke Symptom dialog.
    a. Make your changes.
    b. Click Save.
  - o Click the Delete button ( ) to delete an existing symptom.
  - o In the text/numeric fields, you can type over or delete the existing data, or select a different option button.
- In the Protocol section, complete any of the following actions:
  - o Click the Add Protocol button ( ) to add a Protocol. The Add

Protocol/Standing Orders dialog opens.

a. Make your selections.

b. Click Save.

- Click the Modify button ( ) to open the Edit Protocol/Standing Orders dialog.

  a. Make your changes.

  b. Click Save.

- Delete button ( ) to delete existing Protocols, as applicable.

- In the text/numeric fields, you can type over or delete the existing data.

- In the Fibrinolytic section, complete any of the following actions:

  - Select the applicable option button.

Note:	The None option button may be used to clear previously selected Fibrinolytic items.

  - In the text/numeric fields, you can type over or delete the existing data.

- In the Stroke Score section, complete any of the following actions:

  - Click the Add Score button ( ). The Add Stroke Score dialog opens.

    a. Select the Stroke Scores option button..

    b. Click Save.

  - Click the Modify button ( ) to open the Edit Stroke Score dialog.

    a. Make any changes.

    b. Click Save.

  - Click the Delete button to open the Delete Score dialog.

a. Select the Stroke Score you want to delete.

b. Click Delete.

4. Click Save. Your changes show in the Stroke event list.

3.3.3 Deleting a Stroke Event

To delete an existing Stroke event, follow these steps:

Note:	To delete findings from individual Stroke events, refer to the Editing a Stroke Event topic.

1. From the list of existing Stroke events, select an event to delete.

Note:	The visit must be open and not locked.

2. Click the Delete button.

Note:	Alternatively, you can right-click on an existing Stroke event in the Stroke Event list and select Delete. A Stroke event must exist in order for the Delete function to be available.

The Delete Stroke Record dialog opens.

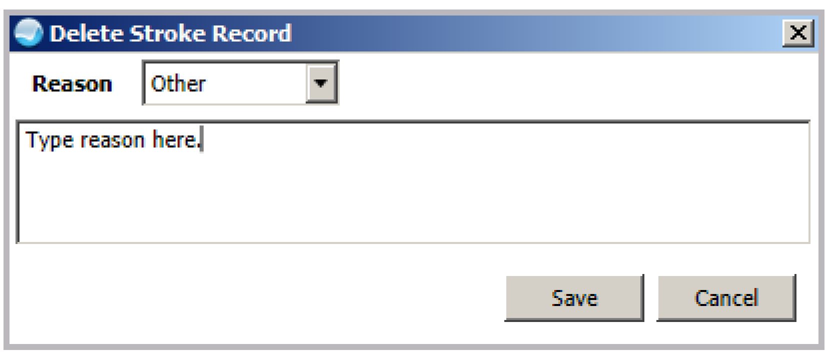


Figure 3-20: Delete Stroke Record Dialog

a. In the Reason drop-down menu, select one of the following:

- Duplicate
- Entered in Error
- Other

b. If Other was selected, type a reason in the field.

c. Click Save.

3. Click Save. The Stroke event is removed from the list.

3.4 Visit Diagnosis

The Visit Diagnosis is a view-only component that displays Purpose of Visit (POV) information for the current patient, as well as information regarding the diagnosis for the visit.

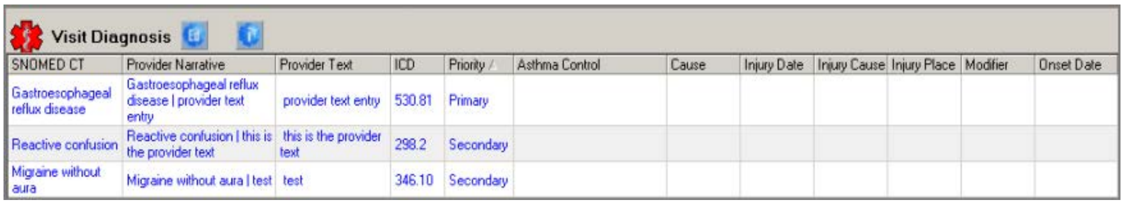


Figure 3-21: Visit Diagnosis Panel

View visit information by selecting a record, and then selecting View Visit Detail on the right-click menu. The Visit Detail dialog opens.

3.4.1 Web Reference Search Function

There are two Web Reference search options available from the Visit Diagnosis component that enable the user to look up information on a highlighted diagnosis from the Provider Narrative column on the Visit Diagnosis dialog:

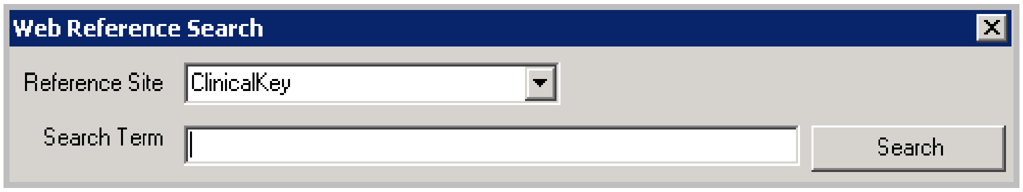
- Education Information button ()
- Clinical Decision Support button ()

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 ClinicalKey Web site is the default.



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.

3.4.2 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 3-22: Medline Plus Web Site

3.4.3 Clinical Decision Support Button

When a patient diagnosis is selected, click the Clinical Decision Support button ( ). This sends a call to the ClinicalKey Web site to provide information regarding the selected topic and the ClinicalKey Web site opens to the related page.

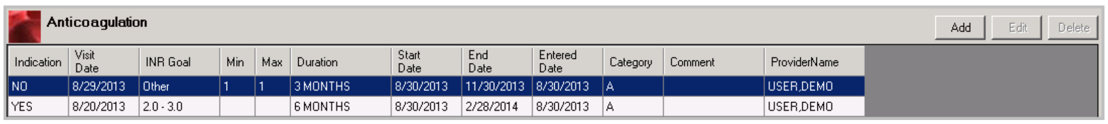
Figure 3-23: ClinicalKey Web Site

4.0 Updated Components

The components in the next sections have been updated with functionality for Patch 14.

4.1 Anticoagulation Goal

The Anticoagulation module enables clinicians to establish anticoagulation goals for their patients. This sets and tracks the goals. The goals can be modified as needed, based on anticoagulation results and current medication therapy.



Anticoagulation   Add   Edit   Delete

Indication	Visit Date	INR Goal	Min	Max	Duration	Start Date	End Date	Entered Date	Category	Comment	ProviderName
NO	8/29/2013	Other	1	1	3 MONTHS	8/30/2013	11/30/2013	8/30/2013	A		USER,DEMO
YES	8/20/2013	2.0 - 3.0			6 MONTHS	8/30/2013	2/28/2014	8/30/2013	A		USER,DEMO

Figure 4-1: Anticoagulation List

The columns of the component are:

- Yes/No field if Warfarin is indicated for this patient
- Visit Date
- INR Goal field
- Minimum INR if Goal selected was Other
- Maximum INR if Goal selected was Other
- Duration
- Start date of therapy
- End date of therapy
- Date therapy entered
- Visit Category
- Comments
- Provider Name

1. Select the patient and encounter.
2. Then navigate to the tab within the chart your organization has placed in the Anticoagulation module.

   Past entries for anticoagulation therapy appear in the module.

   Each column in the display can be used to sort the list.

4.1.1 Adding an Anticoagulation Entry

1. Click the Add button to add a new Anticoagulation Goal for the patient. The Add Anticoagulation Goal dialog opens.

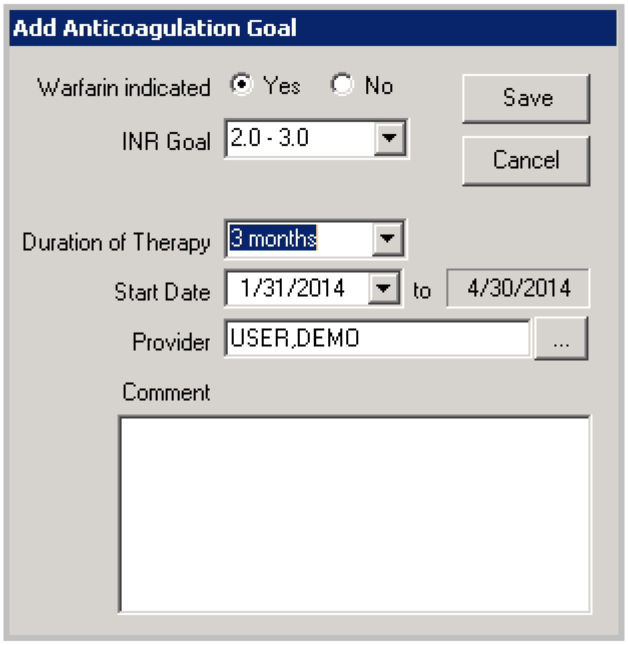


Figure 4-2: Add an INR Goal

2. In Warfarin indicated, click the Yes or No option button. The default is Yes.

   If No is selected, the INR Goal drop-down menu defaults to N/A. The INR Goal field cannot be changed unless Yes is selected in Warfarin indicated.

3. In INR Goal, select the INR goal from the drop-down menu.

Note:	This is organization-specific. It can be modified by what your organization sets as the primary goals desired, or it can be national best practice goals.

The two most common INR Goals can be selected from the drop-down menu, or select Other.

If you select Other as the INR Goal, new entry fields appear. These fields enable entry of the minimum and maximum amounts using the Up and Down arrows or the figures may be typed into the field.

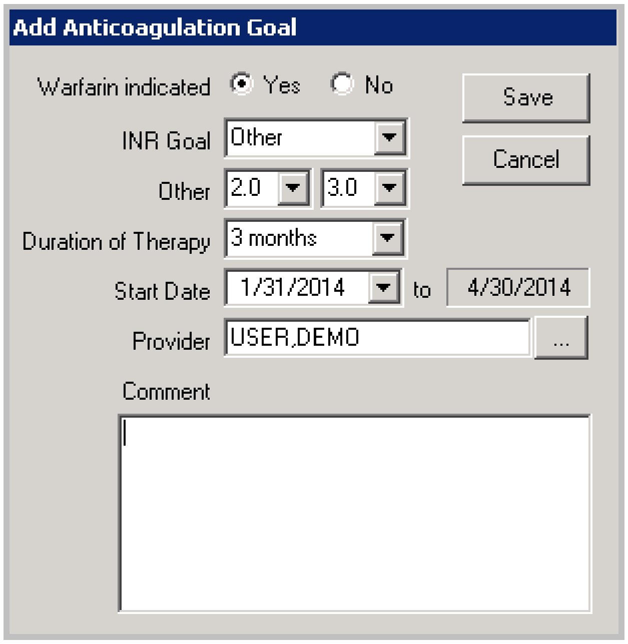


Figure 4-3: Min and Max INR Goals

4. In Duration of Therapy, select the applicable length of time from the drop-down menu.

5. In Start Date, select a date. The default is today's date.

Note:	The end date is automatically set according to the Duration of Therapy selected.

6. If the provider of the exam is different from what is displayed in the Provider field, click the Ellipsis button to open the Lookup Provider dialog where you can select a different provider.

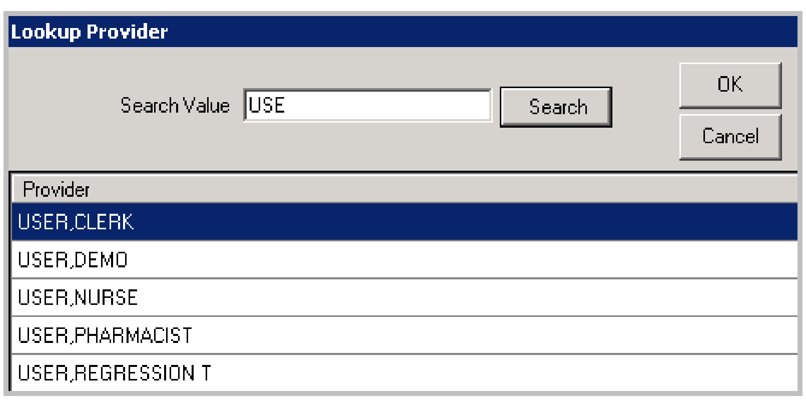


Figure 4-4: Lookup Provider Dialog

a. In Search Value, type a different provider name or enter the first few letters of the name and click Search. The list refreshes with matching names.

b. Select the applicable name and click OK. The Provider field on the Add Anticoagulation Goal dialog populates with your selection.

7. If needed, add Comments for the goal.

8. Click Save. The Anticoagulation main window displays the message, This visit has an entry. The new anticoagulation goal is saved to the patient's chart.

4.1.2 Editing an Anticoagulation Goal

1. To modify an Anticoagulation Goal, select a patient and visit.

2. Highlight the goal you want to edit and click the Edit button at the top-right of the Anticoagulation module. The Edit Anticoagulation Goal dialog opens.

Note: The visit must be an unlocked visit.

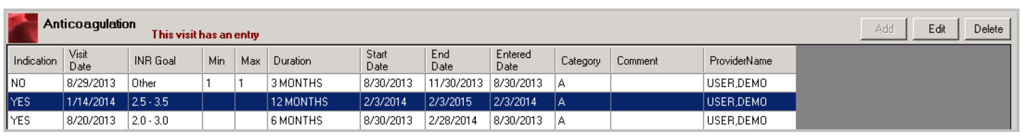


Figure 4-5: Anticoagulation Goals for Edit

3. Modify the fields, as necessary. If you change a goal of Other to a standard goal, the Min and Max fields are deleted.

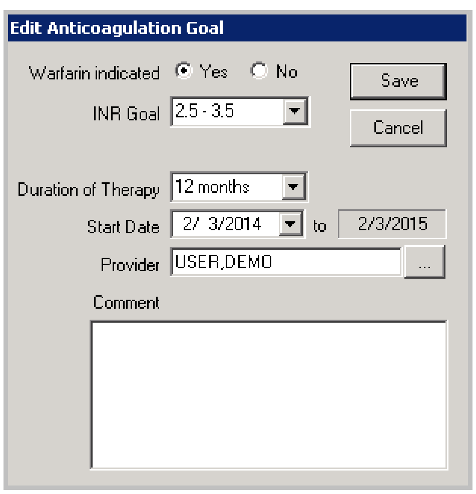


Figure 4-6: Edit Anticoagulation Goal

4. Click Save.

4.1.3 Deleting an Anticoagulation Goal

1. To delete an Anticoagulation Goal, select a patient and visit.

> **Note:** The visit must be an unlocked visit and the entry can only be deleted for the visit on which it was created.

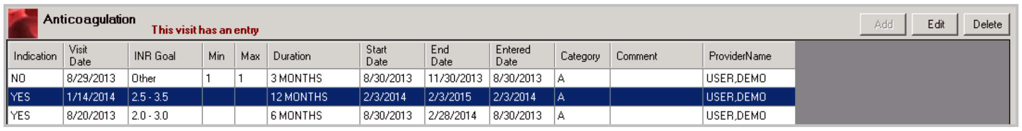


Figure 4-7: Anticoagulation Goals for Delete

2. Highlight the goal you want to delete and click the Delete button at the top-right of the Anticoagulation module. The Delete Anticoagulation Record dialog opens.

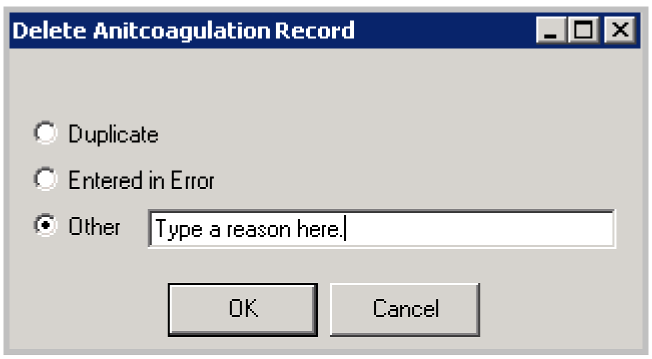


Figure 4-8: Delete Anticoagulation Record

3. Select one of the following option buttons for the reason for the deletion.

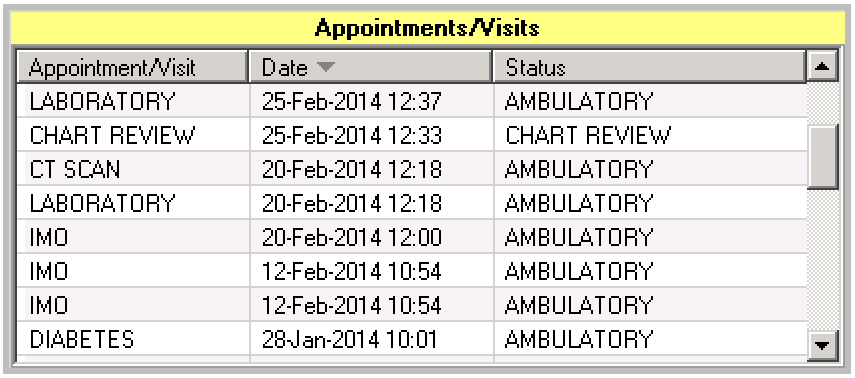
    - Duplicate
    - Entered in Error
    - Other
        - If Other is selected, type a reason in the field.

> **Note:** The OK button does not become active unless a reason is typed when Other is selected.

4. Click OK.

4.2 Appointments and Visits

The Appointments and Visits panel lists the appointments for the current patient. The list includes future appointments created through scheduling where no visit currently exists.


Appointments/Visits

Appointment/Visit	Date	Status
LABORATORY	25-Feb-2014 12:37	AMBULATORY
CHART REVIEW	25-Feb-2014 12:33	CHART REVIEW
CT SCAN	20-Feb-2014 12:18	AMBULATORY
LABORATORY	20-Feb-2014 12:18	AMBULATORY
IMO	20-Feb-2014 12:00	AMBULATORY
IMO	12-Feb-2014 10:54	AMBULATORY
IMO	12-Feb-2014 10:54	AMBULATORY
DIABETES	28-Jan-2014 10:01	AMBULATORY

Figure 4-9: Appointments and Visits Panel

The date range of appointments that appear on this panel is controlled by a parameter that is setup by the Clinical Applications Coordinator (CAC).

The default sort is by date, with the newest at the top. Any column can be sorted by clicking the heading.

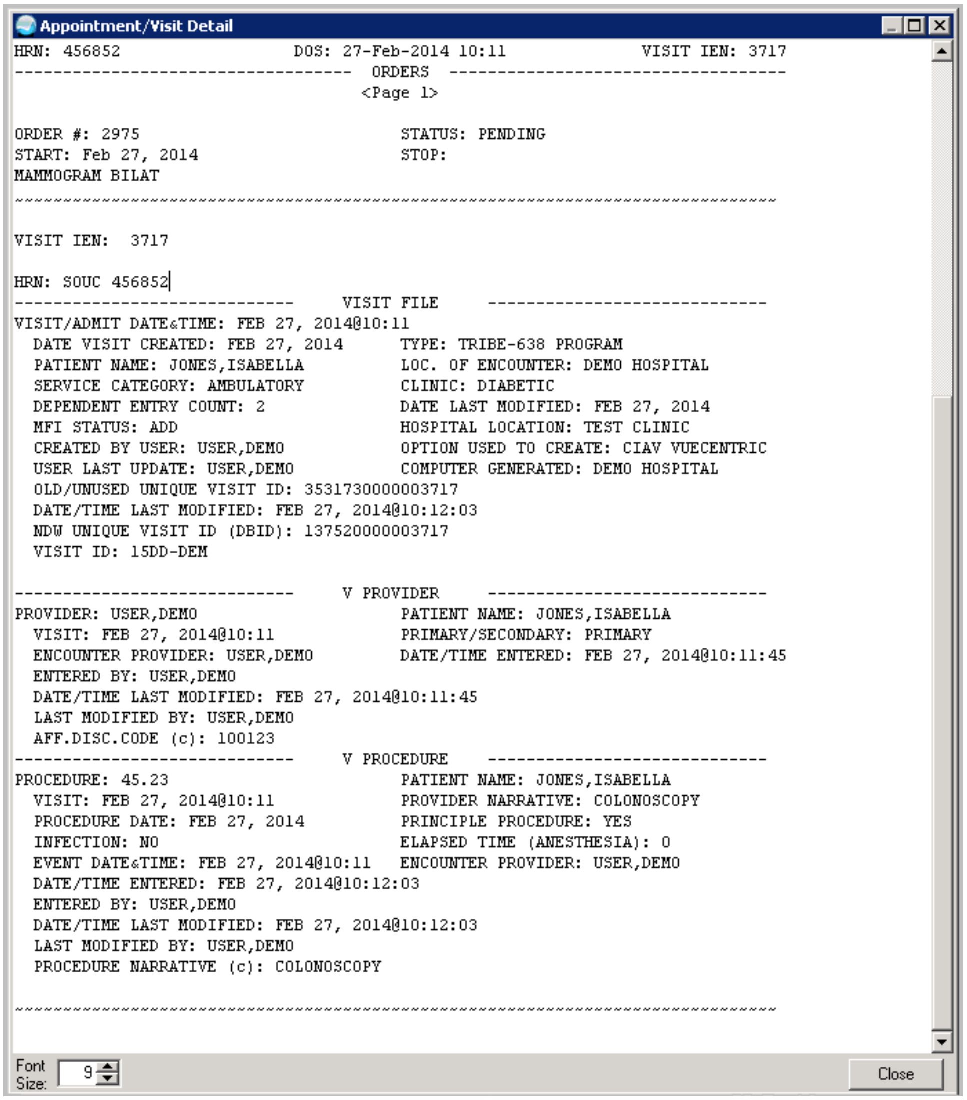
Select Refresh from the right-click menu to re-display the patient’s information to show recent changes.

4.2.1 Appointment/Visit Detail

If your application is configured for a pop-up window, the Appointment/Visit Detail (contents of the Visit File) displays when a table entry is selected.

Note: If a visit dated prior to the implementation date is selected, ICD-9 codes are shown. If a visit dated on or after the implementation date is selected, ICD-10 codes are shown.

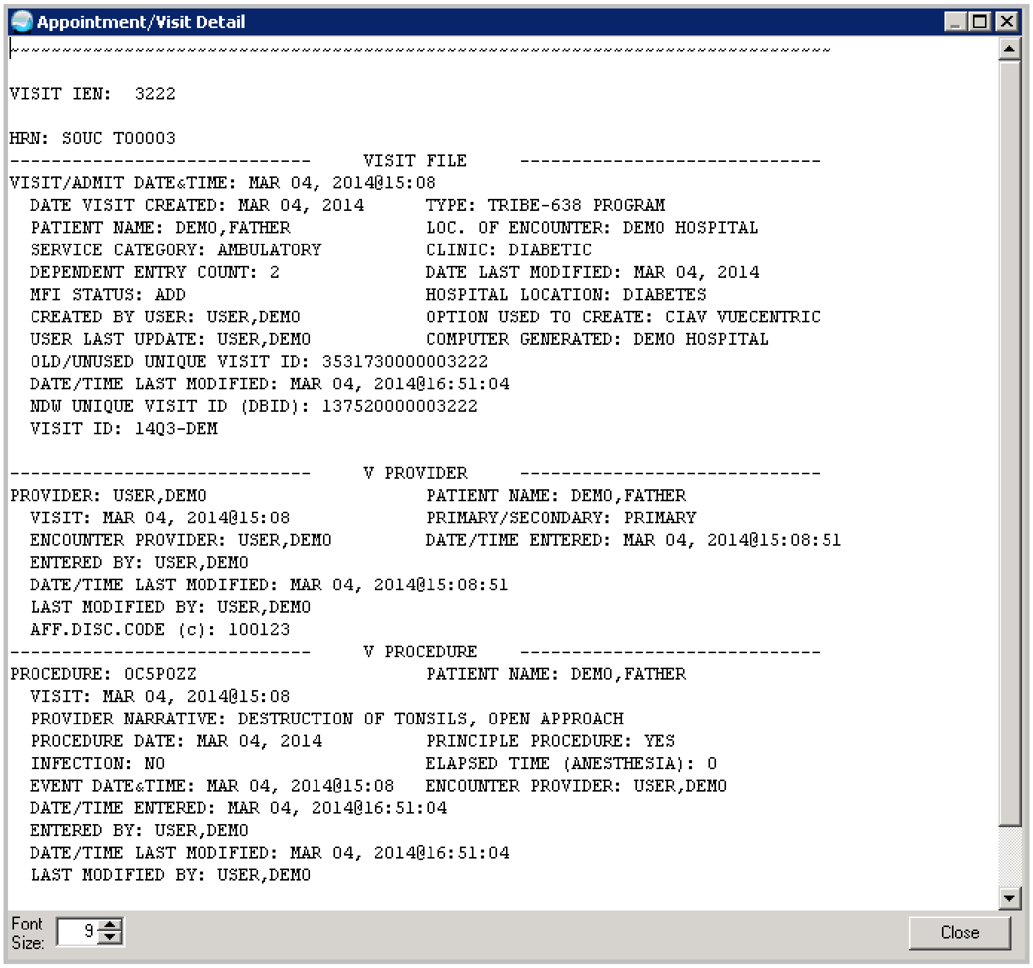
4.2.1.1 Visit Detail Prior to Implementation



```
Appointment/Visit Detail
HRN: 456852                  DOS: 27-Feb-2014 10:11              VISIT IEN: 3717
-----------------------------------  ORDERS  -----------------------------------
                                   <Page 1>

ORDER #: 2975                           STATUS: PENDING
START: Feb 27, 2014                     STOP:
MAMMOGRAM BILAT
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

VISIT IEN:  3717

HRN: SOUC 456852
-----------------------------     VISIT FILE     -----------------------------
VISIT/ADMIT DATE&TIME: FEB 27, 2014@10:11
  DATE VISIT CREATED: FEB 27, 2014      TYPE: TRIBE-638 PROGRAM
  PATIENT NAME: JONES,ISABELLA          LOC. OF ENCOUNTER: DEMO HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: DIABETIC
  DEPENDENT ENTRY COUNT: 2              DATE LAST MODIFIED: FEB 27, 2014
  MFI STATUS: ADD                       HOSPITAL LOCATION: TEST CLINIC
  CREATED BY USER: USER,DEMO            OPTION USED TO CREATE: CIAV VUECENTRIC
  USER LAST UPDATE: USER,DEMO           COMPUTER GENERATED: DEMO HOSPITAL
  OLD/UNUSED UNIQUE VISIT ID: 3531730000003717
  DATE/TIME LAST MODIFIED: FEB 27, 2014@10:12:03
  NDW UNIQUE VISIT ID (DBID): 137520000003717
  VISIT ID: 15DD-DEM

-----------------------------     V PROVIDER     -----------------------------
PROVIDER: USER,DEMO                     PATIENT NAME: JONES,ISABELLA
  VISIT: FEB 27, 2014@10:11             PRIMARY/SECONDARY: PRIMARY
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: FEB 27, 2014@10:11:45
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: FEB 27, 2014@10:11:45
  LAST MODIFIED BY: USER,DEMO
  AFF.DISC.CODE (c): 100123
-----------------------------     V PROCEDURE     -----------------------------
PROCEDURE: 45.23                        PATIENT NAME: JONES,ISABELLA
  VISIT: FEB 27, 2014@10:11             PROVIDER NARRATIVE: COLONOSCOPY
  PROCEDURE DATE: FEB 27, 2014          PRINCIPLE PROCEDURE: YES
  INFECTION: NO                         ELAPSED TIME (ANESTHESIA): 0
  EVENT DATE&TIME: FEB 27, 2014@10:11   ENCOUNTER PROVIDER: USER,DEMO
  DATE/TIME ENTERED: FEB 27, 2014@10:12:03
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: FEB 27, 2014@10:12:03
  LAST MODIFIED BY: USER,DEMO
  PROCEDURE NARRATIVE (c): COLONOSCOPY

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Font Size: 9                                                              Close
```

Figure 4-10: Appointment/Visit Detail Prior to Implementation

4.2.1.2 Visit Detail After Implementation




```
VISIT IEN:  3222

HRN: SOUC T00003
-----------------------------     VISIT FILE     -----------------------------
VISIT/ADMIT DATE&TIME: MAR 04, 2014@15:08
  DATE VISIT CREATED: MAR 04, 2014      TYPE: TRIBE-638 PROGRAM
  PATIENT NAME: DEMO,FATHER             LOC. OF ENCOUNTER: DEMO HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: DIABETIC
  DEPENDENT ENTRY COUNT: 2              DATE LAST MODIFIED: MAR 04, 2014
  MFI STATUS: ADD                       HOSPITAL LOCATION: DIABETES
  CREATED BY USER: USER,DEMO            OPTION USED TO CREATE: CIAV VUECENTRIC
  USER LAST UPDATE: USER,DEMO           COMPUTER GENERATED: DEMO HOSPITAL
  OLD/UNUSED UNIQUE VISIT ID: 3531730000003222
  DATE/TIME LAST MODIFIED: MAR 04, 2014@16:51:04
  NDW UNIQUE VISIT ID (DBID): 137520000003222
  VISIT ID: 14Q3-DEM

-----------------------------     V PROVIDER     -----------------------------
PROVIDER: USER,DEMO                     PATIENT NAME: DEMO,FATHER
  VISIT: MAR 04, 2014@15:08             PRIMARY/SECONDARY: PRIMARY
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: MAR 04, 2014@15:08:51
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: MAR 04, 2014@15:08:51
  LAST MODIFIED BY: USER,DEMO
  AFF.DISC.CODE (c): 100123
-----------------------------     V PROCEDURE    -----------------------------
PROCEDURE: 0C5P0ZZ                      PATIENT NAME: DEMO,FATHER
  VISIT: MAR 04, 2014@15:08
  PROVIDER NARRATIVE: DESTRUCTION OF TONSILS, OPEN APPROACH
  PROCEDURE DATE: MAR 04, 2014          PRINCIPLE PROCEDURE: YES
  INFECTION: NO                         ELAPSED TIME (ANESTHESIA): 0
  EVENT DATE&TIME: MAR 04, 2014@15:08   ENCOUNTER PROVIDER: USER,DEMO
  DATE/TIME ENTERED: MAR 04, 2014@16:51:04
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: MAR 04, 2014@16:51:04
  LAST MODIFIED BY: USER,DEMO
```


Figure 4-11: Appointment/Visit Detail After Implementation

The font size of the text displayed can be changed by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows). This does not change the size of the text on the output when you print.

1. Click Print to choose a printer and to output the entire contents of this pop-up window to the specified printer. The Print button appears depending on how your application is configured.

   There is 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 such as MS Word.

2. Click Close to dismiss the pop-up window.

4.3 Chart Review

As a part of Meaningful Use, providers are required to document that they have reviewed the patient's problem list, medication list, and allergies. Providers must report if a patient has no problems, allergies and/or active medications.

To gather this information easily, the Update/Review component can capture all of this data in one area. Providers can then sign off on all the updates at one time.

When a medication, allergy, or problem is added or edited, the update action is automatically recorded.

The Update/Review component appears as shown below. The action is reset for each visit of the patient. When the provider initially logs on to the visit, all items appear as needing review.

Figure 4-12: Needs Review at Start of Visit

4.3.1 Reviewing Actions

1. Click any button to bring up one of two actions. If the patient has problems, medications, or allergies, the Reviewed action can be selected.

Figure 4-13: Patient with Allergies

If the patient does not have any of the items in review, the No Active action can be selected.

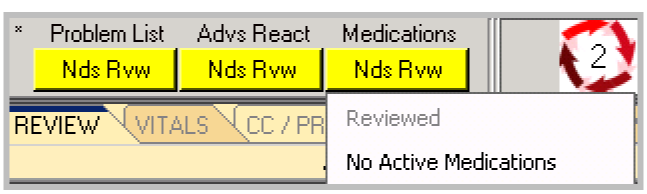


Figure 4-14: Patient with No Active Medications

2. Select the action to be performed. When the item is reviewed, an [R] appears, since it has not yet been signed.

Figure 4-15: Reviewed Before Signature

- If the action is no active medications, problems, allergies, then [RN] appears indicating that it has been reviewed and has not yet been signed.

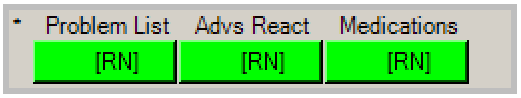


Figure 4-16: No Active Problems, Allergies, or Medications Before Signature

- If a medication, allergy, or problem is added or updated during the visit, a [U] appears, indicating that it has been updated.

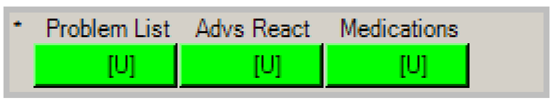


Figure 4-17: Updated Before Signature Items

- If a medication, allergy, or problem was added or updated and reviewed but not signed yet during the visit, an [RU] appears in the appropriate area.

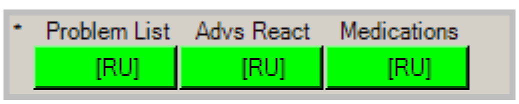


Figure 4-18: Reviewed, Updated, and Unsigned

- If medications, allergies, or problems have been updated so that there are no active items remaining and the No Active action has been selected, [RUN] appears in the appropriate area.

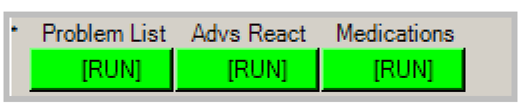


Figure 4-19: Reviewed, Updated, and No Active Problems, Allergies, and Medications

3. The Signature Tool is now enabled and the provider is able to sign. Click the Signature took and sign. The check boxes can be cleared of any items that are no longer applicable and the Reviewed actions are signed.

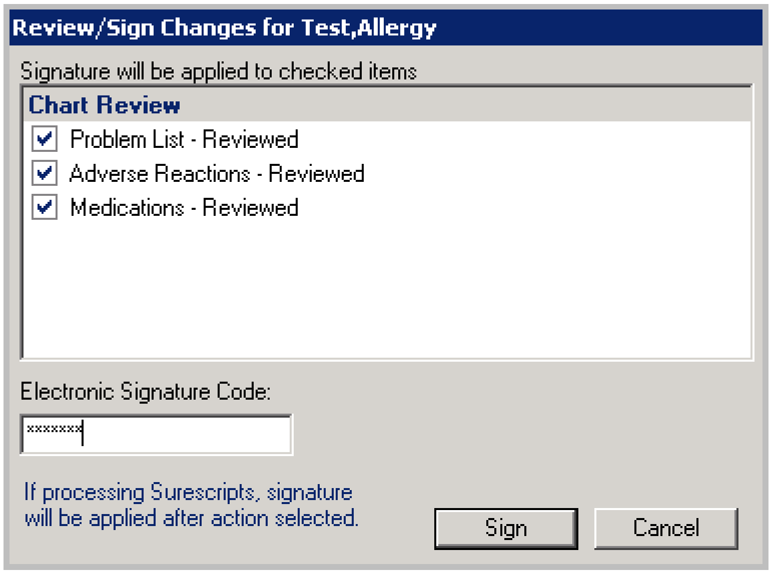


Figure 4-20: Signature Tool

Once signed, the buttons display R without the brackets.

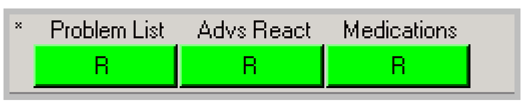


Figure 4-21: Items Reviewed

4.3.2 Updating from Components

Components on the Cover Sheet incorporate the Chart Review. The provider can also right-click the problem list, allergies, or medications components on the Cover Sheet to review or document no active allergies, medications, or problems. Once Chart Review is selected, the function works the same as using the Chart Review component directly.

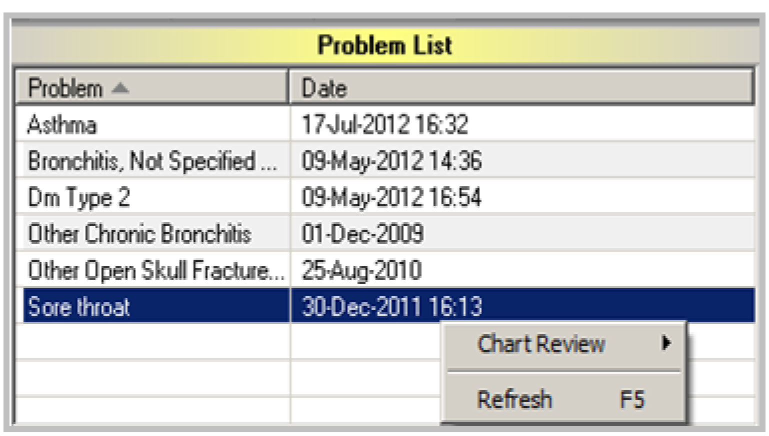


Figure 4-22: Chart Review on Problems

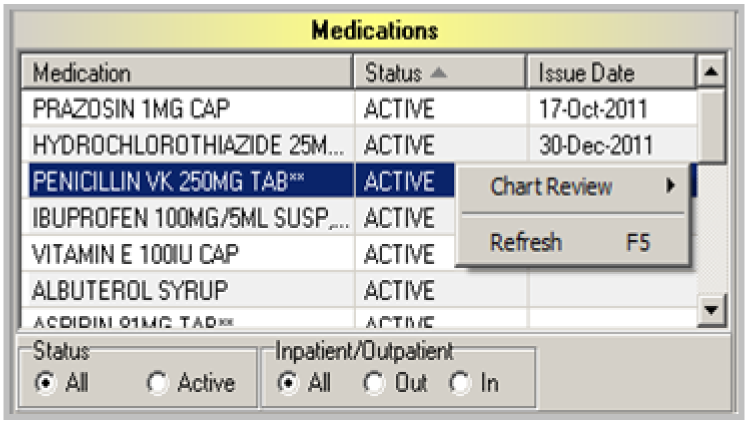


Figure 4-23: Chart Review on Medications

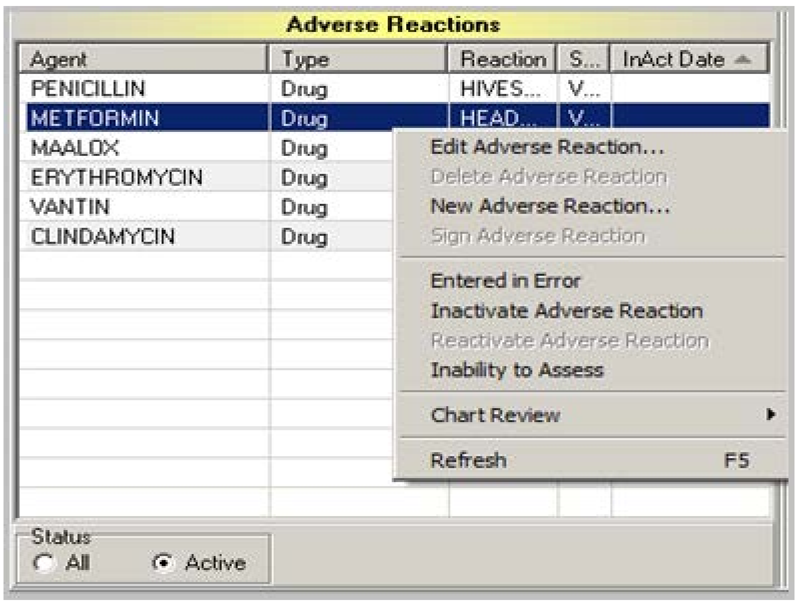


Figure 4-24: Chart Review on Allergies

Documenting the Chart Review from the Cover Sheet component enters the [R] in the Chart Review component. It enables the Signature Tool, which performs as if entered directly from the Chart Review component itself.

4.4 Clinical Information Reconciliation (CIR)

The Clinical Information Reconciliation (CIR) module 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.

4.4.1 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.

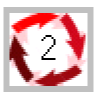


Figure 4-25: Unreconciled CIR Button

- 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 4-26: Reconciled CIR Button

Note:	If no patient is selected, the CIR button displays in green with the initials CIR in the center. If you briefly rest your mouse pointer on the button, the title Clinical Information Reconciliation (CIR) displays. 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 4-27: Reconciled Message

4.4.2 Orientation

The CIR Tool contains the following panes, tabs, columns, menus, and buttons. Their functionality is outlined below.

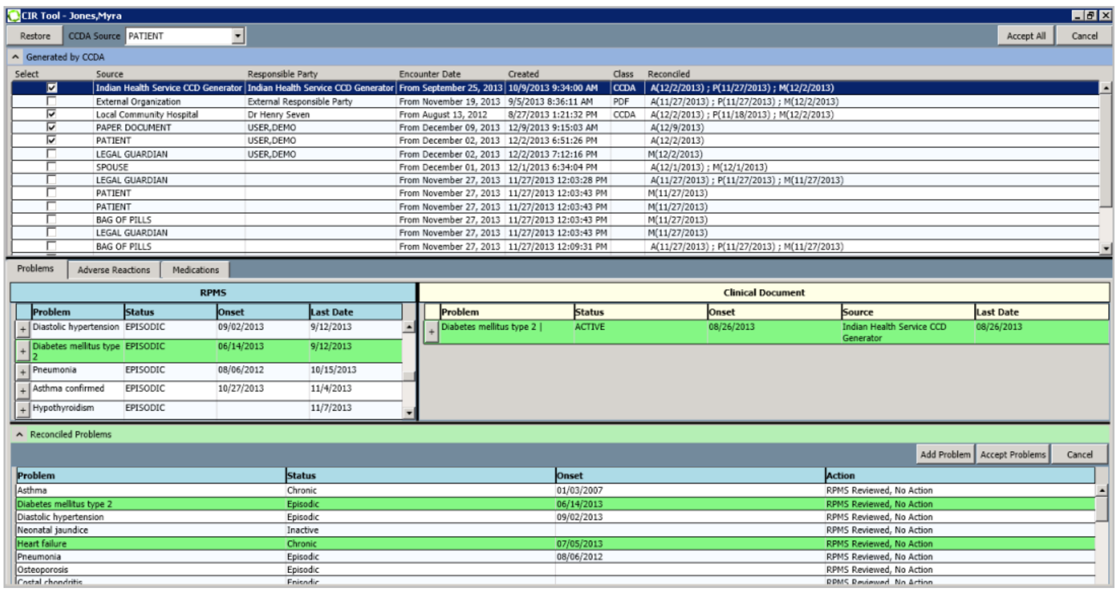


Figure 4-28: CIR Tool Main Window with Problems Tab Selected

4.4.2.1 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 Document

If no CCDA document is available, the ability to select an information source and reconcile the chart can be completed by selecting one of the sources listed above.

- **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 Continuity of Care Record.
  - **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.

4.4.2.2 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

4.4.2.3 Columns

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

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.

4.4.2.4 Right-Click Menus

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.

Figure 4-29: CCD Right-Click Menu

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

Figure 4-30: 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.

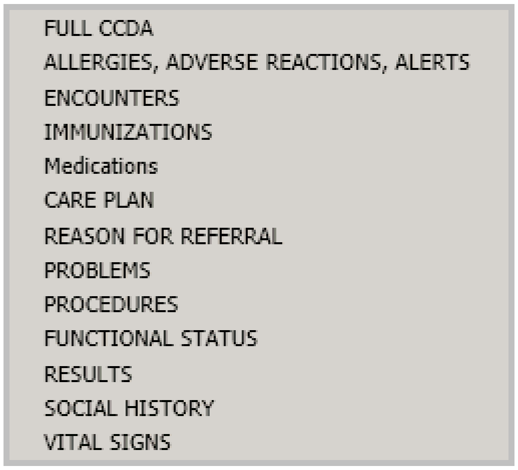


Figure 4-31: CCDA Right-Click Menu

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

Figure 4-32: 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 below.

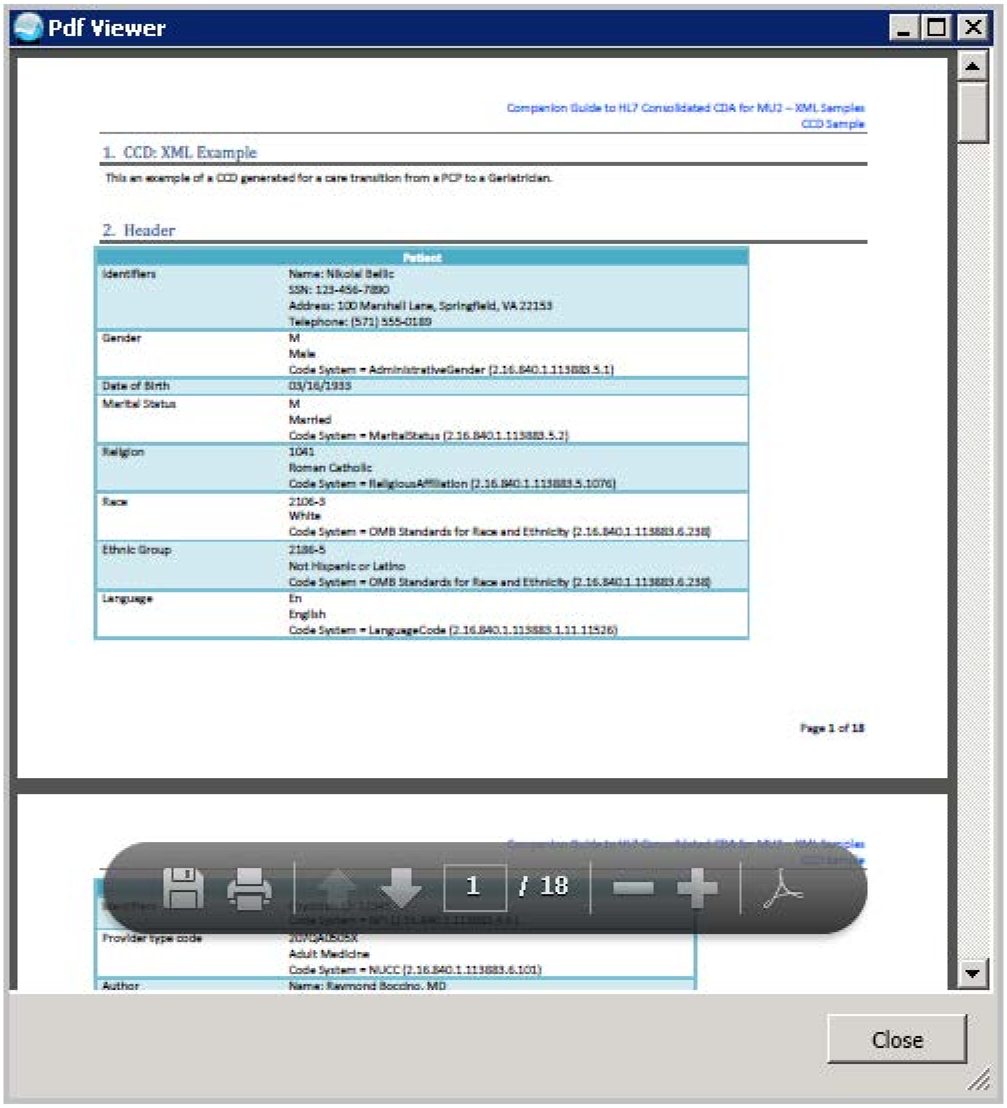


Figure 4-33: PDF Viewer

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.

4.4.2.5 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.
- **Expand button:** Click the Expand button (+) in the RPMS or Clinical Document pane next an item to view additional details, such as Problem ID, Status, Description, and so on.

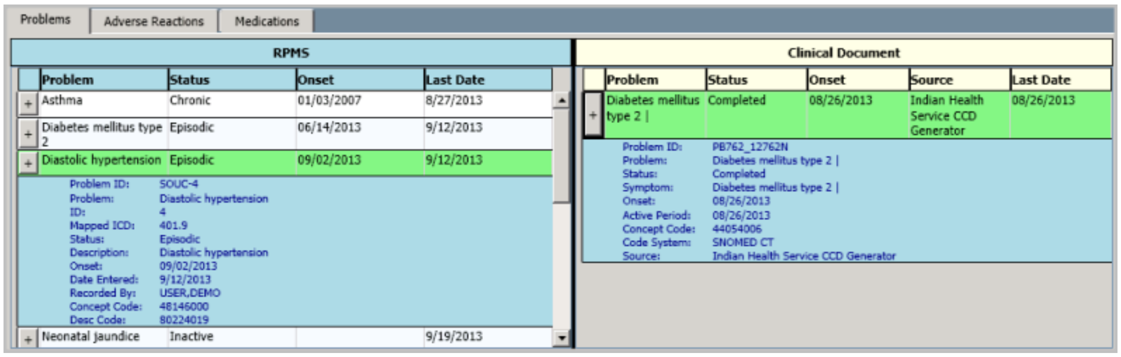


Figure 4-34: Expand Details

4.4.3 Problems

4.4.3.1 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 .xml.

An example of the Problems tab and corresponding Clinical Document and Reconciled panes is shown below.

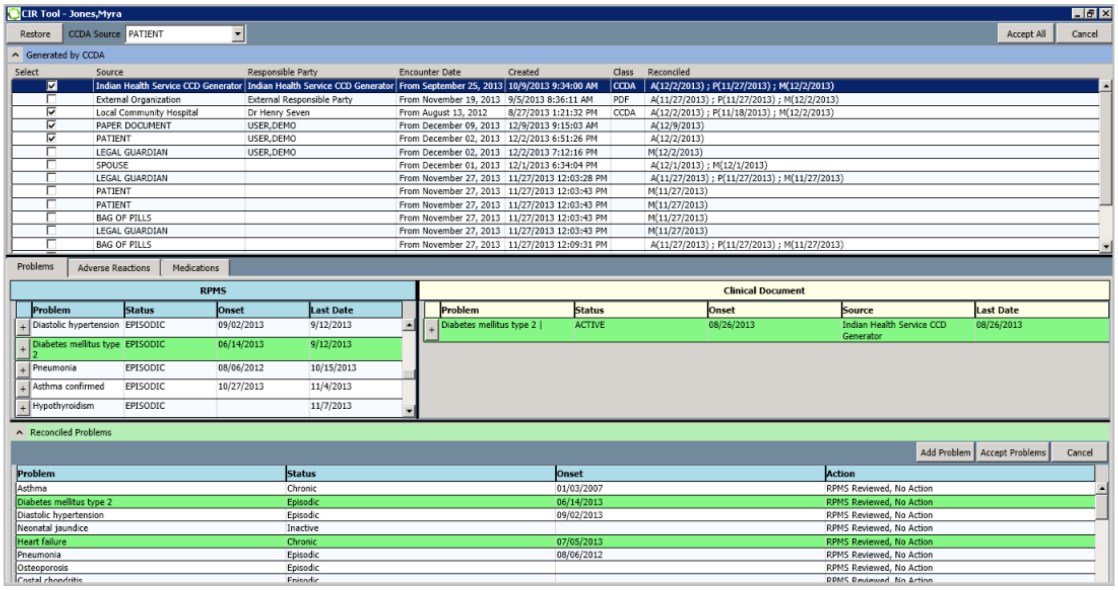


Figure 4-35: CIR Tool Problems Tab

4.4.3.2 RPMS Pane

The problems listed in the RPMS pane that have a match (by SNOMED 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 coded, an asterisk shows before the problem name.

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

4.4.3.2.1 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.

4.4.3.2.2 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 RPMS pane contains the following commands:

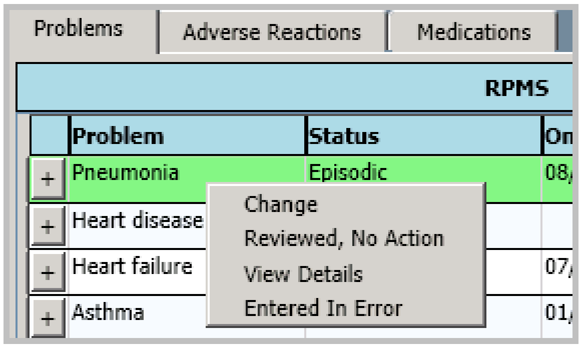


Figure 4-36: Problem RPMS Right-Click Menu

- **Change:** The Reconcile RPMS Problem dialog opens. Refer to the Changing 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 above. Refer to the applicable sections in this Help for details.

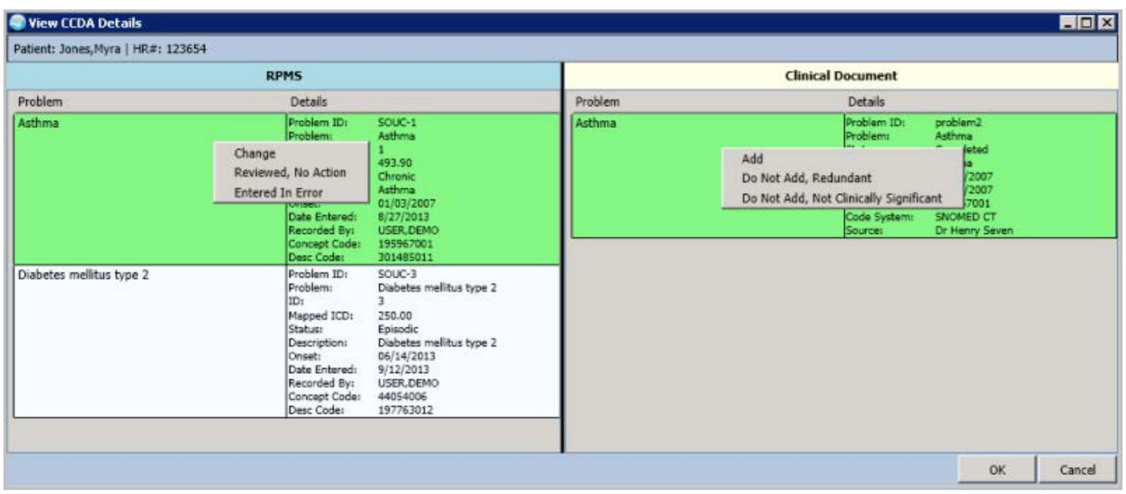


Figure 4-37: View Problem Details Dialog

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

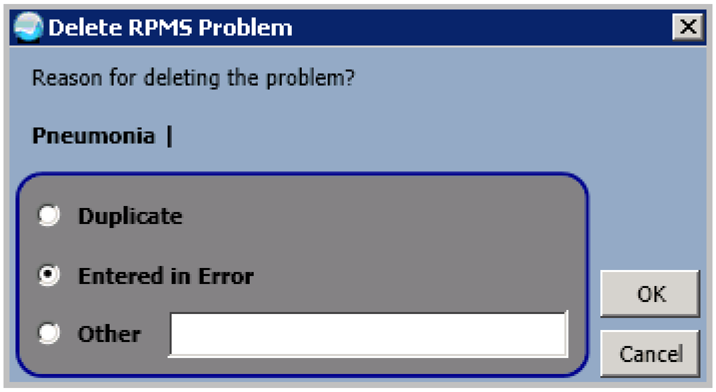


Figure 4-38: Delete RPMS Problem Dialog

> **Note:** A problem can only be deleted if it never was used as a POV for the visit, and does not contain Visit Instructions, Care Planning, and goals.

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.

4.4.3.3 Clinical Document Pane

4.4.3.3.1 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.

4.4.3.3.2 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:

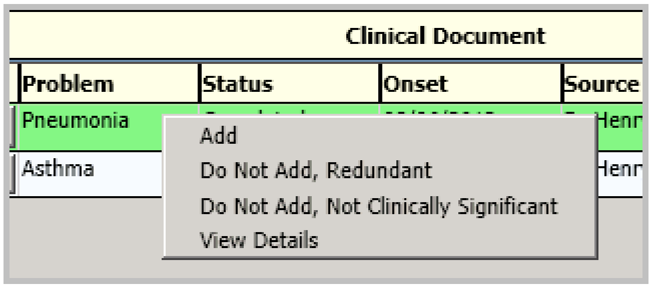


Figure 4-39: Clinical Document Right-Click Menu

- **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.

4.4.3.4 Reconciled Problems Pane

4.4.3.4.1 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.

4.4.3.4.2 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.

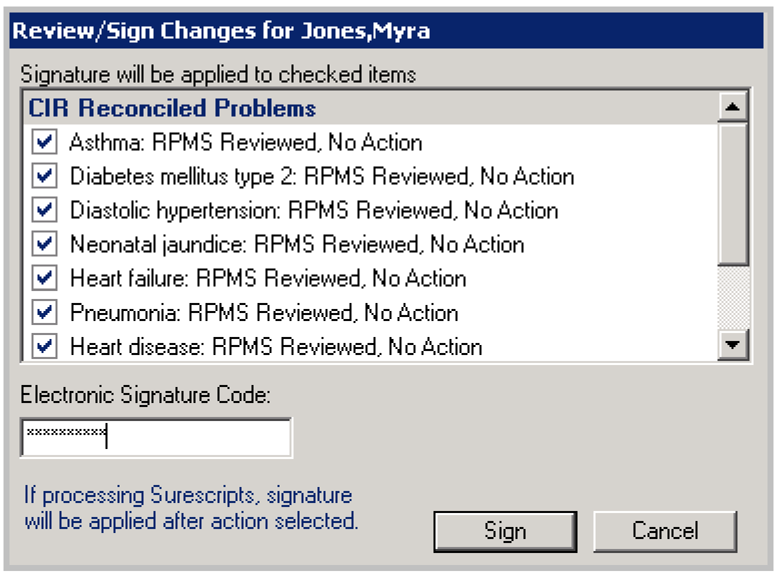


Figure 4-40: Review/Sign Changes for Patient Name Dialog

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.

4.4.4 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:

- SNOMED CT code
- Status is Episodic by default

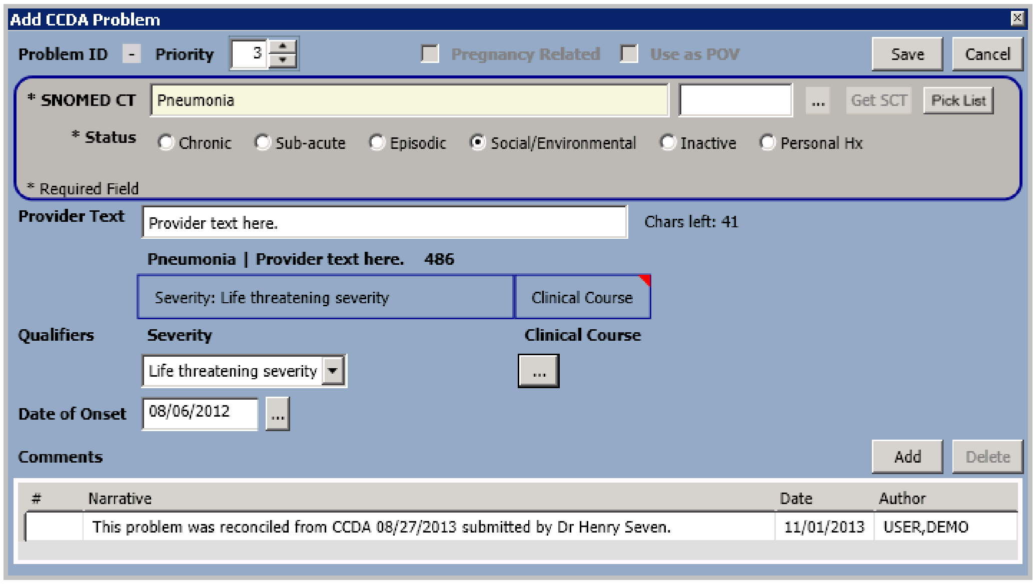


Figure 4-41: Completed Add CCDA Problem Dialog

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

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

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

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

   If the selected SNOMED CT matches an existing entry in the problem file for the patient, an information message displays that a problem with the same SNOMED ConceptID already exists. Click OK to dismiss the message and select a different SNOMED CT.

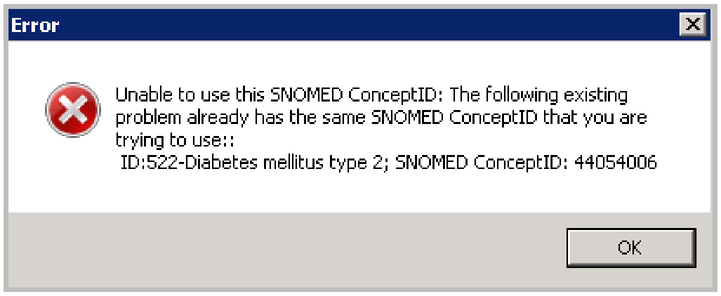


Figure 4-42: Duplicate SNOMED CT Error Message

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

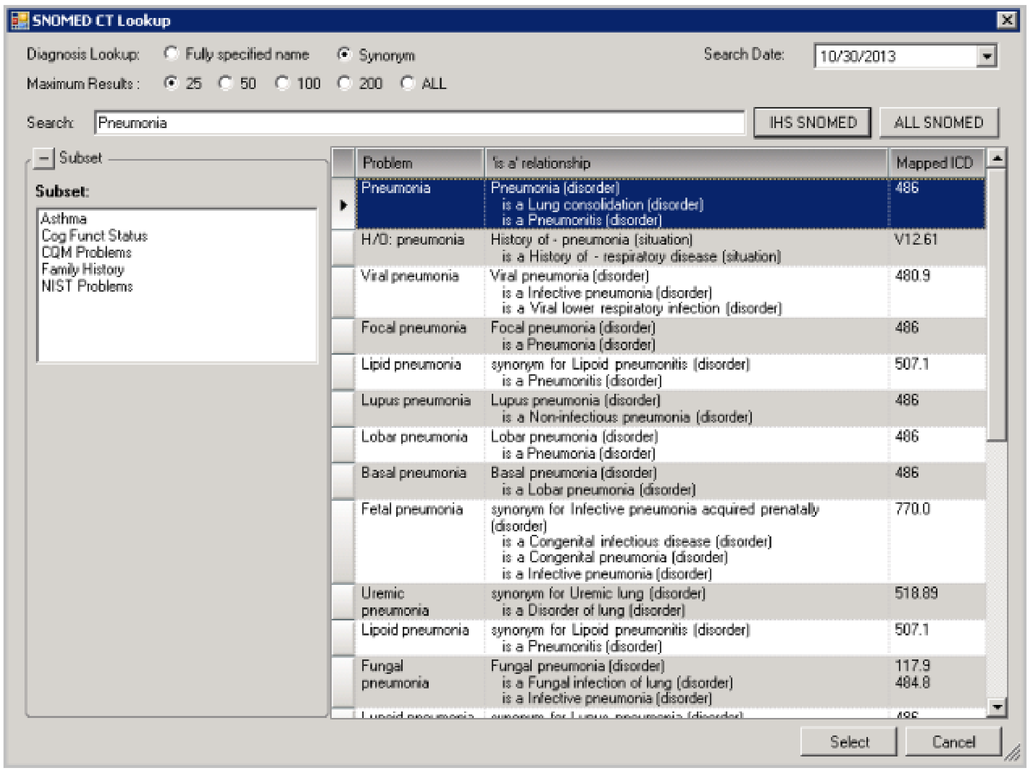


Figure 4-43: SNOMED CT Dialog

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:

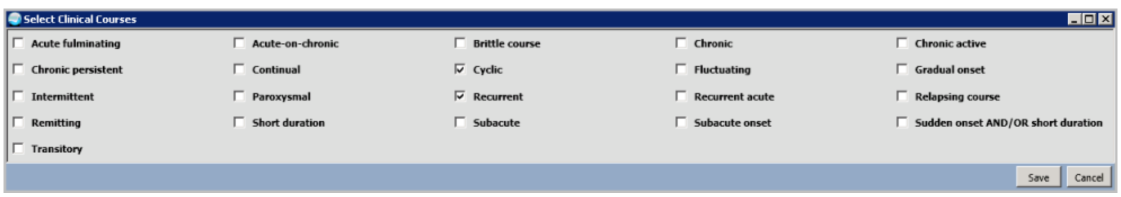


Figure 4-44: Select Clinical Courses Dialog

> **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, the Reconciled Problems pane shows a CCDA: Add Problem status in the Action column, and the problem is added to the Integrated Problem List (IPL).

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

4.4.5 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.

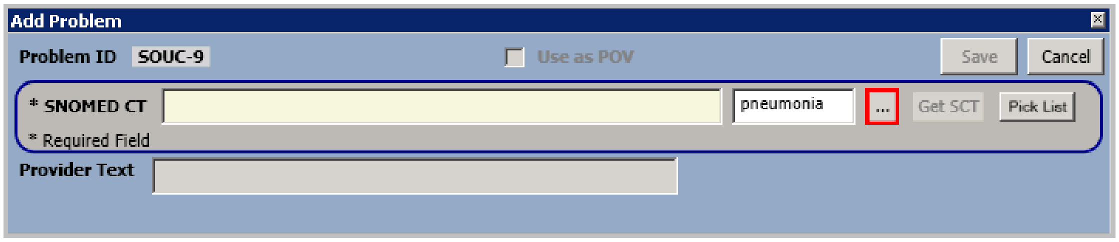


Figure 4-45: Add Problem Dialog from Reconciled Problems Pane

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 terms in the list.

   If the selected SNOMED CT matches an existing entry in the problem file for the patient, an error message displays that a problem with the same SNOMED ConceptID already exists. Click OK to dismiss the message and select a different SNOMED CT.

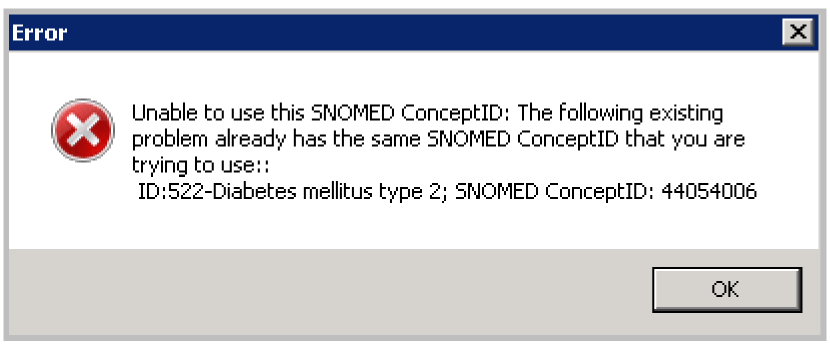


Figure 4-46: Duplicate SNOMED CT Error Message

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

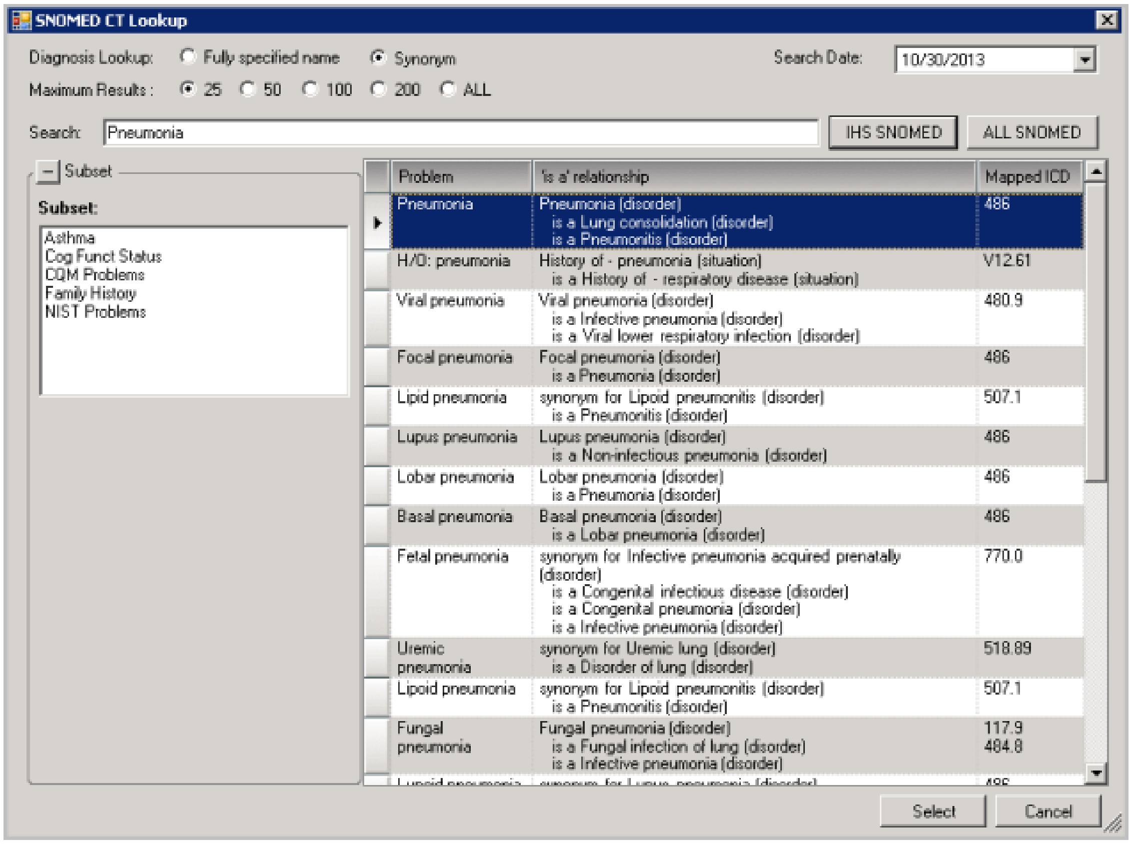


Figure 4-47: SNOMED CT Dialog

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 to search.

e. In Subset, you can select a subset to search, if needed.

f. Click either the IHS SNOMED or the ALL SNOMED 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:

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

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:

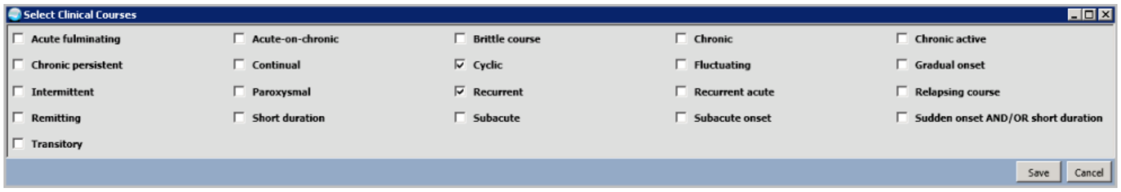


Figure 4-48: Select Clinical Courses Dialog

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.

8. Click Save in the top-right portion of the Add CCDA Problem dialog. Your changes are saved, the Reconciled Problems pane shows a CCDA: Add Problem status in the Action column, and the problem is added to the Integrated Problem List (IPL).

4.4.6 Changing RPMS Problems

From the PRMS Pane right-click menu, if the Change option is selected, the Edit Problem dialog opens. Follow the steps below to complete the dialog.

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

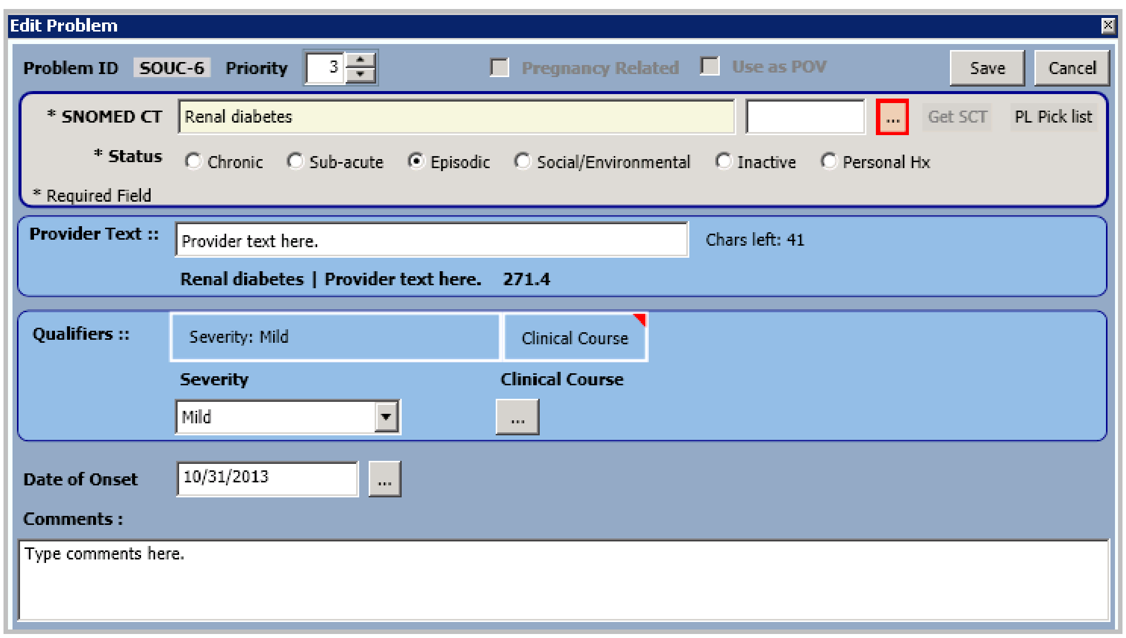


Figure 4-49: Edit Problem Dialog

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

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

2. In the SNOMED CT field, the selected problem is auto-populated. Click the Ellipsis button to search for the SNOMED CT Code. The SNOMED CT Lookup dialog opens.

   If the selected SNOMED CT matches an existing entry in the problem file for the patient, an information message displays that a problem with the same SNOMED ConceptID already exists. Click OK to dismiss the message and select a different SNOMED CT.

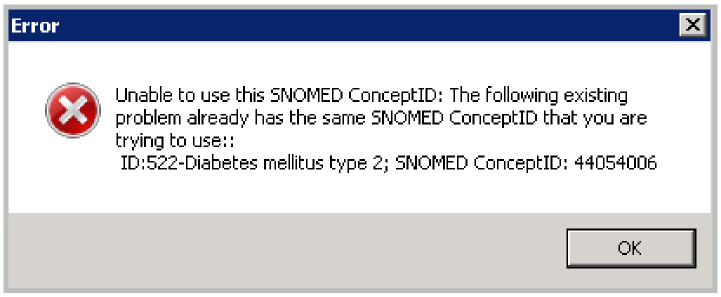


Figure 4-50: Duplicate SNOMED CT Error Message

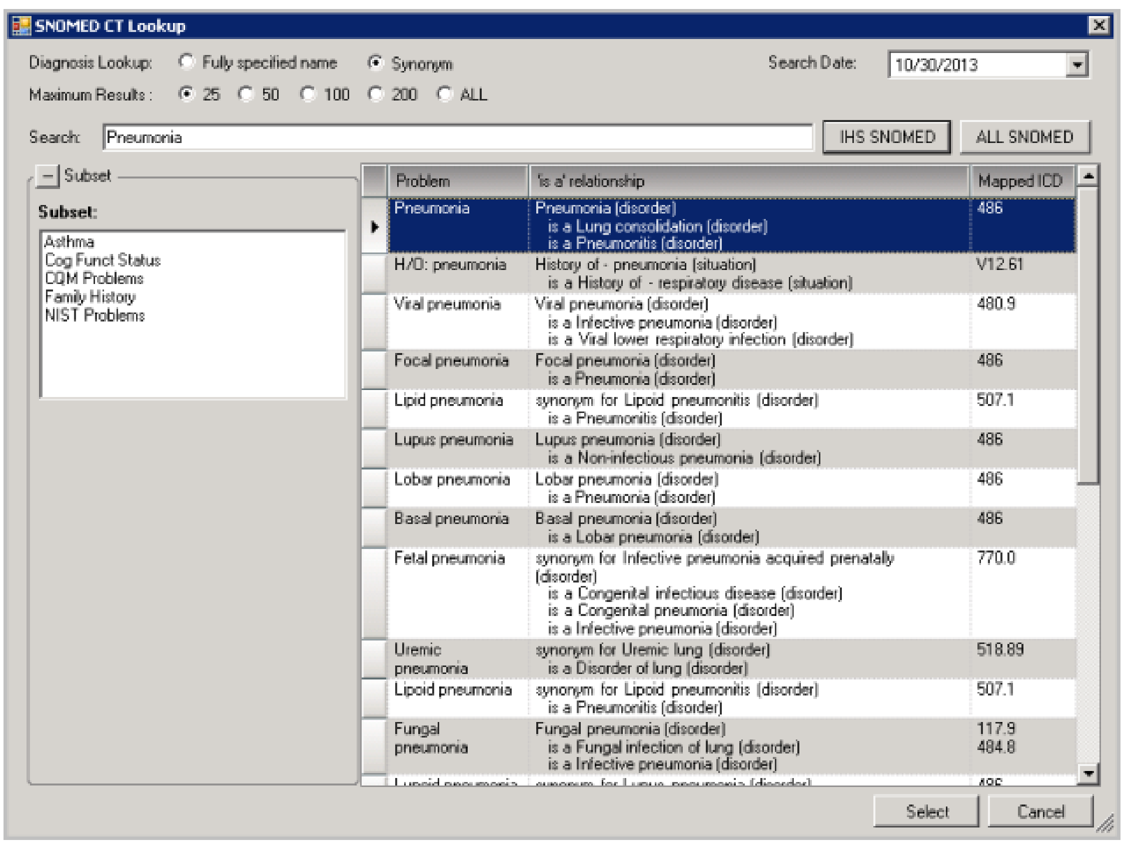


Figure 4-51: SNOMED CT Dialog

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 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
   - 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 to search for.

e. In Subset, you can select a subset to search, if needed.

f. Click either the IHS SNOMED or the ALL SNOMED 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.

3. If the Problem is ICD coded, but not SNOMED coded, click the Get SCT button. Refer to the Using the Get SCT Button topic for details.

Note:	The Get SCT button is only active if the Problem is ICD coded, but not yet SNOMED coded.

4. In Status, select the applicable option button:

   - Chronic
   - Sub-acute
   - Episodic

- Social/Environmental
- Inactive
- Personal Hx

5. 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.

6. 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

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

8. Select one or more of applicable check boxes:

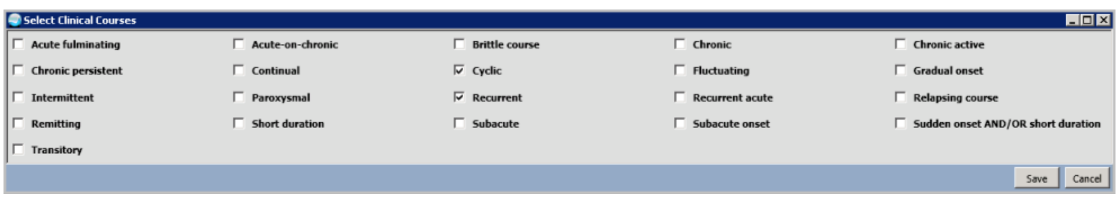


Figure 4-52: Select Clinical Courses Dialog

9. 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.

10. In Comments, type a comment in the field.

11. 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.

4.4.7 Using the Get SCT Button

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

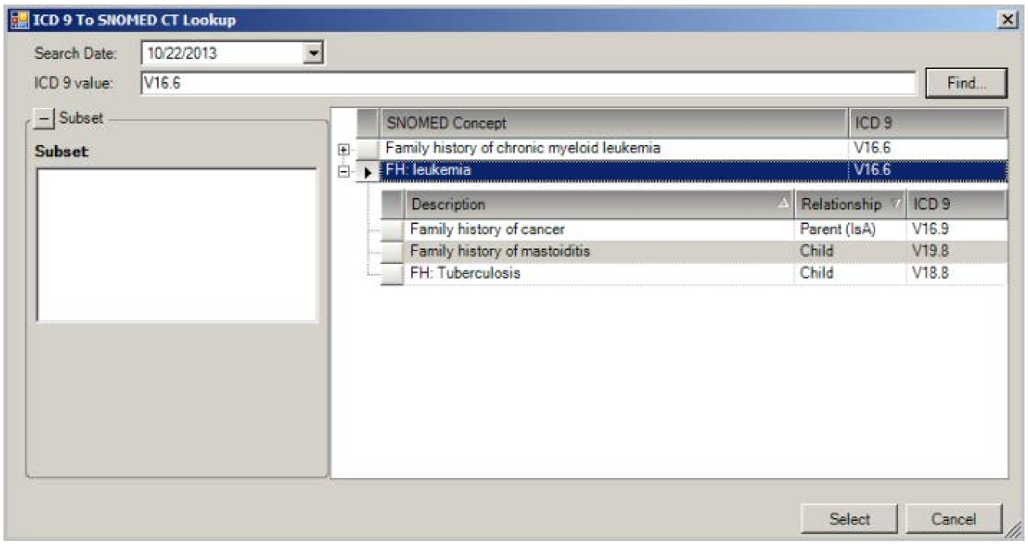


Figure 4-53: ICD 9 to SNOMED CT Lookup Dialog

2. The Search Date field automatically defaults to the current date. Click the 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 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.

4.4.8 Using the PickList Button

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

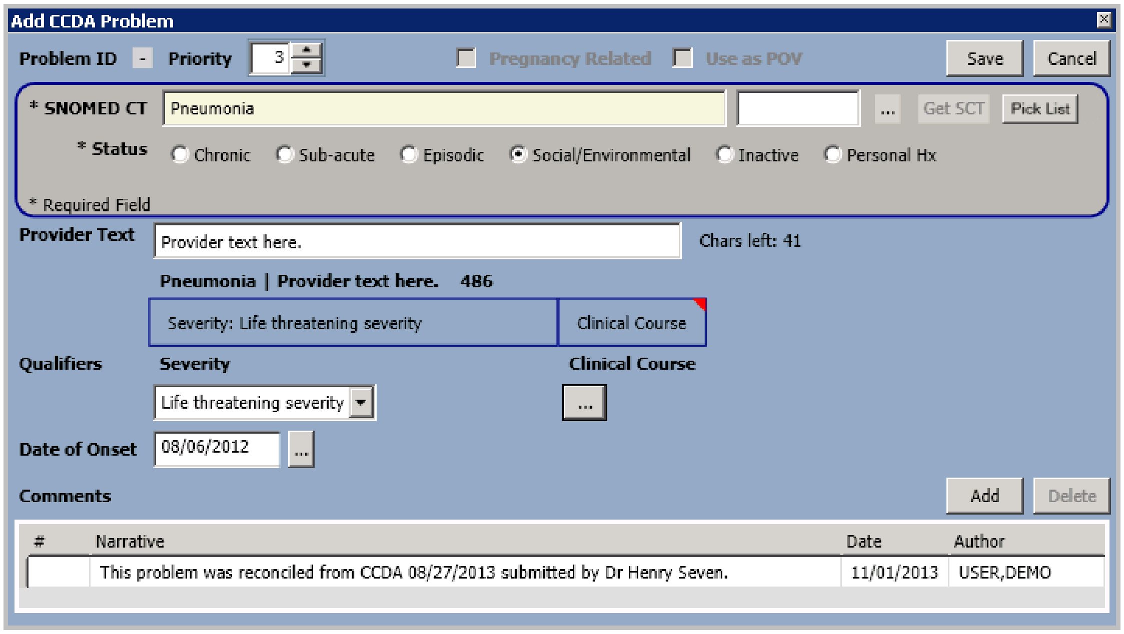


Figure 4-54: Add CCDA Problem Dialog with PickList Button

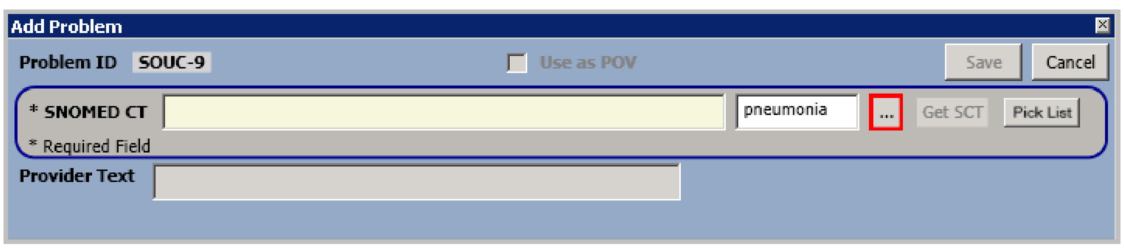


Figure 4-55: Add Problem Dialog with PickList Problem

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

1. Click the PickList button. The PickList Selection dialog opens.

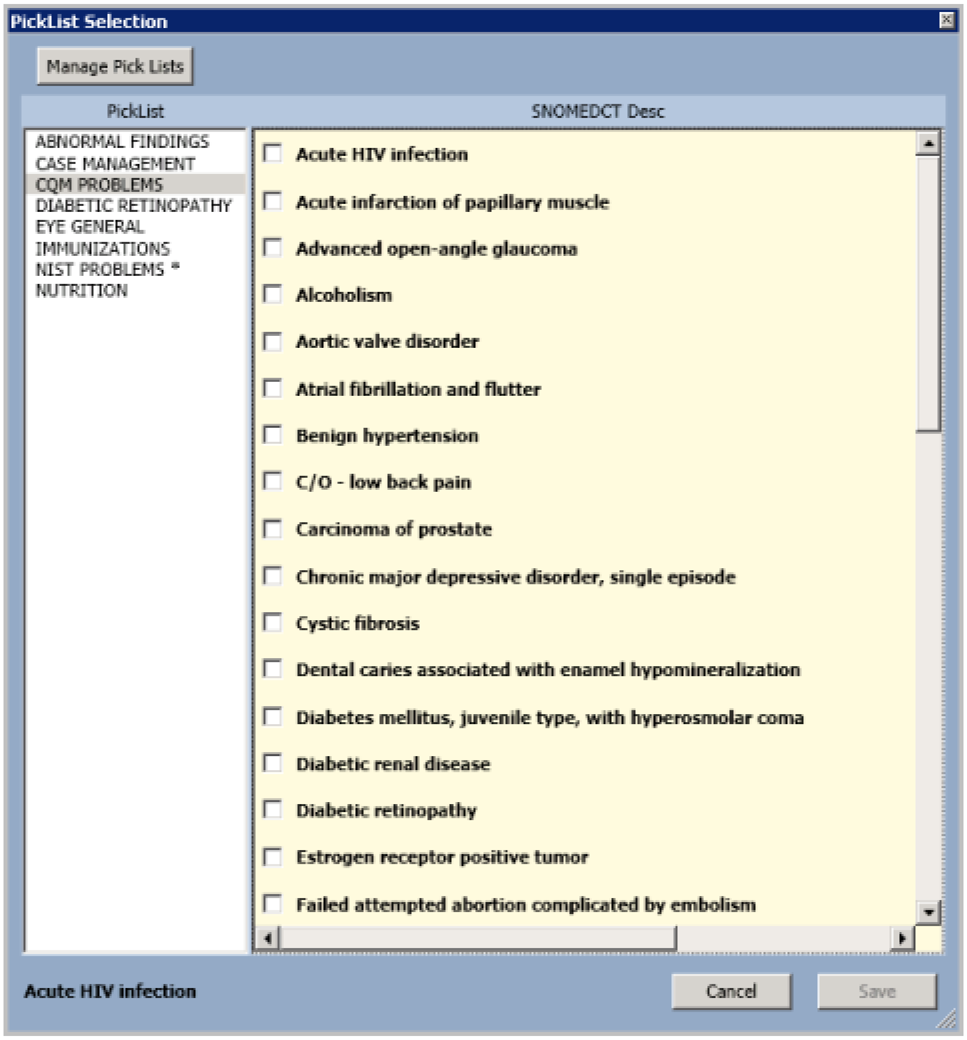


Figure 4-56: Picklist Selection Dialog

2. In the PickList column, select one or more picklists. The SNOMED CT Description column refreshes with the picklist you selected.

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

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

4.4.9 Adverse Reactions Tab

Adverse reactions or allergies may be reconciled by a nurse, pharmacist, provider, or case manager at triage. This may take place at the time of the provider appointment, at pharmacy medication pickup or pharmacy medication management visit, or at a Public Health Nurse (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 below.

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.

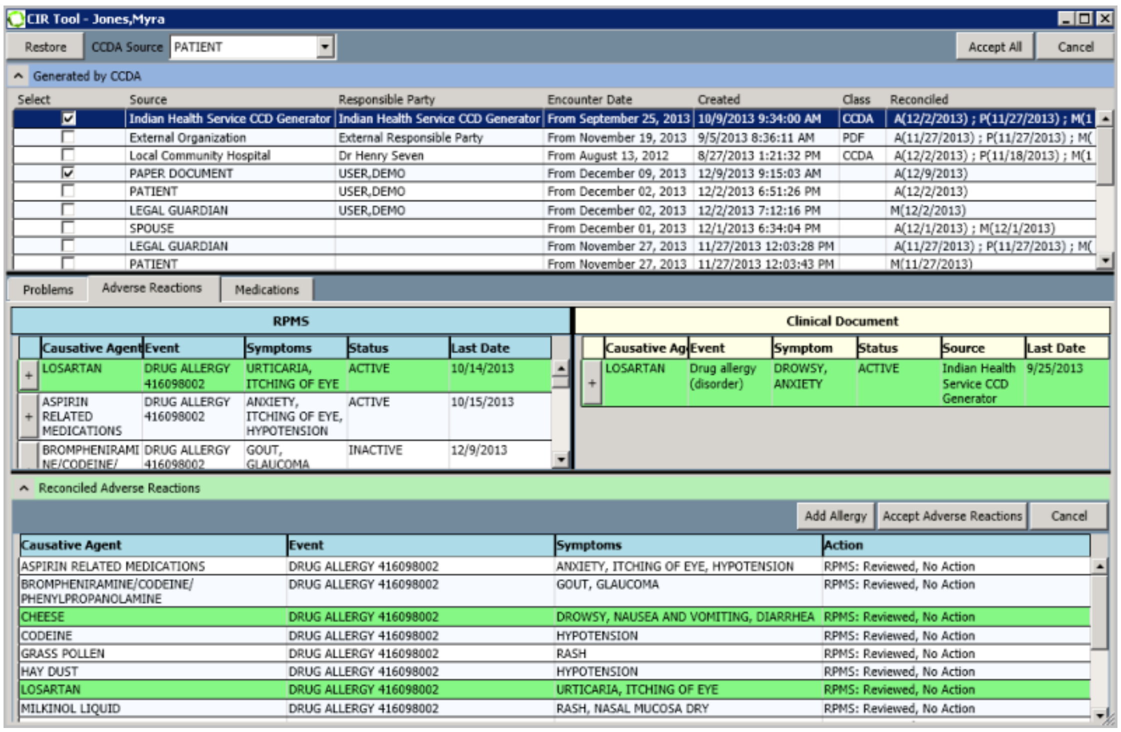


Figure 4-57: CIR Tool Adverse Reactions Tab Main Window

4.4.9.1 RPMS Pane

4.4.9.1.1 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 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

4.4.9.1.2 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:

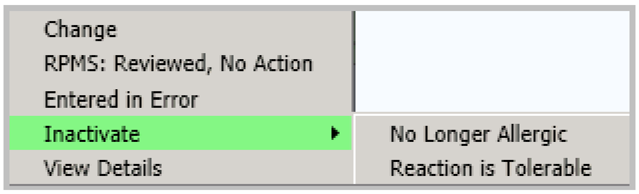


Figure 4-58: Adverse Reaction RPMS Right-Click Menu

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

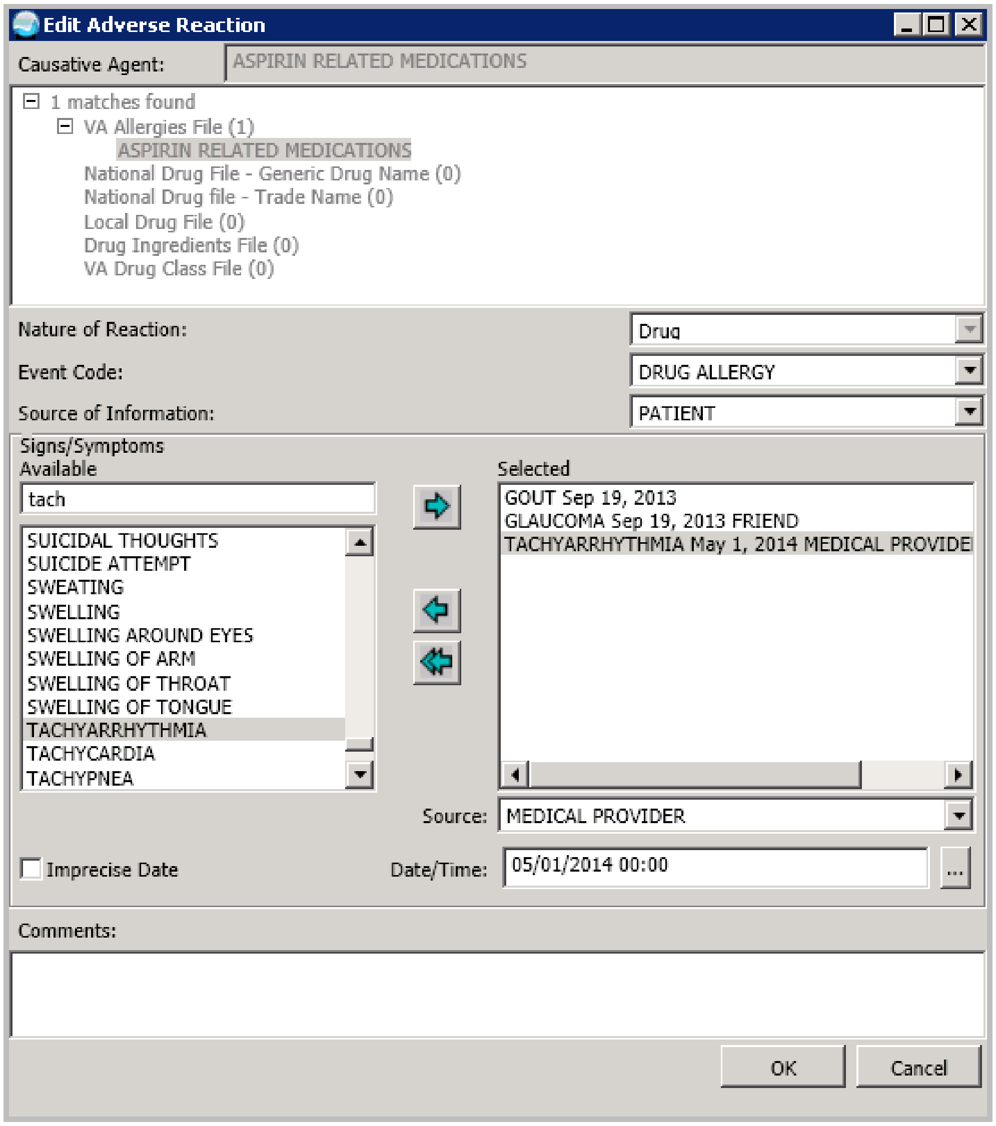


Figure 4-59: Edit Adverse Reaction Dialog

1. The Causative Agent field auto-populates with your selection from the RPMS pane.

2. The Nature of Reaction view-only field is auto-populated depending on the Causative Agent selected when the Adverse Reaction was created.

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, Available field:
   a. Begin typing the first few letters of the sign or symptom. The list refreshes with matching entries as you type.
   b. Select one or more applicable symptoms by clicking your selection and clicking the arrow. As you click the arrow, your selections are moved to the Selected field.

> **Note:** You can click the Move arrows to remove newly added symptoms (all or one at a time) on the current change session. Symptoms previously added cannot be deleted.

6. In the Source (of Signs/Symptoms) field, select one of the drop-down menu options, as listed in step 4.

> **Note:** This field does not become active until a new Sign or Symptom is selected and moved to the Selected field.

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:

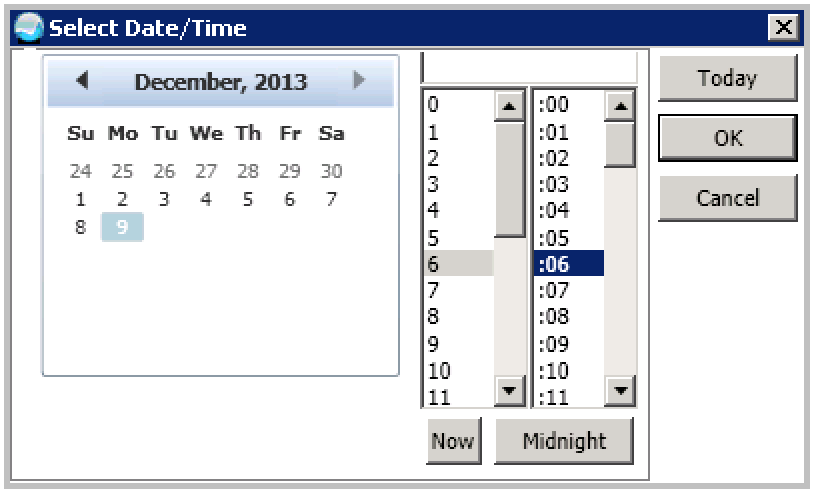


Figure 4-60: Select Date/Time Dialog

- o Select the applicable date and time from the calendar and time sliding scales, and then click OK.
- o Click the Today button to automatically input the current date, and then click OK.
- o Click the Now button to automatically input the current date and time, and then click OK.
- o 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. The Date/Time field changes to a Month and Year menu.

9. Click OK. The Adverse Reaction is updated with your changes in the Reconciled Adverse Reactions pane and shows RPMS: Changed Only, 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.

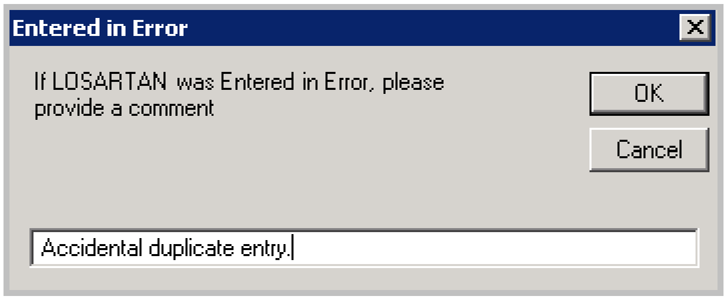


Figure 4-61.Allergy Entered in Error Dialog

1. In the field, type a reason for the error.
2. Click OK. The Reconciled Adverse Reactions pane is updated with the status of RPMS: Entered in Error 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
  - **RPMS Inactive**
  - **RPMS Reactivate**

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 below. Refer to the applicable sections in this Help for details.

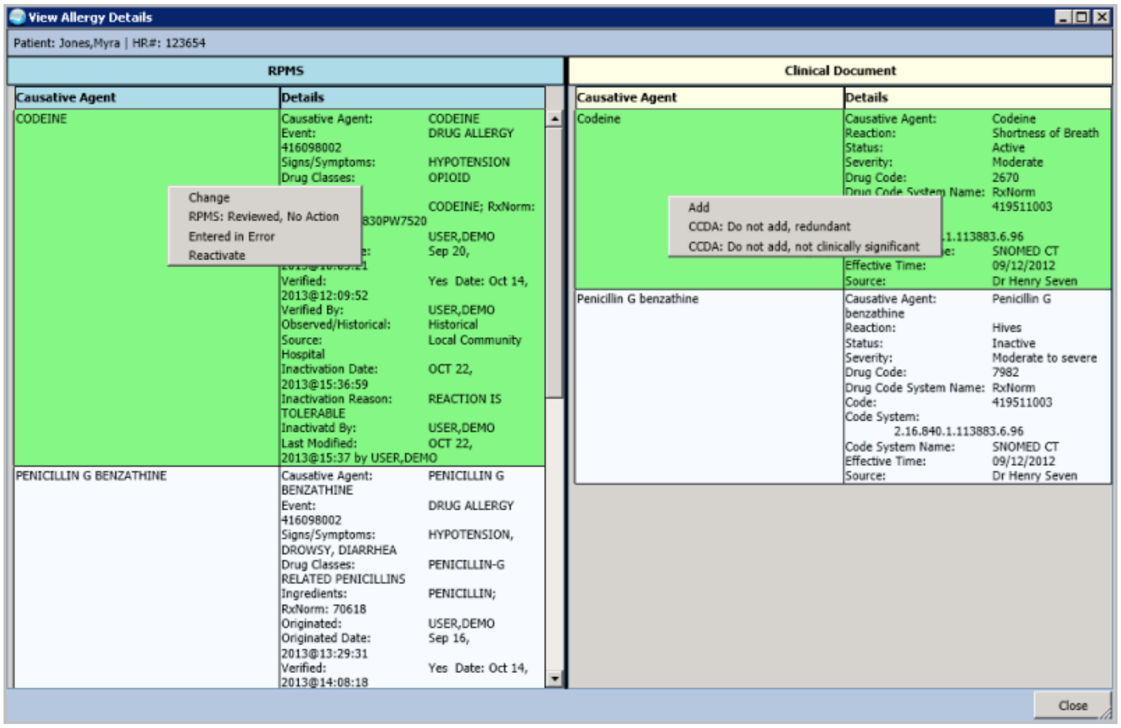


Figure 4-62: View Allergy Details Dialog

4.4.9.2 Clinical Document Pane

4.4.9.2.1 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

4.4.9.2.2 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:

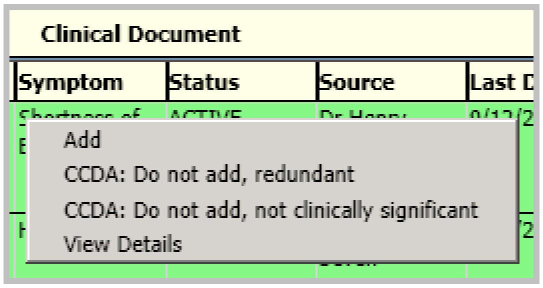


Figure 4-63: Adverse Reaction Clinical Document Right-Click Menu

- **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.

4.4.9.3 Reconciled Adverse Reactions Pane

4.4.9.3.1 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 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.

4.4.9.3.2 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 do not 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.

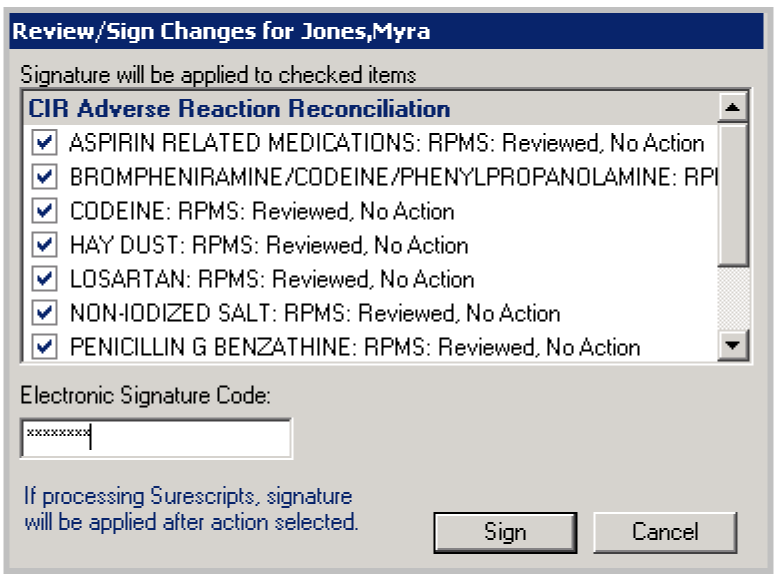


Figure 4-64: Review/Sign Changes for Patient Name Dialog

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.

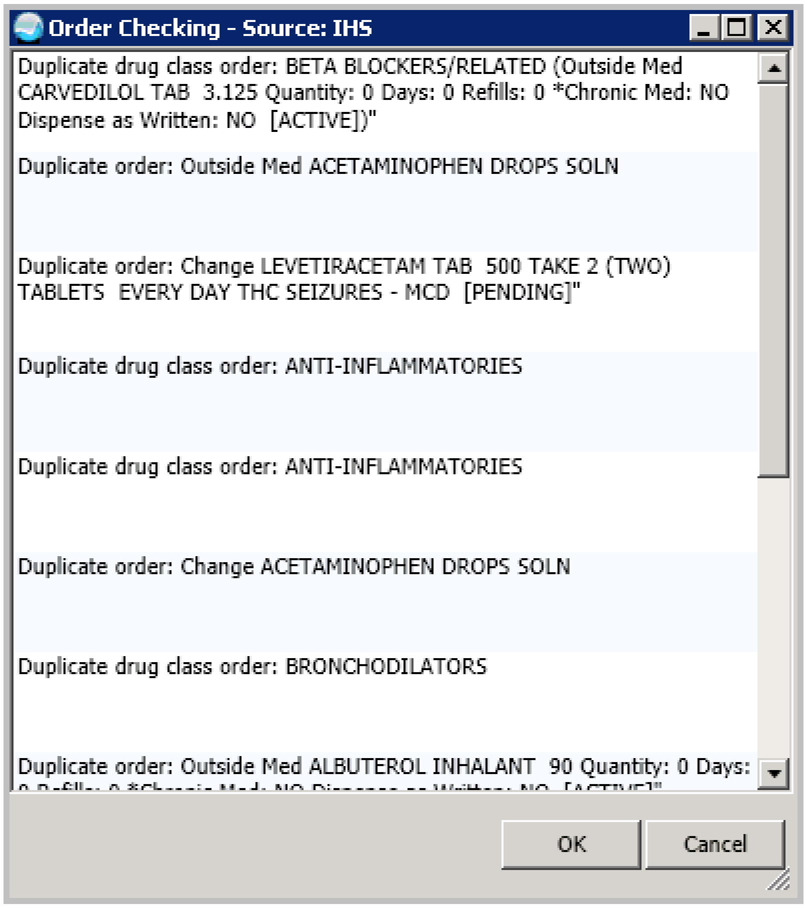


Figure 4-65: Order Checking - Source: IHS Dialog when Accepting Adverse Reactions

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, above.

- **Cancel Button:** Cancels the action.

4.4.9.4 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.

Follow the steps below to complete the Create Adverse Reaction dialog:

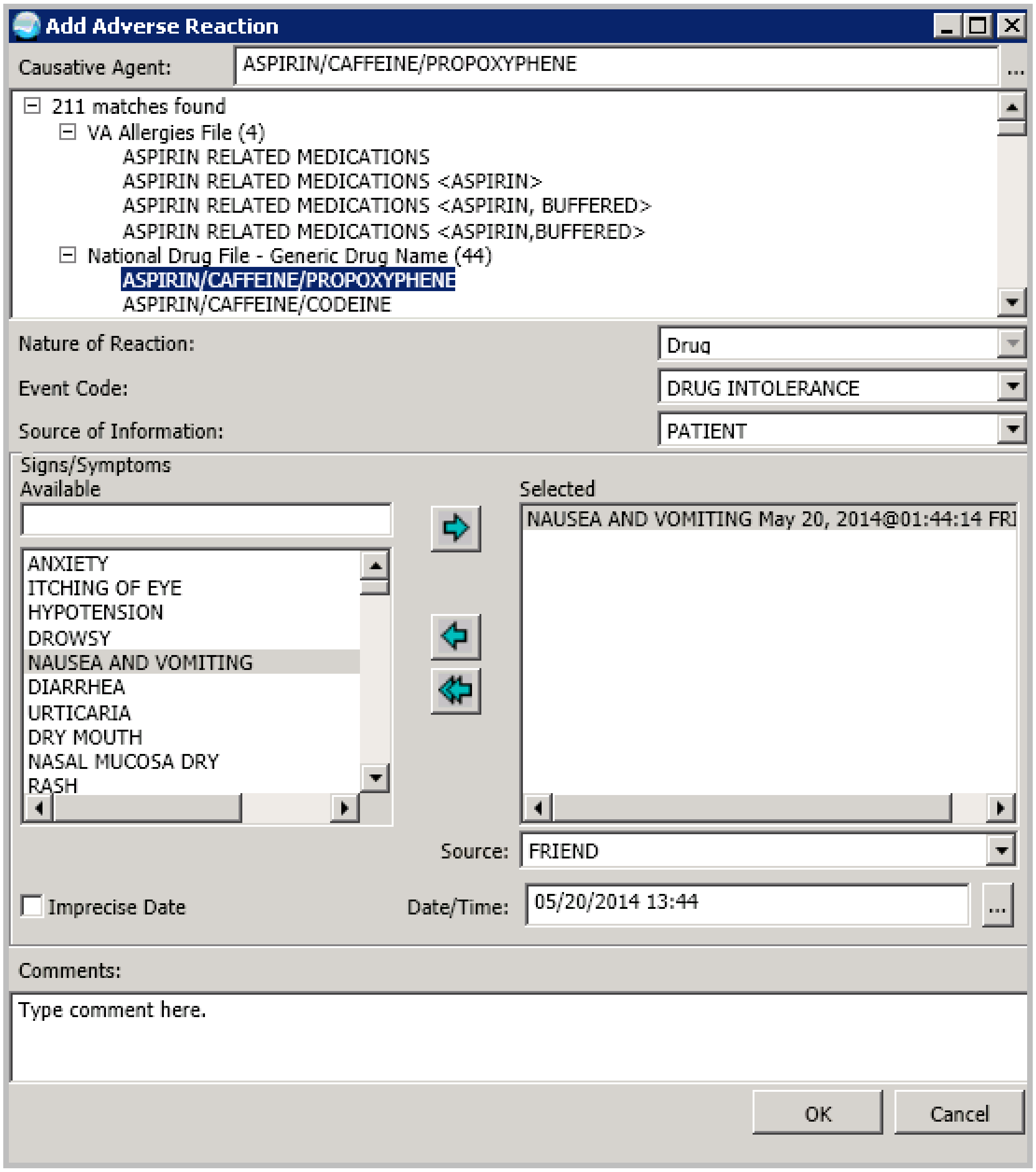


Figure 4-66: Completed Create Adverse Reaction Dialog

1. The Causative Agent field is either blank if adding from the Reconciled Adverse Reactions pane, or is auto-populated with the selected causative agent 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.

2. The Nature of Reaction view-only field is auto-populated depending on the Causative Agent selected.

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, Available field:

   a. Begin typing the first few letters of the sign or symptom. The list refreshes with matching entries as you type.

   b. Select one or more applicable symptoms by clicking your selection and clicking the arrow. As you click the arrow, your selections are moved to the Selected field.

> **Note:** You can click the Move arrows to remove newly added symptoms (all or one at a time) on the current change session. Symptoms previously added cannot be deleted.

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:

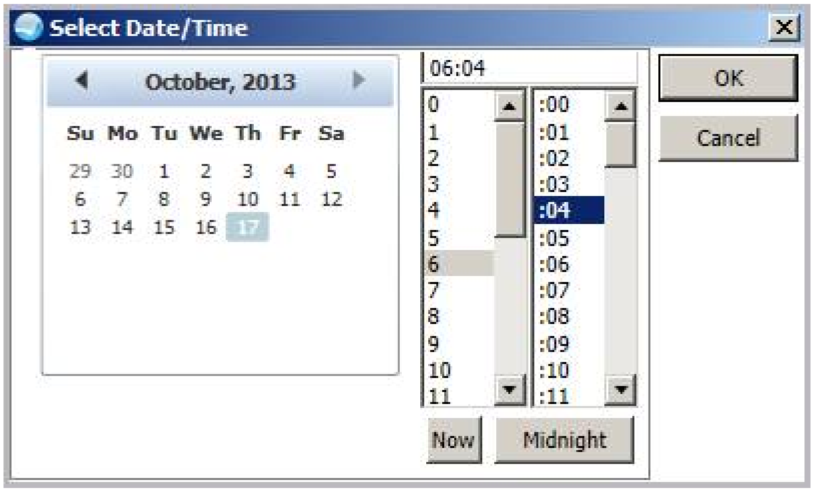


Figure 4-67: Select Date/Time Dialog

- 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. The Date/Time field changes to a Month and Year menu.
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.

4.4.10 Medications

4.4.10.1 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 Public Health Nurse (PHN) or case manager visit.

An example of the Medications tab and corresponding Clinical Document and Reconciled Medications panes is shown below.

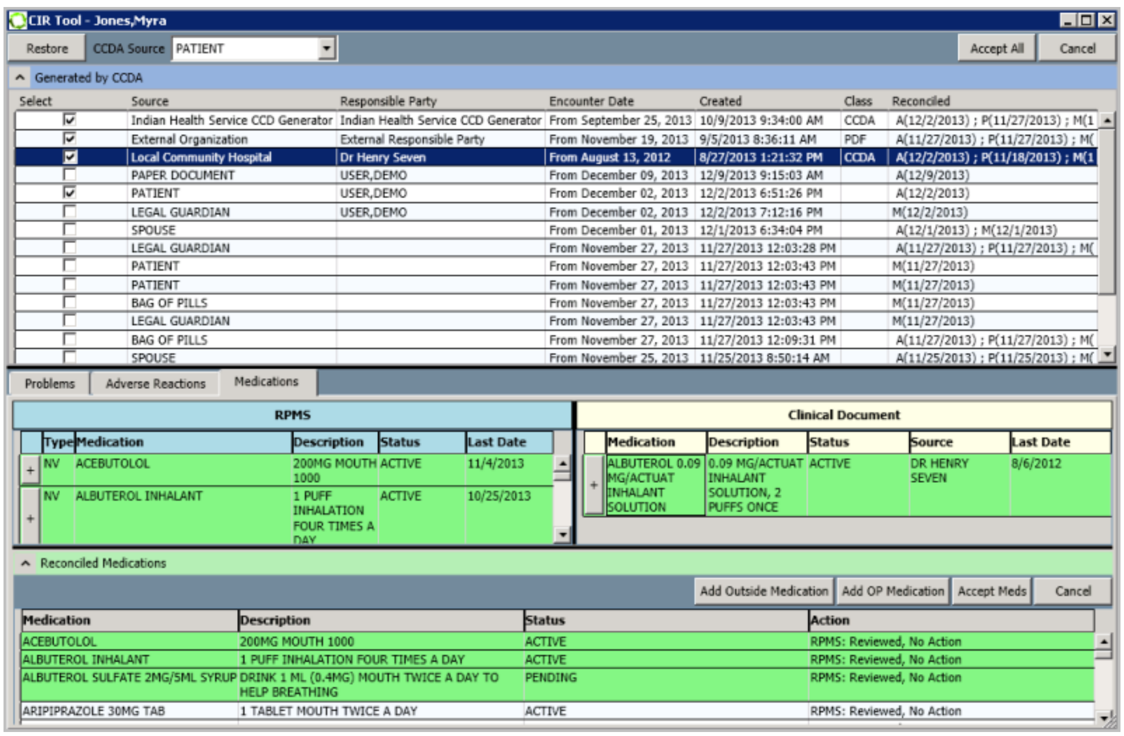


Figure 4-68: Medications Tab and Corresponding Panes

4.4.10.2 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:

4.4.10.2.1 Columns

When the Medications Tab is selected, the RPMS pane displays 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.

4.4.10.2.2 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 Medications tab, RPMS pane contains the following commands:

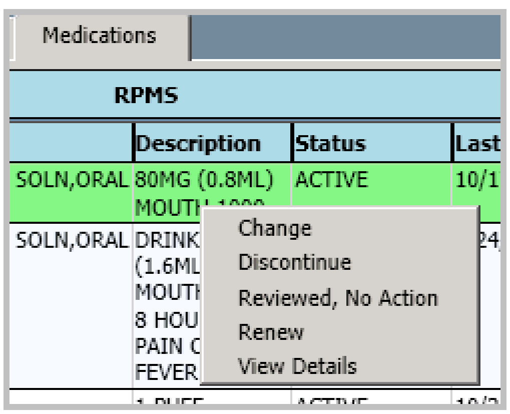


Figure 4-69: Medications RPMS Right Click Menu

- **Change:** The pre-populated Edit Medication dialog opens. Complete any changes and 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.

- o Click Accept Order. The Renew Order dialog opens. Refer to the Renewing Medication Orders topic for details.
- o 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 below. Refer to the applicable sections in this Help for details.

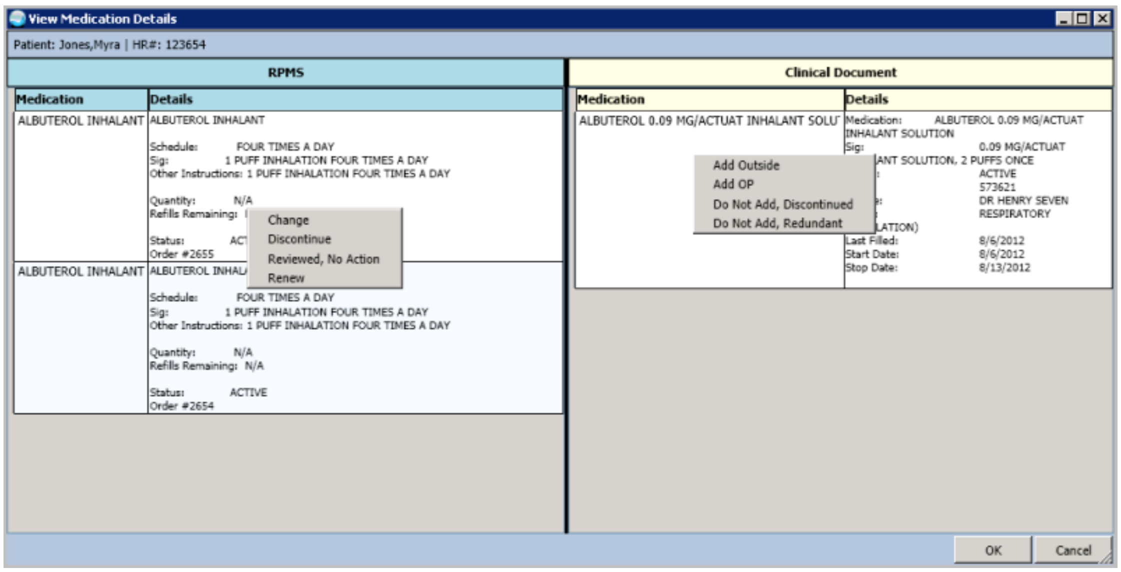


Figure 4-70: View Medication Details Dialog

4.4.10.3 Clinical Document Pane

4.4.10.3.1 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

4.4.10.3.2 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 Clinical Document pane contains the following commands:

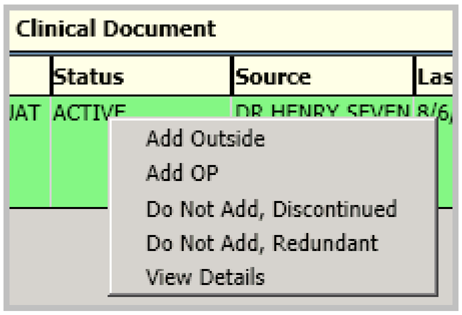


Figure 4-71: Medications Clinical Document Right-Click Menu

- **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.

4.4.10.4 Reconciled Medications Pane

4.4.10.4.1 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.

4.4.10.4.2 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 do not want to include for signature.

Note:	You may see other items, for example Adverse Reactions or other unsigned orders (as shown below), in the Review/Sign Changes dialog if they were not signed previously.

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

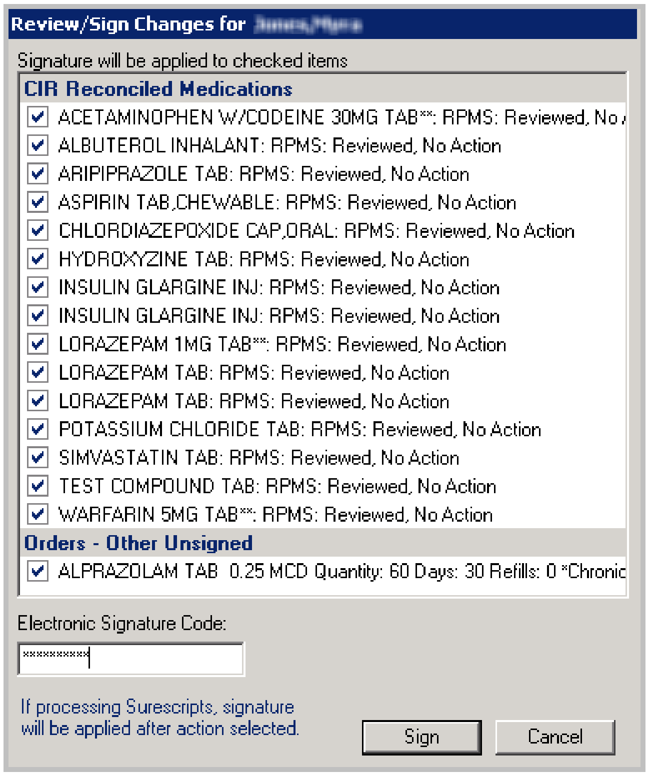


Figure 4-72: Review/Sign Changes for Patient Name Dialog

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.

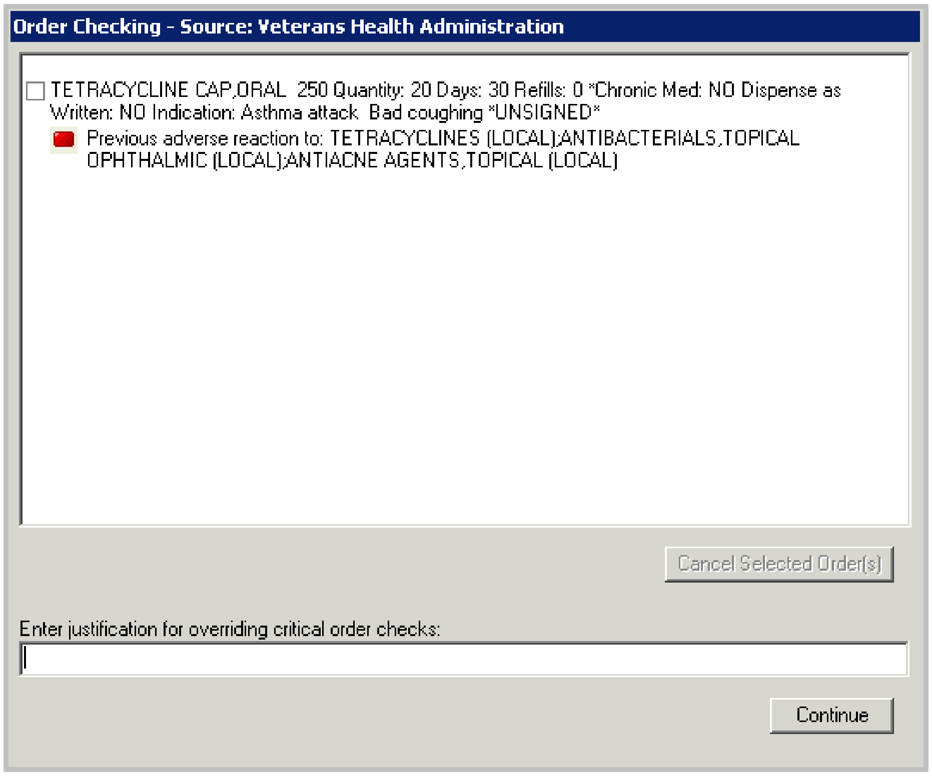


Figure 4-73: Order Checking - Source Dialog when Accepting Medications

3. 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.

4. Repeat steps 1 and 2, above.

- **Cancel:** Cancels the action.

4.4.11 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.

Follow the steps below to complete the Add Non-VA Medication dialog:

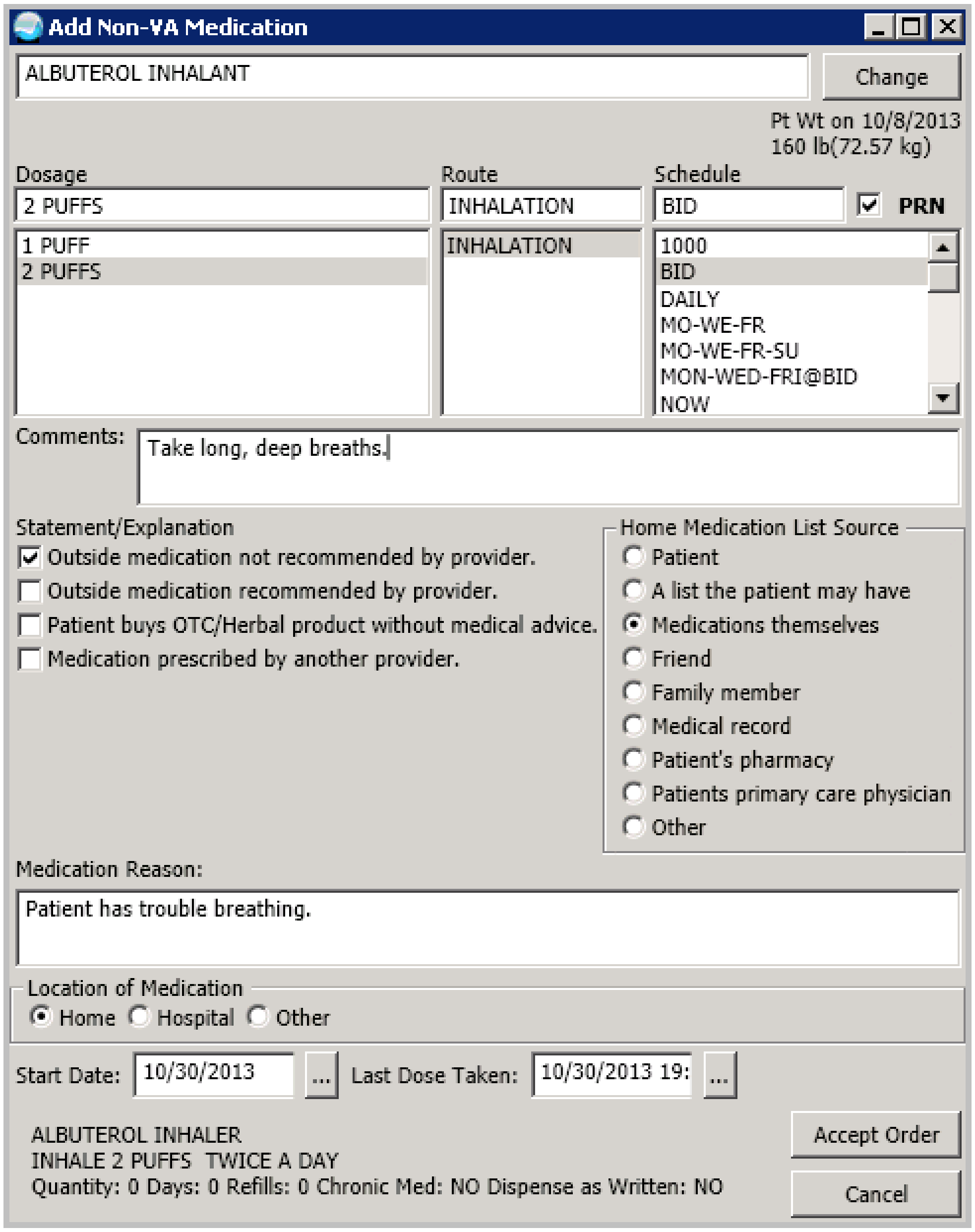


Figure 4-74: Completed Non-VA Medication Dialog

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.

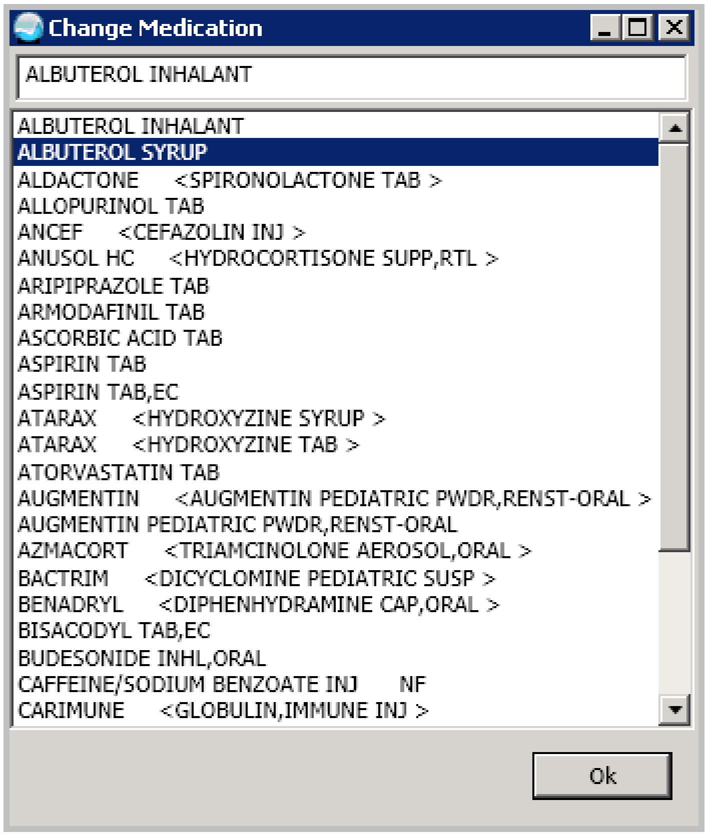


Figure 4-75: Change Medication Dialog

a. Scroll through the list 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.
12. Do any of the following:

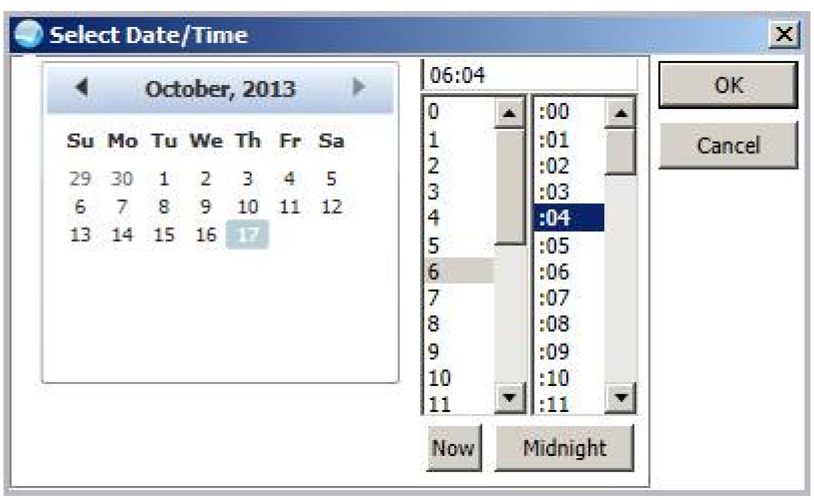


Figure 4-76: Select Date/Time Dialog

- Select the applicable date and time from the calendar and time sliding scales, and then 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.

13. In Last Dose Taken, type a date or click the Ellipsis button to open the Select Date/Time dialog. Do any of the above steps in the dialog.

14. Click Accept Order.

4.4.12 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. Use the following steps to select a medication.

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

    2. Type the first few letters of a medication in the field. The list updates with matching medications when you stop typing.

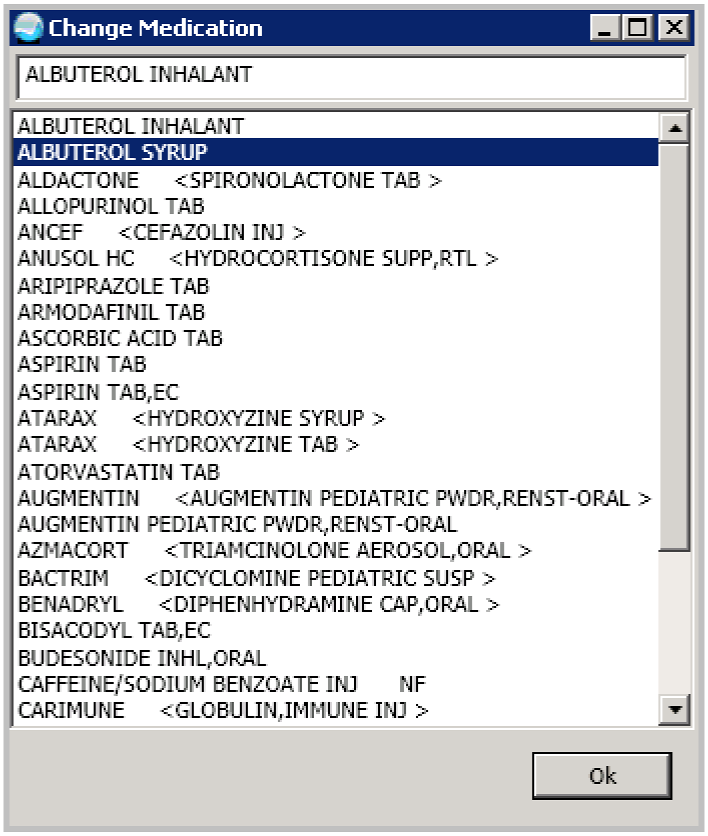


Figure 4-77: Change Medication Dialog

3. Scroll through the list and select the medication you want.
4. Click OK. The Medication field of the Add Outpatient Medication dialog updates with your selection.
5. Click the ADR's button to open the Patient Postings dialog.
6. Click Done after reviewing the ADRs.

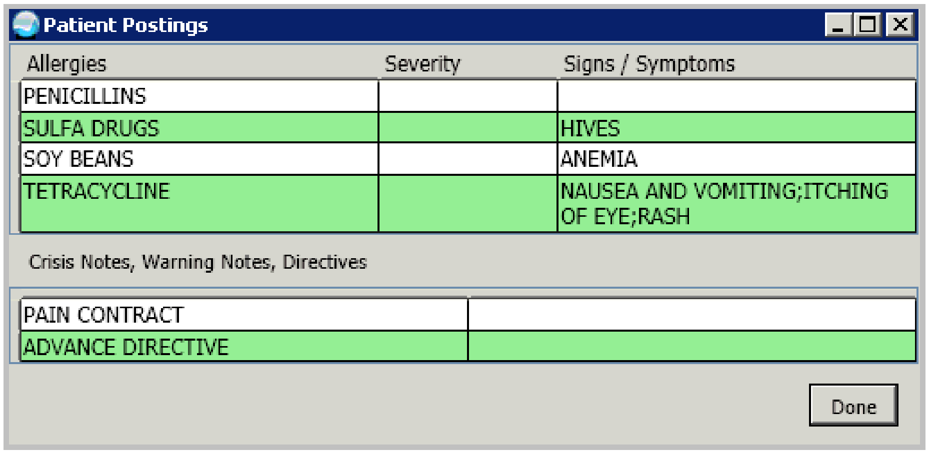


Figure 4-78: Patient Postings Dialog

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

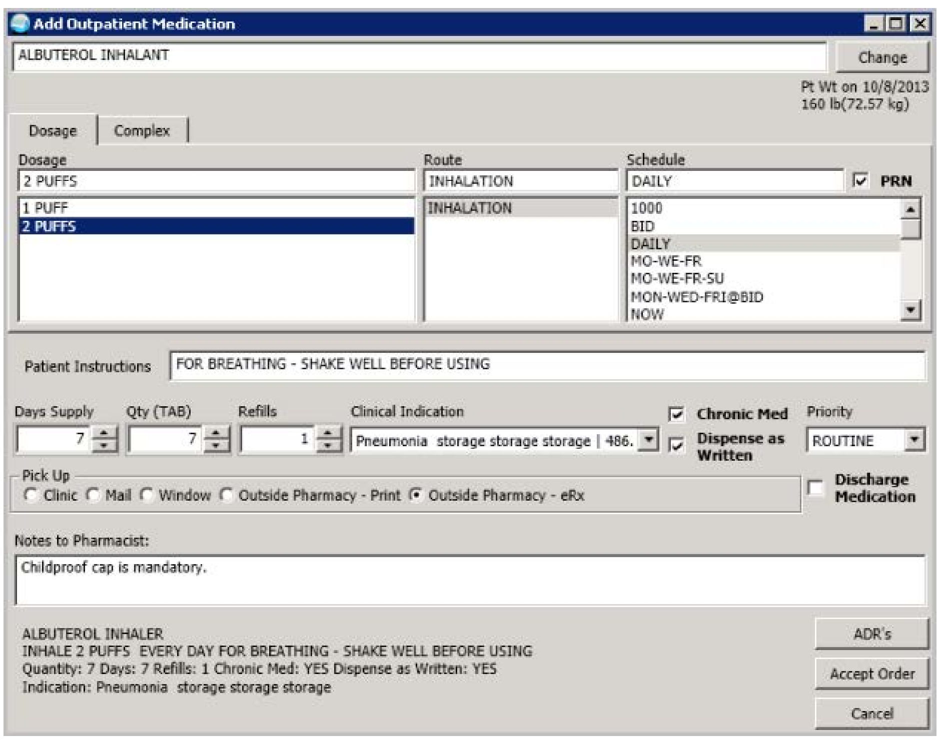


Figure 4-79: Completed Add Outpatient Medication Dialog

7. Click Accept Order.

   If a dosing schedule is not defined when the Accept Order button is clicked, the following error message appears:

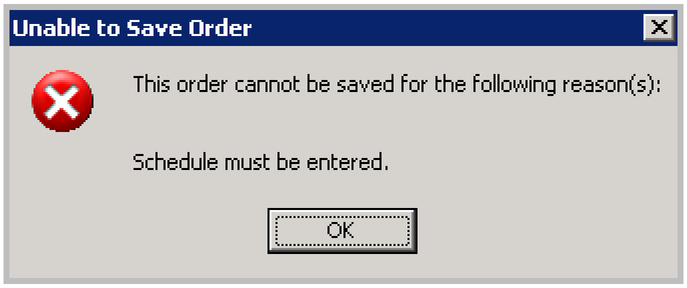


Figure 4-80: Scheduling Error Message

4.4.13 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.

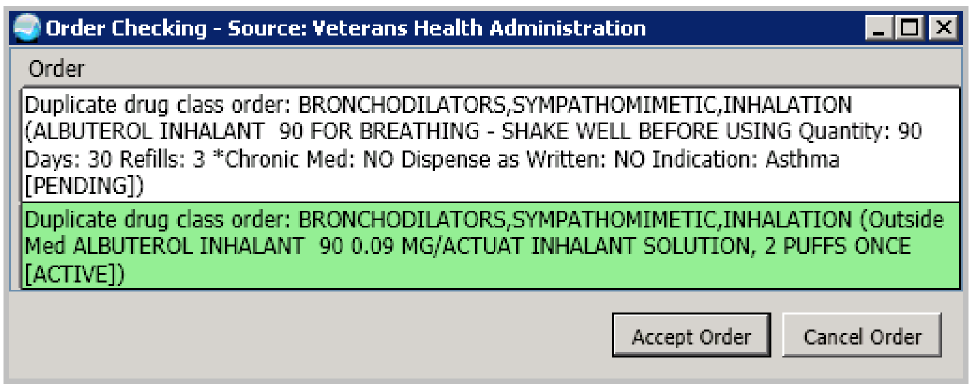


Figure 4-81: Order Checking – Source: Veterans Health Administration Dialog

Click one of the buttons on the dialog to continue:

- 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.

4.4.14 Discontinuing Medication Orders

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

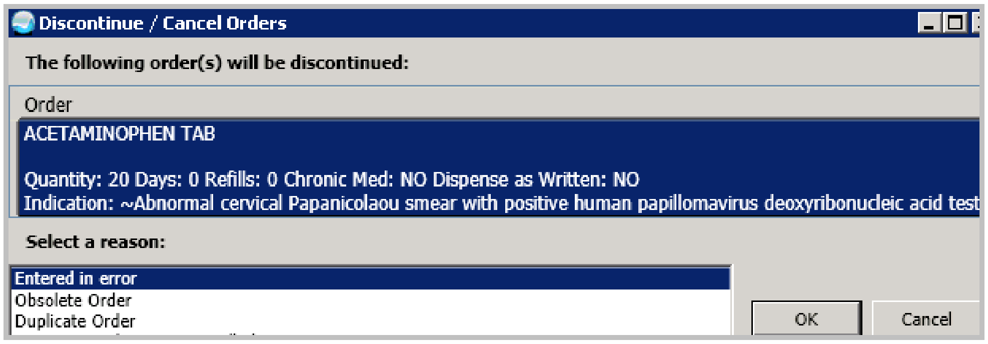


Figure 4-82: Discontinue/Cancel Orders Dialog

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 RPMS: Discontinue status in the Action column.

4.5 Immunizations

The Immunizations module enables the viewing, editing, and adding of immunization information for patients into the Resource and Patient Management System (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.

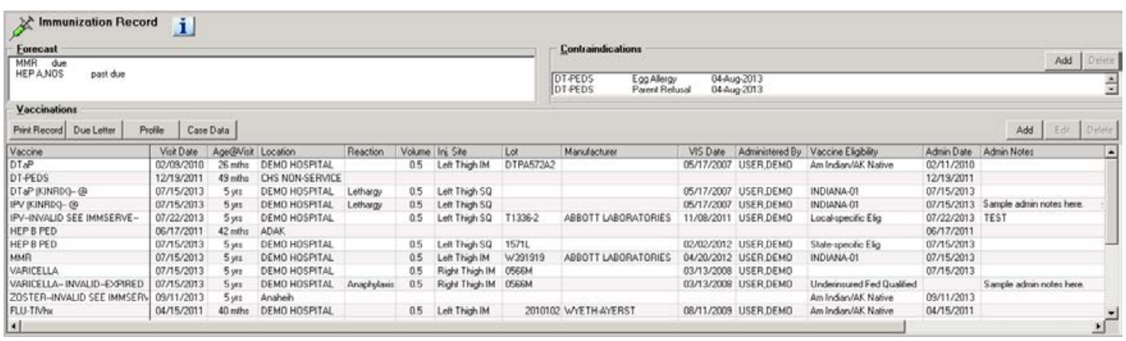


Figure 4-83: Immunization Panel

- 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 clicking on 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

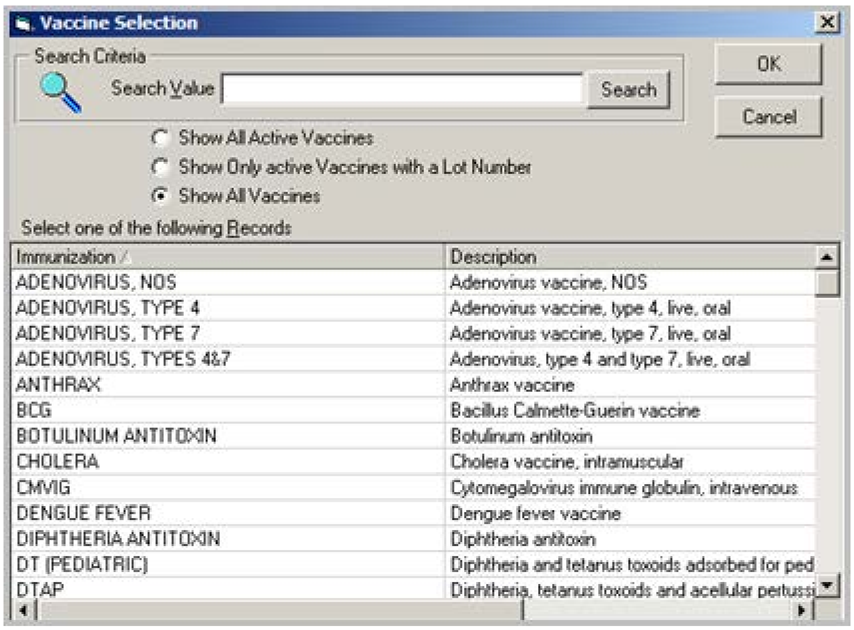


Figure 4-84: Selecting a Vaccine Dialog

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:	Only Lot Numbers designated to the facility to which the user is logged on display for selection.

2. 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 on the vaccine entry in the grid, highlight it

and click OK, or highlight it and press Enter. (Otherwise, click Cancel).

Note:	If you select an Inactive vaccine, it will be marked as a historical vaccination entry.

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.

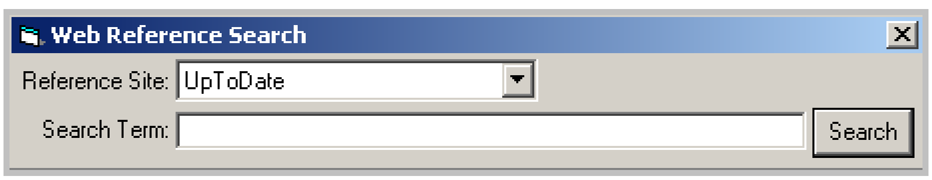


Figure 4-85: Web Reference Search Dialog

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.

4.5.4 Adding a Vaccination

To add a Vaccination 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. 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.

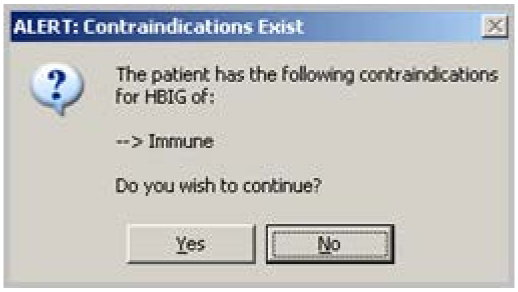


Figure 4-86: Contraindication Alert

The Current, Historical, and Not Done option button topics address information about these functions.

4.5.4.1 Current

If a compound vaccine is selected, then a separate immunization record is added for each component.

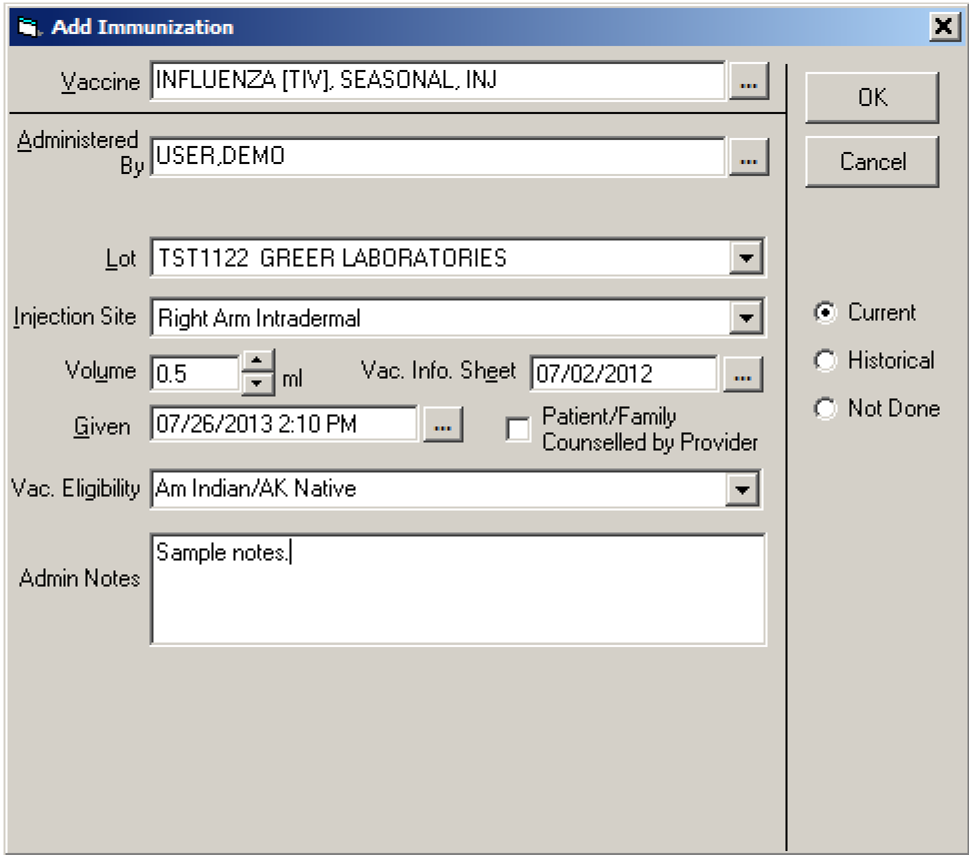


Figure 4-87: Add Immunization Dialog

1. You can change the Administered By field, if necessary. Click the Ellipsis button to select another person.

2. In the Lot field, select the applicable lot and manufacturer from the drop-down menu.

> **Note:** Only Lot Numbers designated to the facility to which the user is logged on display for selection.

3. Populate the Injection Site field by selecting from the drop-down list.

4. 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.

5. 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.

6. 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.

7. In the Vac. Eligibility field, click to select an applicable vaccination eligibility from the drop-down menu.

8. In the Admin Notes field, type any applicable notes.

9. When the Add Immunization dialog is complete, click OK to add the vaccination to the Vaccinations group box. (Otherwise, click Cancel.)

4.5.4.2 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.

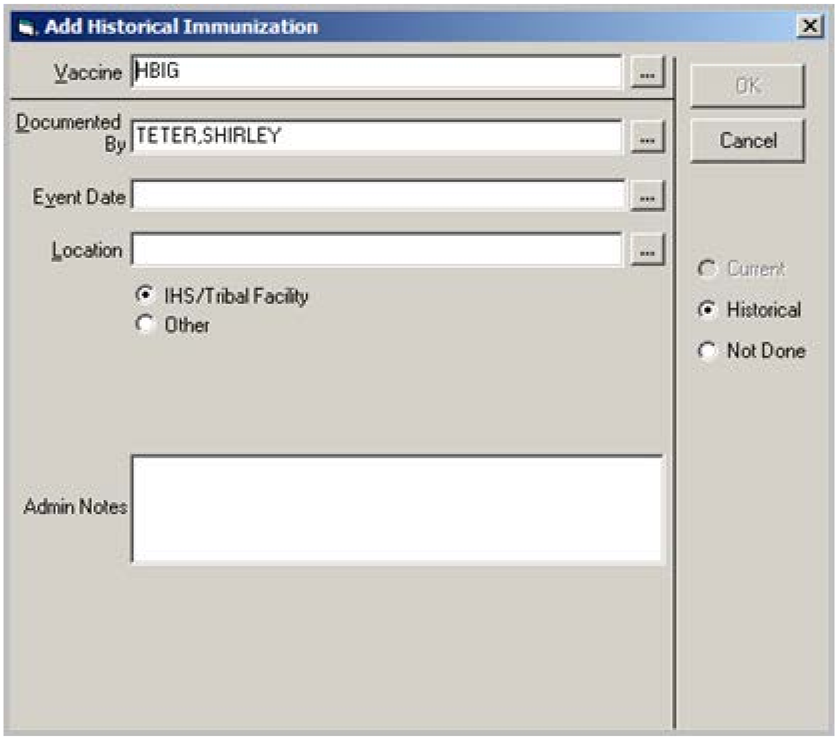


Figure 4-88: Add Historical Immunization Dialog

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.

4. 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.

5. If the location is not an official IHS facility, check the Other option button. Enter the non-official location (for example, Dr. Name Example).

6. 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 pop-up, the default outside location displays at the LOC. OF ENCOUNTER field.

7. In the Admin Notes field, type any notes, as needed.

8. When the Add Historical Immunization dialog is complete, click OK to add the historic vaccination to the Vaccinations group box. (Otherwise, click Cancel.)

4.5.4.3 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.

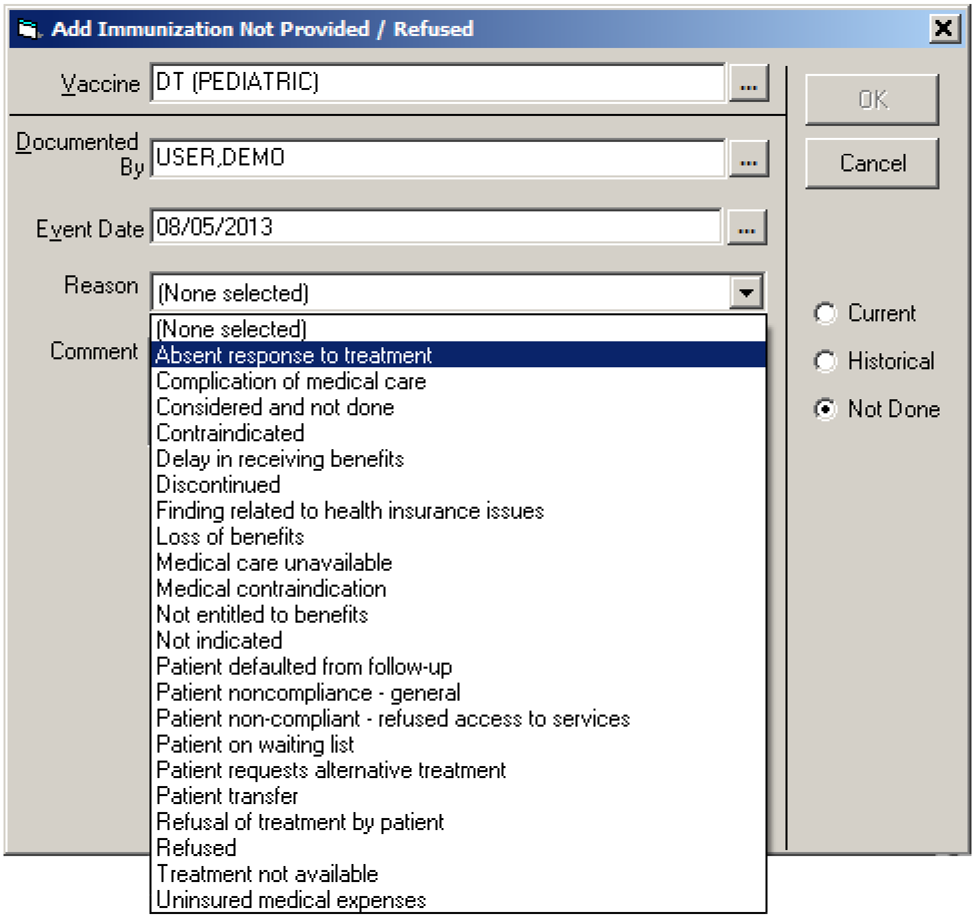


Figure 4-89: Add Immunization Refusal Dialog

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.)

4.5.5 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 the Edit button 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.

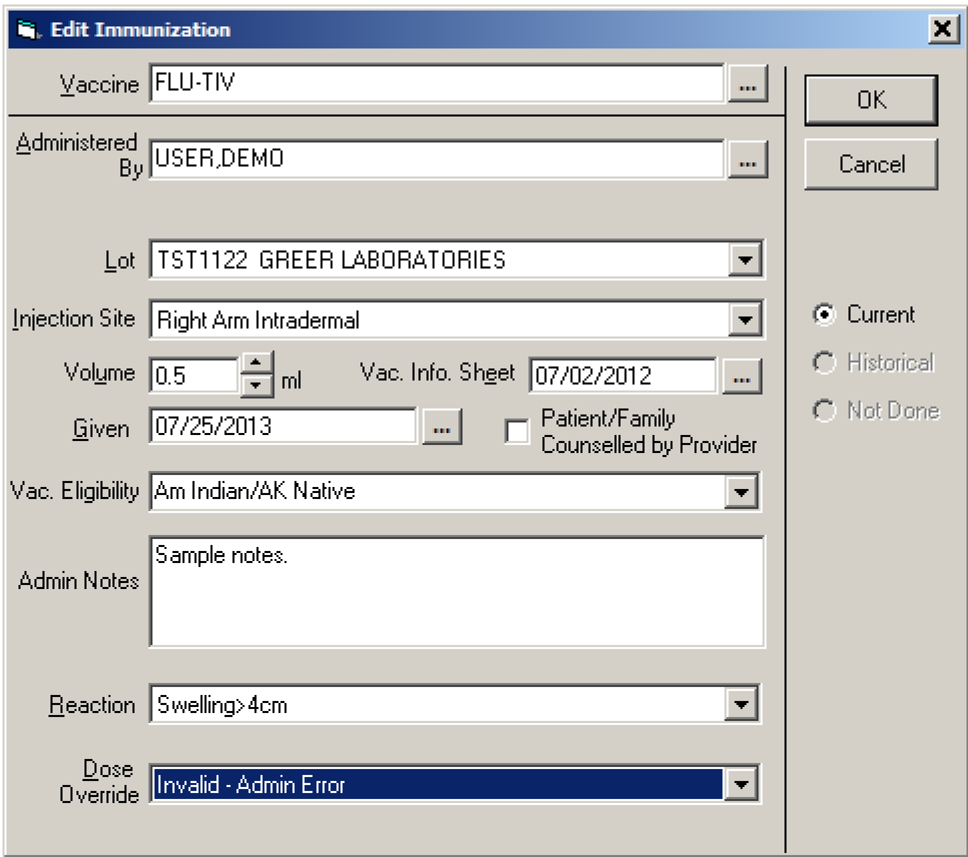


Figure 4-90: Edit Immunization Dialog

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.

   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 won't affect school) or invalid (due to expired vaccine, and so on).

5. Enter a reaction by selecting from the drop-down list for the Reaction field.

6. When a reaction is entered, if it is either: 'Anaphylaxis, Convulsions, Lethargy or Fever>104', then a corresponding contraindication is automatically added.

7. 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.

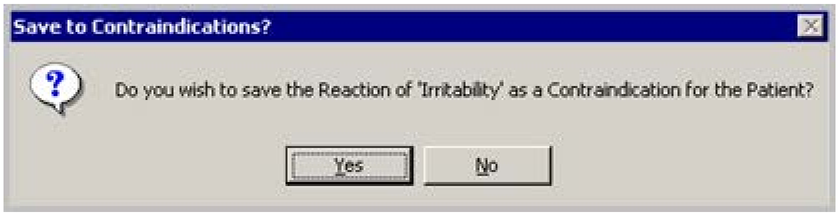


Figure 4-91: Information Message when Saving Contraindication

8. Click Yes to save the reaction as a contraindication. (Otherwise, click No.)

9. When the Edit Immunization dialog is complete, click OK to change the information about the selected record. (Otherwise, click Cancel.)

4.5.6 Deleting a Vaccination

Follow these steps 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 the Delete button (or select Delete Vaccination on the right-click menu) to display the Remove Vaccination? information message.

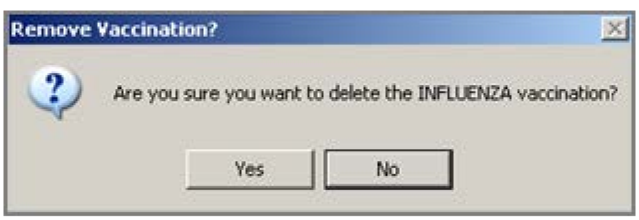


Figure 4-92: Remove Vaccination Information Message

3. Click Yes to remove the vaccination from the Vaccinations grid. (Otherwise, click No.)

4.5.7 Vaccinations Group Box Buttons

4.5.7.1 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.

4.5.7.2 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).

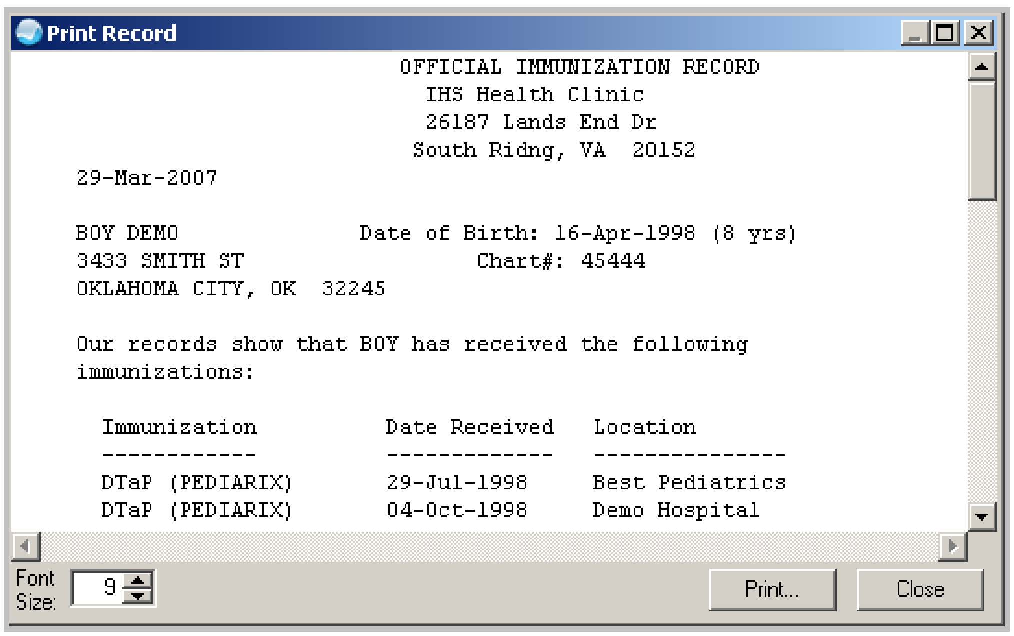


Figure 4-93: Official Immunization Record

2. You can change the font size of the text displayed in this pop-up 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).

3. Click Print to choose a printer and to output the (entire) contents of this pop-up

to the specified printer. The pop-up 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.

4. Click Close to dismiss the pop-up.

4.5.7.3 Due Letter Button

1. 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).

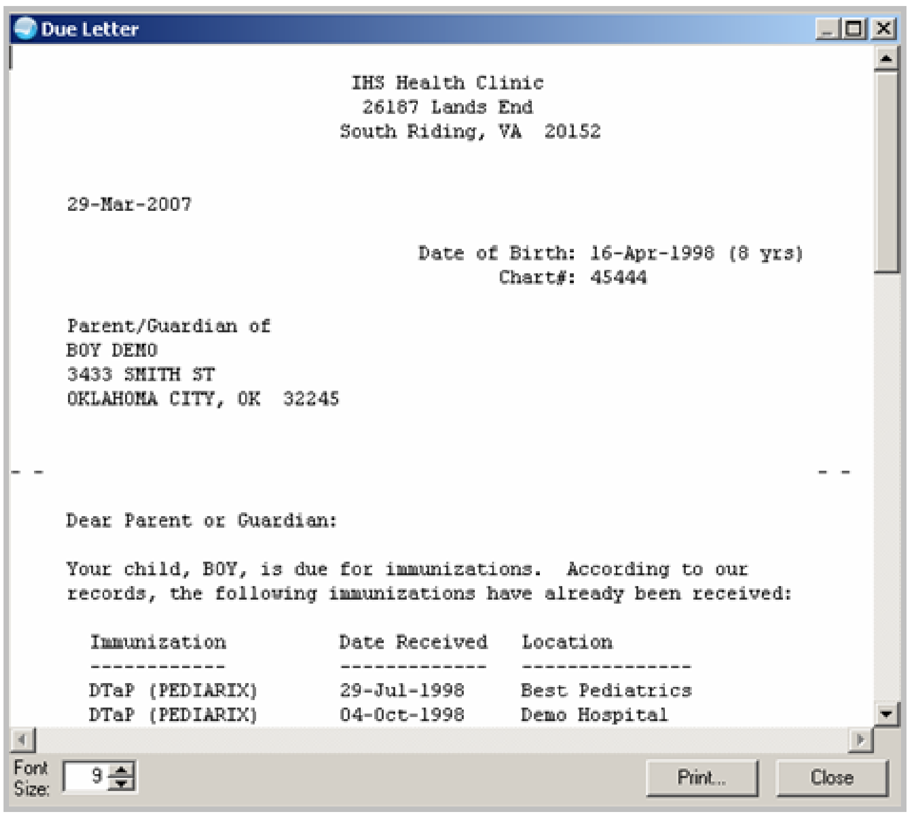


Figure 4-94: Due Letter

2. You can change the font size of the text displayed in this pop-up 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).

3. Click Print to choose a printer and to output the (entire) contents of this pop-up to the specified printer. The pop-up 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.

4. Click Close to dismiss the pop-up.

4.5.7.4 Profile Button

1. Click the Profile button (or select Print Profile on the right-click menu) in the Vaccinations group box to display/print the Immunization Profile pop-up. 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.

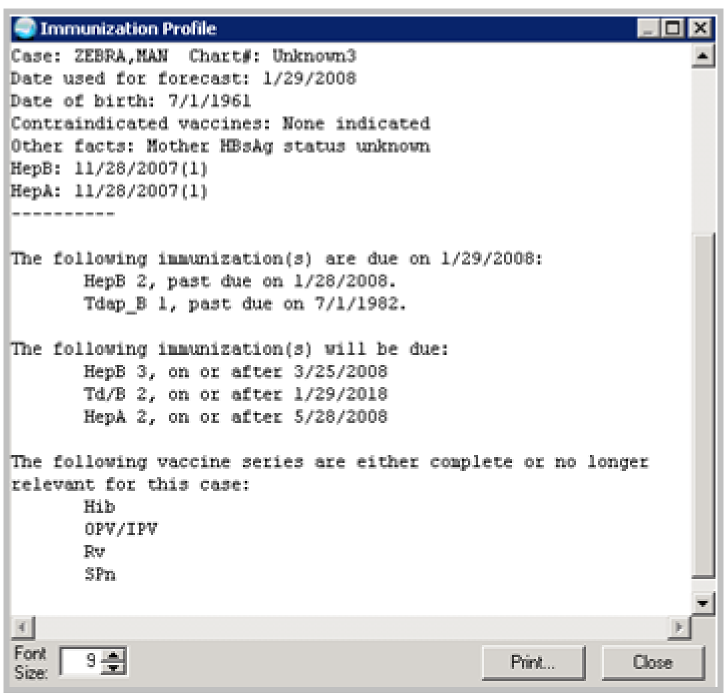


Figure 4-95: Immunization Profile Information

2. You can change the font size of the text displayed in this pop-up 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).

3. Click Print to choose a printer and to output the (entire) contents of this pop-up to the specified printer. The pop-up 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.

4. Click Close to dismiss the pop-up.

4.5.7.5 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.

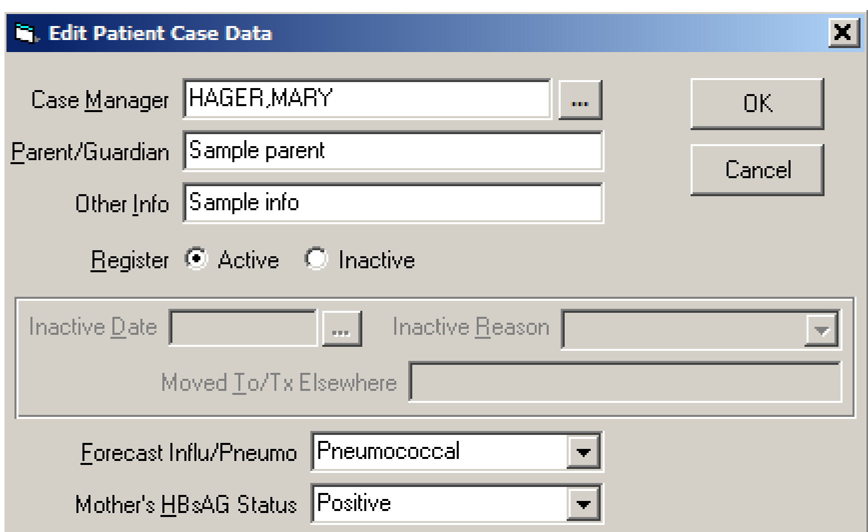


Figure 4-96: Edit Active Patient Case Data

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 is 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.

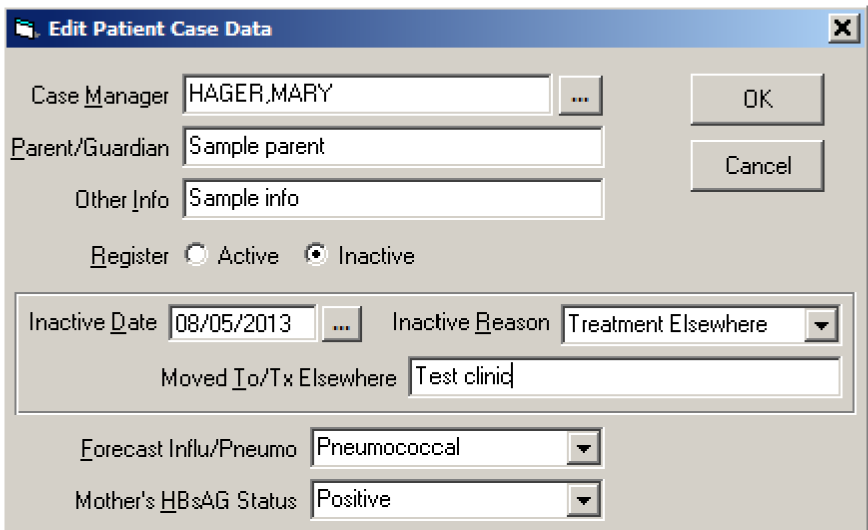


Figure 4-97: Inactive Data Group Box Fields

If a name is included 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.

Populate the remaining field by selecting from the drop-down lists.

Click OK to update the immunization register with the entered data. (Otherwise, click Cancel.)

4.5.8 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.

4.5.9 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.

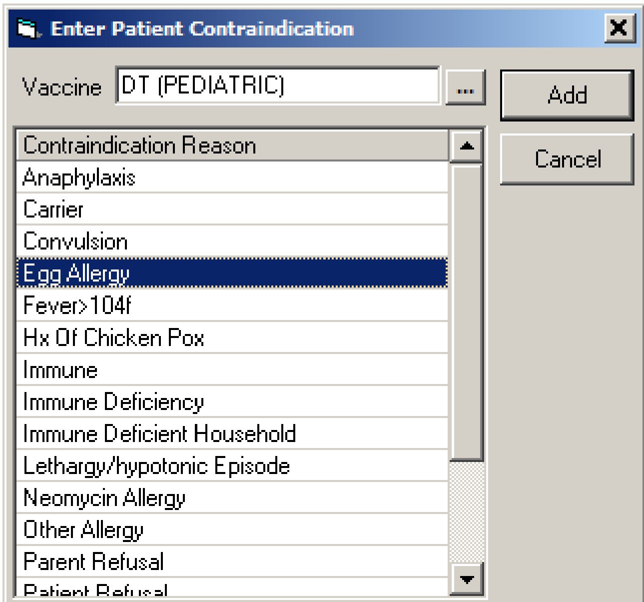
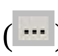


Figure 4-98: Adding a Contraindication Dialog

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 Contraindication panel. (Otherwise, click Cancel.)

   The contraindication shows in the Contraindications group box and in the patient's Official Immunization Record.

4.5.10 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.

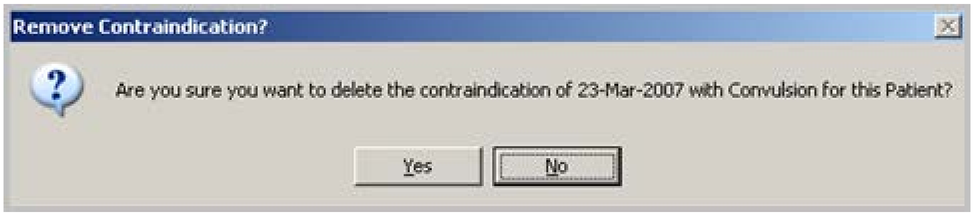


Figure 4-99: Remove Contraindication Information Message

3. Click Yes to remove the contraindication from the Contraindication field. (Otherwise, click No.)

4.5.11 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.

```
Visit Detail

VISIT IEN:  1993

HRN: SOUC 65788
-----------------------------      VISIT FILE      -----------------------------
VISIT/ADMIT DATE&TIME: JUN 14, 2012@16:33
  DATE VISIT CREATED: JUN 14, 2012      TYPE: TRIBE-638 PROGRAM
  PATIENT NAME: ZAVALA,INFANT           LOC. OF ENCOUNTER: DEMO HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: PEDIATRIC
  DEPENDENT ENTRY COUNT: 5              DATE LAST MODIFIED: JUN 14, 2012
  MFI STATUS: ADD                       HOSPITAL LOCATION: PEDIATRICS
  CREATED BY USER: USER,DEMO            OPTION USED TO CREATE: CIAV VUECENTRIC
  USER LAST UPDATE: USER,DEMO           COMPUTER GENERATED: DEMO HOSPITAL
  OLD/UNUSED UNIQUE VISIT ID: 3531730000001993
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:50:38
  NDW UNIQUE VISIT ID (DBID): 137520000001993
  VISIT ID: 132P-DEM

-----------------------------      V PROVIDER      -----------------------------
PROVIDER: USER,DEMO                     PATIENT NAME: ZAVALA,INFANT
  VISIT: JUN 14, 2012@16:33             PRIMARY/SECONDARY: PRIMARY
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: JUN 14, 2012@16:33:23
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:33:23
  LAST MODIFIED BY: USER,DEMO
  AFF.DISC.CODE (c): 100123
-----------------------------        V POV        -----------------------------
POV: V06.1                              PATIENT NAME: ZAVALA,INFANT
  VISIT: JUN 14, 2012@16:33
  PROVIDER NARRATIVE: VACCINATION FOR DTP-DTAP
  PRIMARY/SECONDARY: PRIMARY
  EVENT DATE AND TIME: JUN 14, 2012@16:34:45
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: JUN 14, 2012@16:34:45
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:34:45
  LAST MODIFIED BY: USER,DEMO
  ICD NARRATIVE (c): VACCINATION FOR DTP-DTAP
POV: V05.3                              PATIENT NAME: ZAVALA,INFANT
  VISIT: JUN 14, 2012@16:33             PROVIDER NARRATIVE: NEED INOC/VIRAL HEP
  PRIMARY/SECONDARY: SECONDARY
  EVENT DATE AND TIME: JUN 14, 2012@16:34:45
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: JUN 14, 2012@16:34:45
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:34:45
  LAST MODIFIED BY: USER,DEMO
  ICD NARRATIVE (c): VACCINATION FOR DTP-DTAP
POV: V05.3                              PATIENT NAME: ZAVALA,INFANT
  VISIT: JUN 14, 2012@16:33             PROVIDER NARRATIVE: NEED INOC/VIRAL HEP
  PRIMARY/SECONDARY: SECONDARY
  EVENT DATE AND TIME: JUN 14, 2012@16:50:38
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: JUN 14, 2012@16:50:38
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:50:38
  LAST MODIFIED BY: USER,DEMO
  ICD NARRATIVE (c): NEED INOC/VIRAL HEP
-----------------------------    V IMMUNIZATION    -----------------------------
IMMUNIZATION: DTAP                      PATIENT NAME: ZAVALA,INFANT
  VISIT: JUN 14, 2012@16:33             LOT: 538A2
  INJECTION SITE: Right Thigh IM        VOLUME: 0.5
  DATE OF VAC INFO STATEMENT: MAY 17, 2007
  VAC ELIGIBILITY: V02                  EVENT DATE AND TIME: JUN 14, 2012@16:33
  ENCOUNTER PROVIDER: USER,DEMO         USER LAST UPDATE: USER,DEMO
  DATE/TIME ENTERED: JUN 14, 2012@16:34:45
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:34:45
  LAST MODIFIED BY: USER,DEMO



IMMUNIZATION: HEP B, ADOLESCENT OR PEDIATRIC
  PATIENT NAME: ZAVALA,INFANT           VISIT: JUN 14, 2012@16:33
  INJECTION SITE: Left Thigh SQ         VOLUME: 0.5
  DATE OF VAC INFO STATEMENT: SEP 18, 2008
  VAC ELIGIBILITY: V04                  EVENT DATE AND TIME: JUN 14, 2012@16:50
  ENCOUNTER PROVIDER: USER,DEMO         USER LAST UPDATE: USER,DEMO
  DATE/TIME ENTERED: JUN 14, 2012@16:50:38
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: JUN 14, 2012@16:50:38
  LAST MODIFIED BY: USER,DEMO

Font Size: 9                                                    Print...   Close
```

Figure 4-100: Visit Detail

2. 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).

3. 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.

4. 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).

5. Click Close to dismiss the Visit Detail dialog.

4.5.12 Using the Lookup Utility Dialog for Location

Access the Lookup Utility by clicking the Ellipsis button at the end of the Location field when adding a Historical Diagnosis. This dialog can be used to search for and select a location for the Location field.

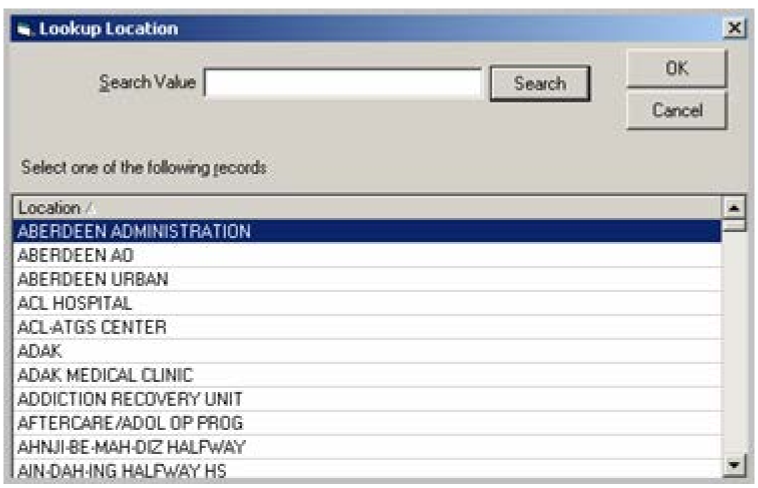


Figure 4-101: Initial Lookup Location Dialog

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.

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

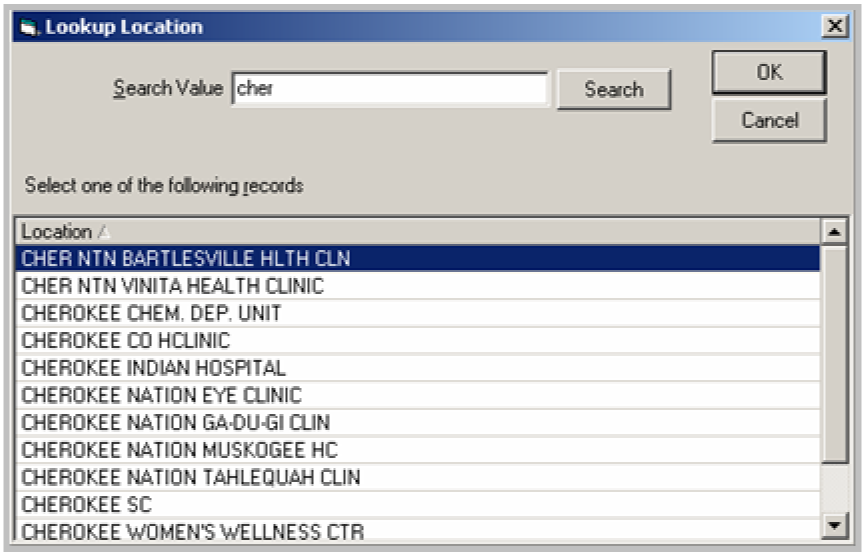


Figure 4-102: Lookup Location Dialog After Search

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

4.6 Integrated Problem List (IPL)

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

- Status
- Onset Date
- Priority
- 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

4.6.1 Orientation

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

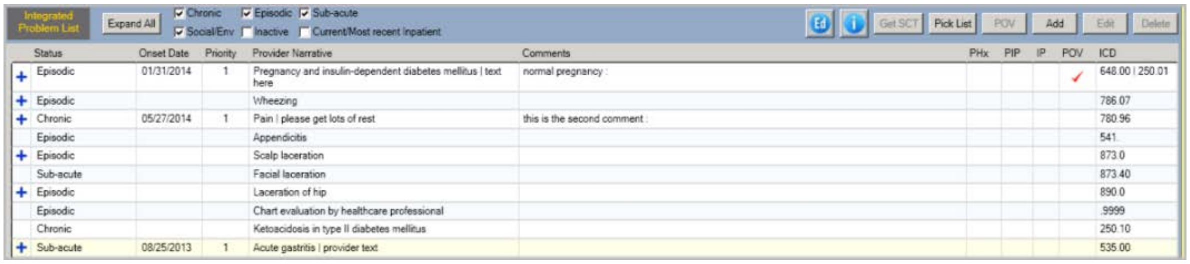


Figure 4-103: IPL Problem List Main Window

4.6.1.1 Features

- An asterisk in the Provider Narrative column indicates problems not SNOMED encoded.

- Briefly rest your mouse pointer over the code in the ICD column to view a window of the map source advice, based on the SNOMED CT code.

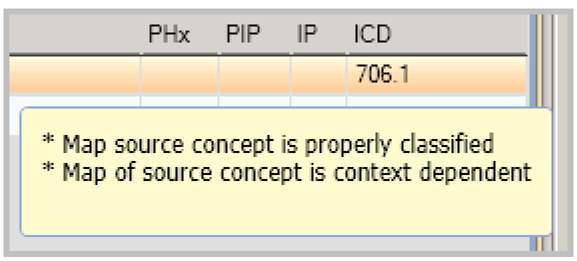


Figure 4-104: Map Source

- For problems with a non-coded SNOMED code, the Edit and POV buttons are disabled.

- Viewing Problem Details – Double-click anywhere in a line item to view the Problem Details window.

- 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 Integrated Problem List (IPL) topic for details.

    - Edit: To edit the line item. Opens the Edit Problem dialog. Refer to the Editing an Integrated Problem List (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

4.6.1.2 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.
- **Clinical Decision Support button ( ):** Click this button for a direct link to ClinicalKey. Refer to the Using the Clinical Decision Support 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 purpose of visit and to add visit, care plan, or goal activity data.
- **PL PickList button:** Click the PL PickList button to select SNOMED CT descriptions by defined picklists.
- **Add button:** Click this button to add a problem. See the Adding an Integrated Problem List (IPL) topic for details.
- **Edit button:** Click this button to edit an existing problem. See the Editing an Integrated Problem List (IPL) topic for details.
- **Delete button:** Click this button to delete a selected problem. See the Deleting

an Integrated Problem List (IPL) topic for details.

4.6.1.3 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

4.6.1.4 Columns

Columns on the main display window 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.

- **Plus or Minus Sign:** 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).
- **Priority column:** Contains the priority level, as set by the user.
- **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 term.

4.6.1.5 Problem Details Window

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

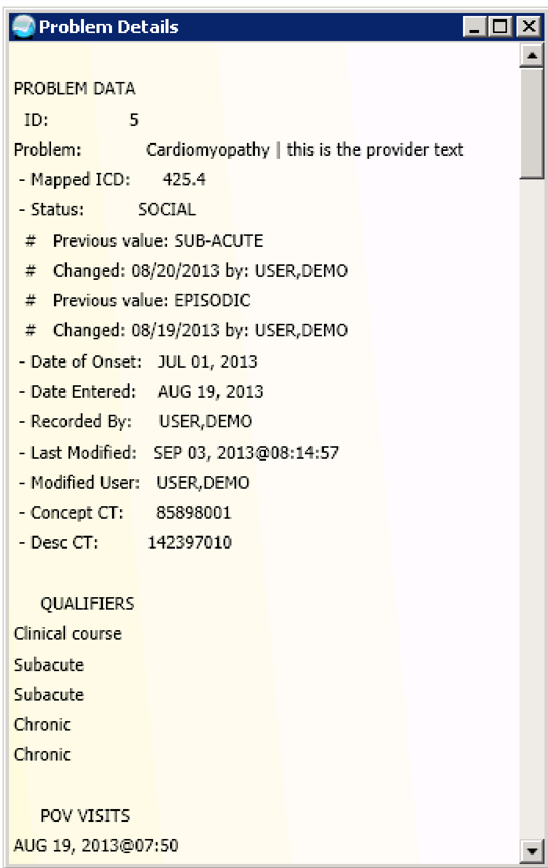


Figure 4-105: Problem Details Window

4.6.2 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 Integrated Problem List (IPL) or Editing an Integrated Problem List (IPL) topics for information on using the Get SCT button from the Add Problem or Edit Problem dialoges.

Note: A visit must be selected.

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

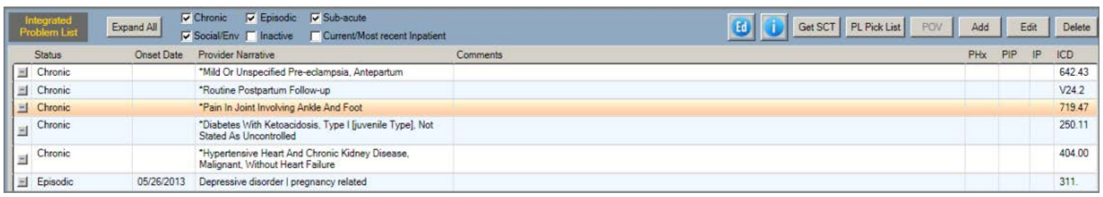


Figure 4-106: Problem List with Get SCT Button Active

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 concepts listed below. Click the Expand button (⊞) next to the Problem name to expand the section and view the list of Synonyms associated with that problem. (Click the Collapse button (⊟) to compress the list.)

   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 where you can select a new date.

   d. Click Find. The SNOMED Concept list refreshes with your findings.

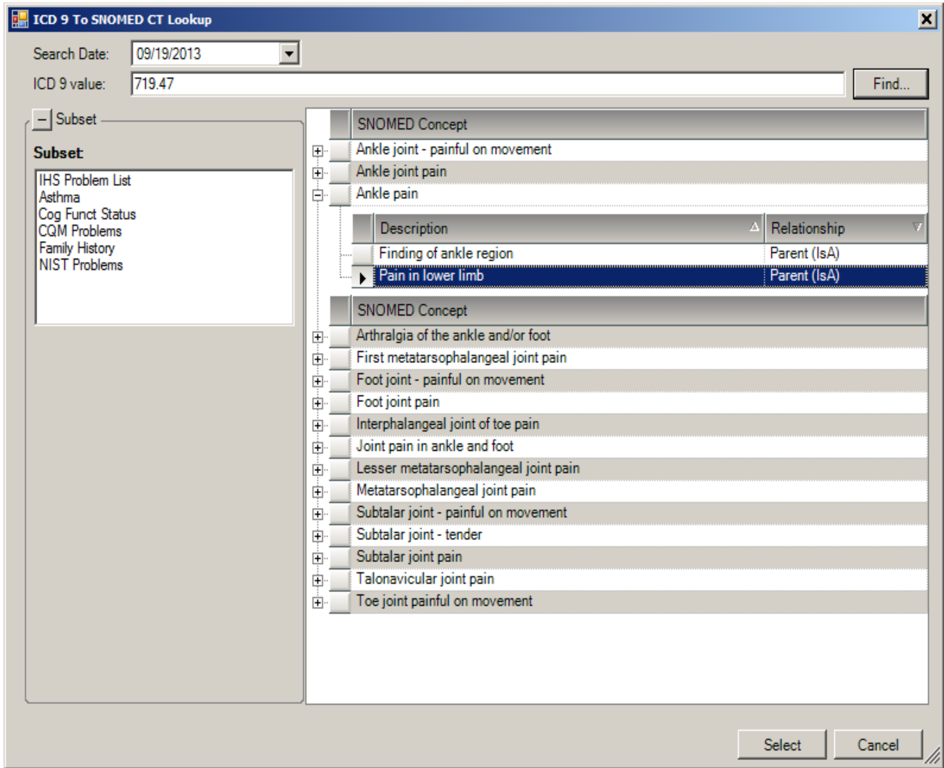


Figure 4-107: ICD 9 to SNOMED CT Lookup

3. Select the SNOMED CT line item you want to use, 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.

4.6.3 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 Integrated Problem List (IPL) or Editing an Integrated Problem List (IPL) topics for information on using the POV button from the Add Problem or Edit Problem dialoges.

Note: An unlocked visit must be selected.

1. From the main screen, select one or more problem line items, 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.

Note:	In instances where there is no existing primary POV and the POV check box was not selected, the problem is automatically made a primary POV (not secondary POV).

Figure 4-108: 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 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 clear them as applicable:

    - First episode
    - New episode
    - Old episode
    - Ongoing episode
    - Undefined episodicity

7. The following columns have a right-click menu:

    - Alternate POV Provider Text
    - Goal Notes
    - Care Plans
    - Visit Instructions

    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 are provided below.

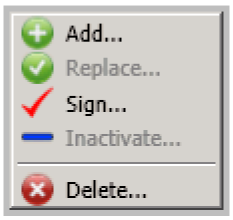


Figure 4-109.POV Right-Click Menu

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

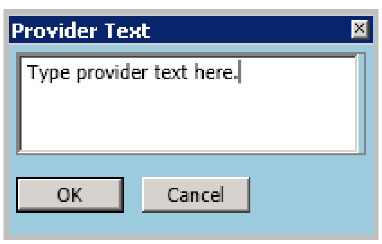


Figure 4-110: Add Dialog

- **Replace:** The Replace function is used to edit existing text. A dialog showing the original text opens. Type the edited text in the Replacing Text field and click OK. The edited text displays.

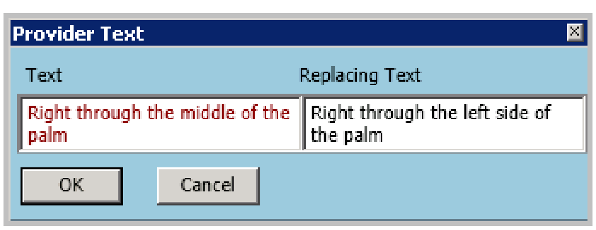


Figure 4-111: Replace Dialog

- **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.

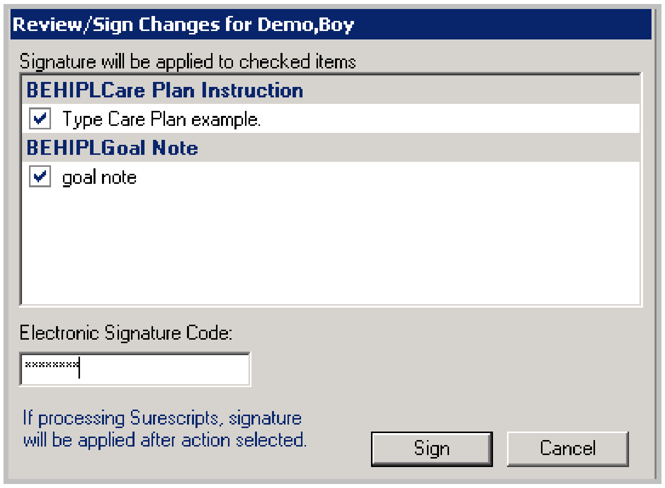


Figure 4-112: Review/Sign Changes for Patient Name for POV

- **Inactivate:** This functionality is intended to inactivate the existing goal or care plan, and initiate a new one. Use this if you want to retain the information for future reference. It will not be seen in the general IPL display, but can be displayed on an RPMS report. Type a comment, and then click Yes.

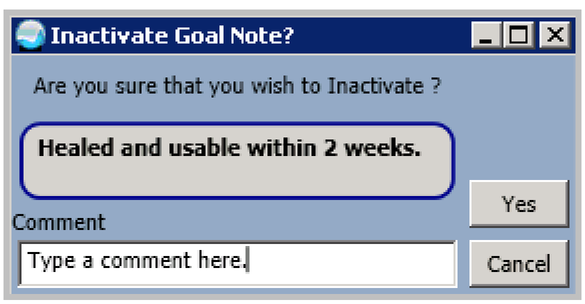


Figure 4-113: Inactivate Item Dialog

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

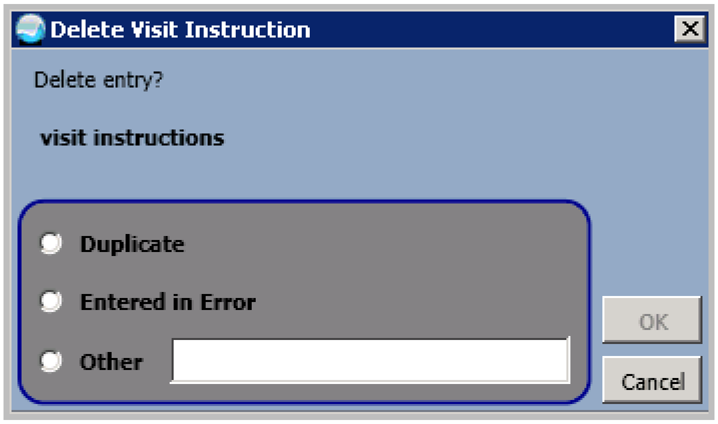


Figure 4-114: Delete Confirm Dialog

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

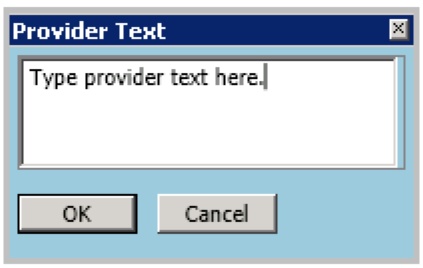


Figure 4-115: Provider Text Dialog

   a. Type provider text to include more detail regarding the problem for TODAYS ENCOUNTER only. So the provider text here is stored only to the Provider Text for the Visit Diagnosis provider narrative.

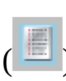
   b. Click OK.

   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.

   a. Type the new provider text in the Replacing Text field.

   b. Click OK. Your change shows in the Prov. Text column.

9. 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.

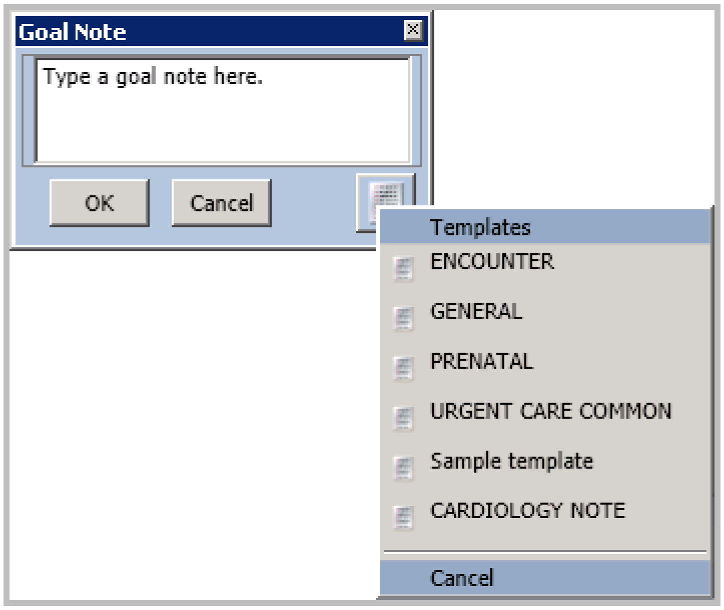
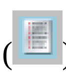


Figure 4-116: Goal Notes Dialog with Templates Menu

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

10. 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.

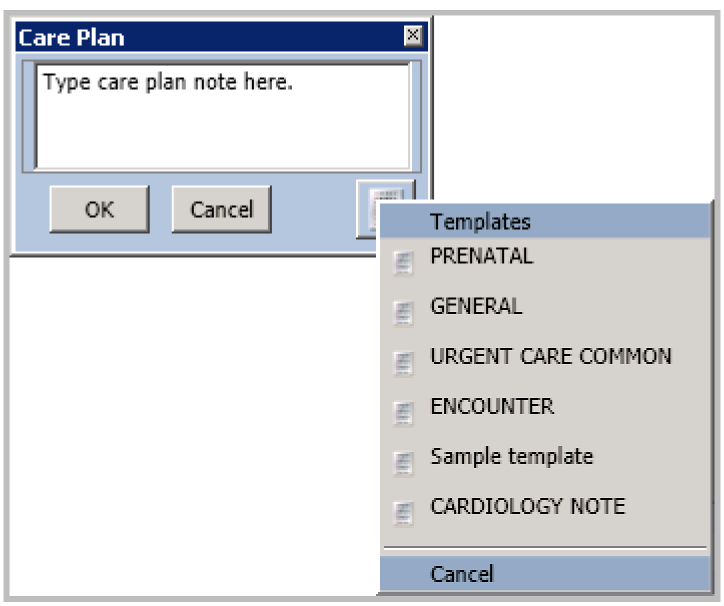


Figure 4-117: Care Plan Dialog with Templates Menu

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

11. 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.

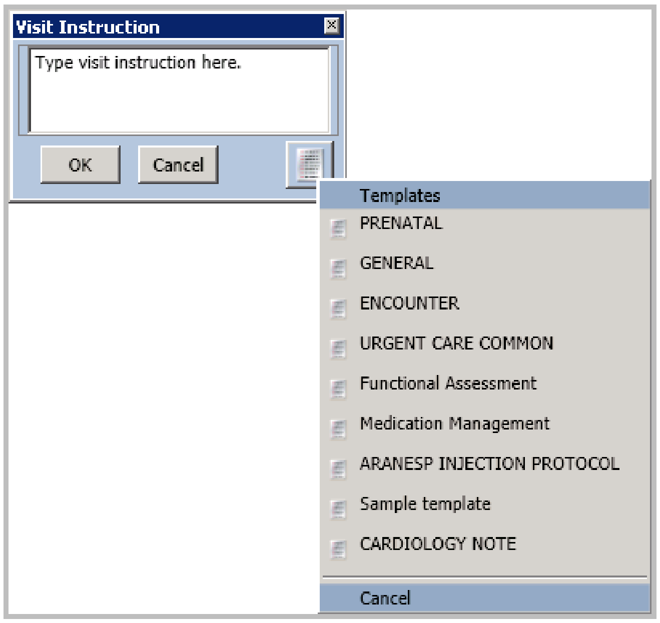


Figure 4-118: Visit Instruction Dialog with Templates Menu

- You can also type over an existing Visit Instruction by selecting the text and making any changes.

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

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

13. 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

14. The Tx/Regimen/FU column contains the Treatment/Regimen button. Click the Treatment/Regimen button (Treatment/ Regimen) 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 below.

Figure 4-119: 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.

15. 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.

16. 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.

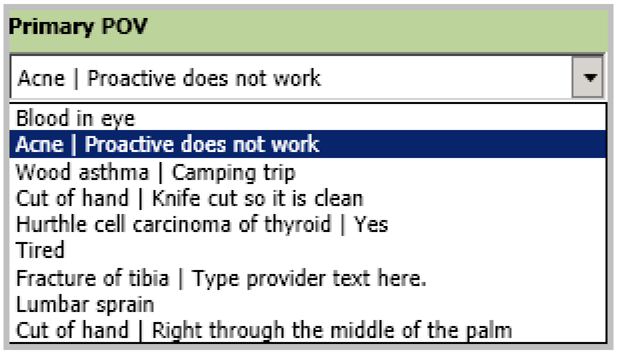
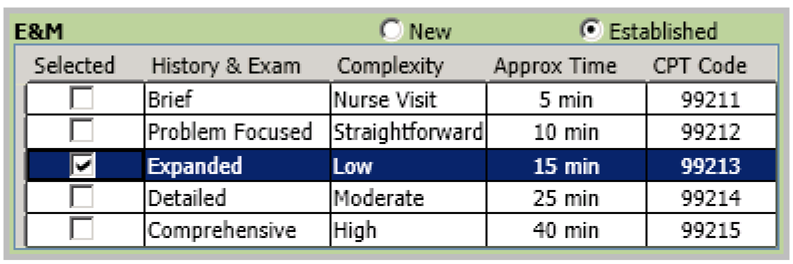


Figure 4-120: Primary POV Drop-down Menu

17. The E&M (Evaluation and Management) table contains all CPT codes defined to office visit per visit type defined by the E&M component. The user is able to select the Evaluation and Management code for the visit within the Select PVs/Update Problems dialog. The list changes the CPT code displayed depending which option button is selected, New or Established.


E&M New Established

Selected	History & Exam	Complexity	Approx Time	CPT Code
☐	Brief	Nurse Visit	5 min	99211
☐	Problem Focused	Straightforward	10 min	99212
☑	Expanded	Low	15 min	99213
☐	Detailed	Moderate	25 min	99214
☐	Comprehensive	High	40 min	99215

Figure 4-121: E&M Table

18. Click Save. A red check mark appears in the POV column of the IPL main window and the eSig tool button may be clicked to sign.

    The Problem List window 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. Then click OK.

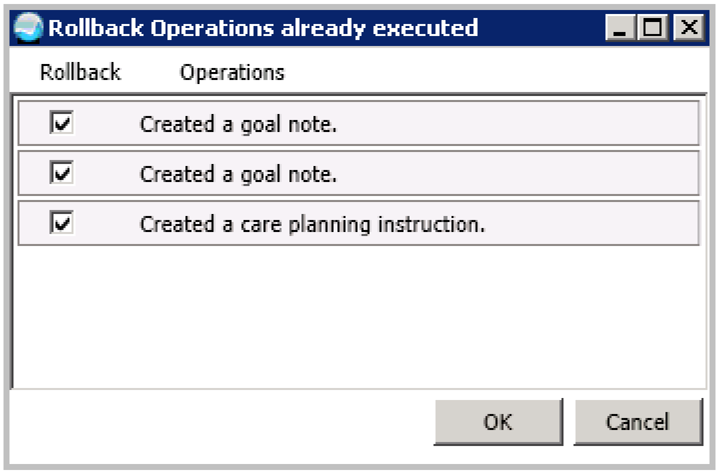


Figure 4-122: Rollback Operation Already Executed Dialog

4.6.4 Using the PL PickList Button

These instructions are for the PickList button on the main screen to update a Picklist. See the Adding an Integrated Problem List (IPL) or Editing an Integrated Problem List (IPL) topics for information on using the PickList button from the Add Problem or Edit Problem dialoges.

> **Note:** If the PickList button is clicked from the main IPL screen, more than one item from a PickList can be selected. If the PickList button is clicked from the Add an Integrated Problem List or the Edit an Integrated Problem List window, only one item from the PickList can be selected.

The PickList button opens the PickList dialog where the user can choose SNOMED CT descriptions by defined picklists. Picklist entries may include associated qualifiers.

> **Note:** The PickList button is enabled and picklists can be managed if no visit is selected.

4.6.4.1 Selecting Problems from a PickList

To select problems from a defined PickList, follow the steps below:

1. Click the PickList button from the IPL main screen or from the Add Problem or Edit Problem dialog. The PickList Selection dialog opens.

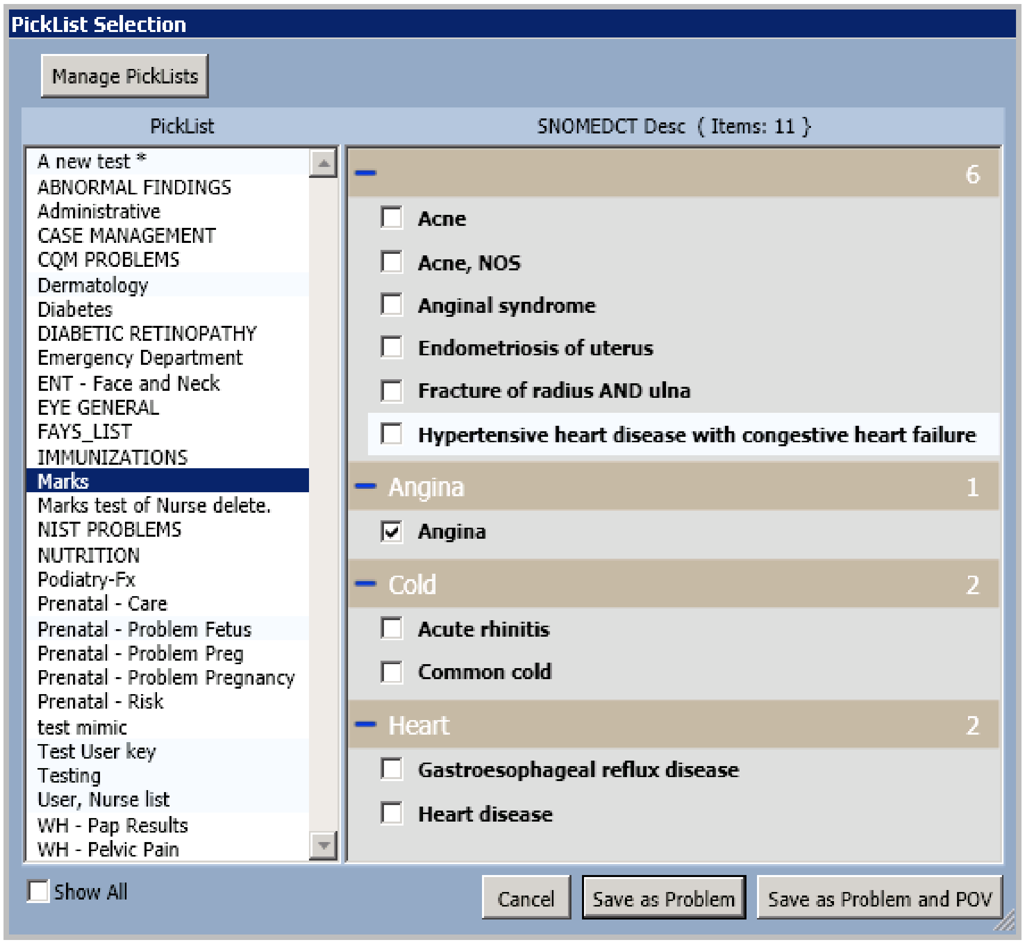


Figure 4-123: PickList Dialog

2. In the PickList column:

- One or more picklists can be selected if the PickList button from main IPL screen is used.
- Only one picklist can be selected if the PickList button from the Add or Edit an Integrated Problem List screen is used.
- Scroll up or down to view the entire list, if needed.
- Select the Show All check box to view any picklists for which the logged-in user is not manager or owner. Users who hold the BGOZ CAC key can view and edit all picklists.
- Picklists with light blue shading indicate an existing problem for the patient. Only new data related to the problem will be saved.
- Both the Save as Problem and the Save as Problem and POV buttons are active

for these picklists if the picklist was stored with the May Store as POVs during configuration in managing the picklist. Refer to the Edit PickList Button section for details.

- An Enabled to set problem to POV message appears when the cursor is rested on picklists with light blue shading.

- Picklists with white shading indicate new problems for the patient and are saved as such.

3. In the SNOMED CT Desc column:

- The SNOMED CT Description column refreshes with the items related to the picklists you selected in the PickList column.

- Problems with light blue shading in the SNOMED CT Desc column indicate existing problems for the patient. If selected, only new data related to the problem will be saved.

- Both the Save as Problem and the Save as Problem and POV buttons are active for these picklists if the picklist was stored with the May Store as POVs during configuration in managing the picklist. Refer to the Edit PickList Button section for details.

- An Item already in Problem List (Save will Edit problem) message appears when the cursor is rested on picklists with light blue shading.

- Problems with white shading indicate new problems for the patient and will be saved as such.

Note:	Both the picklists 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 picklist.

4. Click the Save as Problem or Save as Problem and POV button, as applicable.

- If the Save as Problem button is clicked, new picklist items display as newly added problems and Chart Review is triggered. The picklist does not add the problem again for a problem that is a duplicate and already on the patient's problem list; only edits to the problem are retained.

- If the Save as Problem and POV button is clicked, the POV dialog opens. see Using the POV Button for details on completing this dialog.

4.6.4.2 Managing PickLists

You can manage picklists by performing the steps that follow for the associated problems.

Important: To manage picklists, users must hold the BGOZ CAC key.

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

2. From the PickLists drop-down menu, select a picklist to manage. The PickList Items list refreshes with the problems associated with that PickList.

3. Select a problem or select multiple problems by clicking the problem while holding down the Ctrl key. The problem displays highlighted in orange.

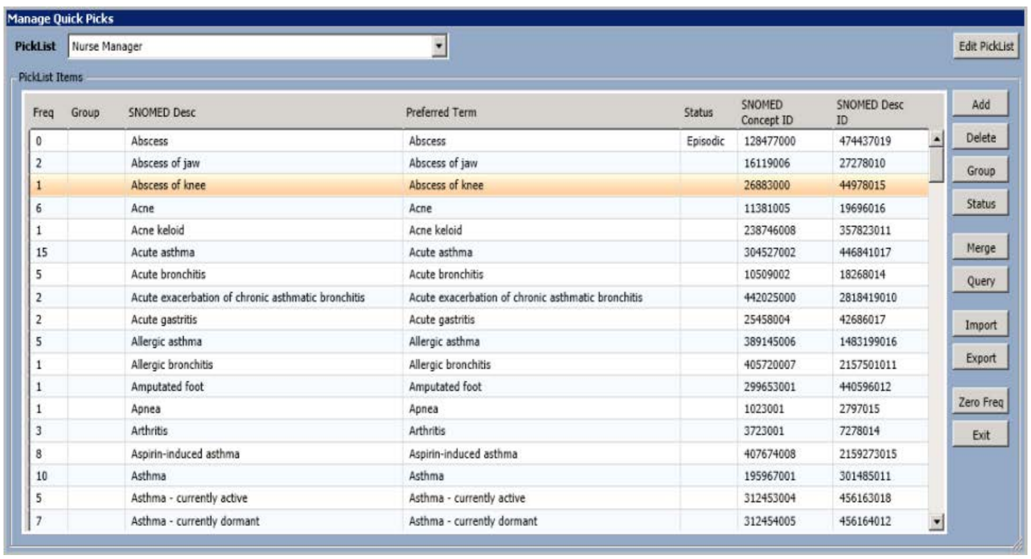


Figure 4-124: Manage Quick Picks Dialog

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

   - **Adding**

     a. Click the Add button from the Manage Quick Picks dialog. The SNOMED CT Lookup dialog opens.

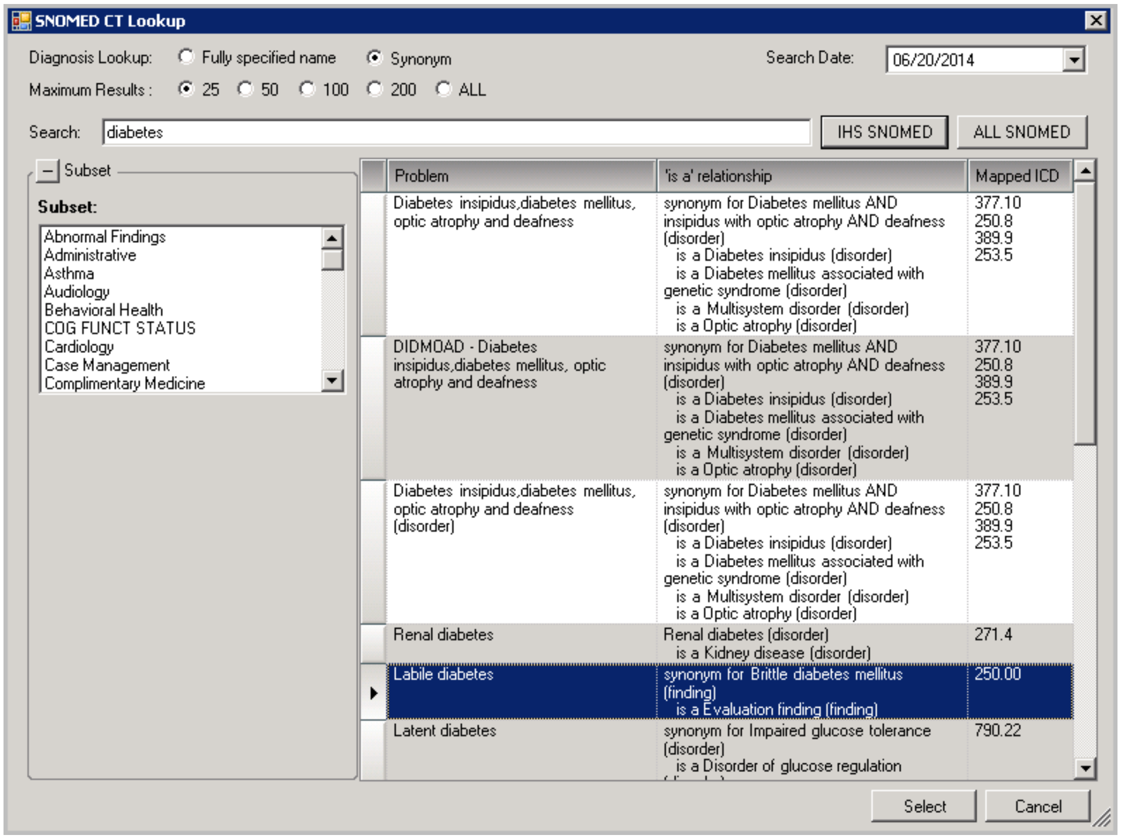


Figure 4-125: SNOMED CT Lookup Dialog

b. 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.

e. In Subset, you can select a subset in which to search, if needed.

f. 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.

g. Click either the IHS SNOMED or ALL SNOMED button. The list of SNOMED CT terms is populated.

h. Select a problem from the list and then click Select. Your selection appears in the PickList Items of the Manage Quick Picks dialog.

- The SNOMED Term column displays the description of the selected SNOMED (for example, the Fully specified name or the Synonym).
- When an item is added to the PickList, the values stored are SNOMED Concept ID and Description ID of the Fully specified name, if the Preferred Term is selected. If a Synonym is selected, the SNOMED Concept ID of the Fully specified name, and the Description ID of the synonym are stored.
- The Descriptor field stores the SNOMED term preferred or synonym, depending on what was selected from the Apelon tool.

- **Deleting**

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

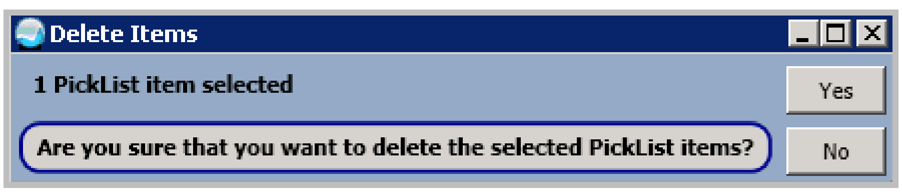


Figure 4-126: Delete PickList Item Confirmation Message

b. Click Yes to Delete, No to cancel. If Yes is clicked, the item is removed from the picklist.

- **Changing Group**

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

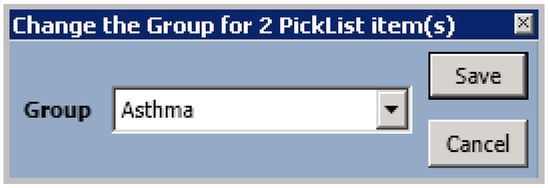


Figure 4-127: Change the Group Dialog

b. In Group, select the group to which you want to move the item from the drop-down menu.

c. Click Save to save the new Group.

- **Changing Status**

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

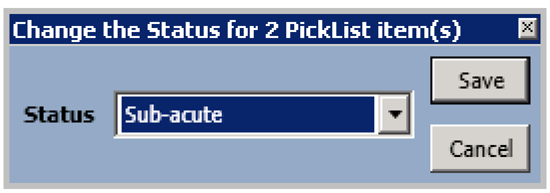


Figure 4-128: Change the Status Dialog

b. In the Status drop-down, select a status to assign:

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

c. Click Save.

- **Merging**

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

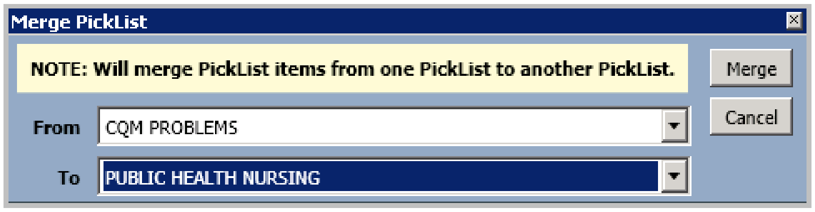


Figure 4-129: Merge PickList

b. In From, select the picklist to merge the item or items from.

c. In To, select the picklist to merge the item or items to.

d. Click Merge.

- **Querying**

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

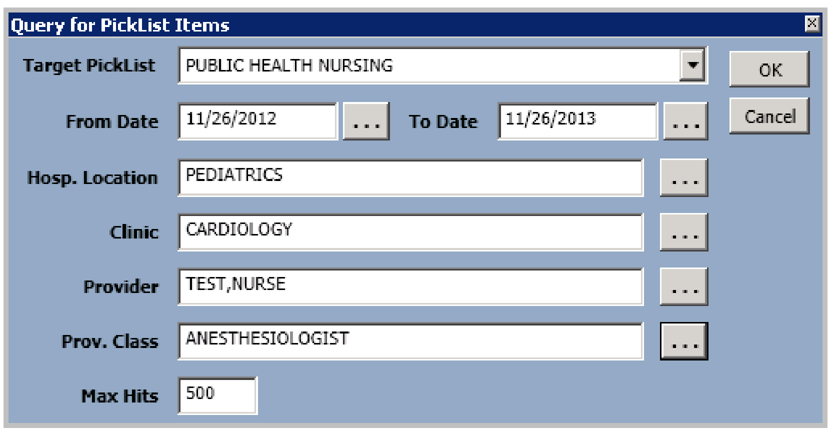


Figure 4-130: Query for PickList Items Dialog

b. In Target PickList, select a picklist to query from the drop-down menu.

c. In From Date, click the Ellipsis button to select a date from the calendar.

d. 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.

e. In Hosp. Location, click the Ellipsis button to select a location. The Select a Location dialog opens.

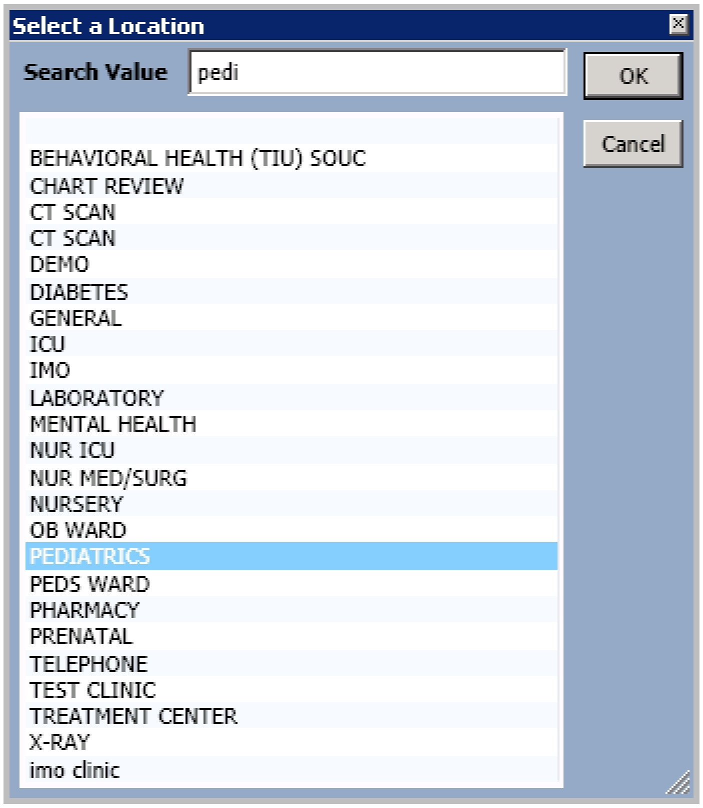


Figure 4-131: Select a Location Dialog

i. In Search Value begin typing the first few letters of the location name. The list refreshes with your location.

ii. Click to select the location, and then click OK. Your selection is populated in the Hosp. Location field.

f. In Clinic, click the Ellipsis button to select a clinic. The Select a Clinic dialog opens.

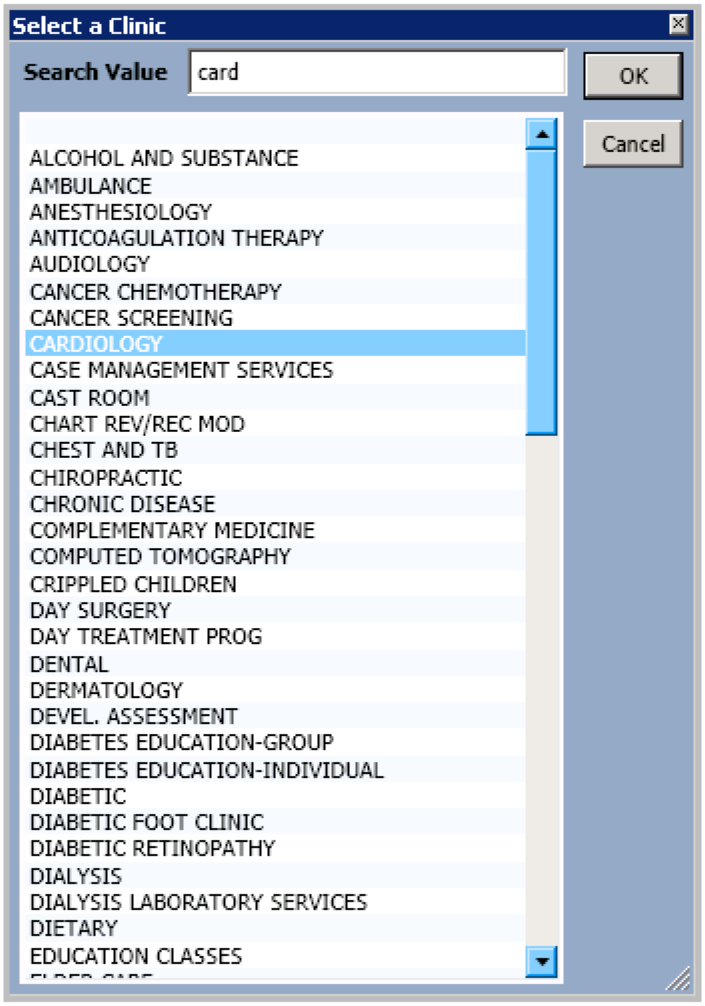


Figure 4-132: Select a Clinic Dialog

i. In Search Value begin typing the first few letters of the clinic name. The list refreshes with your clinic.

ii. Click to select the clinic, and then click OK. Your selection is populated in the Clinic field.

g. In Provider, click the Ellipsis button to select a provider. The Select a Provider dialog opens.

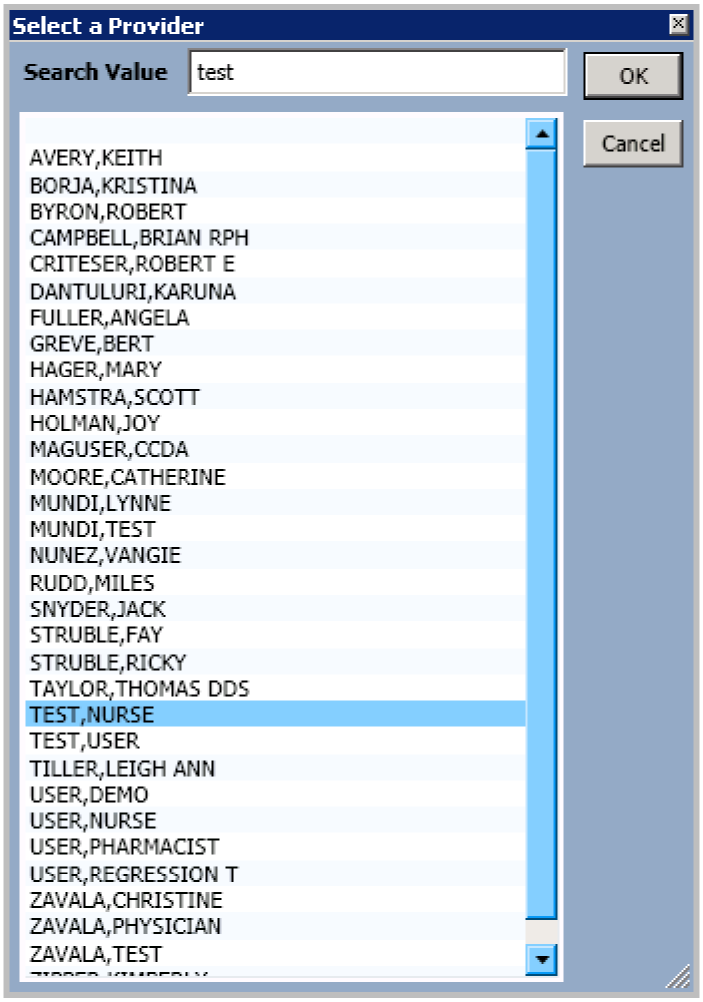


Figure 4-133: Select a Provider Dialog

i. In Search Value, begin typing the first few letters of the provider name. The list refreshes with providers.

ii. Click to select the provider, and then click OK. Your selection is populated in the Provider field.

h. In Prov. Class, click the Ellipsis button to select a provider class. The Select a Provider Class dialog opens.

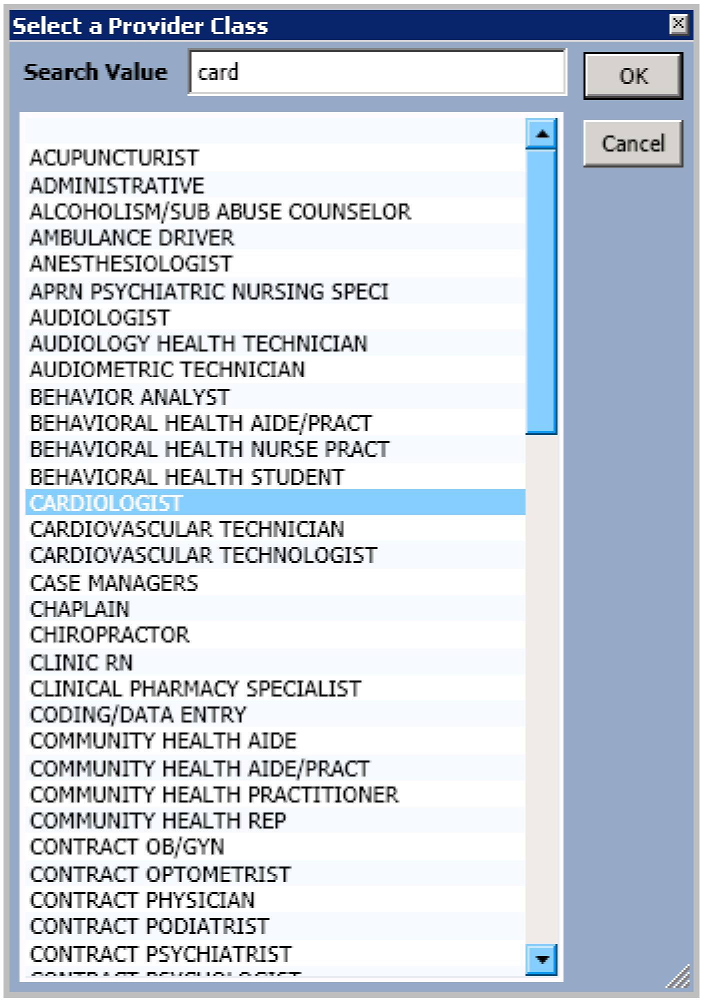


Figure 4-134: Select a Provider Class Dialog

i. In Search Value begin typing the first few letters of the provider's class. The list refreshes with provider classes.

ii. Click to select the provider class, and then click OK. Your selection is populated in the Prov. Class field.

i. In Max hits, 500 is the default. Type a number of hits to return if you want to change the number of hits returned.

j. Click OK on the Query for PickList Items dialog. An information message appears, showing the number of returned records.

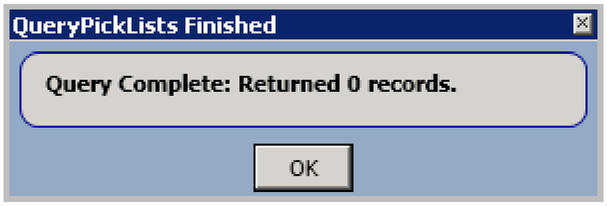


Figure 4-135.Query PickLists Finished Information Message

- **Importing**

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

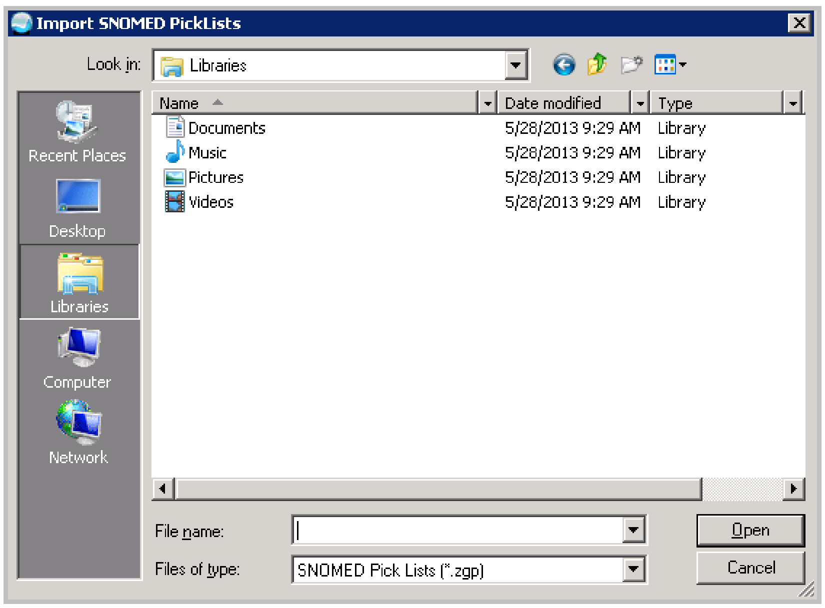


Figure 4-136: Import SNOMED PickLists Dialog

    b. In Look in, select a location from which to import.

    c. Locate the file you want to import. The Files of Type defaults to SNOMED PickLists (*zgp).

    d. Click Open. Your file is imported.

- **Exporting**

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

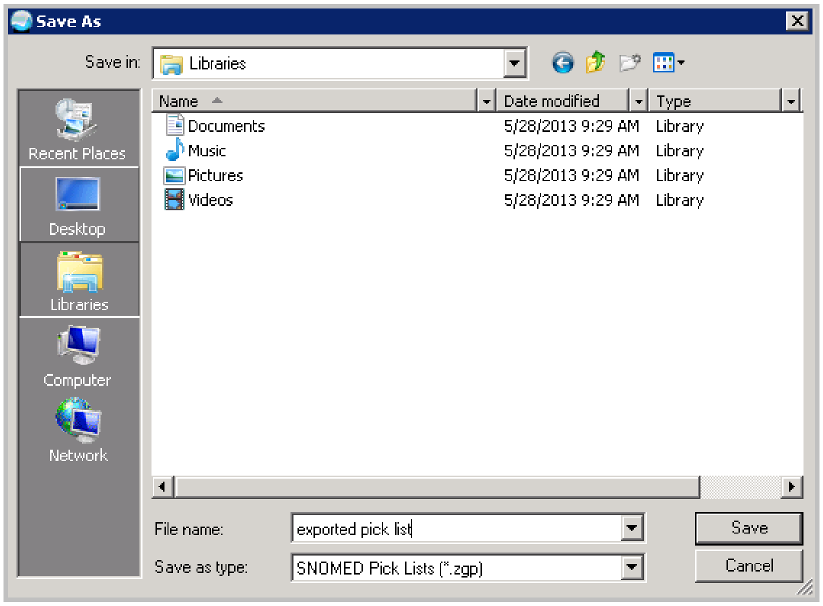


Figure 4-137: Save As (Export PickList) Dialog

b. Select a location to save and type a file name and then click Save. Your SNOMED PickList is saved as .zgp file type, ready for exporting.

- **Marking Zero Freq(uency).**

  a. Click the Zero Freq button from the Manage Quick Picks dialog. A frequency of zero (0) is assigned to the picklist item.

5. Click Exit to close the Manage Quick Picks dialog.

4.6.4.3 Edit PickList Button

From the Manage Quick Picks dialog, click the Edit PickLists button to add, edit, delete, or import a subset to an existing picklist.

1. Click the Edit PickLists button. The Edit PickLists dialog opens.

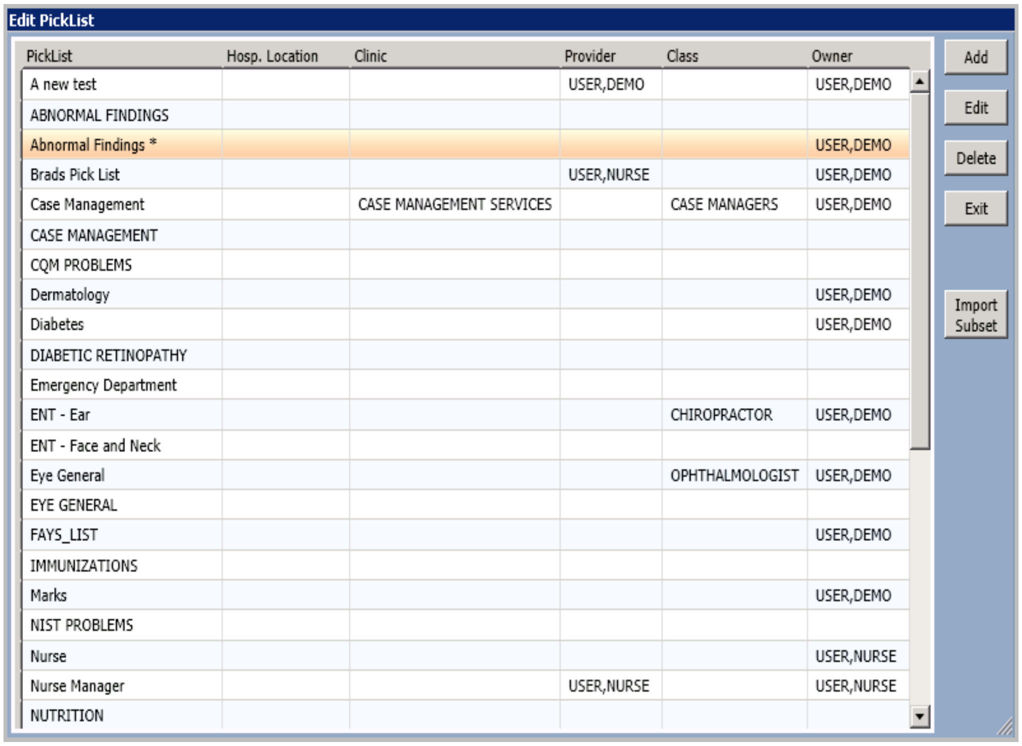


Figure 4-138: Edit PickLists Dialog

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

   - **Add**

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

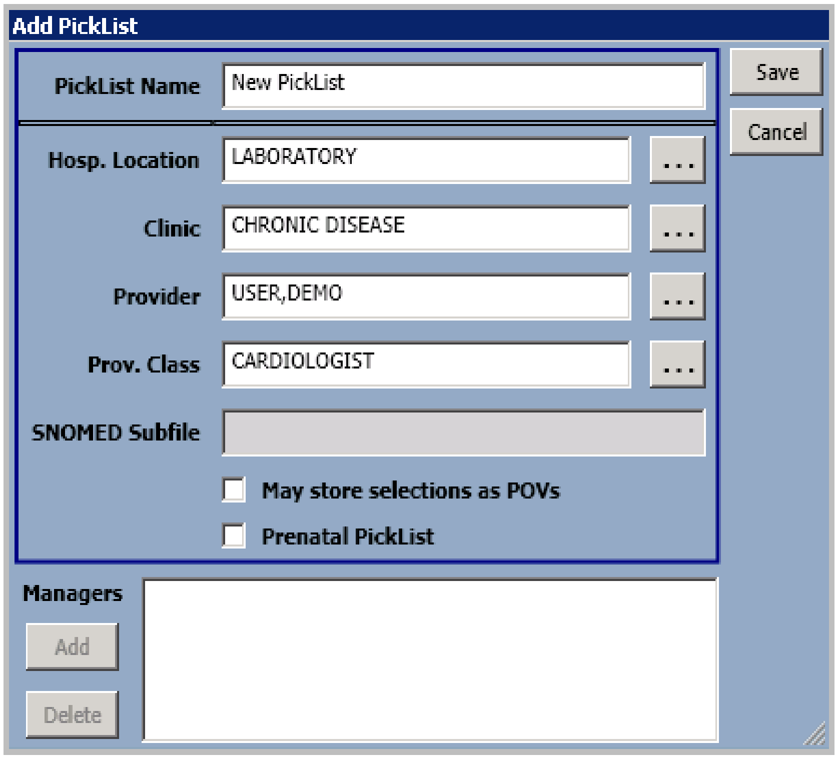


Figure 4-139: Add PickList Dialog

b. In PickList Name, type a name for the picklist.

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

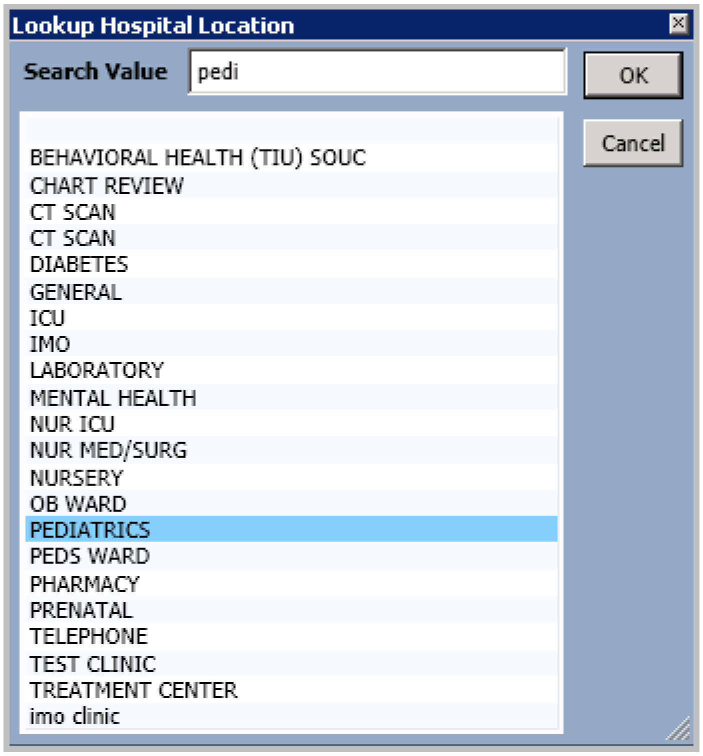


Figure 4-140: Lookup Hospital Location Dialog

i. In Search Value, begin typing the first few letters of the location name. The list refreshes with your location.

ii. Click to select the location, then click OK. Your selection is populated in the Hosp. Location field.

d. In Clinic, click the Ellipsis button to select a clinic. The Select a Clinic dialog opens.

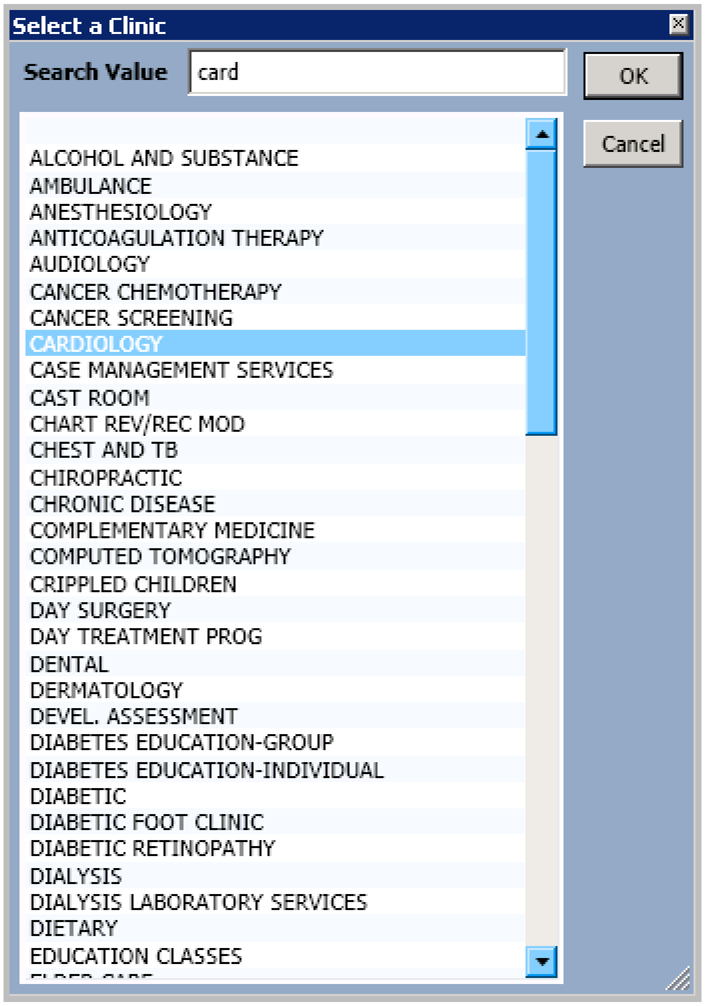


Figure 4-141: Select a Clinic Dialog

i. In Search Value begin typing the first few letters of the clinic name. The list refreshes with your clinic.

ii. Click to select the clinic, and then click OK. Your selection is populated in the Clinic field.

e. In Provider, click the Ellipsis button to select a provider. The Select a Provider dialog opens.

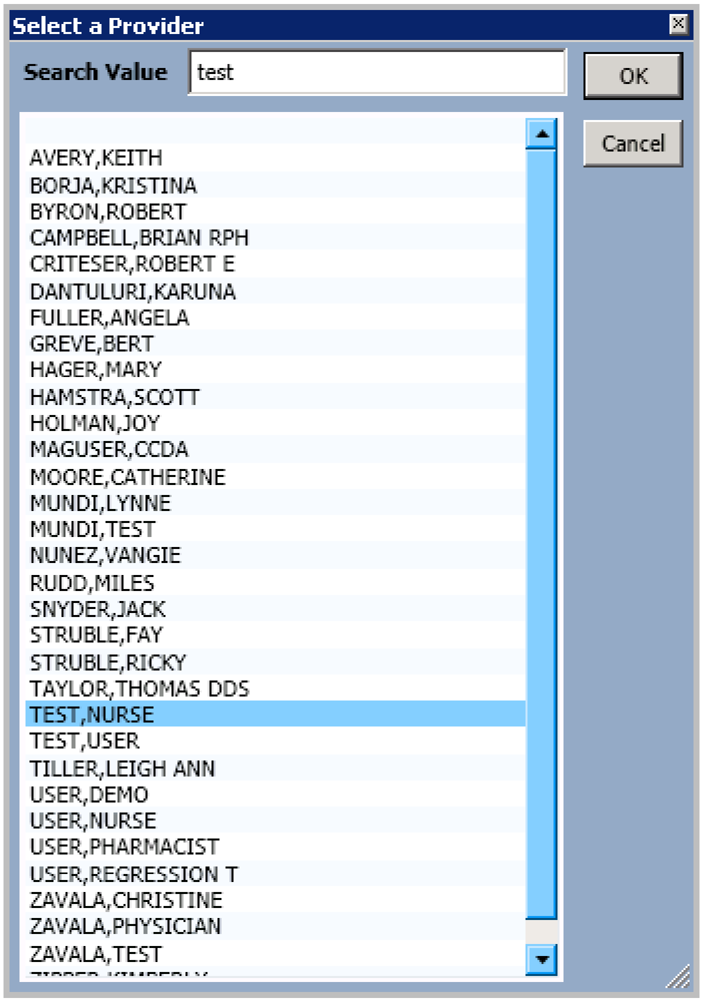


Figure 4-142: Select a Provider Dialog

i. In Search Value begin typing the first few letters of the provider name. The list refreshes with providers.

ii. Click to select the provider, and then click OK. Your selection is populated in the Provider field.

f. In Prov. Class, click the Ellipsis button to select a provider class. The Select a Provider Class dialog opens.

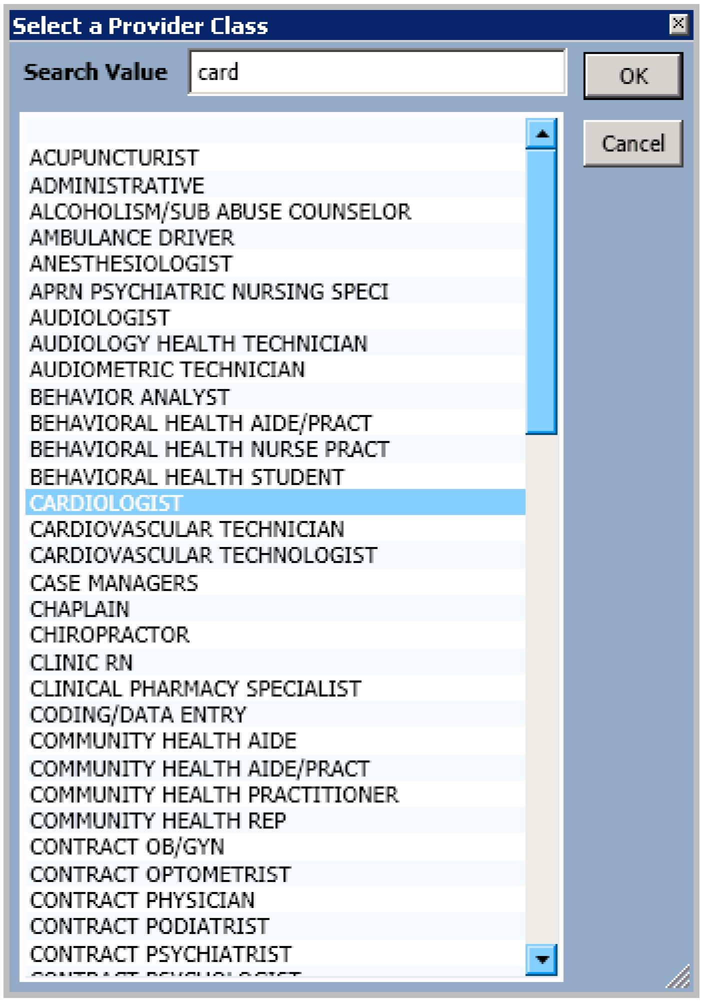


Figure 4-143: Select a Provider Class Dialog

i. In Search Value begin typing the first few letters of the provider's class. The list refreshes with provider classes.

ii. Click to select the provider class, and then click OK. Your selection is populated in the Prov. Class field.

- The SNOMED 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 Subfile field.
- The Managers section is inactive until a picklist is created and edited. Refer to the Edit section below.

g. If applicable, select the May store selections as POVs checkbox. The problems in the picklist can be saved as POV and this enables the Save as Problem and POV button on the PickList Selection dialog. See the Selecting Problems from a PickList section, above.

h. If applicable, select the Prenatal PickList checkbox.

i. Click Save. Your entries show in the Manage PickLists dialog.

- **Edit Button**

a. Click to select a picklist to edit from the Manage PickList Dialog. The Edit PickList dialog opens.

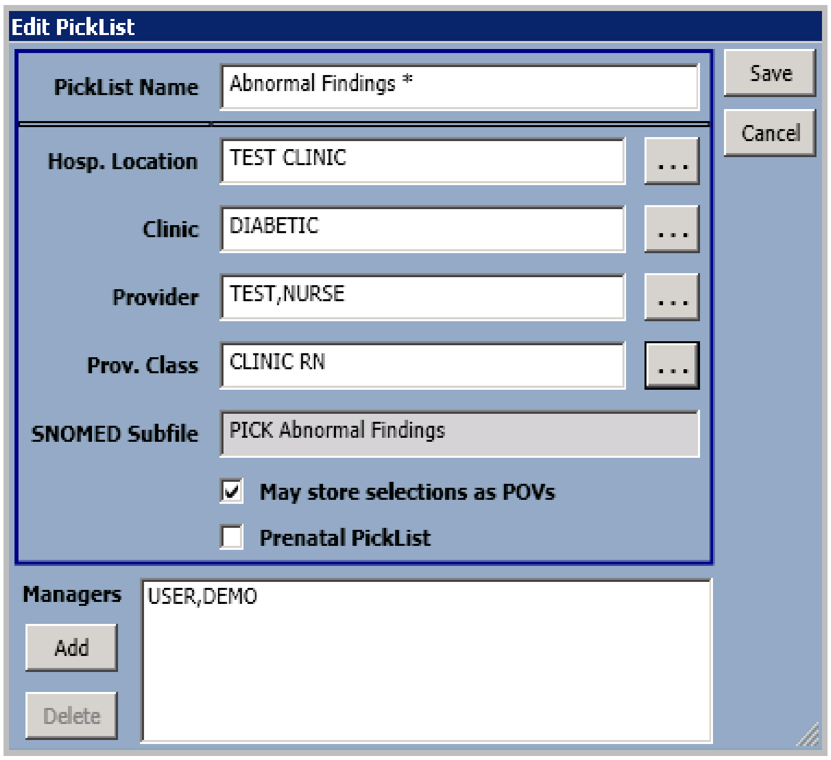


Figure 4-144: Edit PickList Dialog

b. Make any necessary changes to the Edit PickList dialog entries. Refer to the Add PickList steps above for details on completing the fields.

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

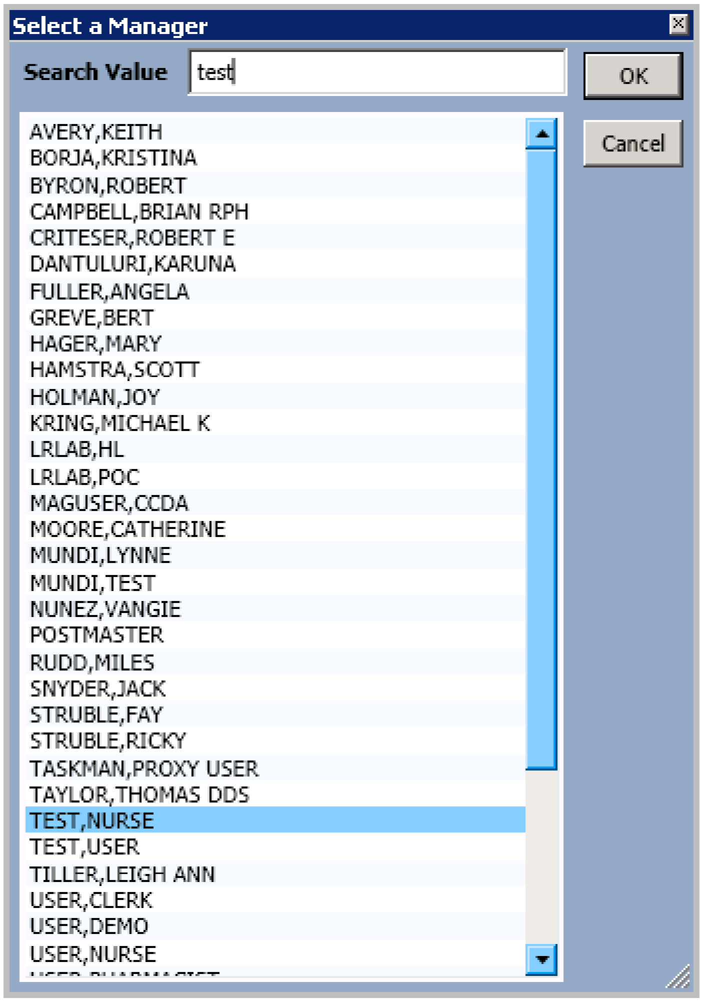


Figure 4-145: Select a Manager Dialog

d. In Search Value, begin typing the first few letters of the person's name. The list refreshes with your selection.

e. Click the name, and then click OK. The Managers field populates with your entry.

f. Click Save on the Edit PickList dialog.

- **Delete Button**

a. Click to select a picklist to delete.

b. Click the Delete button. A Delete Picklist information message appears.

Figure 4-146: Delete PickList Information Message

c. Click Yes to delete the list, or No to cancel. If Yes, the picklist is deleted from the list.

- **Import Subset Button**

a. Click to select a picklist, and then click the Import Subset button. The Import Subset dialog opens.

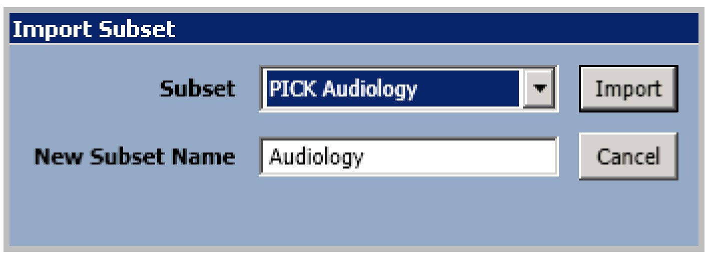


Figure 4-147: Import Subset Dialog

b. In Subset, select a subset to import from the drop-down menu. The New Subset Name field populates with your selection.

c. Click Import.

3. Click Exit to exit the Manage PickLists dialog.

4.6.5 Using the Education Information Button

The Education Information search enables you to look up information on a highlighted problem.

If an active visit is not selected when the Education Information button is clicked, the following message appears. Click Yes to select an active visit. If No is clicked, MedlinePlus opens, but the Add Patient Education Event dialog does not open.

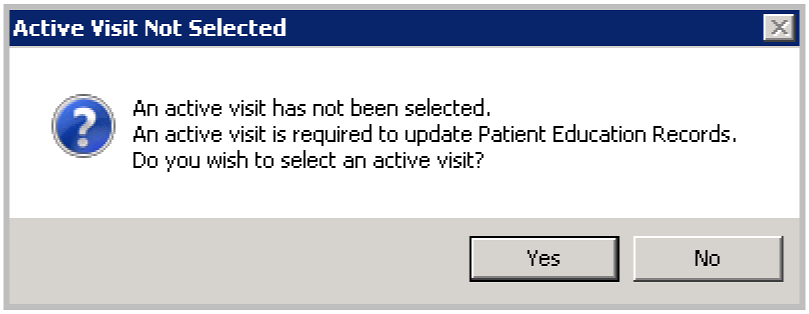


Figure 4-148: Active Visit Not Selected Information Message

The 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.

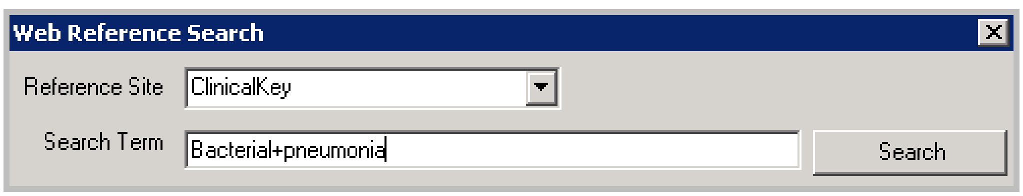


Figure 4-149: Web Reference Search

Select a Reference Site, if needed; the default is the ClinicalKey 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.

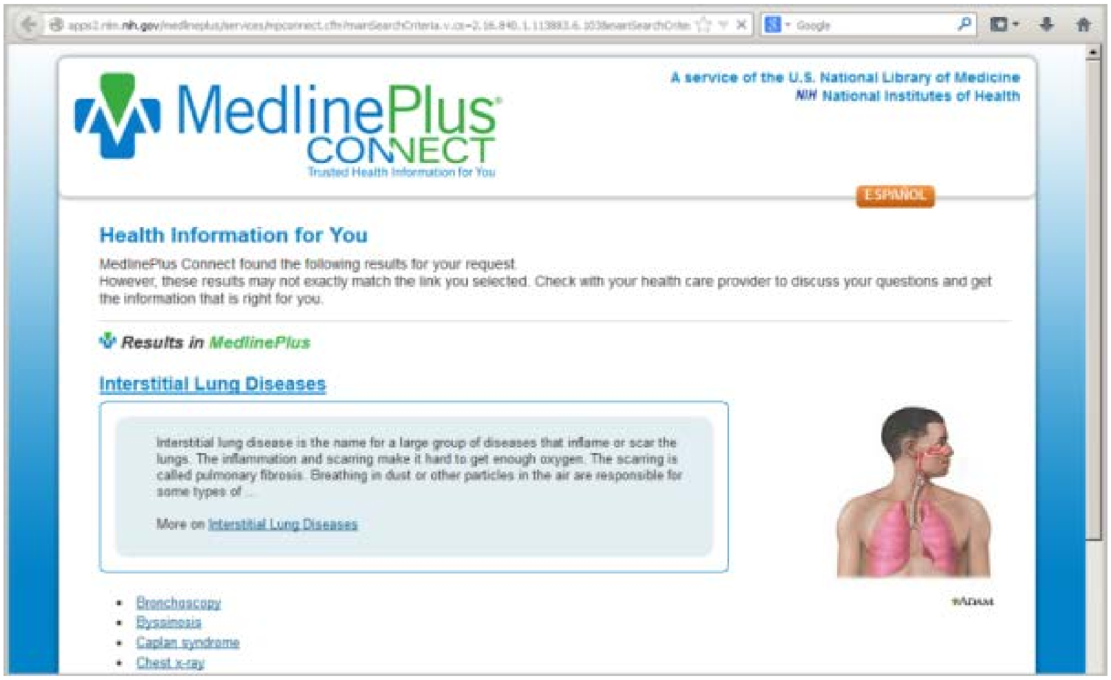


Figure 4-150: MedlinePlus

4.6.6 Using the Clinical Decision Support Button

The Clinical Decision Support search 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 ClinicalKey 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 ClinicalKey.

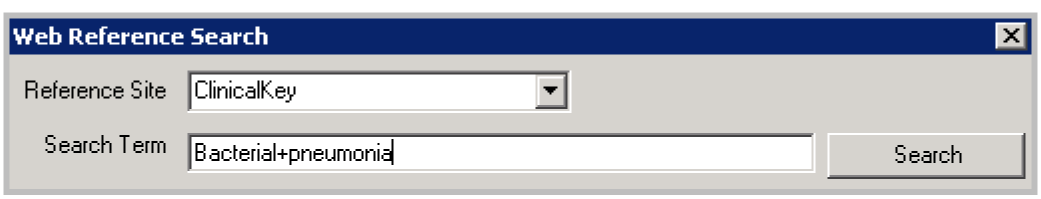


Figure 4-151: Web Reference Search

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

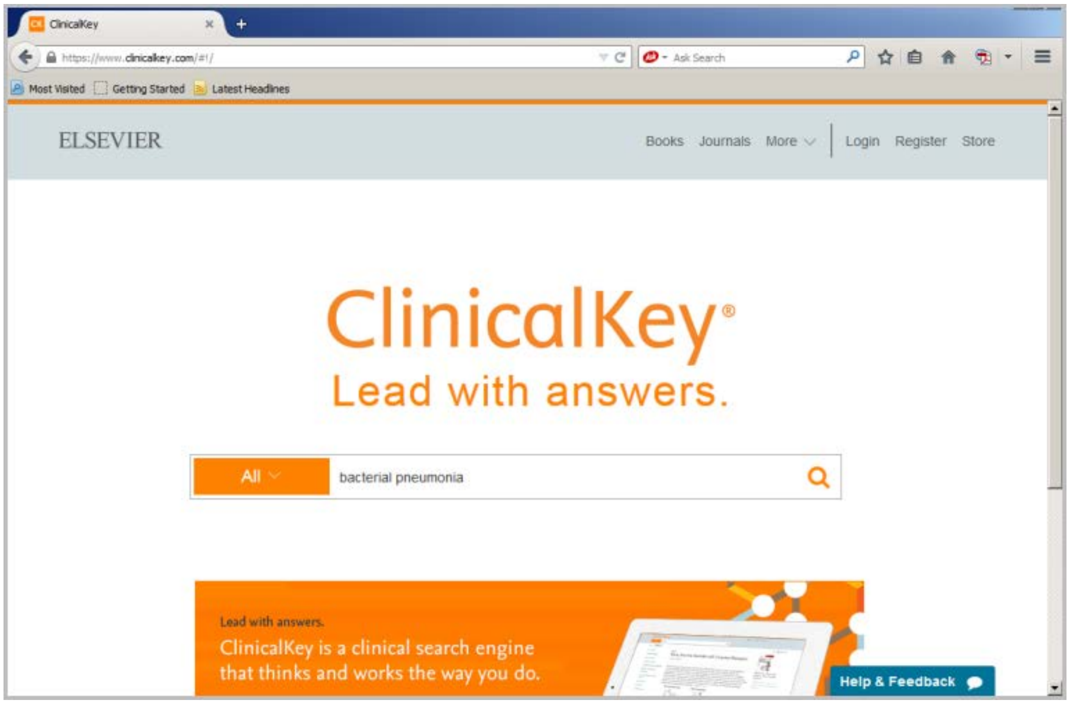


Figure 4-152: ClinicalKey Website

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.

4.6.7 Care Planning Feature

Clicking the Expand All button (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.

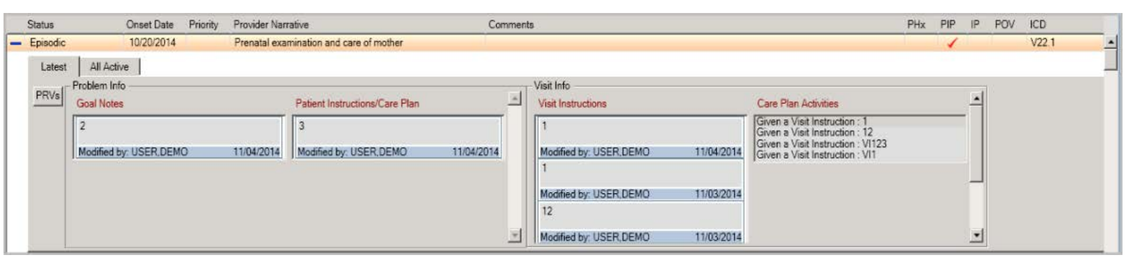


Figure 4-153: Expanded Care Plan

- Goal Notes with a status for each date entered.
- Patient Instructions/Care Plan with a status for each date entered.

- Visit Instructions for each visit.
- Care plan activities for each visit.
- Whether any of the items above were modified, and if so, by whom and when (date/time). Refer to the PRV Button section below for details on how to view by user.

4.6.7.1 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.

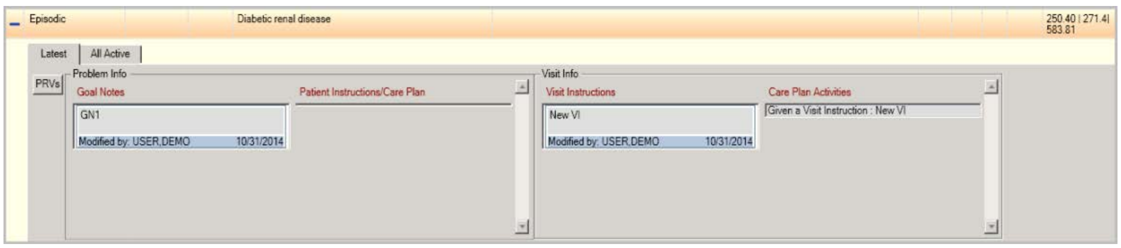


Figure 4-154: Latest Care Plan

4.6.7.1.1 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.

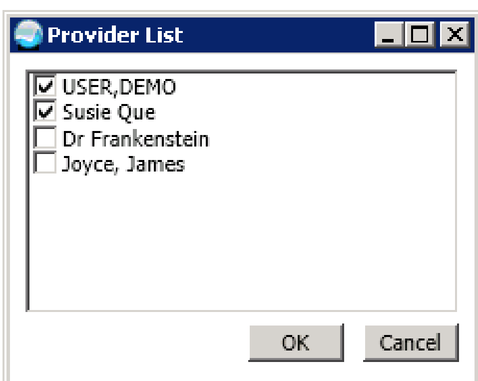


Figure 4-155: Provider List Dialog

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.

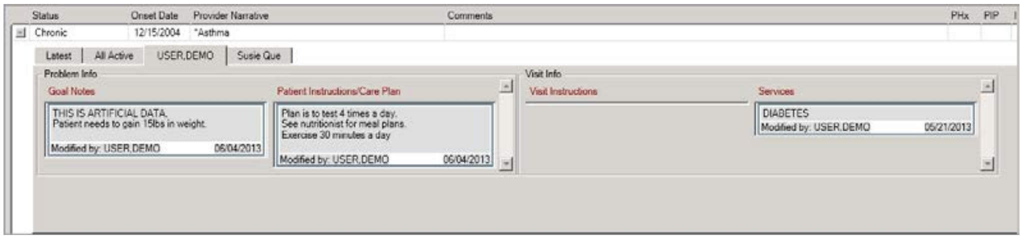


Figure 4-156: Provider List Results

4.6.7.1.2 All Active Tab

On the All Active tab, all care planning activities are shown.

Figure 4-157: All Active Care Plans

4.6.8 Completing IPL Tasks

The following tasks can be completed in the Integrated Problem list module by clicking the Add, Edit, or Delete button from the main screen.

4.6.9 Adding an Integrated Problem List (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.

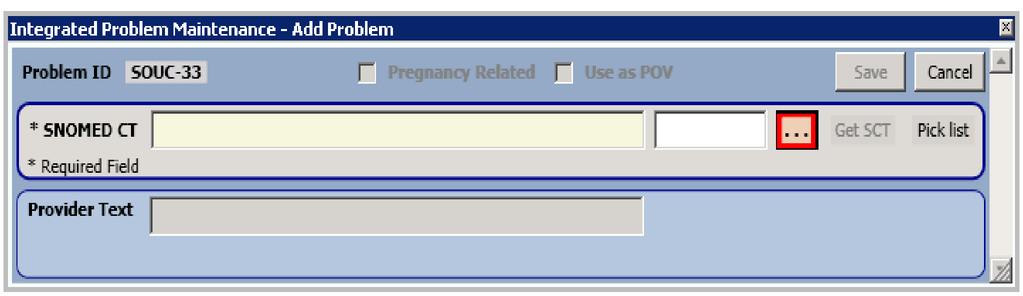


Figure 4-158: Initial Add Problem Dialog

Note:	A visit is not required to view the IPL details, however a visit must be selected to enable the Add button.

Note:	The Problem ID field is system populated.

2. Select the Pregnancy Related check box, if applicable. The Pregnancy Related check box is only available for female patients.

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

4. Select the Use as POV check box, if applicable. The POV check box is only available 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, and a red check mark appears in the POV column of the IPL main window. Inactive problems may be POV.

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

   - **SNOMED CT Field**

     a. Type a term in the SNOMED CT field, and then press Enter or click the Ellipsis button. The SNOMED CT Lookup dialog opens with your term populated in the Search field and a list of IHS SNOMED terms.

     b. If you want to search all SNOMED terms, in the initial Add Problem dialog, leave the SNOMED CT field blank and click the Ellipsis button. The SNOMED CT Lookup dialog opens.

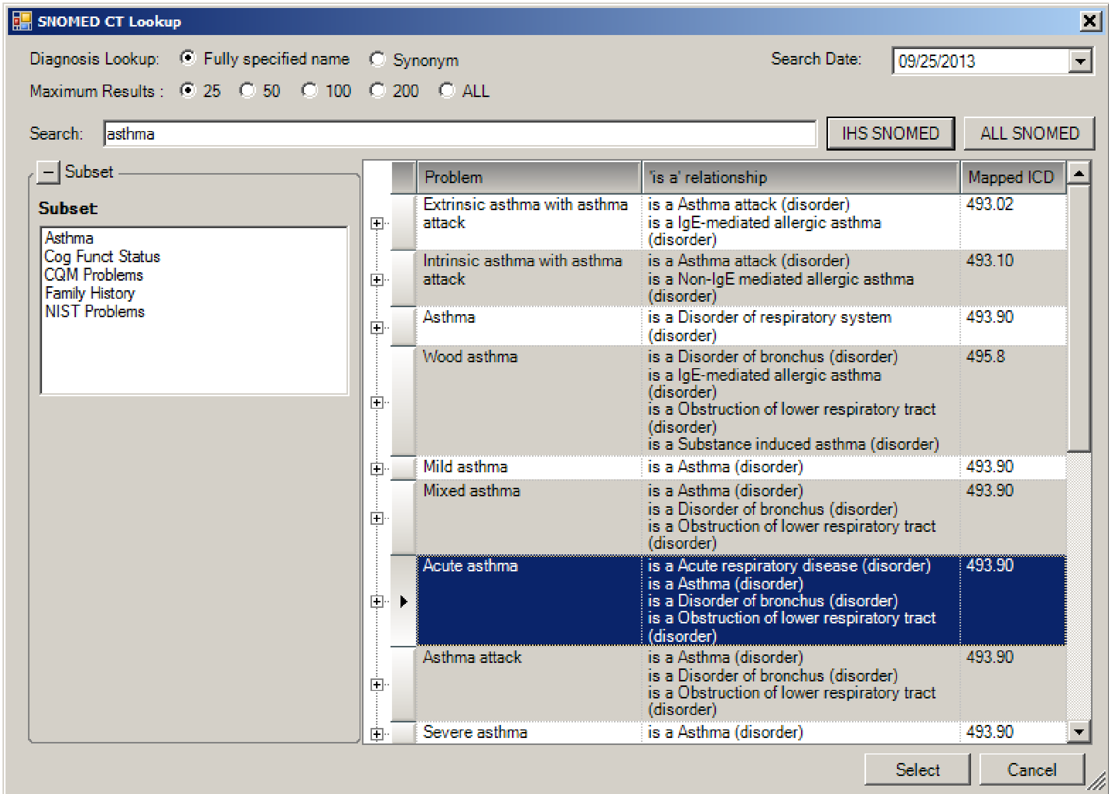


Figure 4-159: SNOMED CT Lookup Dialog

c. In the SNOMED CT lookup dialog, in the Diagnosis Lookup section, select either the Fully Specified Name or Synonym option buttons.

  - 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.

d. In Maximum Results, click one of the following option buttons to limit the number of results (or click ALL):

  - 25
  - 50
  - 100
  - 200
  - ALL

e. In Search, type the term to search for.

f. In Subset, you can select a subset to search for, if needed.

g. 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.

h. Click either the IHS SNOMED or ALL SNOMED button. The list of SNOMED CT terms is populated.

i. 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.

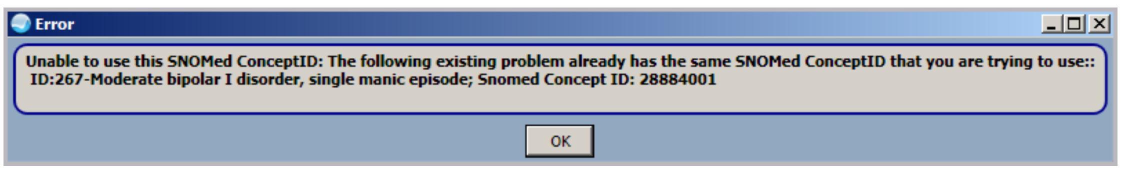


Figure 4-160: Duplicate SNOMED CT Code Error Message

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

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

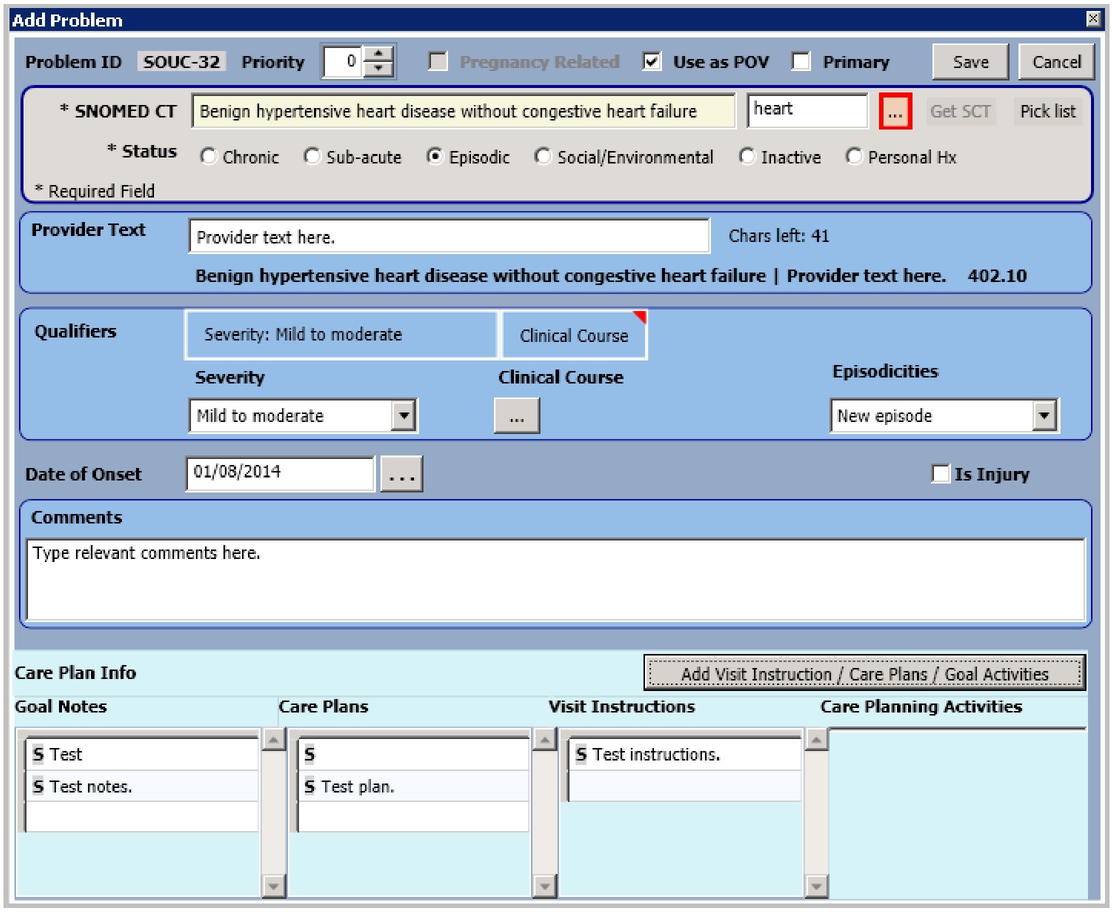


Figure 4-161: Expanded Add Problem Dialog with Asthma

6. In Priority, use the Up and Down arrows to select a priority level.

7. For pregnant patients, the Pregnancy Related check box is auto-selected if a problem was created in the Pregnancy and Issues component and saved as POV. A red check mark appears in the PIP column of the IPL main screen in these cases.

8. If primary problem, select the Primary check box.

Note:	The Primary check box is only visible if the POV has been completed. Refer to the Using the POV Button topic for details.

9. In Status, click the applicable option button:

   - Chronic
   - Sub-acute
   - Episodic

- Social/Environmental
- Inactive
- Personal Hx

Note: Chart Review is triggered if you are editing a problem in IPL and the Status of a problem is changed and saved.

10. 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.

11. In Severity, select one or more of the following:

- Fatal
- Life Threatening
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

12. Click the Clinical Course Ellipsis to populate the Clinical Course field. The Select Clinical Courses dialog opens.

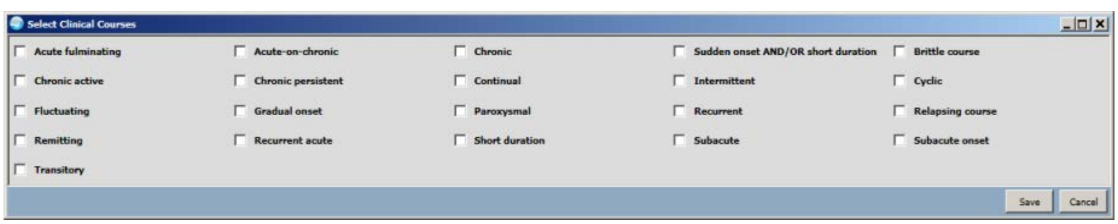


Figure 4-162.Select Clinical Courses Dialog

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.

13. In Episodicities, select one of the following from the drop-down menu.

- First episode
- New episode
- Old episode
- Ongoing episode
- Undefined episodicity

14. 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.

Note:	Only one Asthma Control entry is allowed per visit.

15. 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. Do one of the following:

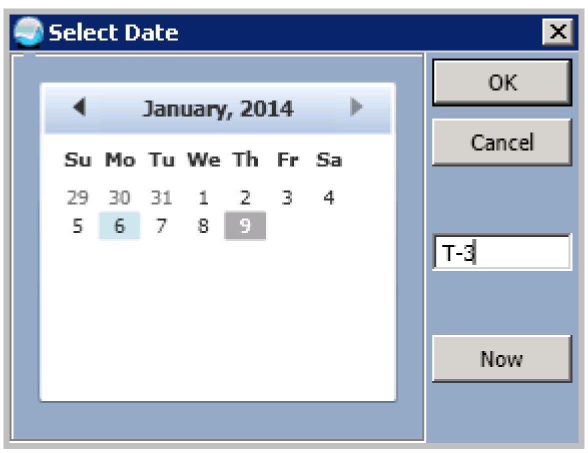


Figure 4-163: Select Date

- Select a date from the calendar, and then click OK. The date selected populates in the Date of Onset field.
- Click the Now button, then click OK. The Date of Onset populates with today's date.
- In the blank field, type T-X, with X indicating number of days passed. The Date of Onset populates with the current date minus the number of days indicated.

16. 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.

Figure 4-164: 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.

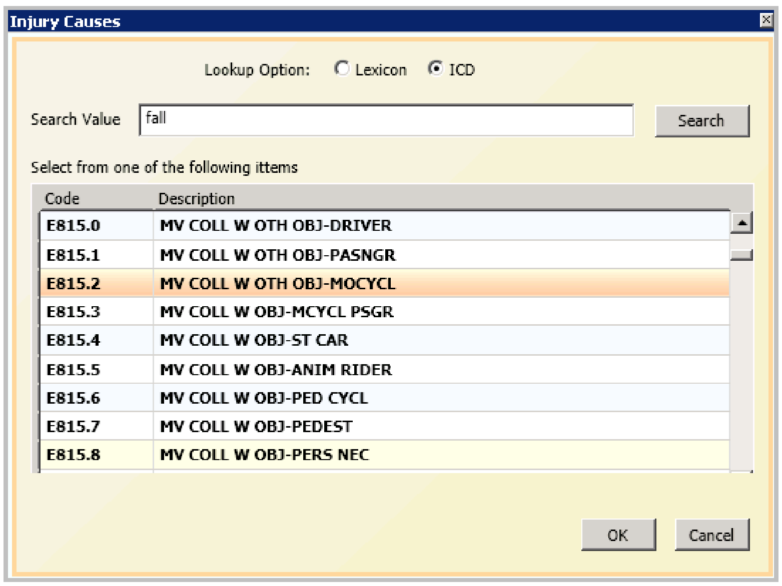


Figure 4-165: Injury Causes with E Codes Dialog

i. In Lookup Option, click either the Lexicon or ICD option button.

ii. 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.

iii. In the returned results list, select the applicable item, then click OK. Your selection shows in Caused By in the Injury section.

17. Type a comment in the Comments section, if needed.

18. 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/Goal Notes/Care Plan Activities dialog opens. Refer to the Adding Visit Instructions/Goal Notes/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.

19. 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.

4.6.10 Editing an Integrated Problem List (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.

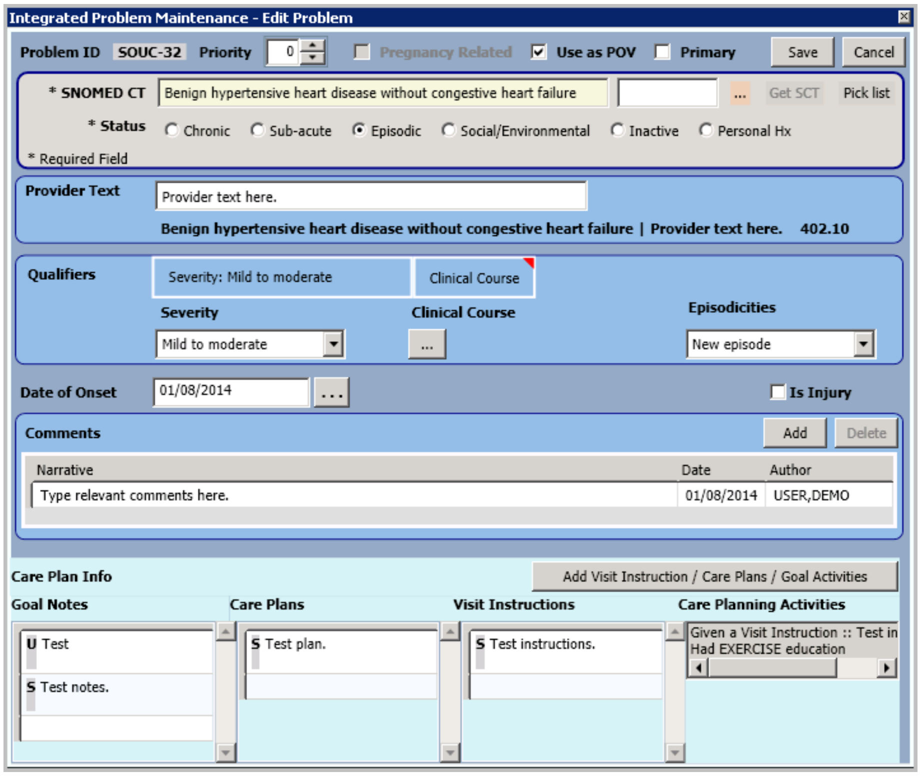


Figure 4-166: Integrated Problem Maintenance - Edit Problem Dialog

4. Edit fields as applicable. Refer to the Adding an Integrated Problem List (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.

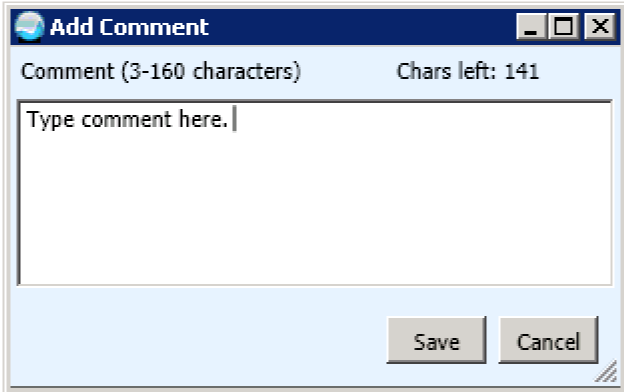


Figure 4-167: Add Comment Dialog

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.

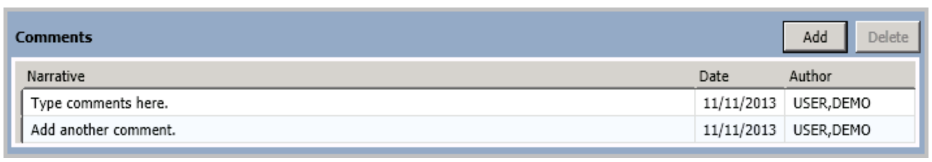


Figure 4-168: Comments List

- 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:

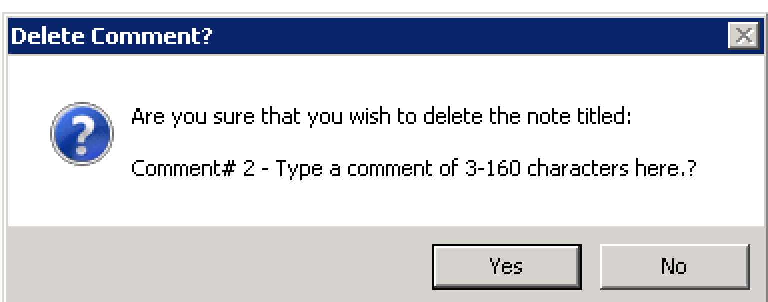


Figure 4-169: Delete Comment Confirmation Message

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.

Note: 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.

4.6.11 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, inactivating, or deleting visit instructions, goals, or Care Plan information. Refer to Using the POV Button for additional information.

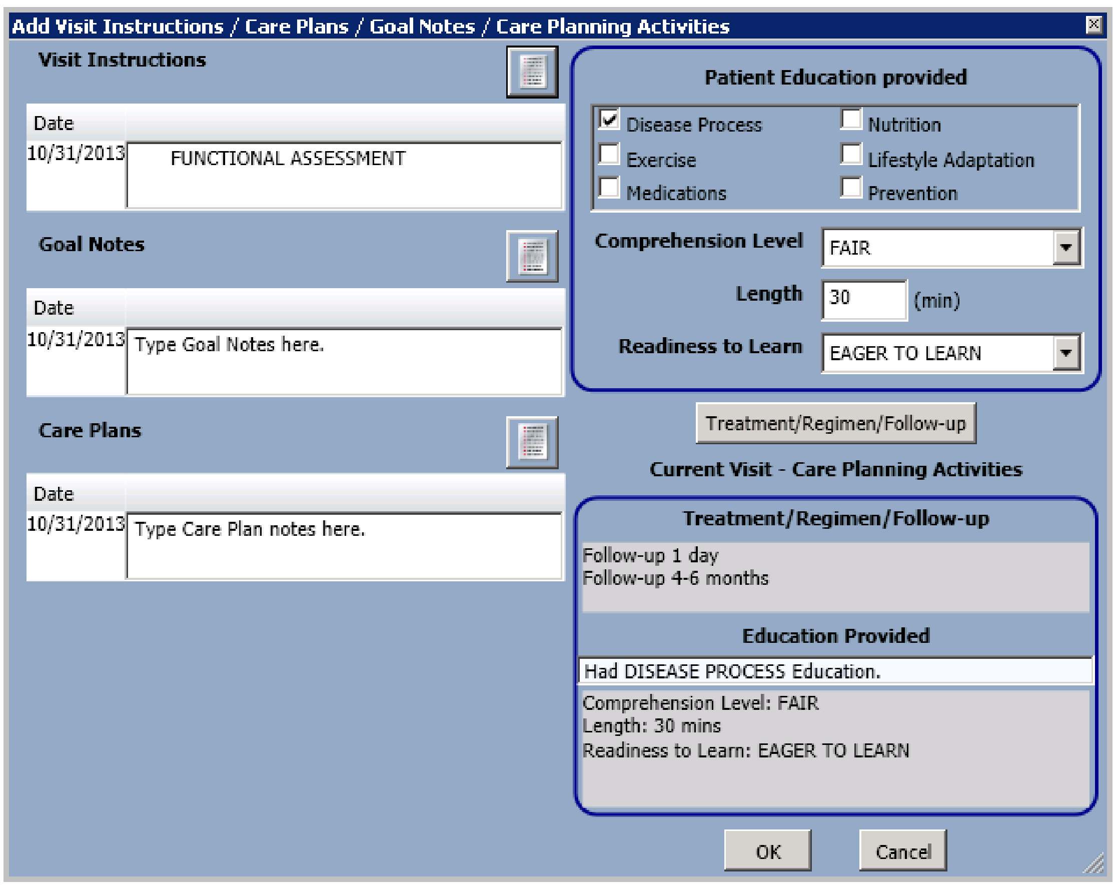
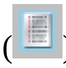


Figure 4-170: Add Visit Instructions/Care Plan/Goal Notes/Care Planning Activities Dialog

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.

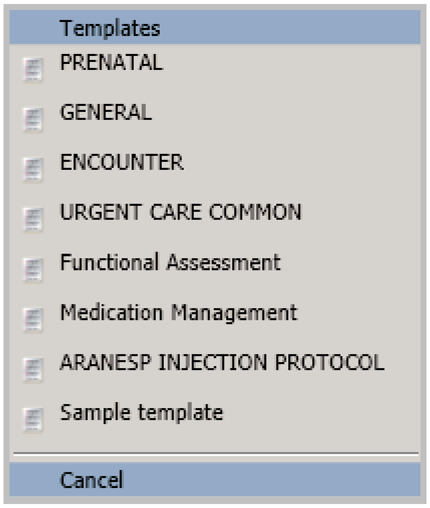


Figure 4-171: Templates List

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

Note:	You can also click the Preview button to view how the template will appear. The Urgent Care Common Template in the Visit Instructions is shown as an example, below.

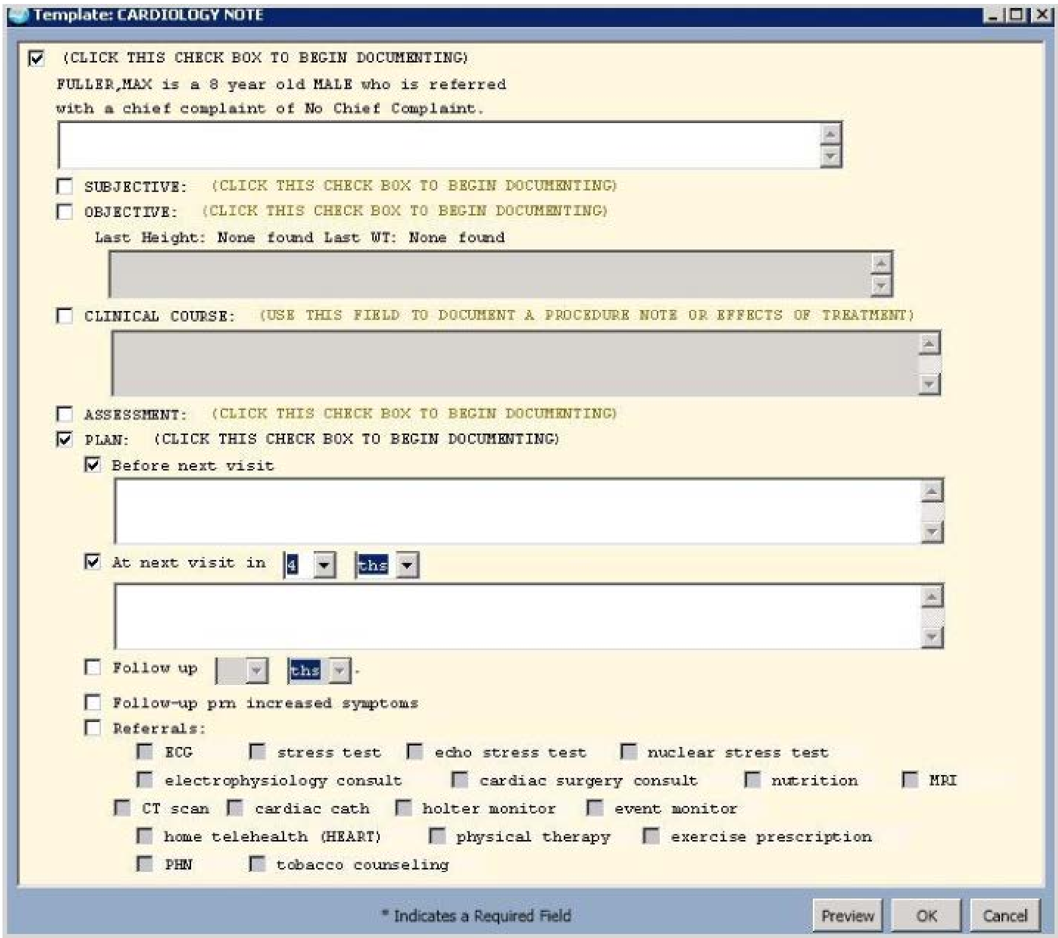


Figure 4-172: Medication Management Template

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 4-173: Treatment/Regimen Dialog

a. Click the Expand button (⊞) on an item in the list to expand the list.

> **Note:** The Treatment/Regimen dialog contains multiple TREG picklists, organized alphabetically.

b. Select one or more treatment, regimen, or follow-up 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:** 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.

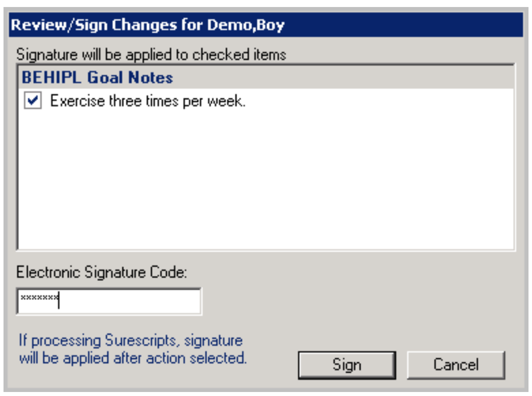


Figure 4-174: Review/Sign Changes for Patient Name

> **Note:** If the plan of care is new, and the old one is outdated, then it should be inactivated and a new one initiated.
>
> For example, for a patient with Polycystic Ovary Syndrome (PCOS) who has a goal of getting pregnant, the care plan is very specific around fertility and medications safe during conception/pregnancy. After the pregnancy, her goal may change to managing the hirsutism and metabolic effects of PCOS and contraception. The current plan would then be inactivated and a new plan written (you may want to see the old care plan notes if she decides to try to conceive again).

4.6.12 Deleting an Integrated Problem List (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 Topic Right-Click Menu 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.

4.6.13 Inactivating an Integrated Problem List (IPL)

This functionality is intended to inactivate the existing goal or care plan, and initiate a new one. Use this if you want to retain the information for future reference. It will not be seen in the general IPL display, but can be displayed on an RPMS report. Type a comment, and then click Yes.

4.7 Items (Super-Bills)

Super-Bills are lists of CPT codes used for billing and for documenting services performed. Each Super-Bill is attached to a visit. The Super-Bills panel shows the items for the Super-Bill category below the Super-Bills button.

Selecting one or more check boxes above the panel determines how Super-Bill items display in the right-hand panel.

> **Note:** A patient must be selected. A visit must be selected when adding an item to Visit Services/Historical Services, and an active visit must be selected to view the Categories and items in the Super-Bills panel. An inactive visit returns an empty Super-Bill.

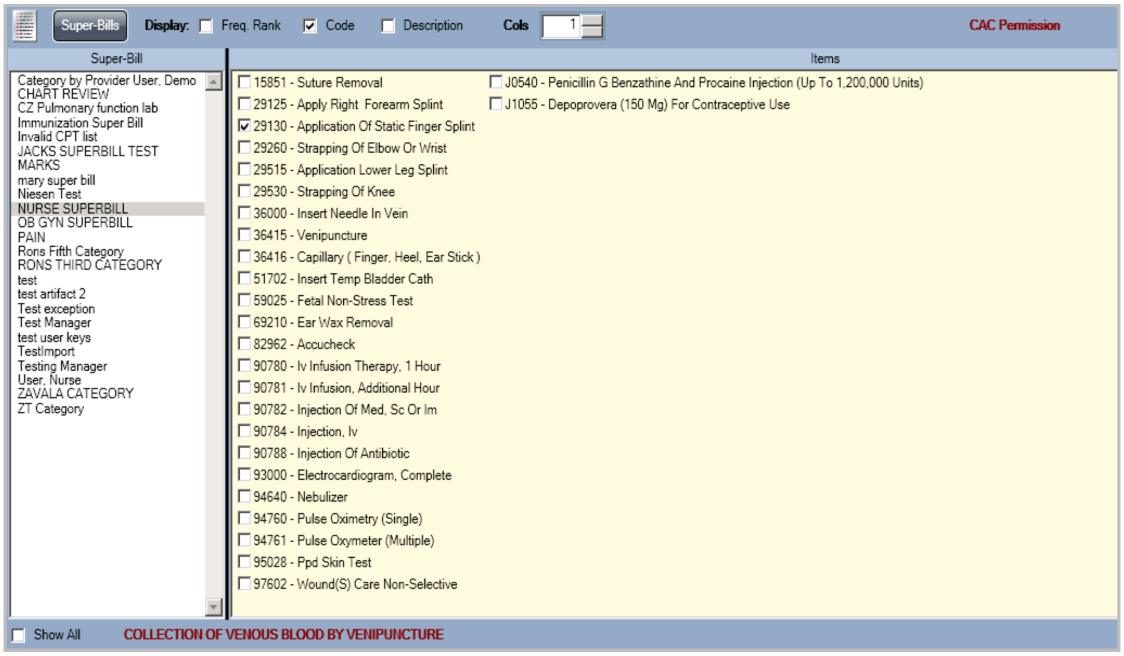


Figure 4-175: Super-Bills Panel

The default view (Show All check box is unchecked) means that only super-bills that either have no assigned clinic, hospital location, provider, or provider discipline and those super-bills that match any of these parameters with those of the currently selected visit are visible.

The Provider can automatically edit this component. Holders of the BGOZ CAC key have full manipulation privileges of all Super-Bill lists even though they may not have been assigned as manager. Holders of the BGOZ VIEW ONLY key cannot edit any data in this panel.

4.7.1 Displaying Super-Bill Items

Follow these steps to view Super-Bill items:

1. Select the Super-Bill Category from the Super-Bill list below the Super-Bills button. The Items field shows the Super-Bill items for the selected Super-Bill Category.

Note:	The Super-Bill Category list is based on what is defined in the Hospital location, Clinic, Provider, and Prov Discipline in the Manage Category dialog for each category. If none of the fields are defined, then that category is available for all users.

2. When none of the check-box fields are selected, the Super-Bill items are listed in alphabetical order.

a. Select the Show All check box to view any pick-lists for which the logged-on user is not manager or owner. Users who hold the BGOZ CAC key can view and edit all pick-lists.

Note:	If the Hospital Location Category is defined (see the Managing Super-Bill Categories topic), the pick-list only displays if the patient is in that hospital location. This is true even for users who hold the BGOZ CAC Key.

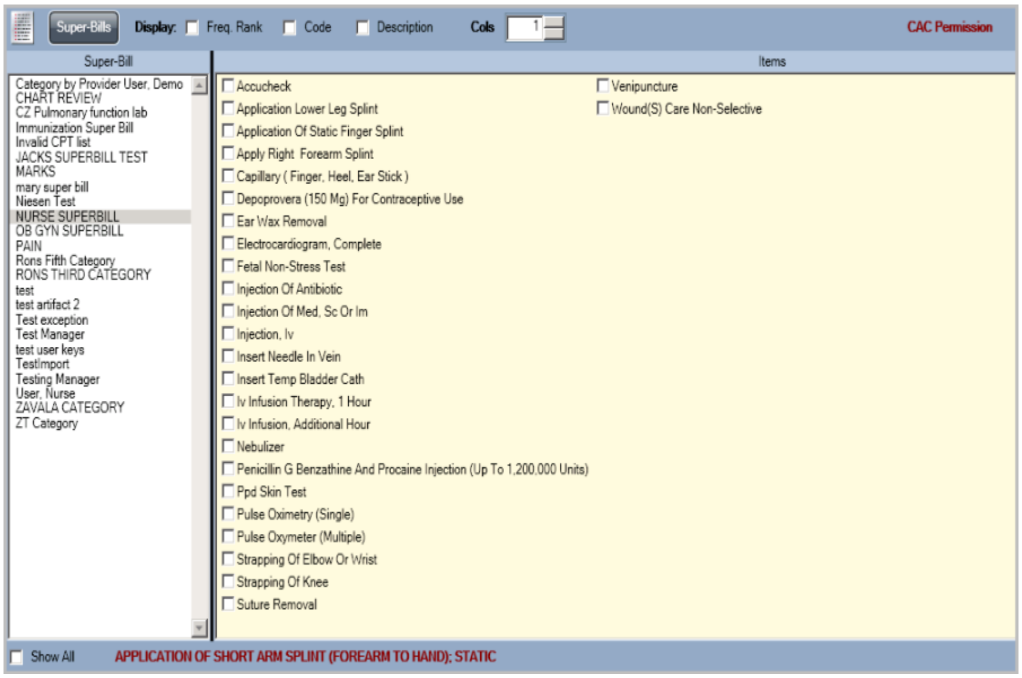


Figure 4-176: Super-Bill Items Listed When No Check Box is Selected

3. When only the Freq. Rank check box is selected, the Super-Bill items are listed by frequency of use.

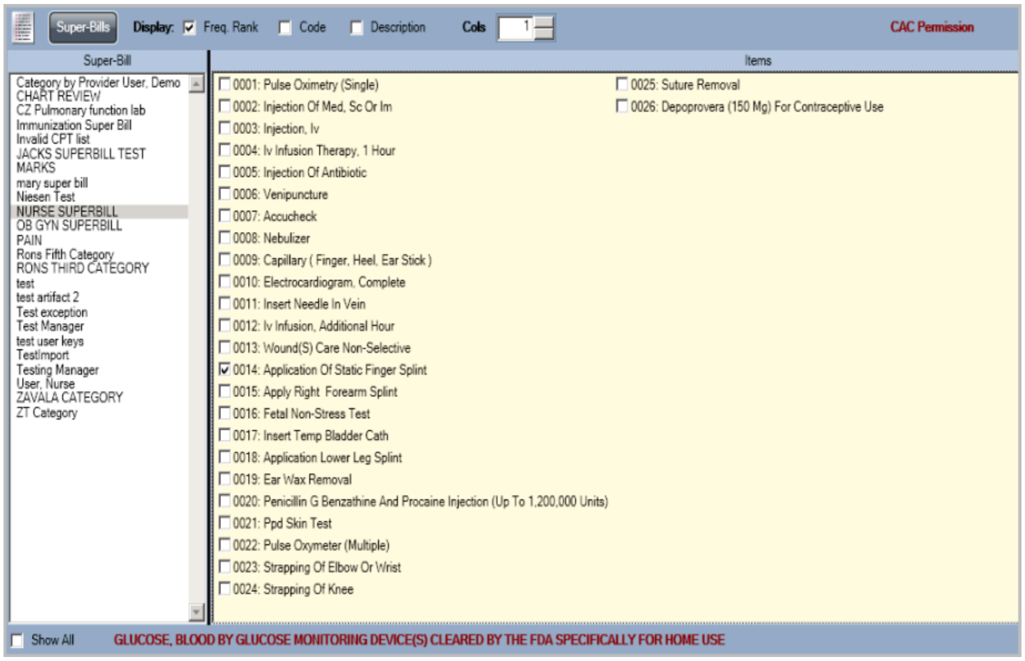


Figure 4-177: Super-Bill Items Listed by Frequency

4. When only the Code field is selected, the Super-Bill items show their CPT codes.

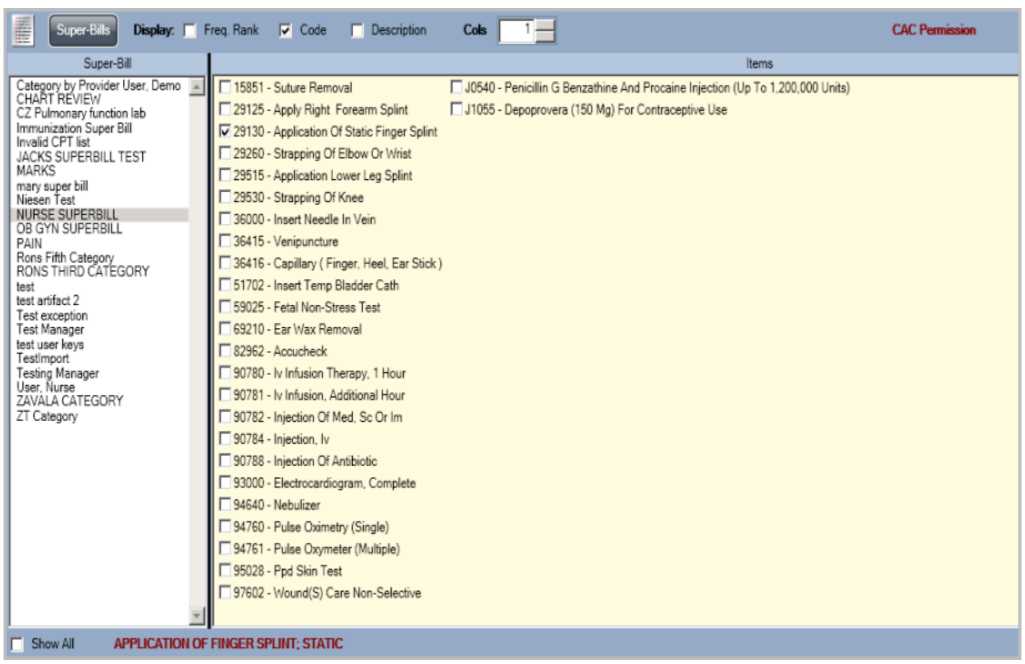


Figure 4-178: Super-Bill Items Listed by Code

5. When only the Description field is selected, the description of each Super-Bill item displays.

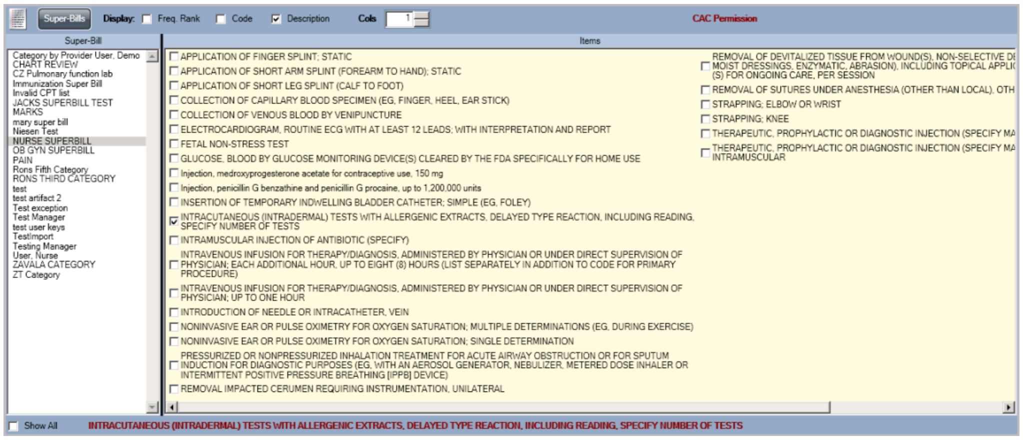


Figure 4-179: Super-Bill Items Listed by Description

Note:	If the descriptions of the Super-Bill items overlap, use the Cols Up and Down arrows to increase or decrease the number of columns. The range is 1 to 9. (This function is currently disabled.)

4.7.2 Query Function

The query function uses the Super-Bills from a specified source to populate the current Super-Bill category.

Follow these steps to perform a query:

1. Click the Super-Bills button. The Manage Super-Bills dialog opens.

2. Click the Query button. The CPT Query dialog opens.

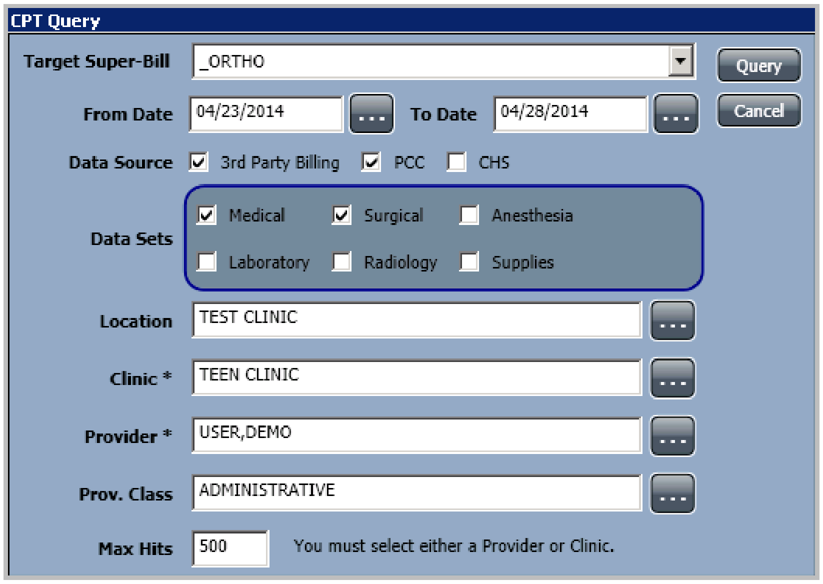


Figure 4-180: CPT Query Dialog

3. In the Target Super-Bill field, change the Super-Bill by clicking the drop-down list and selecting another source, as needed.

Note:	An asterisk next to the Super-Bill item indicates the default category.

4. In the From Date and To Date fields, type a date or click the Ellipsis button to select a date from the calendar. The Select Date dialog opens. Do one of the following:

Note:	The To Date auto-fills with the current date and the From Date auto-fills with a date one year in the past.

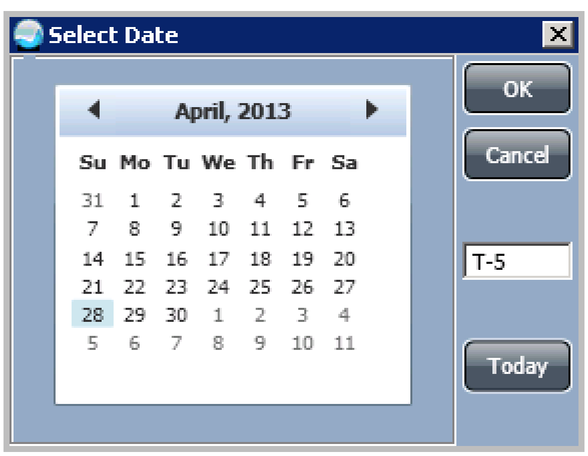


Figure 4-181: Select Date Dialog

a. Click a date on the calendar, and then click OK.

b. In the open field, type T-X (Today minus X days), and then click OK.

c. Click the Today button to automatically input the current date, and then click OK.

5. In Data Source, select one or more of the following sources:

    - 3rd Party Billing (default)
    - PCC (default)
    - CHS

6. In the Data Sets section, select one or more of the following data sets:

    - Medical (default)
    - Surgical (default)
    - Anesthesia
    - Laboratory
    - Radiology
    - Supplies

7. In the Location field do one of the following:

    - Begin typing in the field:

        a. Type the first few letters of the location, and then press Enter. The Lookup Location dialog opens with a list of matching entries.

        b. Select the applicable location and click OK.

    - Click the Ellipsis button:

        a. In the Lookup Location dialog, type the first few letters of the location name in the Search Criteria field.

        b. Click Search. The list jumps to the applicable location.

        c. Select the location and click OK.

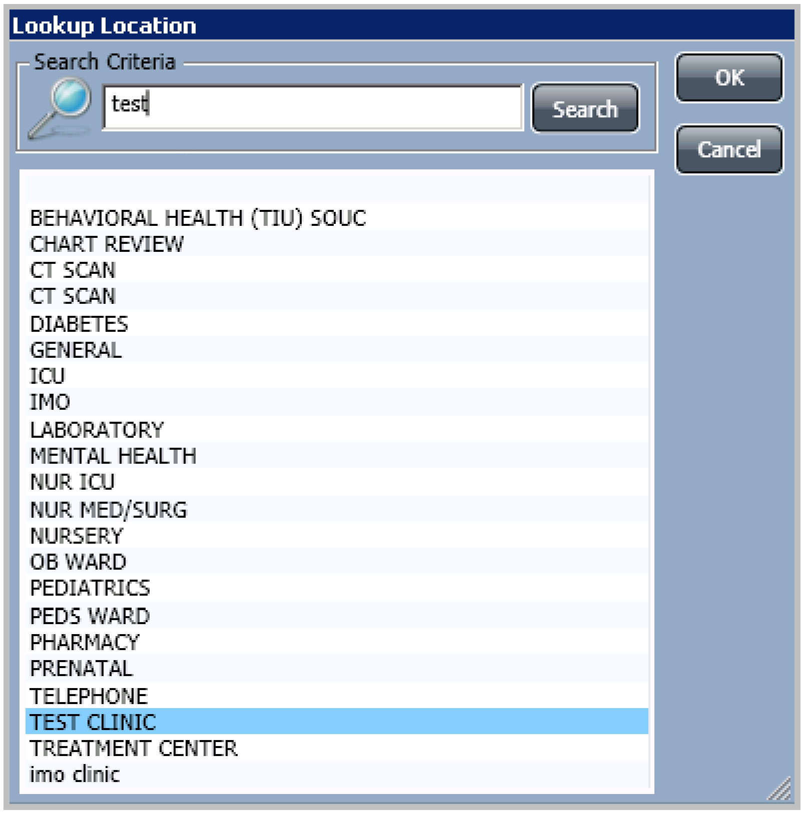


Figure 4-182: Lookup Location Dialog

Your selected location is populated in the Location field of the CPT Query dialog.

8. In the Clinic field do one of the following:

   - Begin typing in the field:

     a. Type the first few letters of the clinic, and then press Enter. The Lookup Clinic dialog opens with a list of matching entries.

     b. Select the applicable clinic and click OK.

   - Click the Ellipsis button:

     a. In the Lookup Clinic dialog, type the first few letters of the clinic name in the Search Criteria field.

     b. Click Search. The list jumps to the applicable clinic.

     c. Select the clinic and click OK.

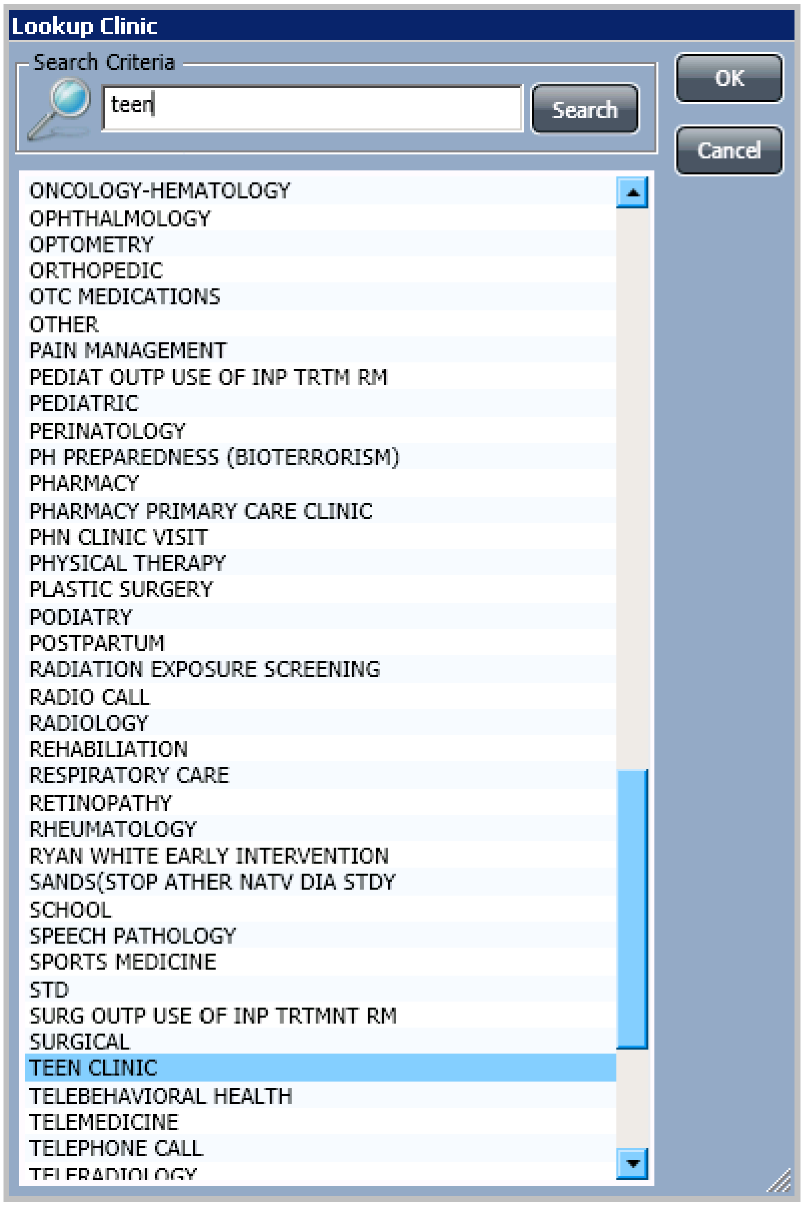


Figure 4-183: Lookup Clinic Dialog

Your selected clinic is populated in the Clinic field of the CPT Query dialog.

9. In the Provider field do one of the following:

    - Begin typing in the field:

        a. Type the first few letters of the provider name, and then press Enter. The Lookup Provider dialog opens with a list of matching entries.

        b. Select the applicable provider and click OK.

- Click the Ellipsis button:

    a. In the Lookup Provider dialog, type the first few letters of the provider name in the Search Criteria field.

    b. Click Search. The list jumps to the applicable name.

    c. Select the provider and click OK.

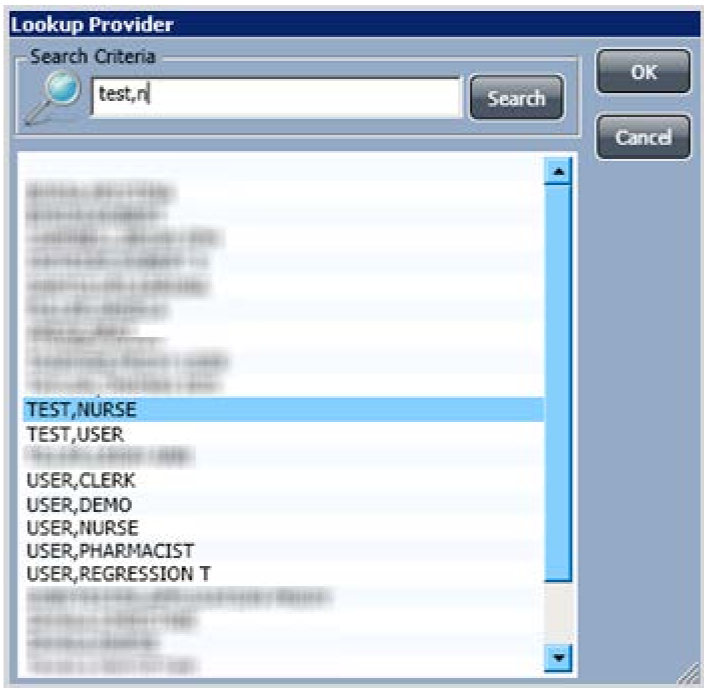


Figure 4-184: Lookup Provider Dialog

Your selected provider is populated in the Provider field of the CPT Query dialog.

10. In the Provider Class field do one of the following:

- Begin typing in the field:

    a. Type the first few letters of the provider class, and then press Enter. The Lookup Provider Class dialog opens with a list of matching entries.

    b. Select the applicable provider class and click OK.

- Click the Ellipsis button:

    a. In the Lookup Provider Class dialog, type the first few letters of the provider class in the Search Criteria field.

b. Click Search. The list jumps to the applicable provider class.

c. Select the provider class and click OK.

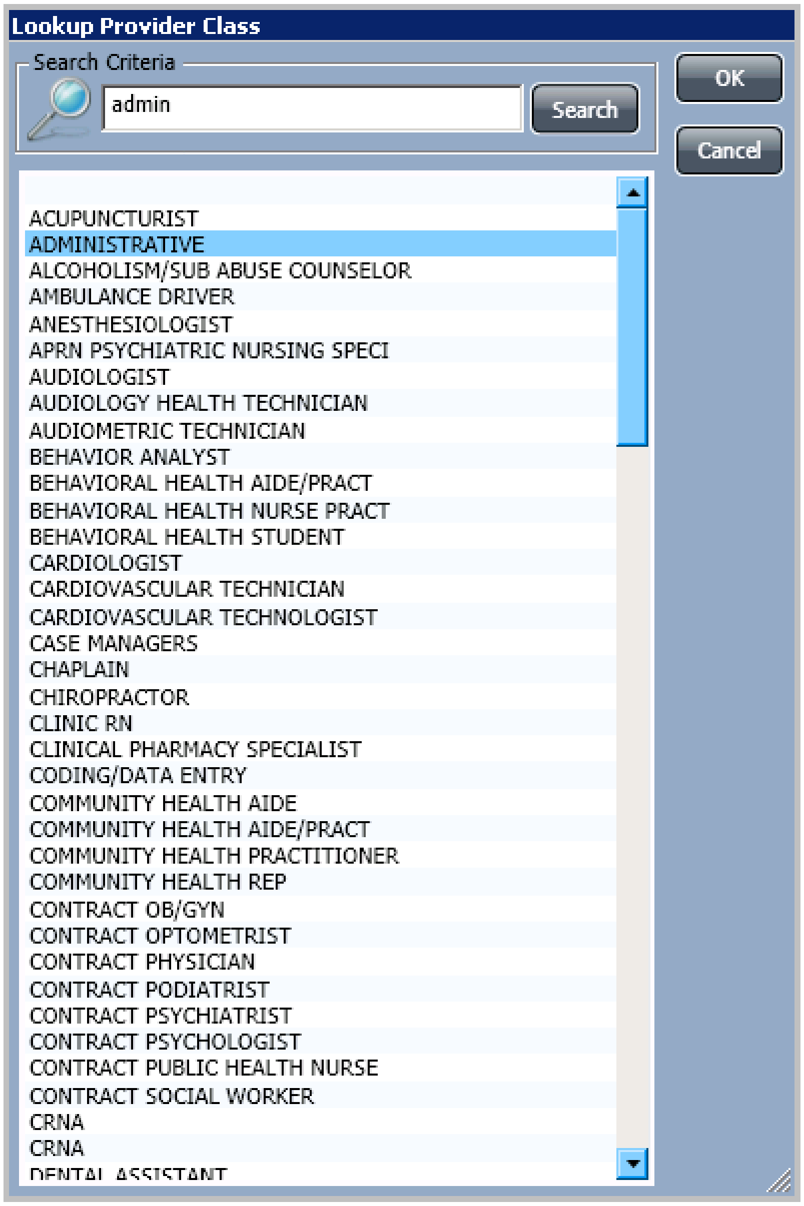


Figure 4-185: Lookup Provider Class Dialog

Your selected provider is populated in the Provider Class field of the CPT Query dialog.

11. In Max Hits, change the number of returned hits, if needed. The default is 500.

12. Click the Query button. The CPT Query Finished information message appears listing the total of the frequency count.

Note:	The Query button is grayed out until a selection is made in one or more of the Clinic or Provider fields.

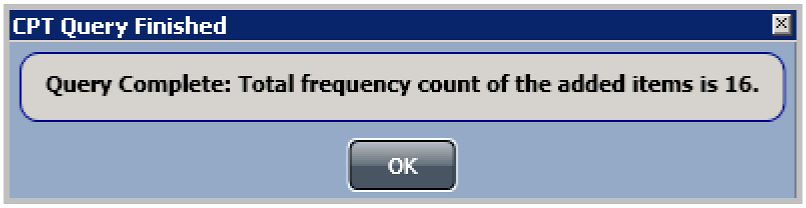


Figure 4-186: CPT Query Finished

13. Click OK to dismiss the message.

    The items appear in the Super-Bill Items group box on the Manage Super-Bills dialog. (This may take some time, depending on the date range and the clinic.)

    Items with only one instance or items that seem inappropriate, such as long function test in an optometry Super-Bill, can be deleted prior to other users viewing the Super-Bill.

4.7.3 Resetting the Frequency of Use

The EHR system keeps track of how many times each CPT code is attached to a service. When copying over a Super-Bill or set of CPT codes from another source, the tracking information recorded for the copied codes is inherited. To start tracking your facility's frequency information, the count of the copied codes can be zeroed out and restarted. This can be useful when importing Super-Bill.

Follow these steps to reset the frequency tracking information:

1. Select the desired Super-Bill to reset the frequency.
2. Click the Super-Bills button. The Manage Super-Bills dialog opens.
3. In the Super-Bills Items list, click the item or items you want to zero out.

Note:	Hold down the Shift key while clicking to select more than one item to zero out.

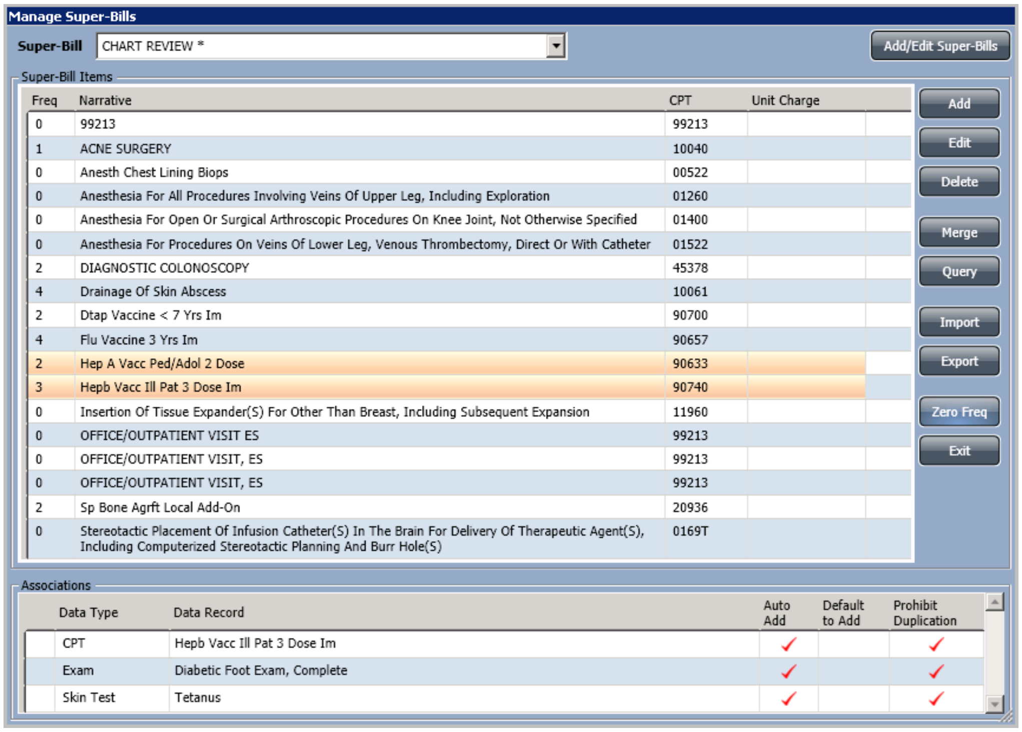


Figure 4-187: Manage Super-Bills with Zero Freq Items Selected

4. Click the Zero Freq button. The Reset Frequency Values information message appears.

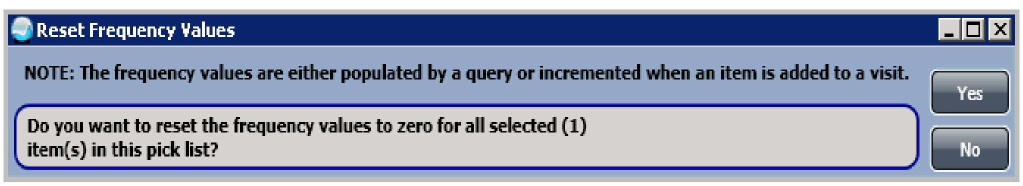


Figure 4-188: Clear Frequency Values Information Message

5. Click Yes to have the frequency values set to zero for the Super-Bill items selected.

4.7.4 Managing Super-Bill Items

Holders of the BGOZ VCPT EDIT key can add or edit CPT codes for visits.

To manage Super-Bill items, click the Super-Bills button to display the Manage Super-Bills dialog.

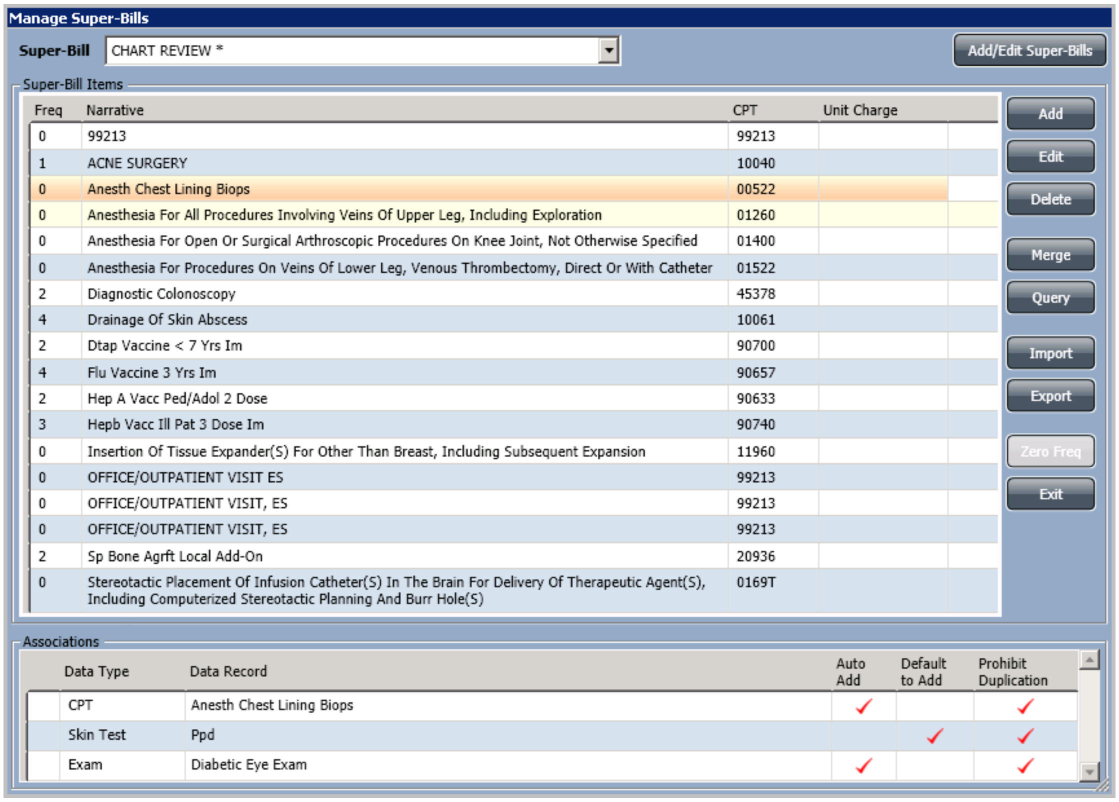


Figure 4-189: Manage Super-Bills Dialog

The Super-Bill drop-down list shows the Super-Bill categories. The items in the Super-Bill Items group box are the Super-Bill items for the selected category.

Most Super-Bill actions are performed from the Manage Super-Bills dialog. Refer to the Query Function topic for information on using the Query button, and the Resetting the Frequency of Use topic for information on using the Zero Freq button.

4.7.4.1 Right-Click Menu

Right-clicking the Super-Bill Items list on the Manage Super-Bills dialog opens the Options menu. The functionality of the right-click menu options correspond with the buttons on the right-hand side of the Manage Super-Bills dialog:

- Add
- Edit
- Delete
- Zero Freq

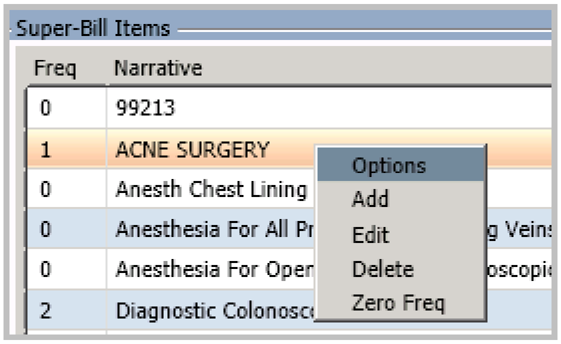


Figure 4-190: Right-Click Menu

4.7.4.2 Tool Tip

Briefly rest the mouse pointer over a Super-Bill Item in the Narrative column to view a screen tip containing more detailed information about the item.

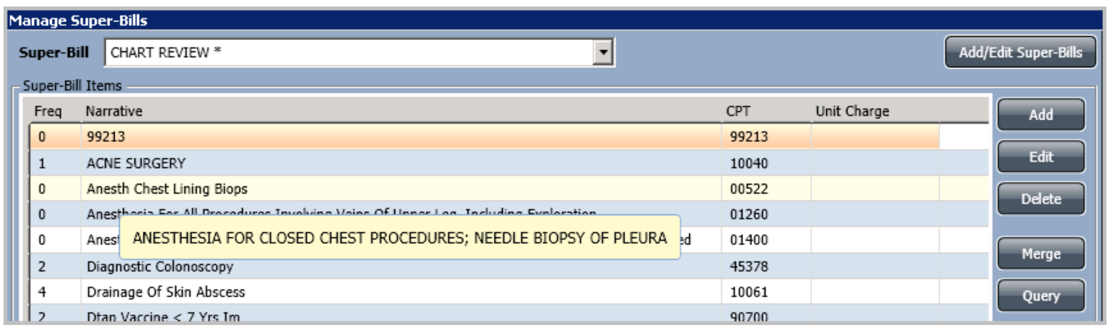


Figure 4-191: Tool Tip

4.7.5 Adding a New Super-Bill Item

This process adds a new Super-Bill item to the Super-Bill Items panel on the Manage Super-Bills dialog.

Follow these steps:

1. From the Manage Super-Bills dialog, click Add. The Procedure Lookup dialog opens.

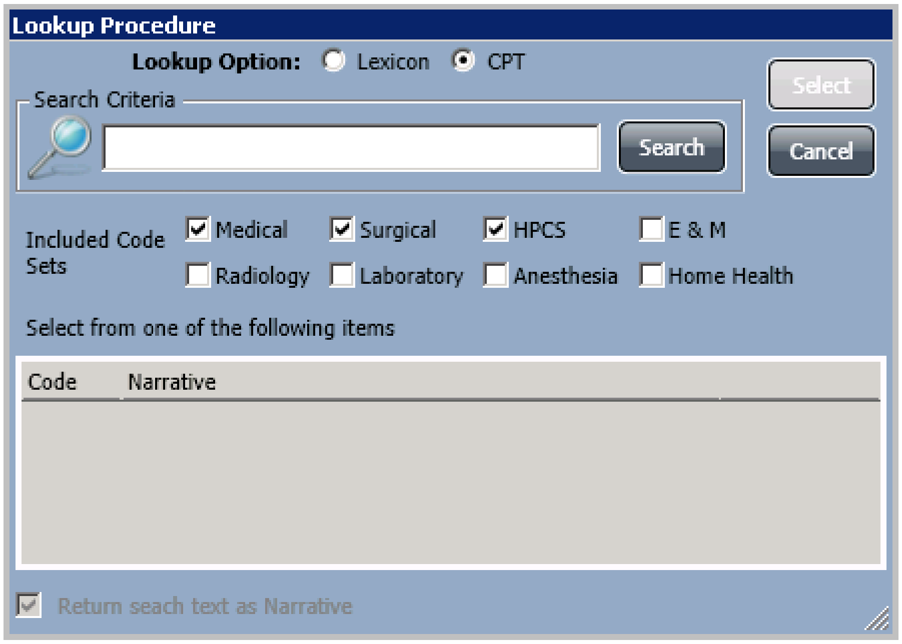


Figure 4-192: Initial Procedure Lookup Dialog

2. In Lookup Option, click the Lexicon or CPT option button.
3. In Search Criteria, type the first few letters of the procedure.
4. In Included Code Sets, select one or more code sets in which to search:
    - Medical (default)
    - Surgical (default)
    - HPCS (default)
    - E&M
    - Radiology
    - Laboratory
    - Anesthesia
    - Home Health
5. Click Search. The Lookup Procedure dialog refreshes with a list of matching procedures.

Note:	There is a right-click menu of Text Options on the Lookup Procedure dialog. Click Display Short Text to display the abbreviated text, or click Upper-Case to view the list in upper case.

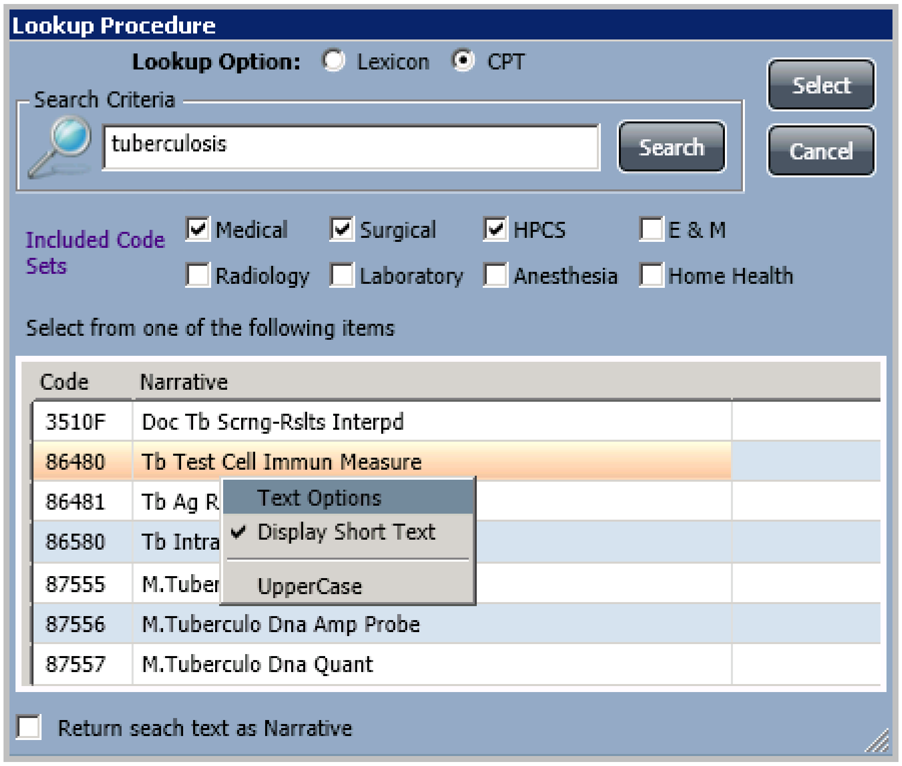


Figure 4-193: Lookup Procedure Dialog with List of Procedures and Right-Click Menu

Note: If no matching items are found, the Search Criteria field turns pink. Type a new term and click Search again.

6. Select one of the items and click OK to have the selected item added to the Super-Bill Items group box on the Manage Super-Bills dialog.

Note: The Return Search Text as Narrative check box (when selected) enables the EHR to populate the Narrative field with whatever you enter in the Search Value field. Otherwise, the Narrative field is populated with the selected CPT description.

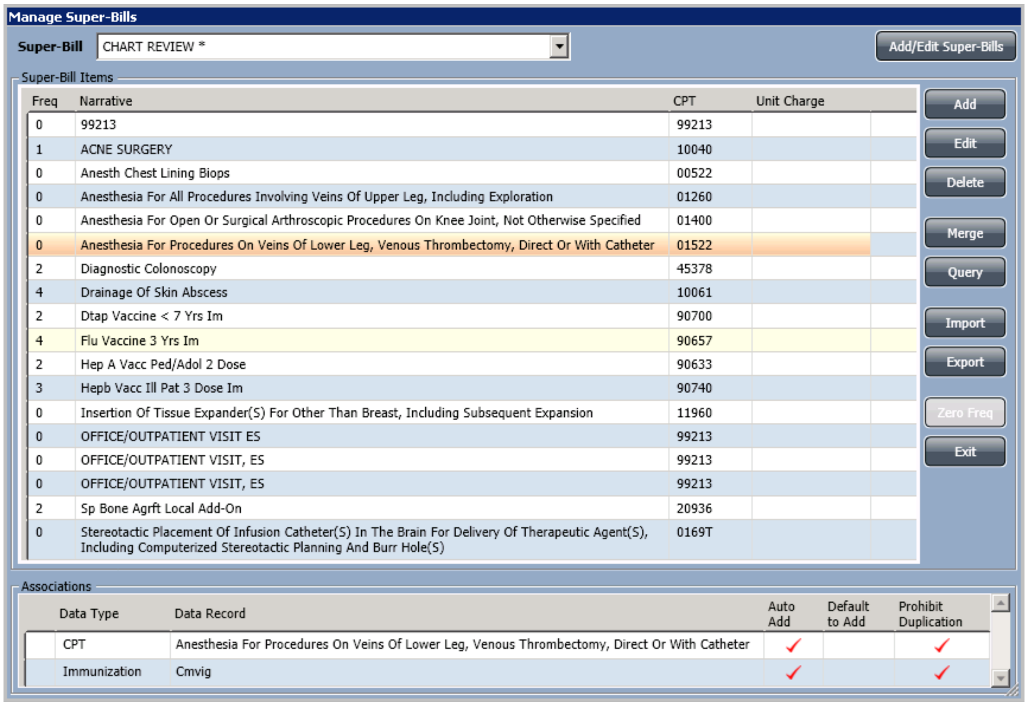


Figure 4-194: Manage Super-Bills Dialog with Added Item

The check boxes at the bottom determine the additional requirements for the association. Associations are used to link additional PCC documentation with a Super-Bill item, such adding an education topic, a health factor, or an exam to the procedure. See the Editing the Associations section in the Editing a Super-Bill Item topic for details.

4.7.6 Adding Super-Bill Items to Visit Services/Historical Services

Note: If a visit prior to 10/01/2014 (ICD-10 Implementation) is selected and an item with an ICD-10 association is selected, or a visit after 10/01/2014 is selected and an item with an ICD-9 association is selected, the following warning message appears, You may not use this diagnosis for this visit date, please assign POV from the IPL.

The following steps provide information for two scenarios:

- When the Super-Bill item does not contain any associations
- When the Super-Bill item does contain associations

Refer to Editing the Associations for more information about Super-Bill item associations.

Holders of the BGOZ VCPT EDIT key can add Super-Bill items to Visit Services/Historical Services.

Super-Bill Item Has No Associations

Selecting a check box in the Super-Bill Items list adds that code to the Visit Services and Historical Services components.

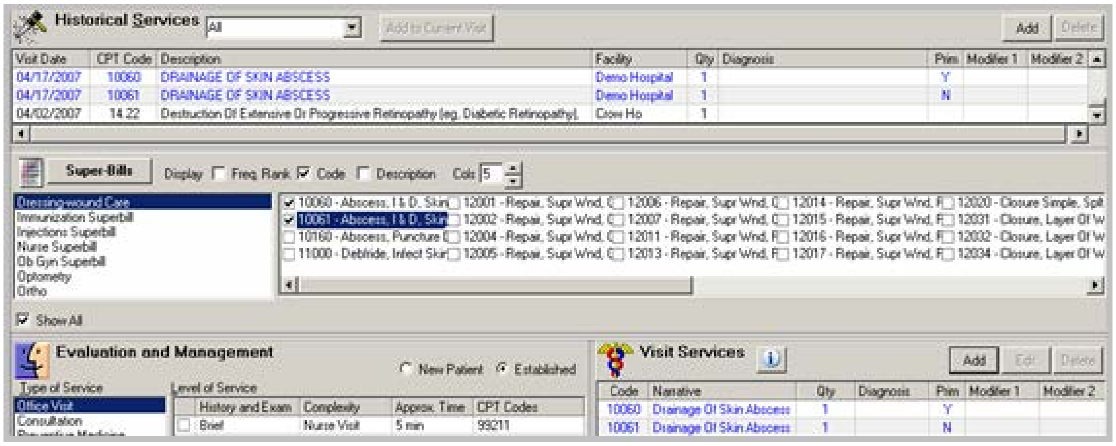


Figure 4-195: Super-Bill Items to Visit Services Component

Likewise, if you clear a check box, it removes that code from the Visit Services and Historical Services components. The Delete Procedure? information message displays.

Figure 4-196: Delete Procedure Information Message

Click Yes to remove the procedure. (Otherwise, click No.)

Super-Bill Item Has Associations

When the association is set to Default to ADD, the user is asked if they want to save the associations and they can de-select ones they do not want to use.

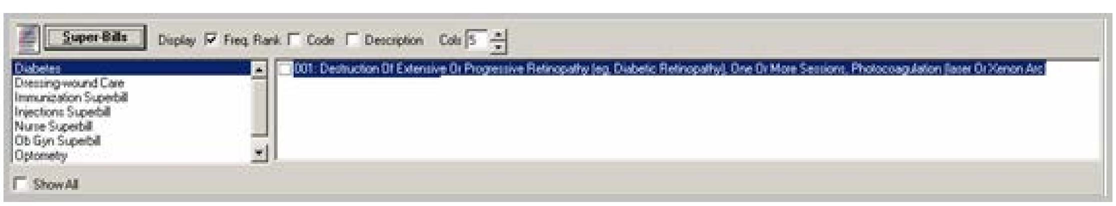


Figure 4-197: Same Super-Bill Item with Default to Add Association

When you click the Super-Bill item name (item 001 in the example), the Items to Save dialog displays.

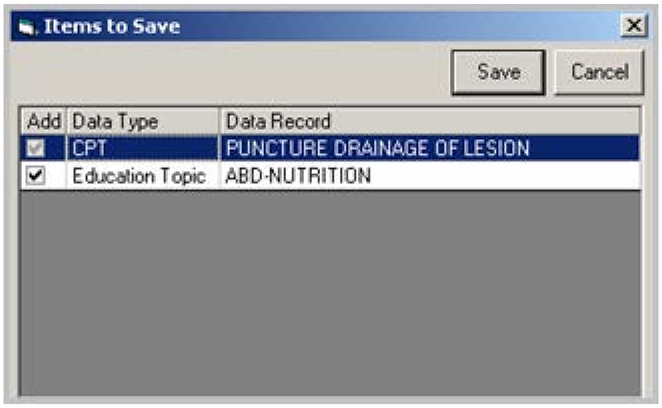


Figure 4-198: Items to Save Dialog

Click Save to have the Super-Bill item with the checked data types added to the Visit Services and Historical Services components.

When you click Save and the Education Topic is selected, the Add Patient Education Event dialog displays.

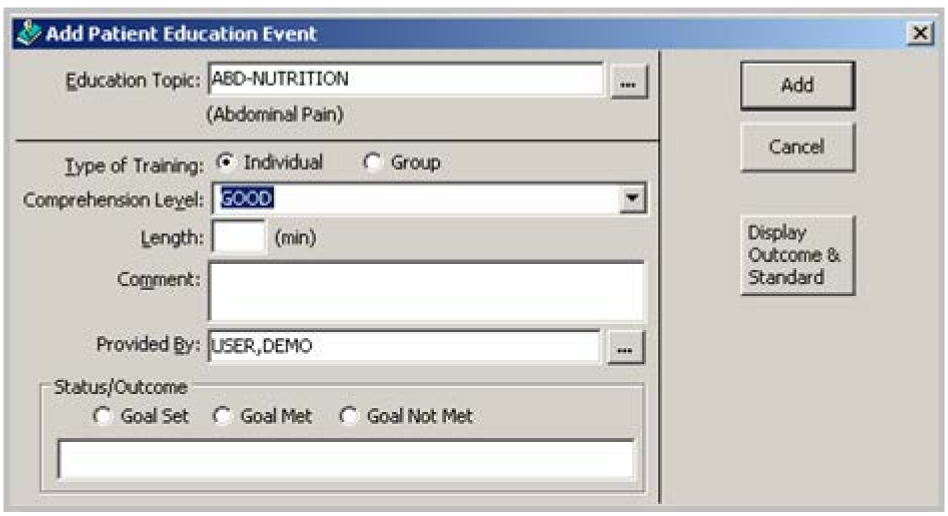


Figure 4-199: Add Education Event Dialog

After you click Add, the topic is added to the Education component (after you change patients or leave and re-enter the EHR). (Otherwise, click Cancel to not save the topic in the Education component.)

Likewise, if you clear the check box to delete the CPT code, you will be asked if you want to delete the other associations, as well.

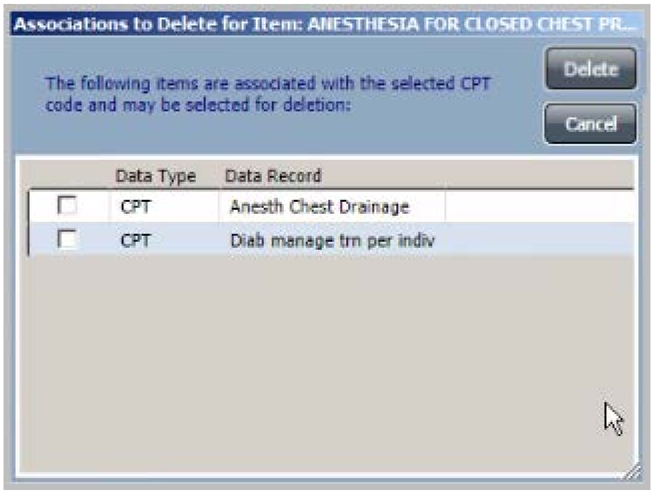


Figure 4-200: Items to Delete Dialog

You can check any data type. Click Delete to delete the data types associated with the Super-Bill item in the Visit Services and Historical Services components. (Otherwise, click Cancel so the Super-Bill item is not changed in either component).

When the association is Auto-Add, then the user is automatically walked through each item if it requires user intervention. Otherwise, it is automatically added.

4.7.7 Merging Super-Bill Items

Super-Bill items can be merged from one Super-Bill category to another.

Follow these steps to merge Super-Bill items from another source:

1. From the Manage Super-Bills dialog, click the Merge button. The Merge CPT Super-Bill dialog opens.

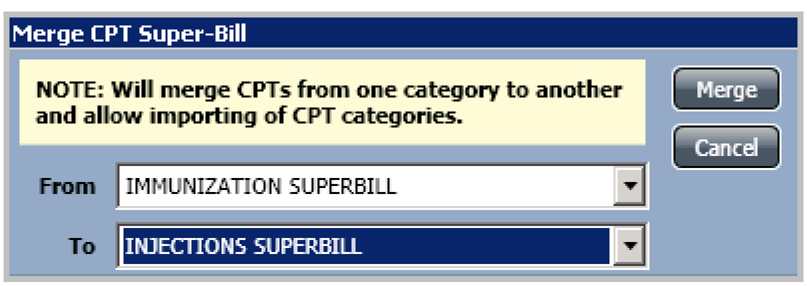


Figure 4-201: Merge CPT Super-Bill Dialog

2. In the From drop-down menu, select the from source.

3. The To field defaults to the Super-Bill category currently selected in the Manage Super-Bills dialog. If needed, select a different category to move the items to in the From drop-down menu.

4. Click Merge. The items are added to the Super-Bill Items list.

4.7.8 Deleting Super-Bill Items

This process deletes one or more Super-Bill items in the Super-Bill Items group box of the Manage Super-Bills dialog.

Follow these steps to delete one or more quick-pick items:

1. From the Manage Super-Bills dialog in the Super-Bill drop-down menu, select the Super-Bill from which you want to remove an item.
2. Highlight the item or items you want to delete on the Manage Super-Bill Items dialog. Hold down the Ctrl key while clicking to select multiple items.
3. Click Delete. The Delete (Number Of) Items information message opens.

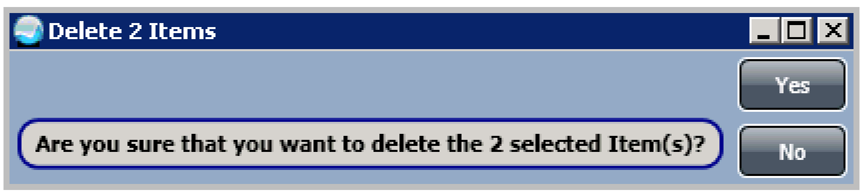


Figure 4-202: Delete Items Information Message

4. Click Yes. The item or items are removed from the Super-Bill list.

4.7.9 Editing a Super-Bill Item

This process edits a selected Super-Bill item in the Super-Bill Items panel on the Manage Super-Bills dialog.

Follow these steps to edit a Super-Bill item:

1. Highlight the Super-Bill item that you want to edit in the Super-Bill Items panel on the Manage Super-Bills dialog.
2. Click the Edit button. The Edit Super-Bill Item dialog opens.

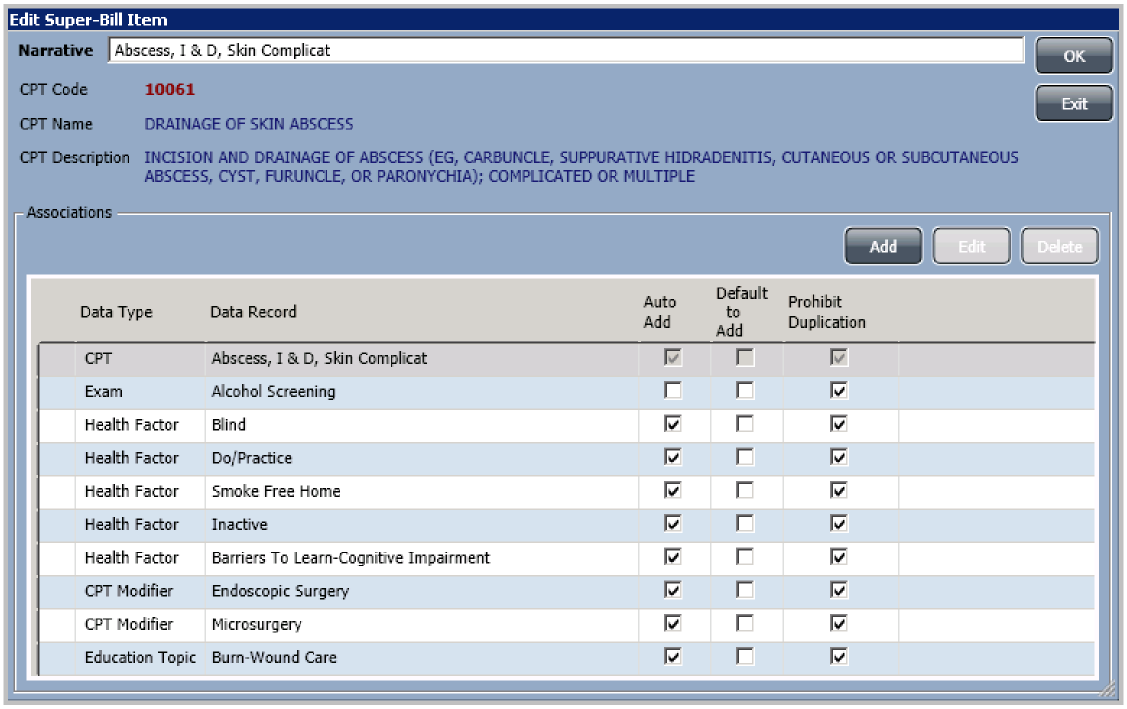


Figure 4-203: Edit Pick-List Dialog

Rename the Super-Bill Item

1. In the Narrative field, edit the information as needed. This field has a right-click menu to aid in editing the text.

2. When finished, click OK. The Narrative is updated for the Super-Bill item.

Editing the Associations

Associations can be added, edited, or deleted for the Super-Bill item. Use the Add, Edit, or Delete buttons or the Options right-click menu to access these functions from the Edit Super-Bill Item dialog.

Add an association:

1. To add an association, click the Add button. The Add Association dialog displays.

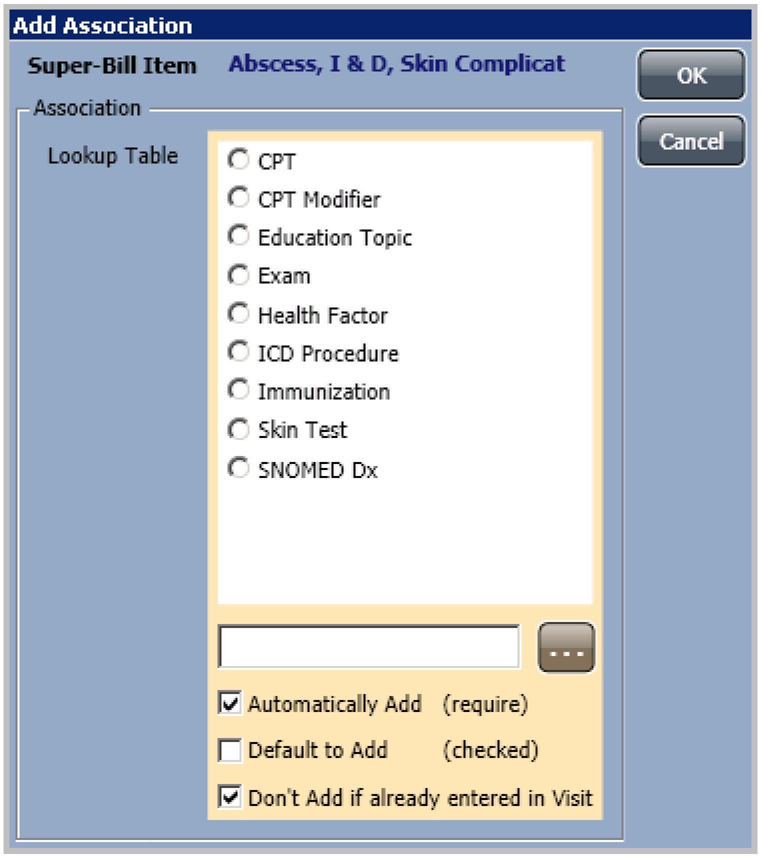


Figure 4-204: Add/Edit Pick-List Association Dialog

2. In the Lookup Table section, select an option button. Depending on the button selected, complete the steps, as applicable:

   - **CPT:**

     a. Click the CPT option button. The Lookup Procedure dialog opens.

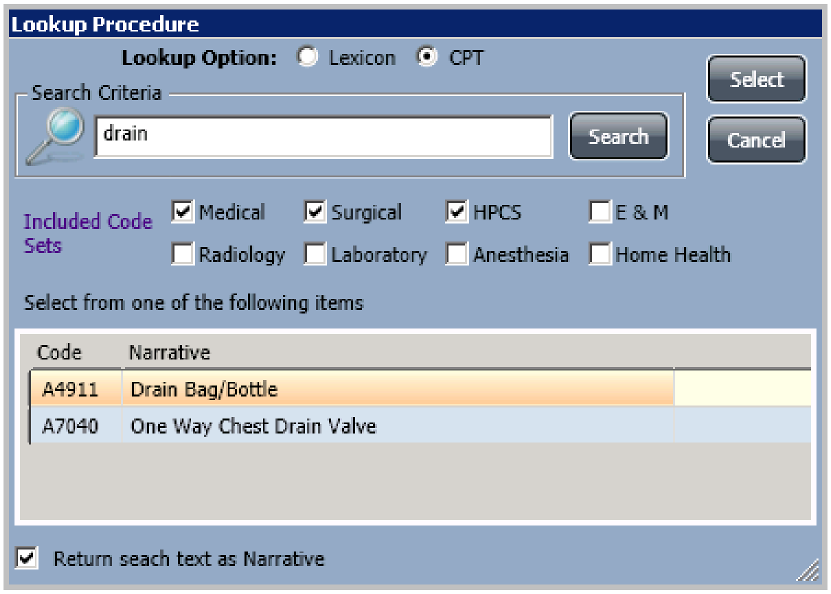


Figure 4-205: Lookup Procedure Dialog

b. In Lookup Option, select the Lexicon or CPT option button.

c. In Search Criteria, type a search term.

d. In Included Code Sets, select one or more check boxes to include the code sets in the search results.

- Medical (default)
- Surgical (default)
- HPCS (default)
- E&M
- Radiology
- Laboratory
- Anesthesia
- Home Health

e. Click Search. A list of CPT Codes is returned.

f. Click a CPT Code, and then click Select. The CPT Code is added to the Edit Super-Bill Item dialog Associations list.

- **CPT Modifier:**

a. Click the CPT Modifier option button. The Lookup CPT Modifiers dialog opens with a list of CPT Modifiers.

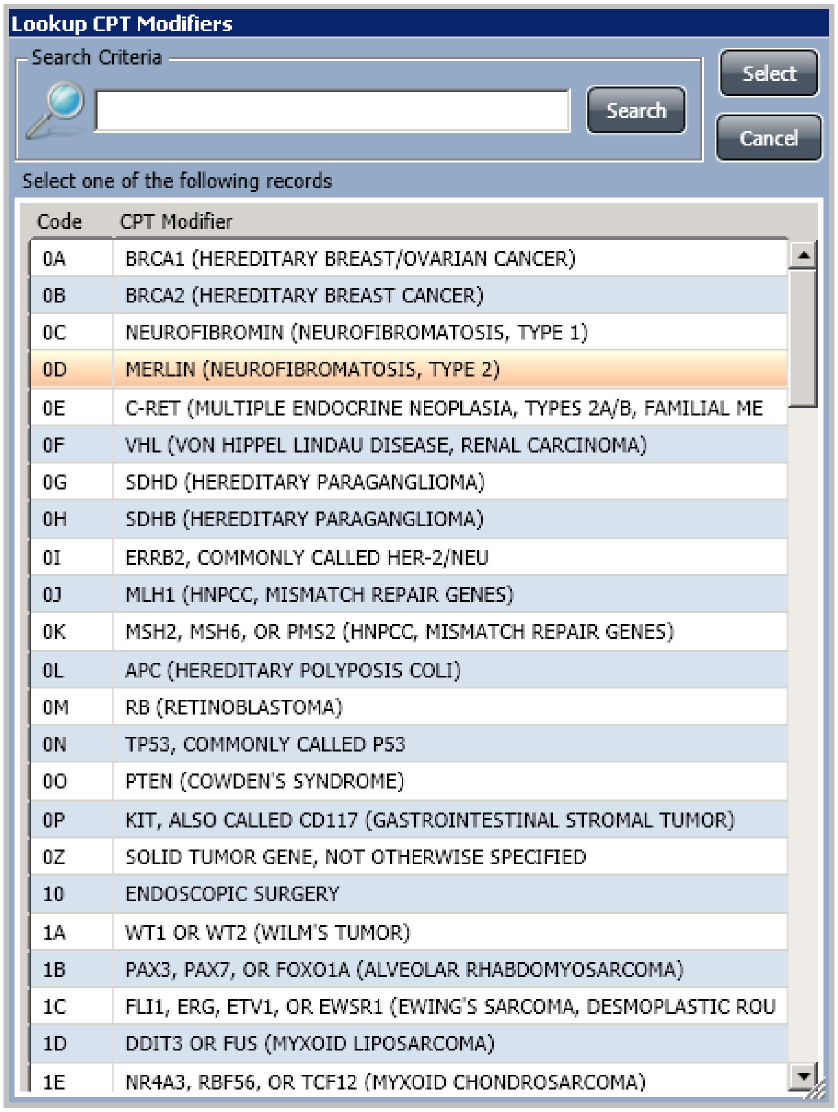


Figure 4-206: Lookup CPT Modifiers

b. Select a CPT Modifier from the list.

Or

c. In Search Criteria, type a search term and then click Search. The Lookup CPT Modifiers list refreshes with matching CPT Modifiers. Select a CPT Modifier from the list.

d. Click the Select button. The CPT Modifier is added to the Edit Super-Bill Item dialog Associations list.

- **Education Topic:**

  a. Click the Education Topic option button. The Education Topic Selection dialog opens.

  b. Select one of the following tabs at the top of the dialog:

     - Category List tab

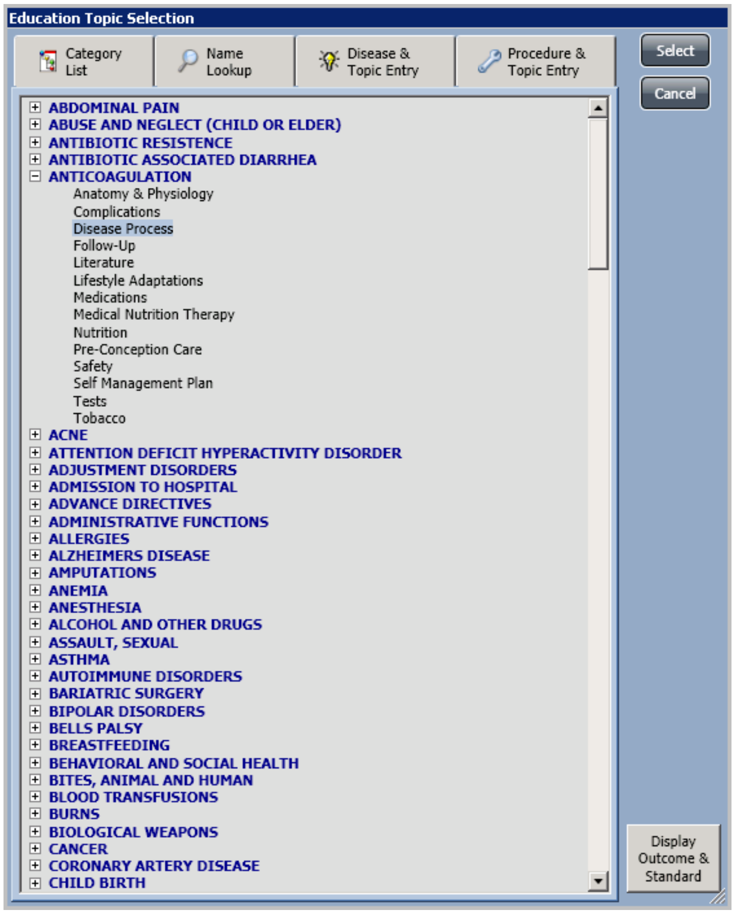


Figure 4-207: Category List Tab of Education Topic Selection Dialog

i. Click the Plus sign (⊞) to expand a category.

ii. Select a topic.

iii. Click the Select button. Your selection is added to the Edit Super-Bill Item dialog Associations list.

- Name Lookup tab

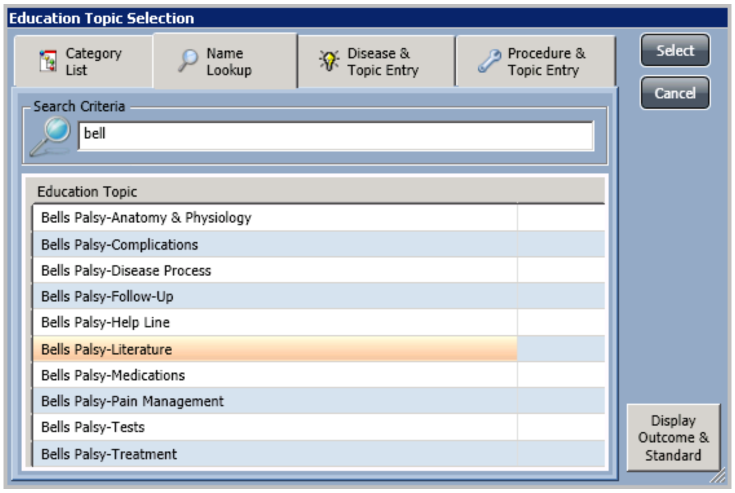


Figure 4-208: Name Lookup Tab of Education Topic Selection Dialog

i. In the Search Criteria field, begin typing the first few letters of the Education Topic to search for. The list narrows as you type.

ii. Select the desired Education Topic.

iii. Click the Select button. Your selection is added to the Edit Super-Bill Item dialog Associations list.

- **Display Outcome & Standard button:**

  The Display Outcome & Standard button on the Category List and Name Lookup tabs of the Education Topic can be clicked once a topic is selected to view the Outcome and Standard information for the topic. Click OK to dismiss the message.

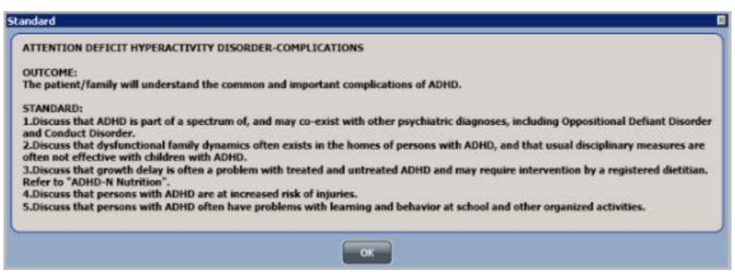


Figure 4-209: Standard Information Message

  - Disease & Topic Entry tab

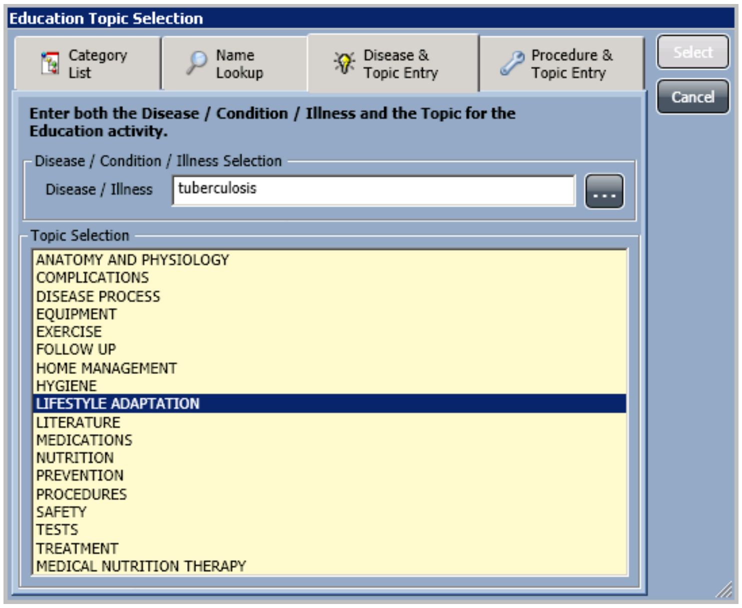


Figure 4-210: Disease & Topic Entry Tab of the Education Topic Selection Dialog

i. In the Disease/Illness field, type a disease, condition, or illness and click the Ellipsis button or press Enter. The SNOMED CT Lookup dialog opens with your term populated in the Search field. Refer to the Using the SNOMED CT Lookup Dialog topic for instructions on using this dialog.

ii. Once you've selected a SNOMED CT code, your entry is populated in the Disease/Illness field of the Education Topic Selection dialog, Disease & Topic Entry tab.

iii. In Topic Selection, select a topic to associate the education topic to.

iv. Click the Select button. Your selection is added to the Edit Super-Bill Item dialog Associations list.

- Procedure & Topic Entry tab

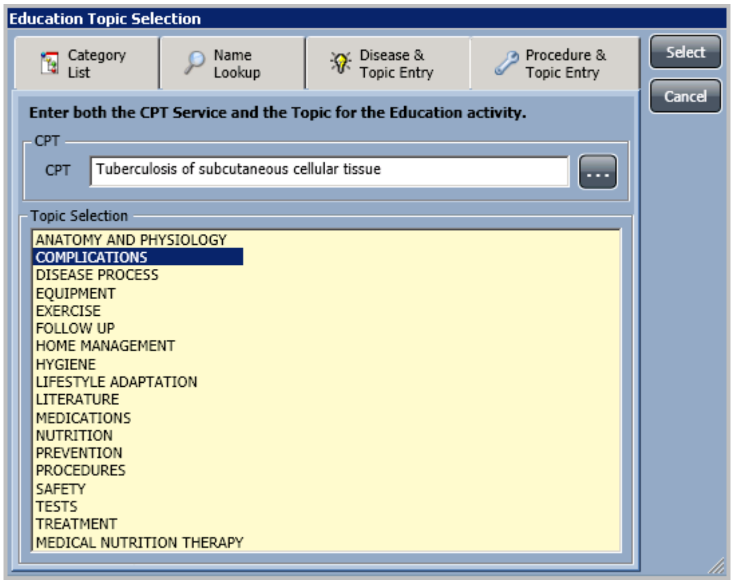


Figure 4-211: Procedure and Topic Entry Tab of the Education Topic Selection Dialog

i. In the CPT field, type a CPT term and click the Ellipsis button or press Enter. The Lookup Procedure dialog opens with your term populated in the Search field. Refer to the Adding a New SuperBill Item topic for instructions on using this dialog.

ii. Once you've selected a CPT CT code, your entry is populated in the CPT field of the Education Topic Selection dialog, Procedure & Topic Entry tab.

iii. In Topic Selection, select a topic to associate the education topic to.

iv. Click the Select button. Your selection is added to the Edit Super-Bill Item dialog Associations list.

- **Exam:**

  a. Click the Exam option button. The Lookup Exams dialog opens.

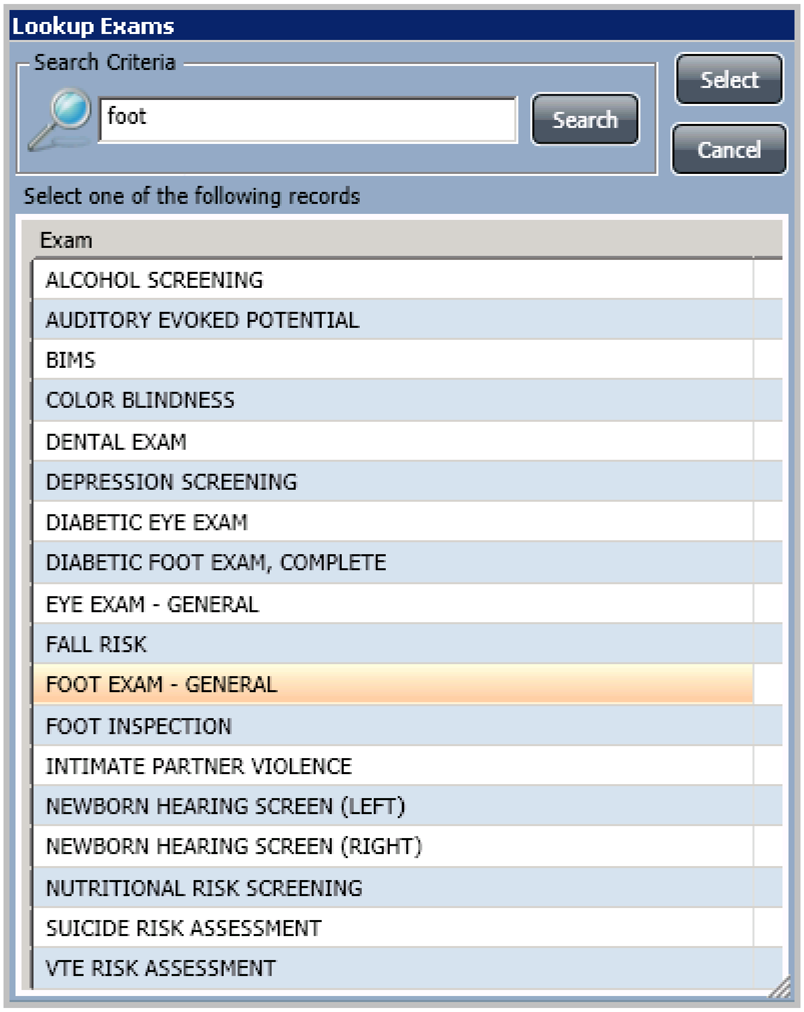


Figure 4-212: Exam Dialog

b. Select an Exam from the list.

   Or

c. In Search Criteria, type a search term and then click Search. The Exam list refreshes with matching exams. Select an exam.

d. Click the Select button. The Exam is added to the Edit Super-Bill Item dialog Associations list.

- **Health Factor:**

  a. Click the Health Factor option button. The Health Factor Selection dialog opens.

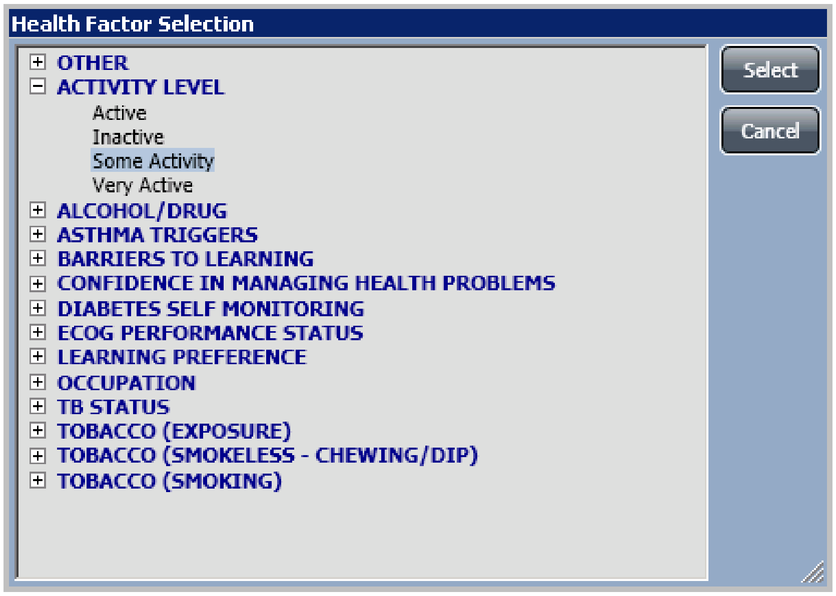


Figure 4-213: Health Factor Selection Dialog

b. Click the Plus sign (⊞) to expand a category.

c. Select a Health Factor from the list.

d. Click the Select button. Your selection is added to the Edit Super-Bill Item dialog Associations list.

- **ICD Procedure:**

a. Click the ICD option button. The Lookup ICD Procedure dialog opens.

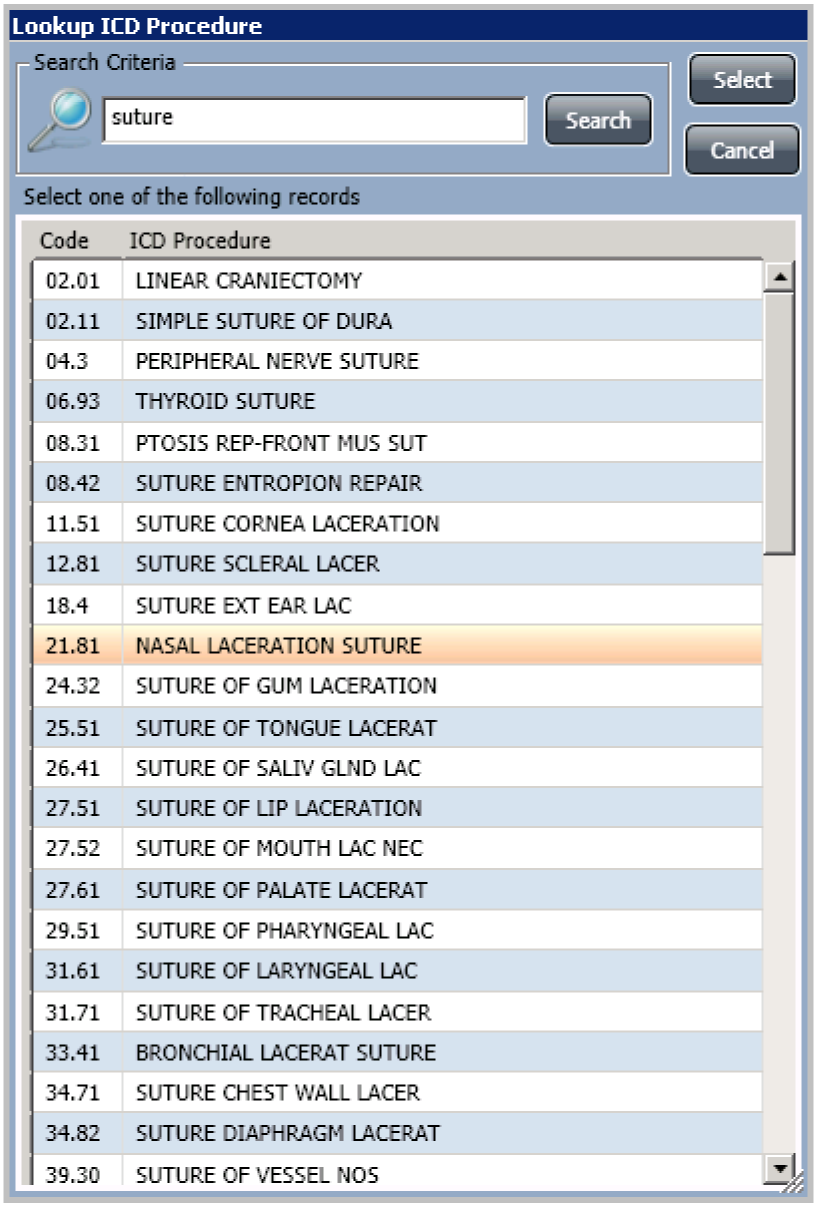


Figure 4-214: Lookup ICD Procedure Dialog

b. In Search Criteria, type an ICD Procedure term and then click Search. The ICD Procedure list refreshes with matching procedures.

c. Select an ICD Procedure.

d. Click the Select button. The ICD Procedure is added to the Edit Super-Bill Item dialog Associations list.

- **Immunization:**

a. Click the Immunization option button. The Vaccine Selection dialog opens.

Figure 4-215: Vaccine Selection Dialog

b. Select an Immunization from the list.

Or

c. In Search Criteria, type a search term and then click Search. The Immunization list refreshes with matching entries.

d. If needed, select one of the following option buttons to filter the list:

- Active Vaccines
- Active Vaccines w/Lot Number
- All Vaccines

e. Select an Immunization.

f. Click the Select button. The Immunization is added to the Edit Super-Bill Item dialog Associations list.

- **Skin Test:**

a. Click the Skin Test option button. The Lookup Skin Test dialog opens.

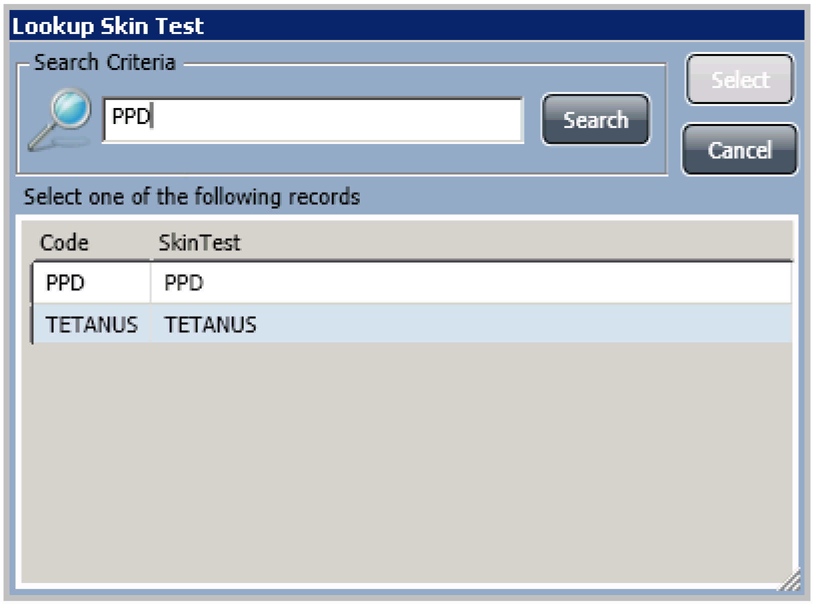


Figure 4-216: Lookup Skin Test Dialog

b. Select a Skin Test from the list.

Or

c. In Search Criteria, type a search term and then click Search. The Skin Test list refreshes with matching entries.

- **SNOMED Dx:**

  Click the SNOMED Dx option button. The SNOMED CT Lookup dialog opens. Refer to the Using the SNOMED CT Lookup Dialog topic.

  Your selection is added to the Edit Super-Bill Item dialog Associations list.

  In the Add Association dialog, the check boxes at the bottom determine the additional requirements for the association. Associations are used to link additional PCC documentation with a Super-Bill item, such adding an education topic, a health factor, or an exam to the procedure.

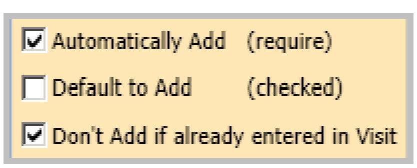


Figure 4-217: Check Boxes for Associations

3. When you select a CPT code that has associations, they may appear with the following features:

Code	Meaning
Automatically Add (Require)	Adding the association is mandatory when using the CPT code from the picklist.
Default to Add (Checked)	The association is marked as a default, but might be unchecked and not added as a data element.
Do Not Add if already entered in visit	The association will not be added if it has already been documented on today's visit.

> **Note:** Either Automatically Add or Default to Add can be checked, but not both.

4. After completing the Add Pick-List Association dialog, click OK. This adds the association for the selected Pick-List item on the Manage Super-Bills dialog.

5. If needed, the ICD Procedure can be removed from the association you just created by clearing the check box next to the super-bill item on the main Super-Bill screen. The Associations to Delete for Item: (item you just added) dialog opens.

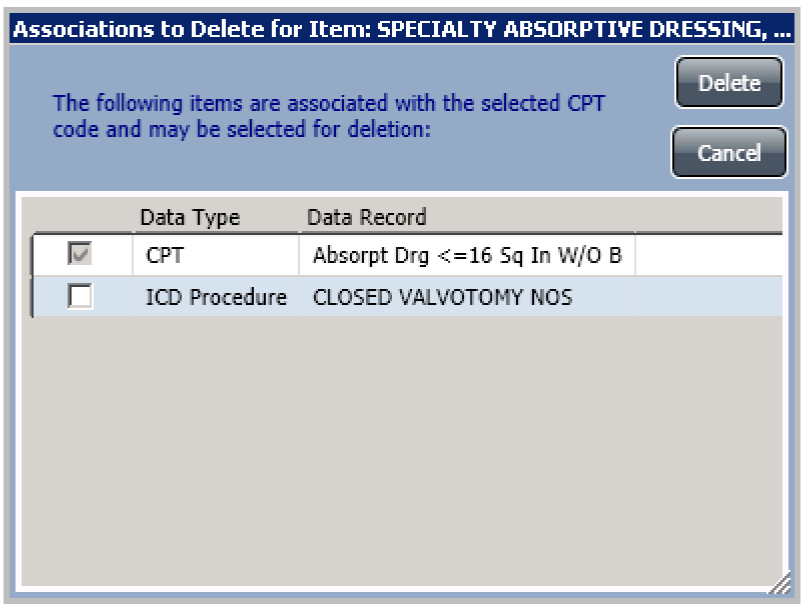


Figure 4-218: Associations to Delete Dialog

   a. Select the ICD Procedure check box.

   > **Note:** The CPT check box is pre-selected and cannot be edited.

   b. Click Delete. The ICD Procedure is removed.

Edit an Association

1. To edit an association, select an Association from the list on the Edit Super-Bill Item dialog and click the Edit button. The Edit Association dialog displays, pre-populated with data from the selected Association. Immunization is used as an example in these steps.

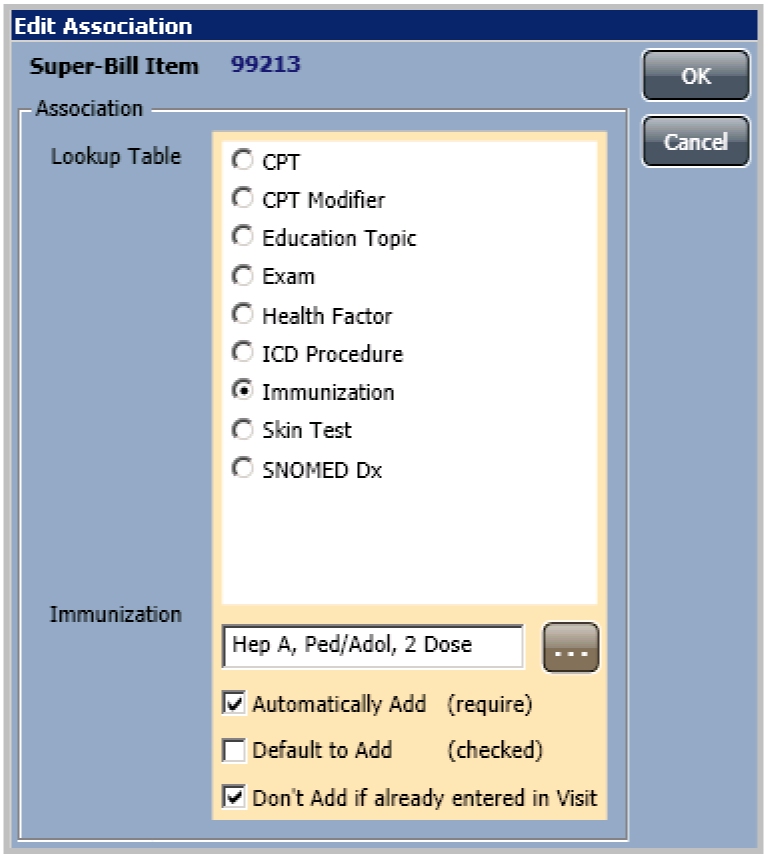


Figure 4-219: Edit Association Dialog

2. In the Immunization field, you can delete the text and type a new term, or click the Ellipsis button. The dialog applicable to the selected association opens, which is the Vaccine Selection dialog in this case.

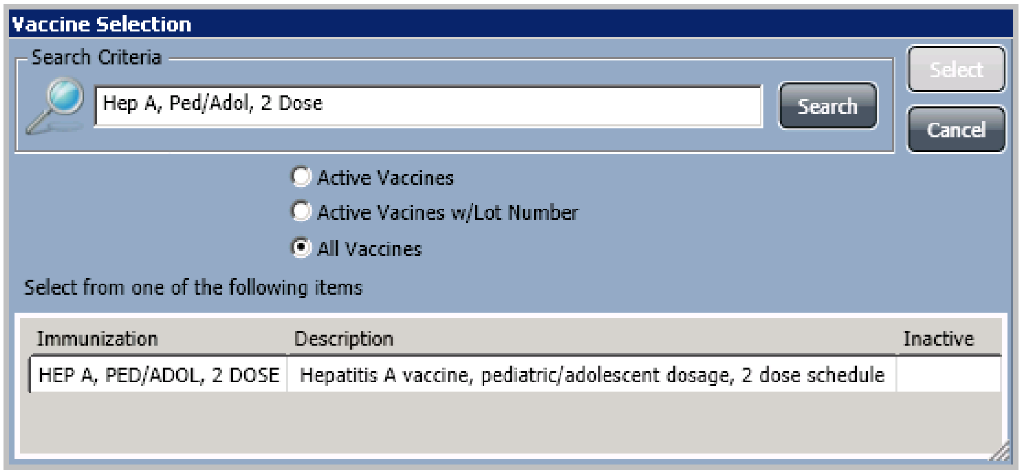


Figure 4-220: Vaccine Selection Dialog with Existing Search Results

3. In Search Criteria, delete the existing entry and type a new search term.
4. Click Search. The list refreshes with results of the new search.

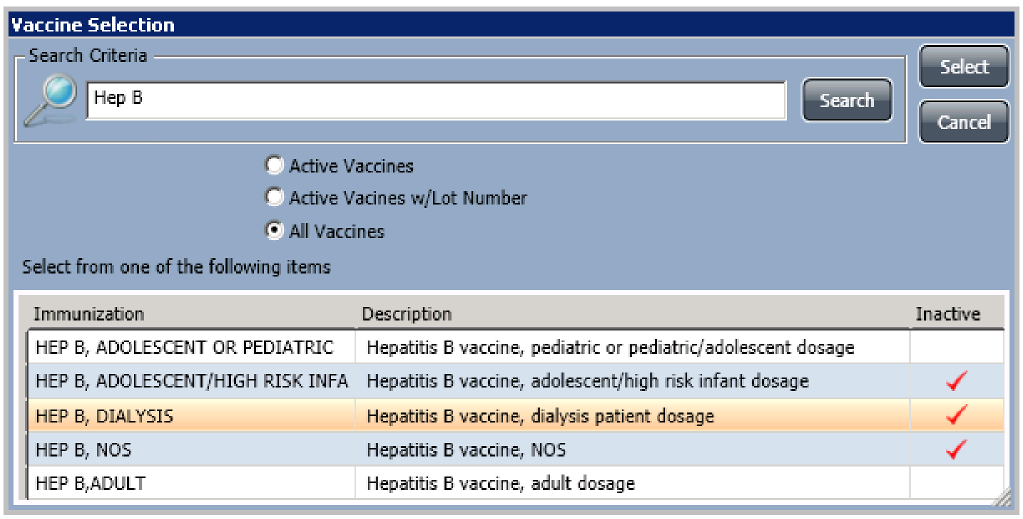


Figure 4-221: Vaccine Selection Dialog with New Search Results

5. Select a new item, and then click Select. The Association is updated in the Edit Super-Bill dialog Associations list.

Delete an Association

1. To delete an association, select an association from the list on the Edit Super-Bill Item dialog. To select multiple associations, press the Ctrl key and select the desired associations.
2. Click the Delete button. A Delete Associations information message opens.

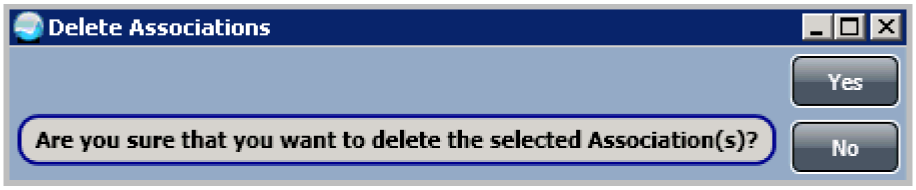


Figure 4-222: Delete Associations Dialog

3. Click Yes. The Edit Association dialog refreshes with the selected Associations deleted.

Note:	The Associations listed in the Association Lookup Table can also be deleted from the respective application. For example, an exam association can also be deleted from the Wellness tab.

4.7.10 Using the SNOMED CT Lookup Dialog

The SNOMED CT Lookup dialog is used to associate SNOMED CT codes with certain Super-Bills. Refer to the Editing a Super-Bill Item topic for details.

In the SNOMED CT Lookup dialog:

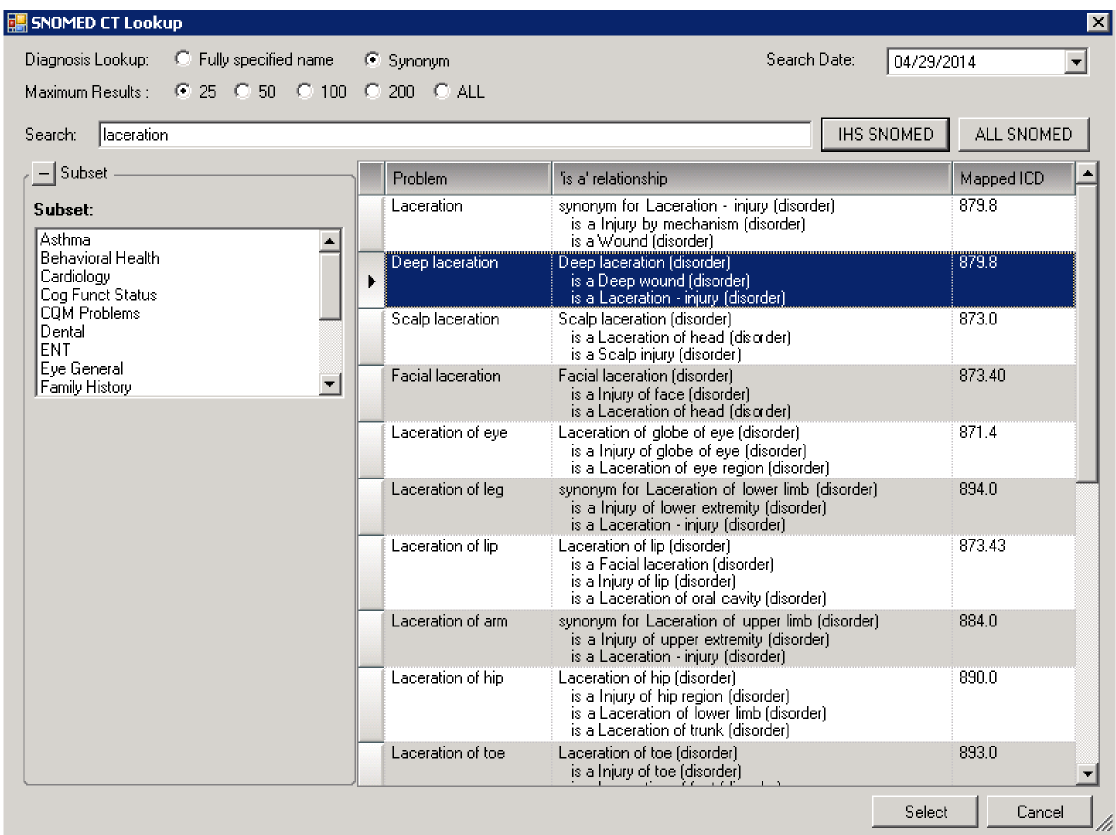


Figure 4-223: SNOMED CT Lookup Dialog

1. In Diagnosis Lookup, select one of the following option buttons:
    - Fully specified name (default)
    - Synonym
2. In Maximum Results, you can specify one of the following restrictions on the number of returned items:
    - 25 (default)
    - 50
    - 100
    - 200
    - ALL
3. In Search Date, you can change today's date by clicking the drop-down arrow to open the calendar and selecting a new date.
4. In Subset, select a subset or multiple subsets to narrow the results.
5. In Search, type a search term.
6. Click the IHS SNOMED or ALL SNOMED button. A list of matching problems is returned.
7. Select a problem and then click Select. The problem is added to the Super-Bill Association.

4.7.11 Exporting Super-Bill Items

This process exports the selected Super-Bill items to a file on your hard drive or network.

Follow these steps to export Super-Bill items:

1. Highlight one or more items in the Super-Bill Items group box of the Manage Super-Bills dialog that you want to export as a super-bill.
2. Click the Export button. The Export Super-Bill dialog opens.

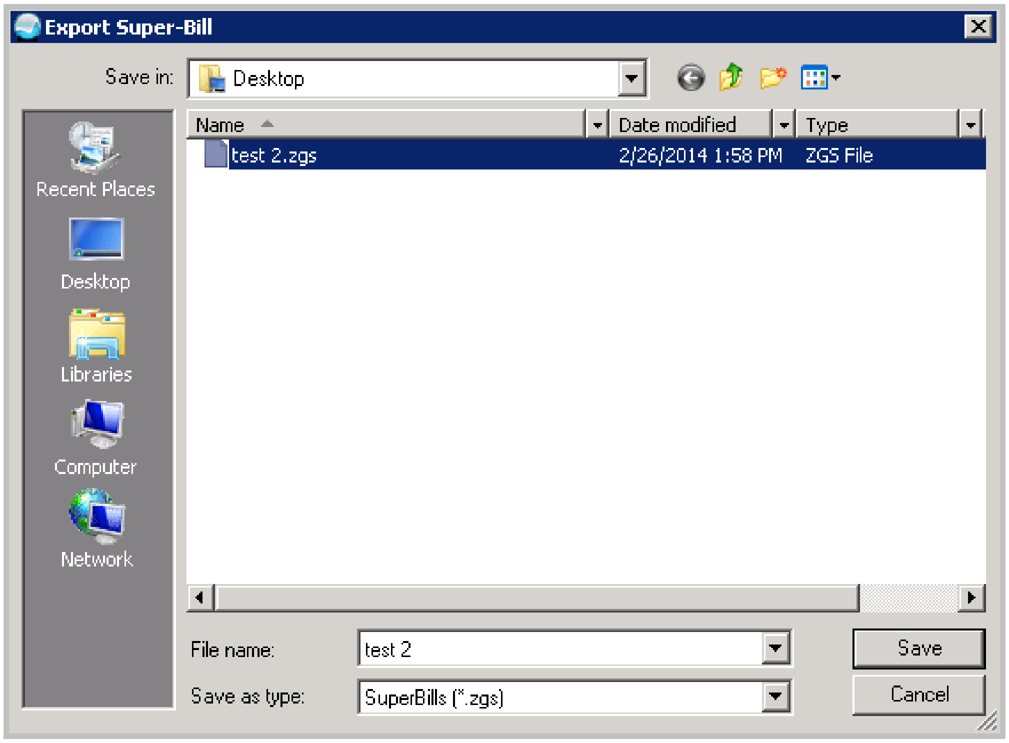


Figure 4-224: Export Super-Bill Dialog

3. In the Save in field, select the location where you want to save the export.
4. In File name, type a name for the file.
5. Click Save. The item is exported.
6. When the export process is finished, a Category Exported information message appears, confirming the export to the selected location. Click OK to dismiss the message.

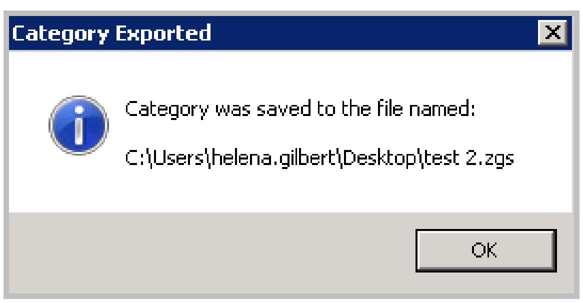


Figure 4-225: Category Exported Information Message

4.7.12 Importing Super-Bills

You can import Super-Bill items from a file that resides on your hard drive or network.

Follow these steps to import a Super-Bill:

1. From the Manage Super-Bills dialog, click the Import button. The Import Super-Bill dialog opens.

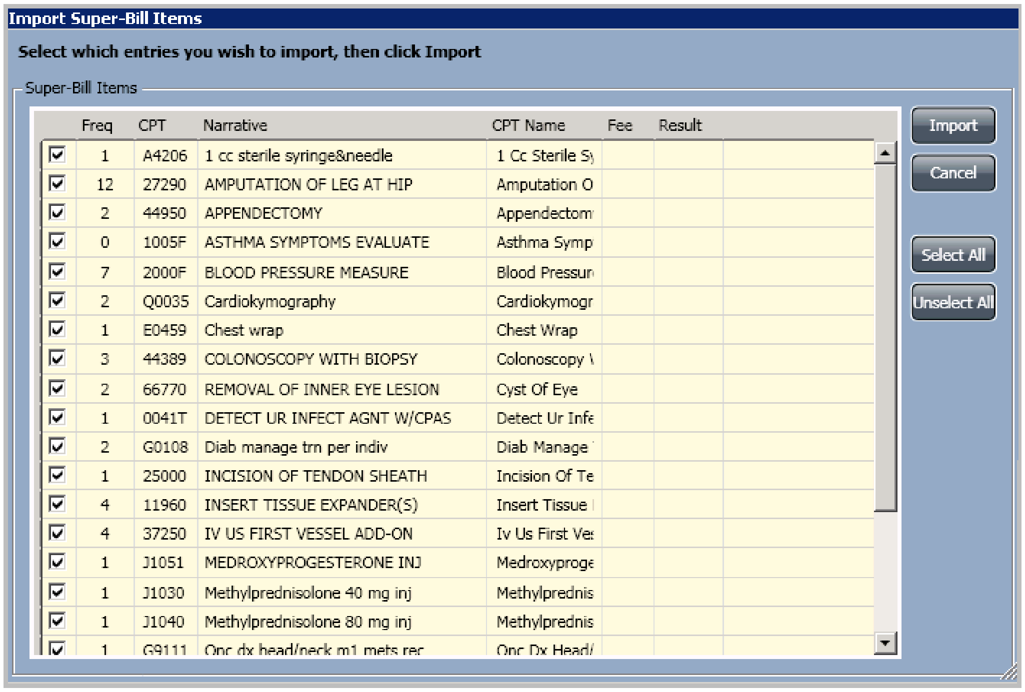


Figure 4-226: Open Dialog

2. Clear the check box next to any files you do not want to import.

   a. Alternatively, you can click the Select All or Unselect All button.

      - Alternatively, you can click the Select All or Unselect All button.

3. Click Import. The item or items are added to the Super-Bill Items panel on the Manage Super-Bills dialog.

4.7.13 Managing Super-Bill Categories

Super-Bill Categories can be managed from the Manage Super-Bills dialog using the Add/Edit Super-Bills button.

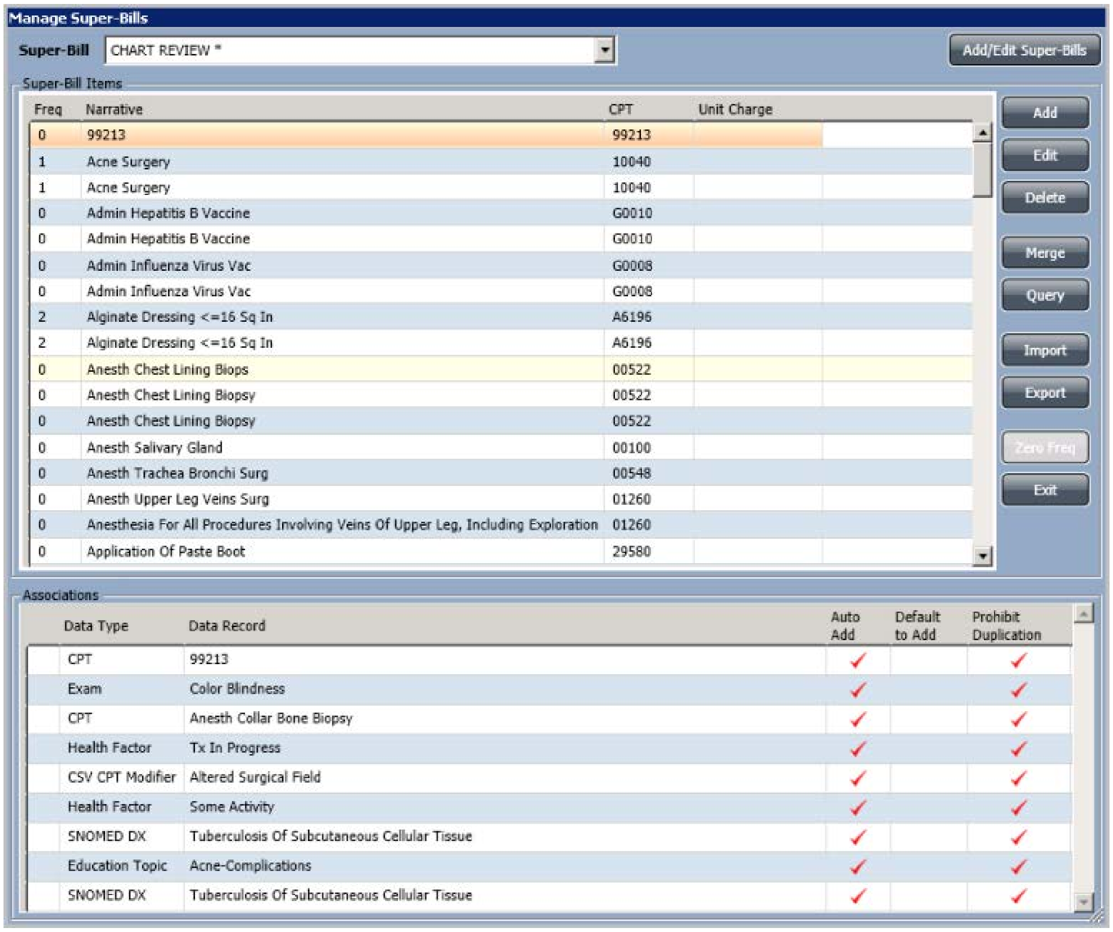


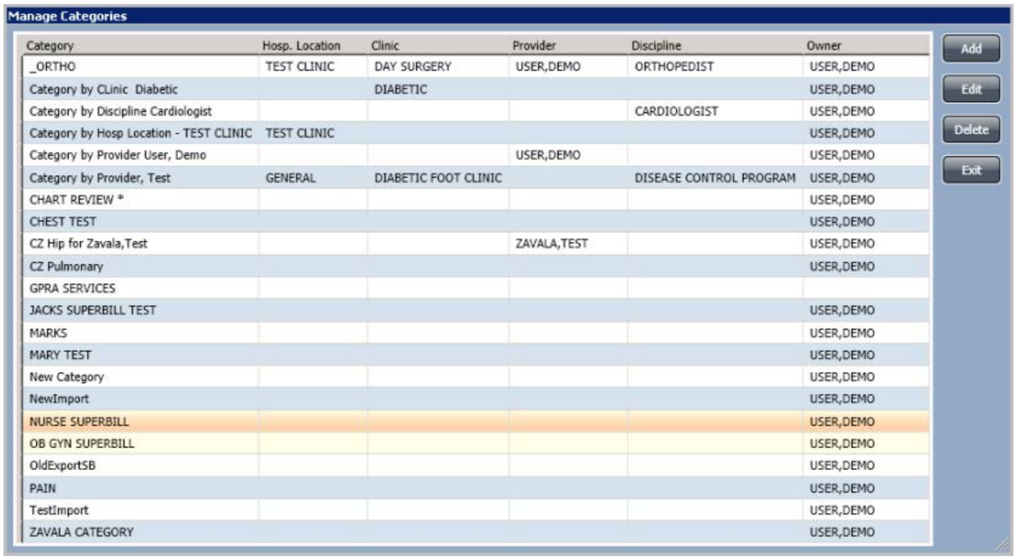
Figure 4-227: Add/Edit Super/Bill Button on the Manage Super-Bills Dialog

4.7.14 Adding a Super-Bill Category

To add a new Super-Bill Category, follow these steps:

1. From the Manage Super-Bills dialog, click the Add/Edit Super-Bills button. The Manage Categories dialog opens.

2. From the Manage Categories dialog, select one of the following to perform the applicable action:



Category	Hosp. Location	Clinic	Provider	Discipline	Owner
_ORTHO	TEST CLINIC	DAY SURGERY	USER,DEMO	ORTHOPEDIST	USER,DEMO
Category by CLinic Diabetic		DIABETIC			USER,DEMO
Category by Discipline Cardiologist				CARDIOLOGIST	USER,DEMO
Category by Hosp Location - TEST CLINIC	TEST CLINIC				USER,DEMO
Category by Provider User, Demo			USER,DEMO		USER,DEMO
Category by Provider, Test	GENERAL	DIABETIC FOOT CLINIC		DISEASE CONTROL PROGRAM	USER,DEMO
CHART REVIEW *					USER,DEMO
CHEST TEST					USER,DEMO
CZ Hip for Zavala,Test			ZAVALA,TEST		USER,DEMO
CZ Pulmonary					USER,DEMO
GPRA SERVICES					
JACKS SUPERBILL TEST					USER,DEMO
MARKS					USER,DEMO
MARY TEST					USER,DEMO
New Category					USER,DEMO
NewImport					USER,DEMO
NURSE SUPERBILL					USER,DEMO
OB GYN SUPERBILL					USER,DEMO
OldExportSB					USER,DEMO
PAIN					USER,DEMO
TestImport					USER,DEMO
ZAVALA CATEGORY					USER,DEMO

Figure 4-228: Manage Categories Dialog

3. Click the Add button. The Add Category dialog opens.

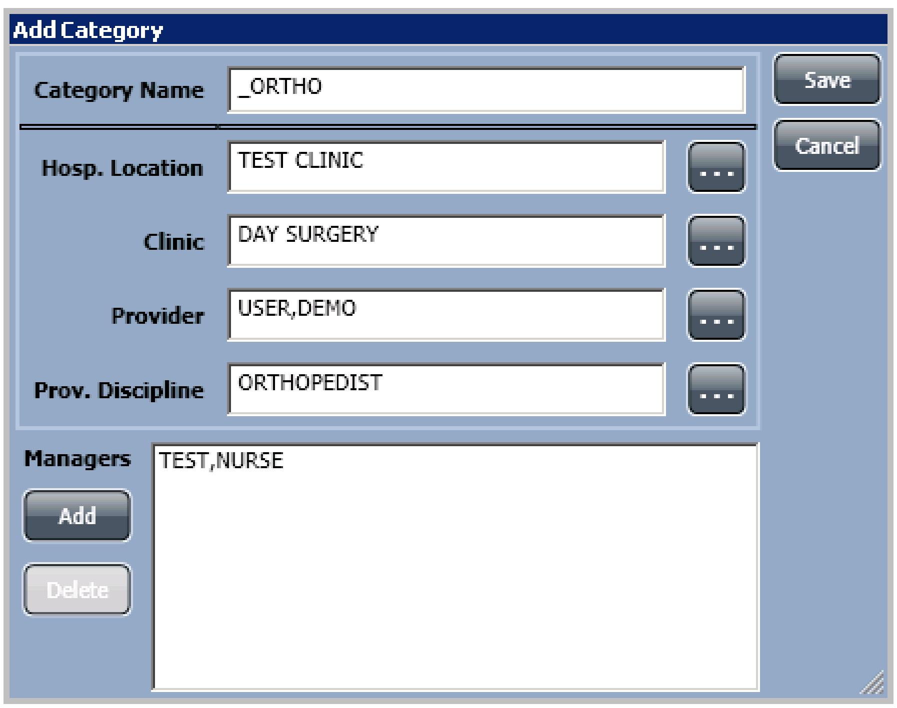


Figure 4-229: Completed Add Category Dialog

4. In Category Name, type a name for the new category.

5. In Hosp. Location, type a hospital location, or click the Ellipsis button to select one from the Lookup Location dialog.

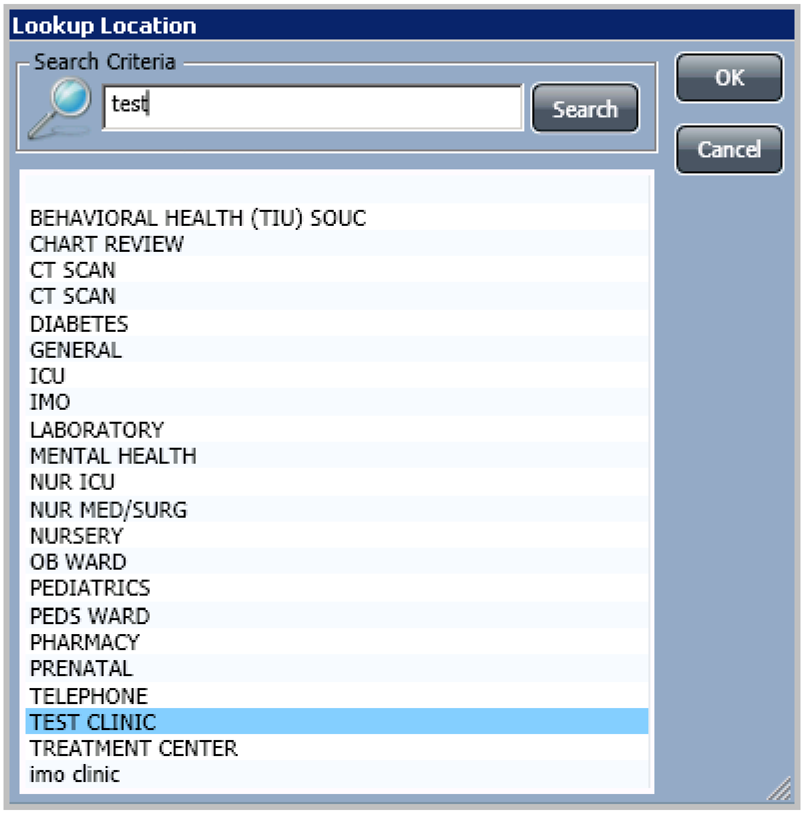


Figure 4-230: Lookup Location Dialog

a. In the Search Criteria field, begin typing the first few letters of the hospital location. The list jumps to the applicable location.

b. Click OK. Your selection populates in the Hosp. Location field.

6. In Clinic, type a clinic name, or click the Ellipsis button to select one from the Lookup Clinic dialog.

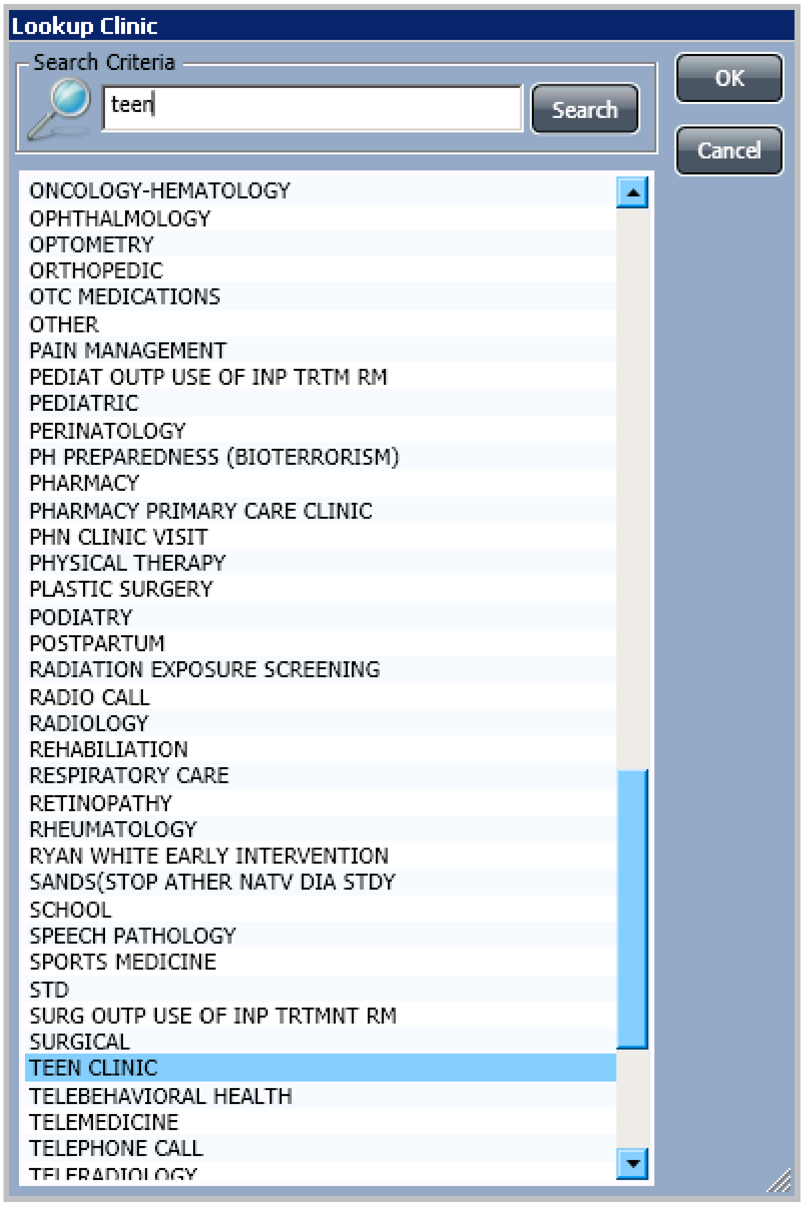


Figure 4-231: Lookup Clinic Dialog

a. In the Search Criteria field, begin typing the first few letters of the clinic. The list jumps to the applicable clinic.

b. Click OK. Your selection populates in the Clinic field.

7. In Provider, type a provider name, or click the Ellipsis button to select one from the Lookup Provider dialog.

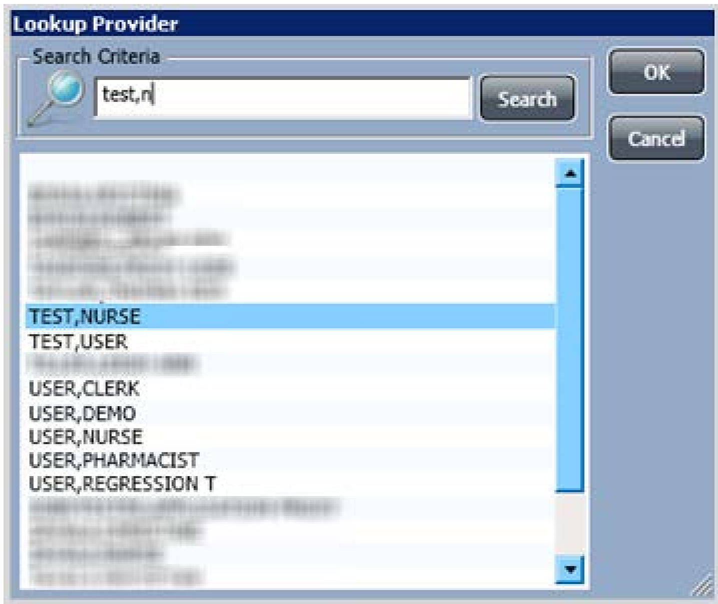


Figure 4-232: Lookup Provider Dialog

a. In the Search Criteria field, begin typing the first few letters of the provider's name. The list jumps to the applicable provider.

b. Click OK. Your selection populates in the Provider field.

8. In Prov. Discipline, type a discipline, or click the Ellipsis button to select one from the Lookup Provider Class dialog.

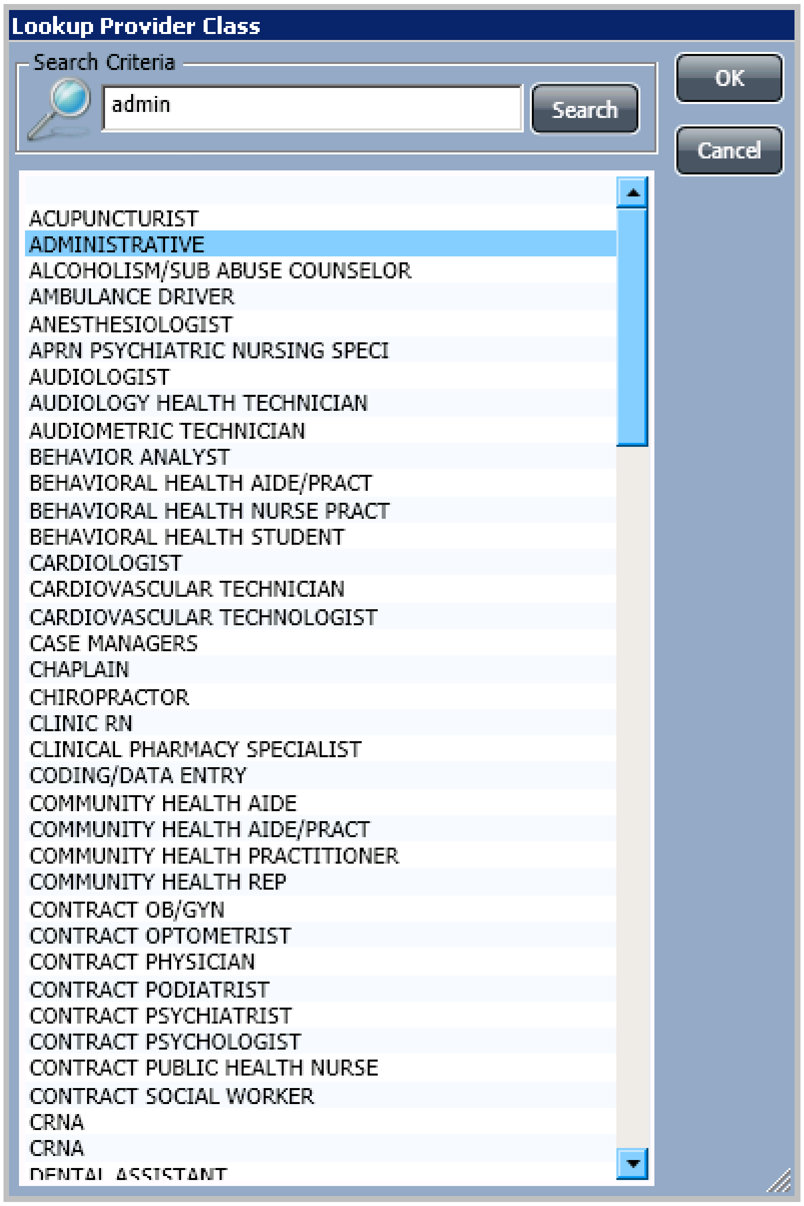


Figure 4-233: Lookup Provider Class Dialog

a. In the Search Criteria field, begin typing the first few letters of the provider class. The list jumps to the applicable class.

b. Click OK. Your selection populates in the Prov. Discipline field.

9. In the Managers field, click the Add button to add a manager. The Add Managers dialog opens.

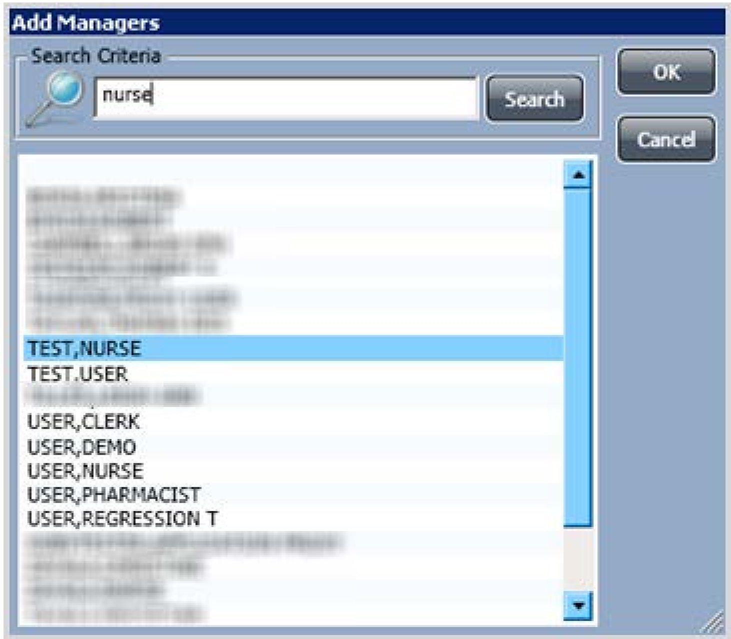


Figure 4-234: Add Manager Dialog

a. In the Search Criteria field, begin typing the first few letters of the manager's name. The list jumps to the applicable name.

b. Click OK. Your selection populates in the Managers field.

10. After completing the fields, click Save. The Manage Super-Bills dialog opens with your newly created category in the Super-Bill field, ready for input. Refer to the Adding a New Super-Bill Item topic for the next steps.

Note:	The Category Name field is the only required field, the other fields on the Add Category dialog are optional.

4.7.15 Editing a Super-Bill Category

To edit a Super-Bill Category, follow these steps:

1. From the Manage Super-Bills dialog, click the Add/Edit Super-Bills button. The Manage Categories dialog opens.

2. From the Manage Categories dialog, select a category from the list.

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

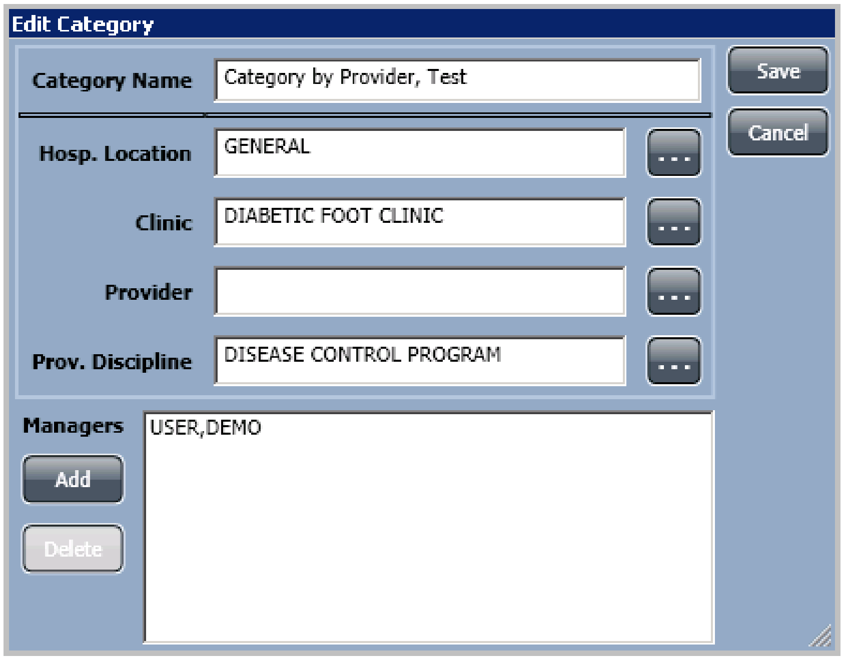


Figure 4-235: Edit Category Dialog

4. Make any changes, as necessary. Refer to the steps in the Add a Super-Bill Category section for details.

5. Click Save. Your changes update in the Manage Categories dialog.

4.7.16 Deleting a Category

A category can only be deleted by users who hold the BGOZ CAC key or are the owner or provider of the category.

To delete a Super-Bill Category, follow these steps:

1. From the Manage Super-Bills dialog, click the Add/Edit Super-Bills button. The Manage Categories dialog opens.

2. From the Manage Categories dialog, select a category from the list.

3. Click the Delete button. The Delete Super-Bill confirmation message opens.

Figure 4-236: Delete Super-Bill Category Confirmation Message

4. Click Yes to delete the Super-Bill Category. The category is removed from the list.

5. Click Exit to close the Manage Categories dialog.

4.8 Lab

4.8.1 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 plus 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.

4. If necessary, select the tests for which you want to see the results.

5. 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).

4.8.1.1 Most Recent (Lab Test Results)

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.

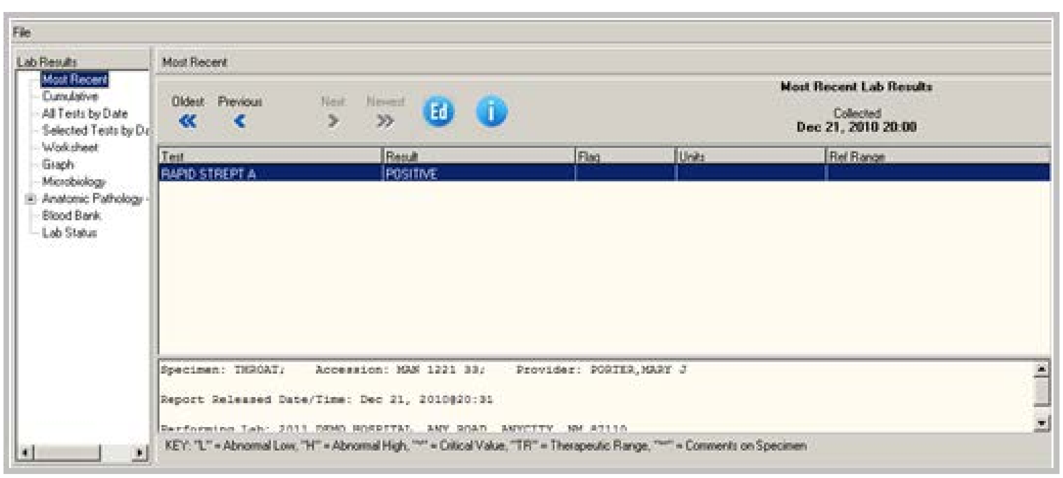


Figure 4-237: Most Recent Laboratory Results Window

4.8.1.2 Cumulative (Lab Test Results)

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.

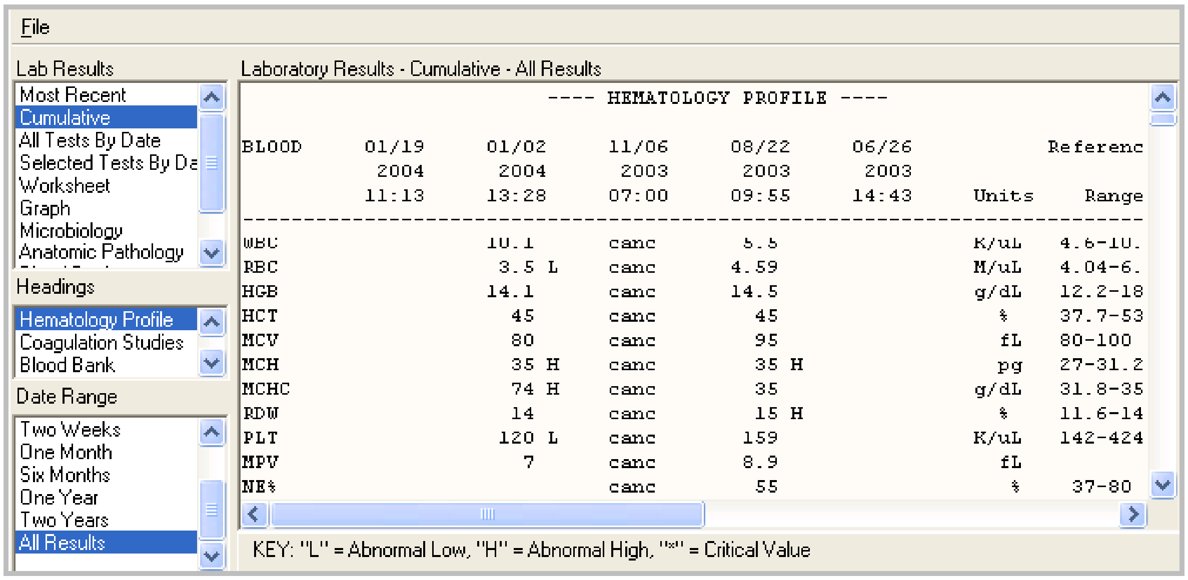


Figure 4-238: Cumulative Report

4.8.1.3 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.

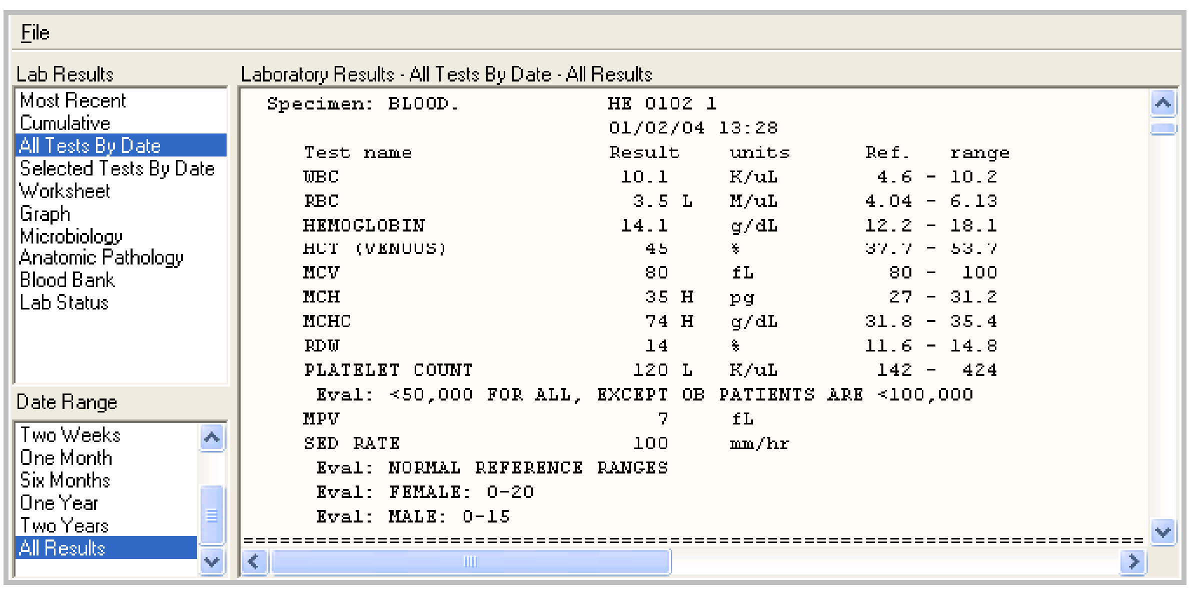


Figure 4-239: All Tests by Date Laboratory Results Report

4.8.2 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:

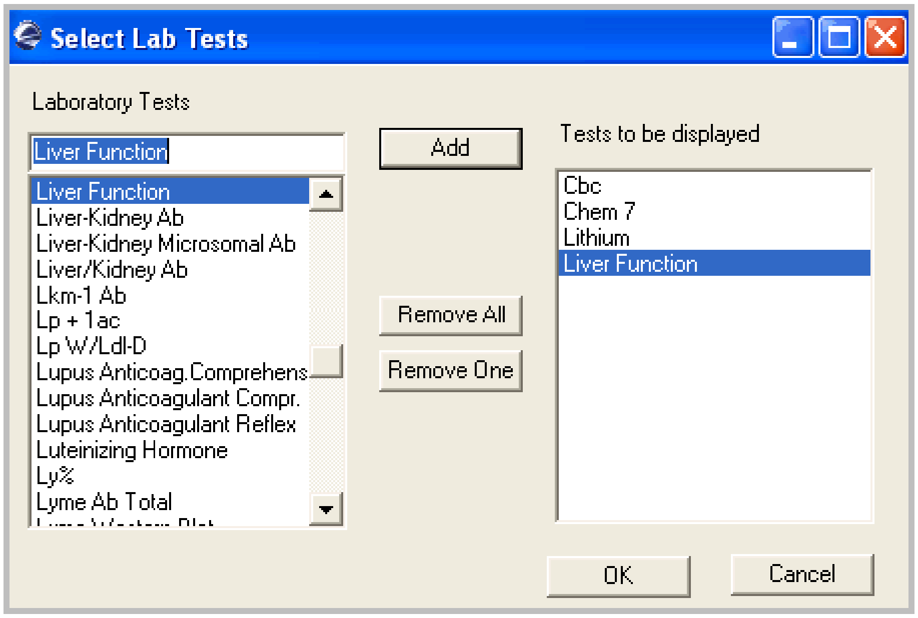


Figure 4-240: Select Laboratory Tests Dialog

In the above example, if you select CBC, Chem 7, Lithium, and Liver Functions, only the results for those tests would be displayed:

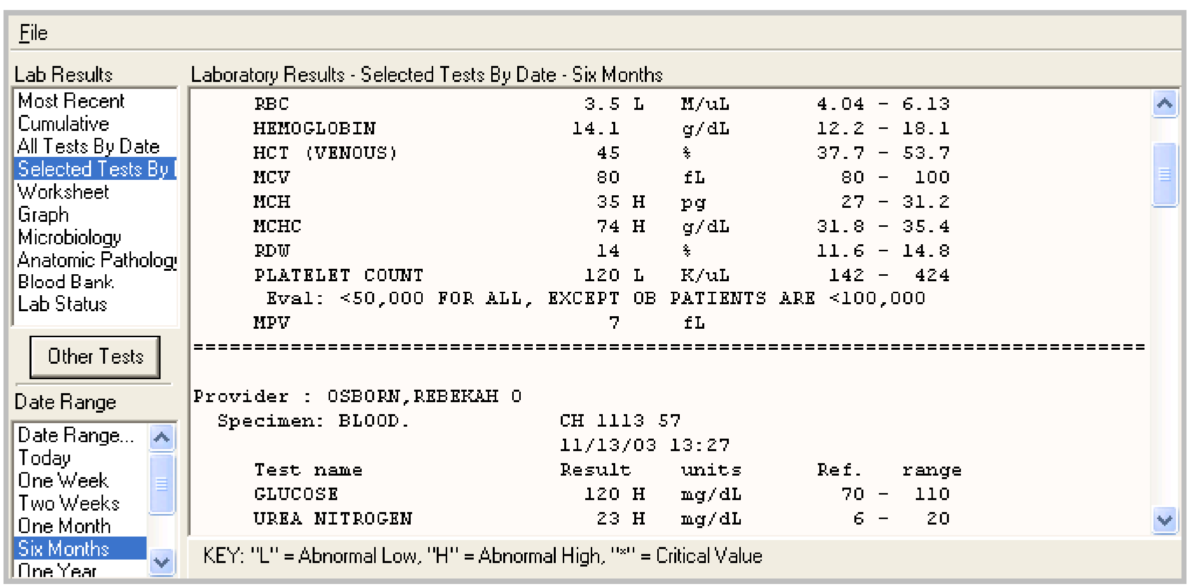


Figure 4-241: Select Lab Results

4.8.3 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.

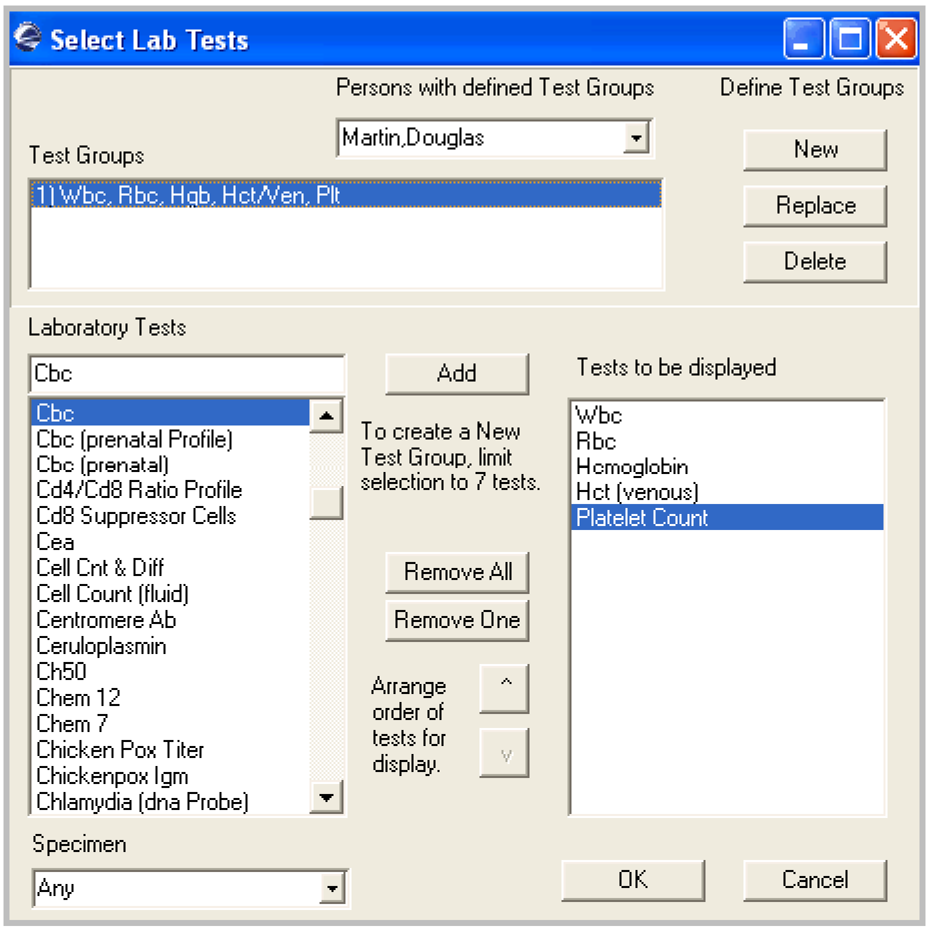


Figure 4-242.Select Laboratory Test Worksheet

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.

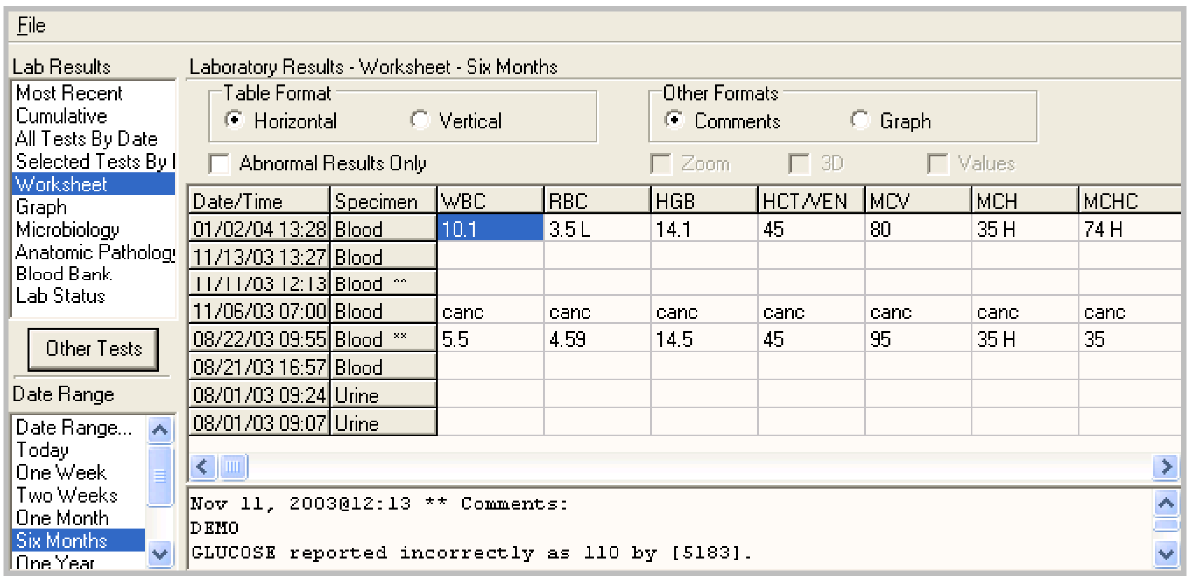


Figure 4-243: Worksheet Display

4.8.4 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 figure below shows an example of the graph feature being used.

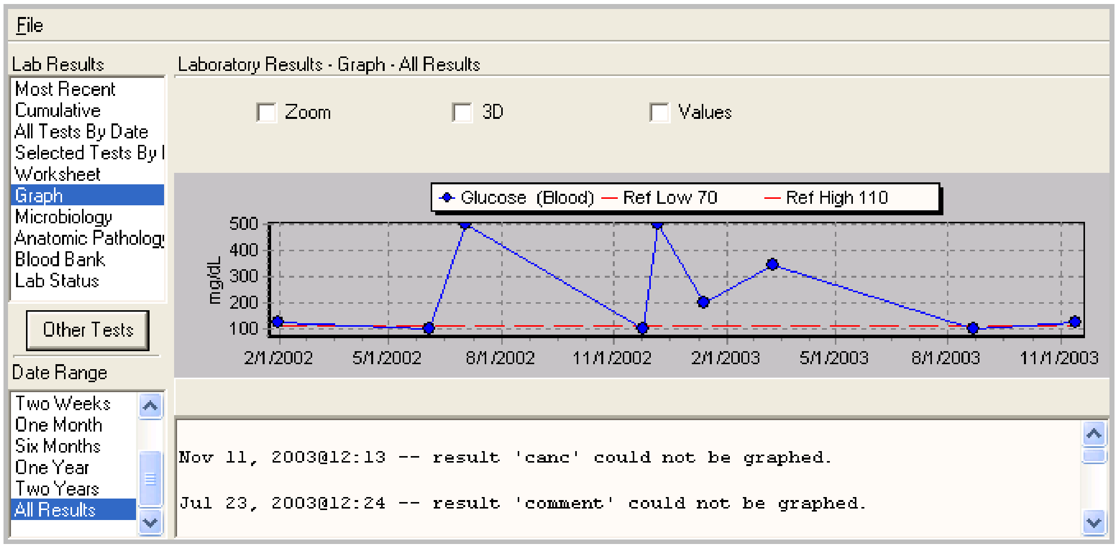


Figure 4-244: Laboratory Graph Feature

If you have created the clinical indexes, the updating graphing will be available on the Lab tab.

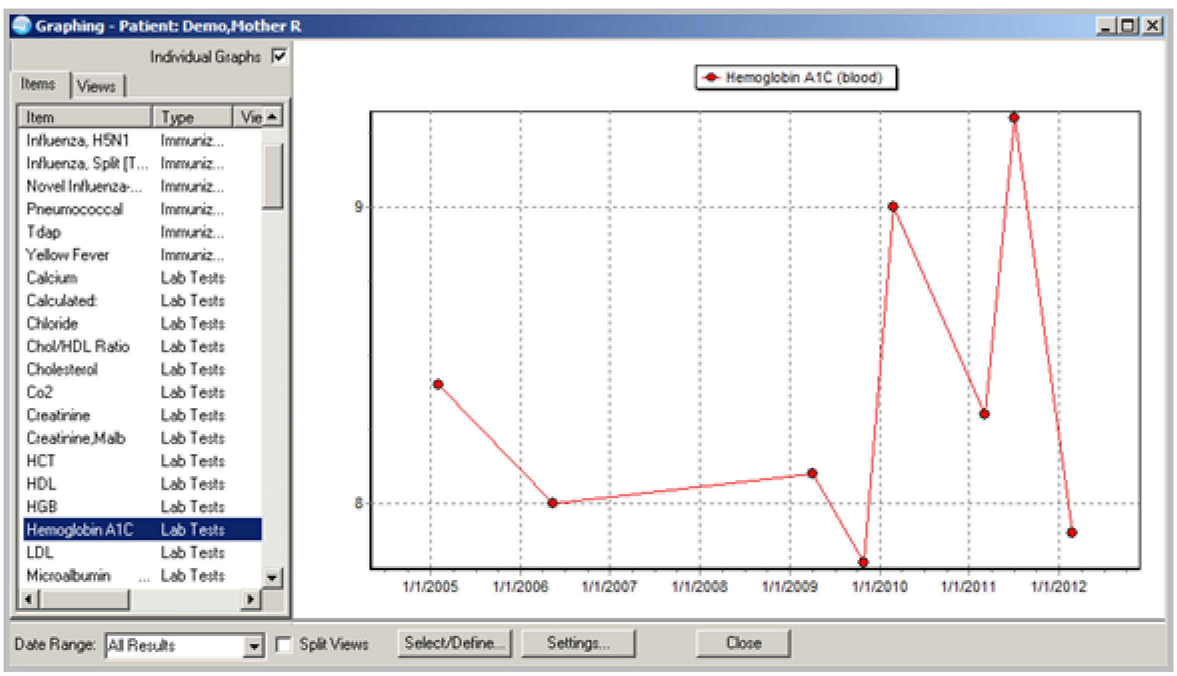


Figure 4-245.Updated Lab Graphing

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.

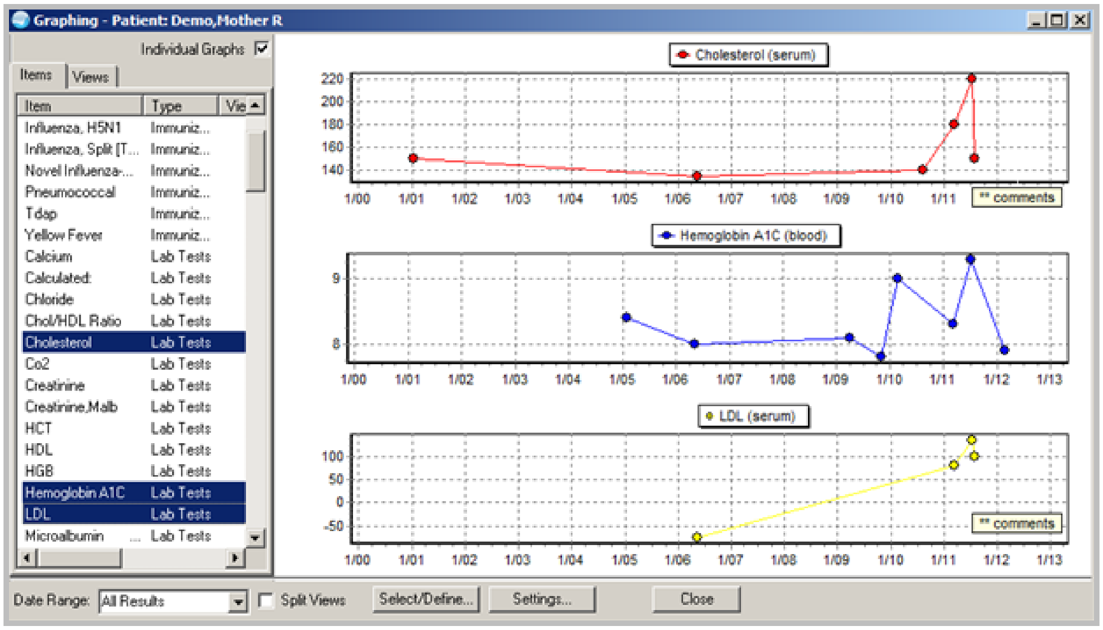


Figure 4-246.Separate Graphs for Tests

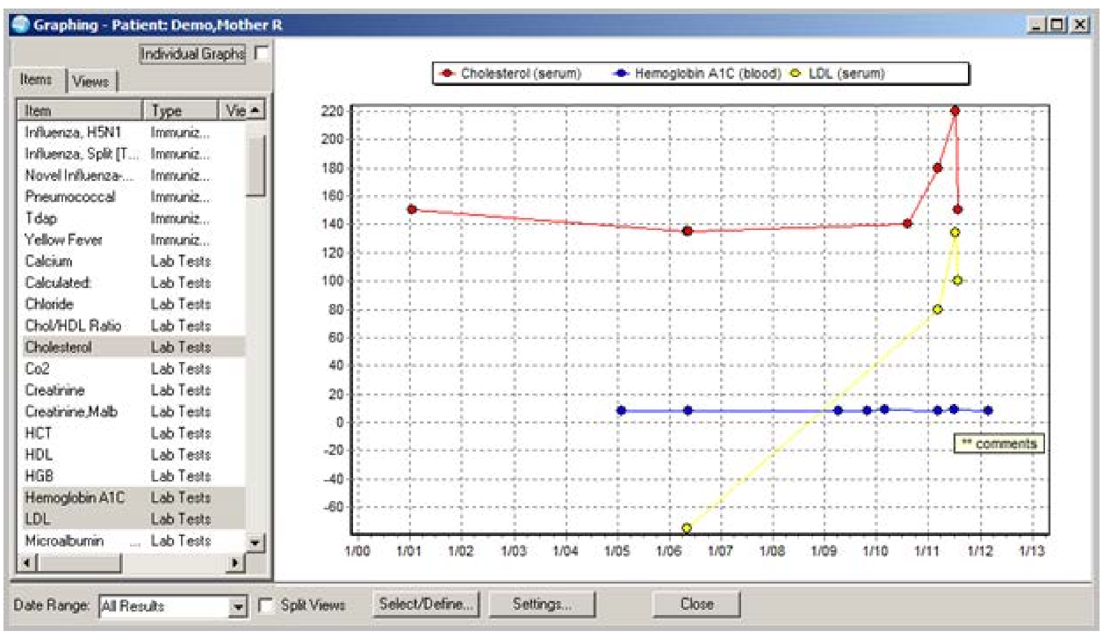


Figure 4-247: Combined Graph for Tests

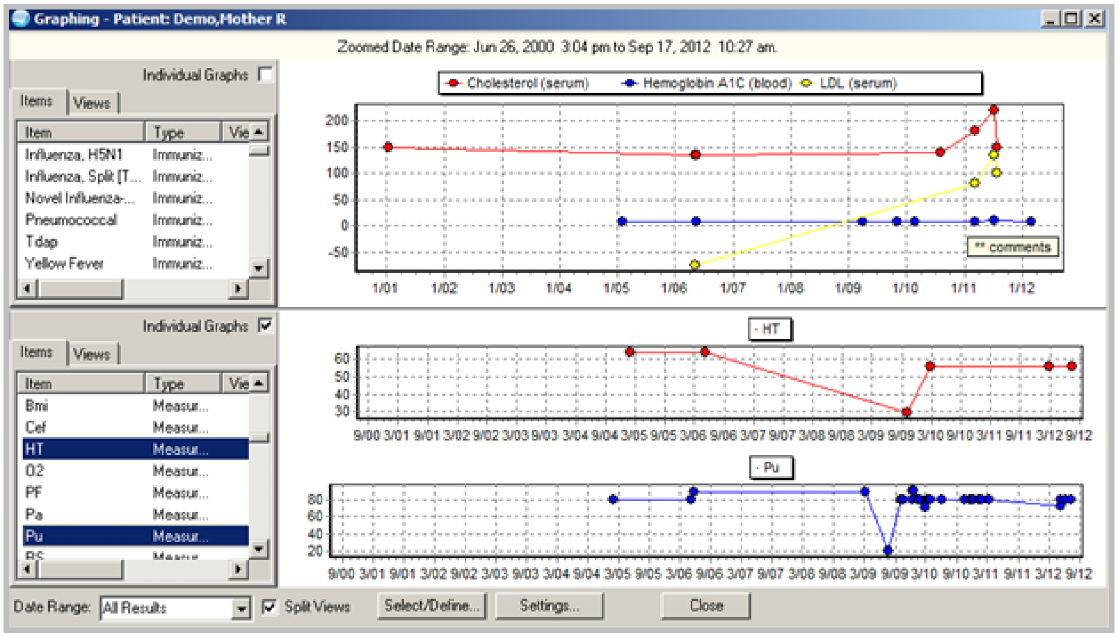


Figure 4-248: Split Views with Multiple Graphs

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.

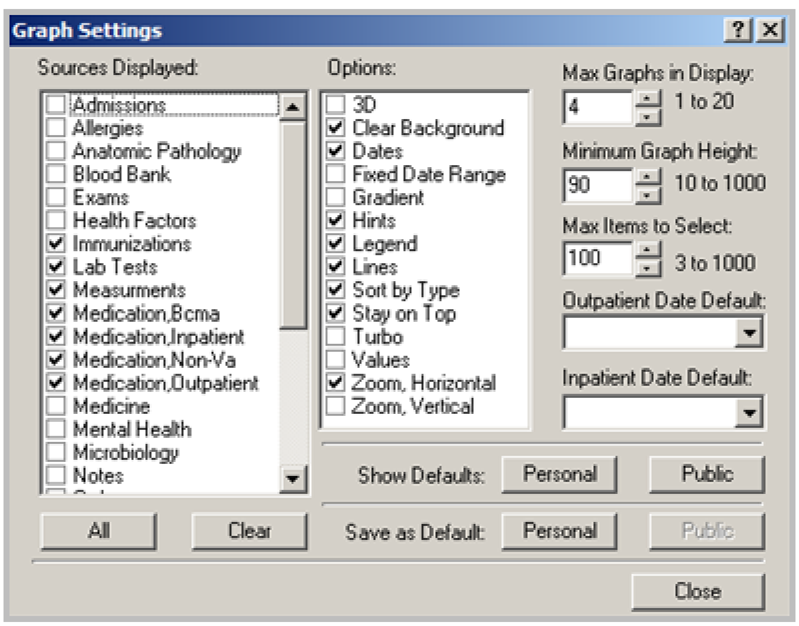


Figure 4-249: Graph Settings Dialog

Users can still make their own Lab groups and then use them for graphing.

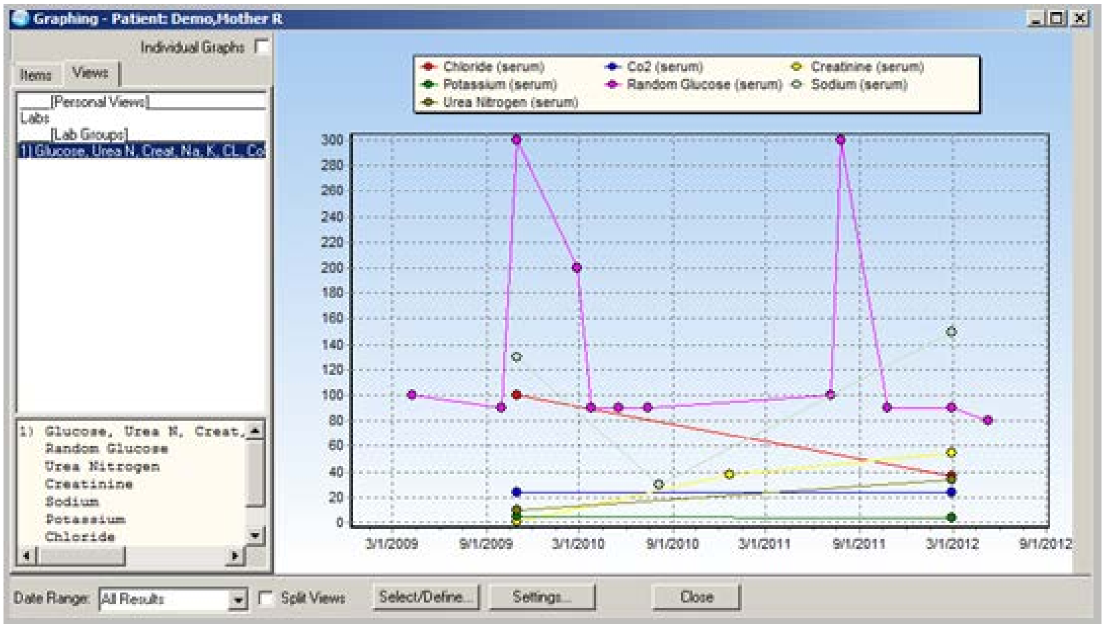


Figure 4-250.Lab Groups

Refer to Graphing for additional information.

4.8.5 Microbiology

Microbiology shows you the results from microbiology for the specified time period.

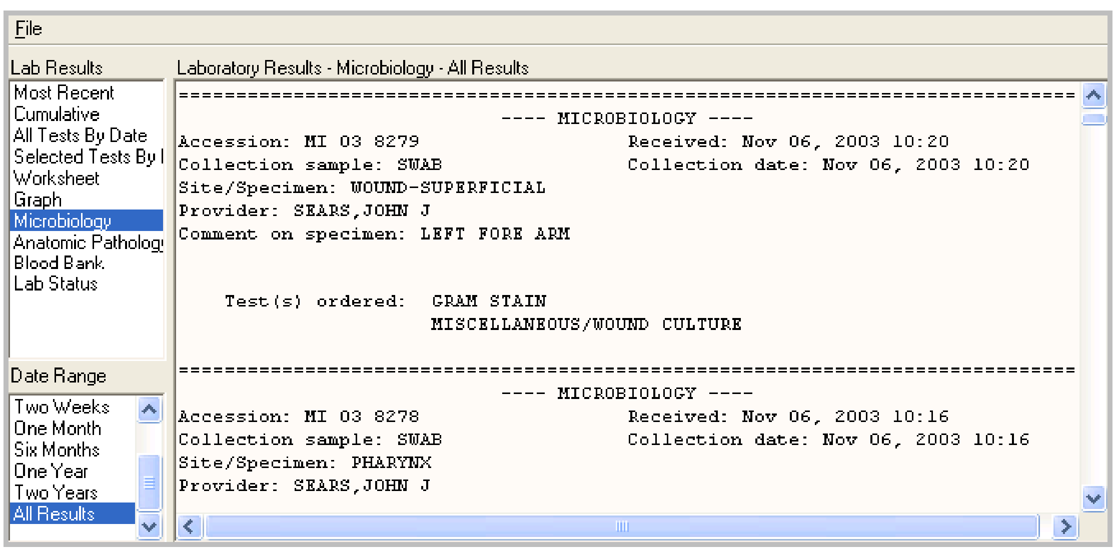


Figure 4-251: Microbiology Laboratory Results

4.8.6 Anatomic Pathology

Anatomic Pathology shows you the results in this section for the specified time period.

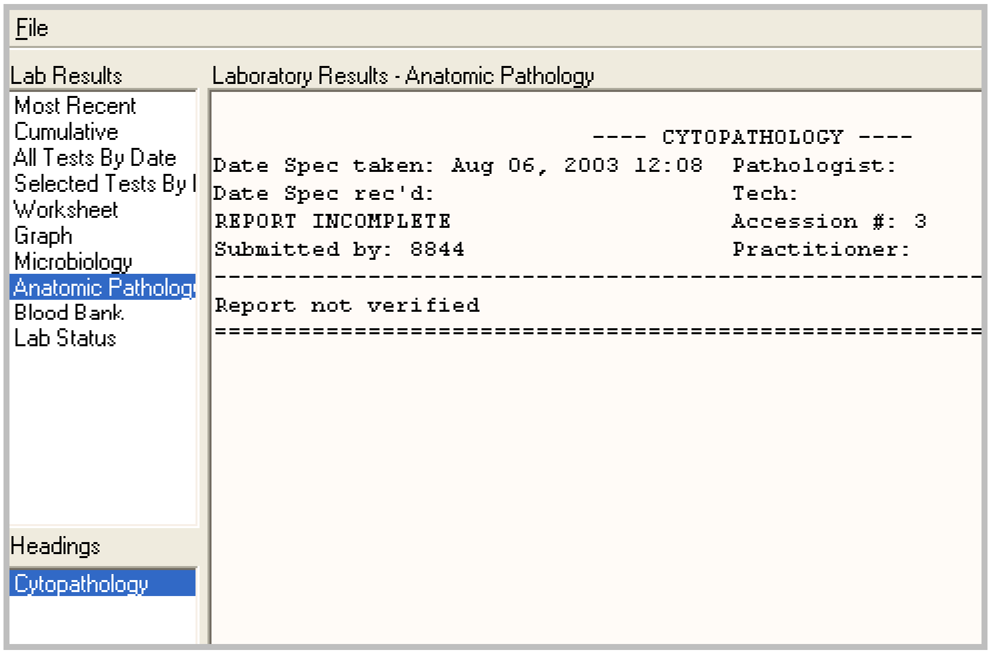


Figure 4-252: Anatomic Pathology Laboratory Results

4.8.7 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.

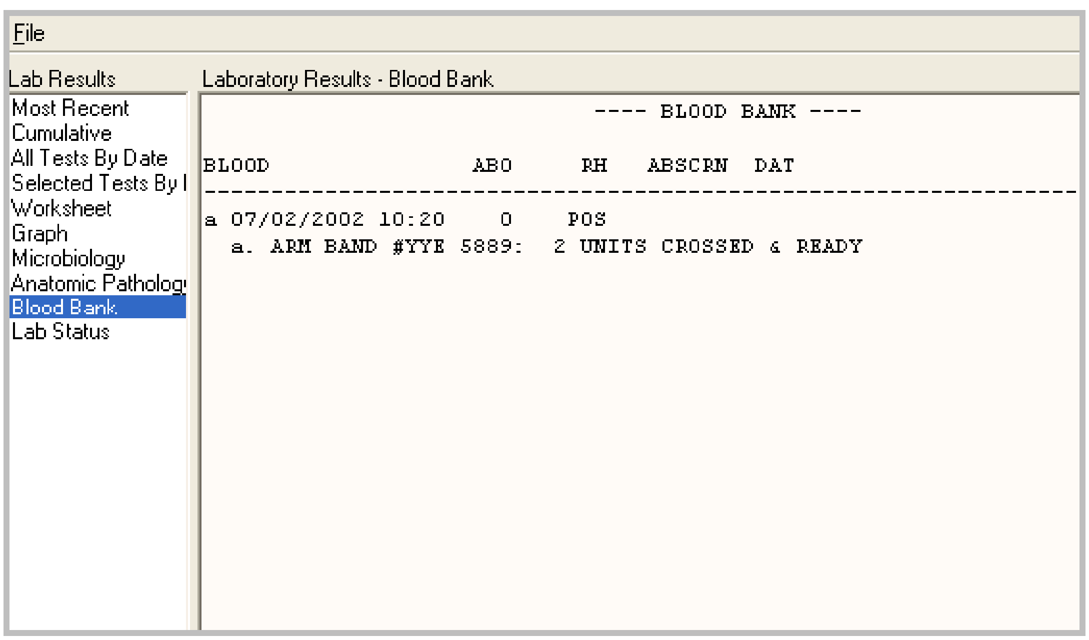


Figure 4-253: Blood Bank Laboratory Results

4.8.8 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.

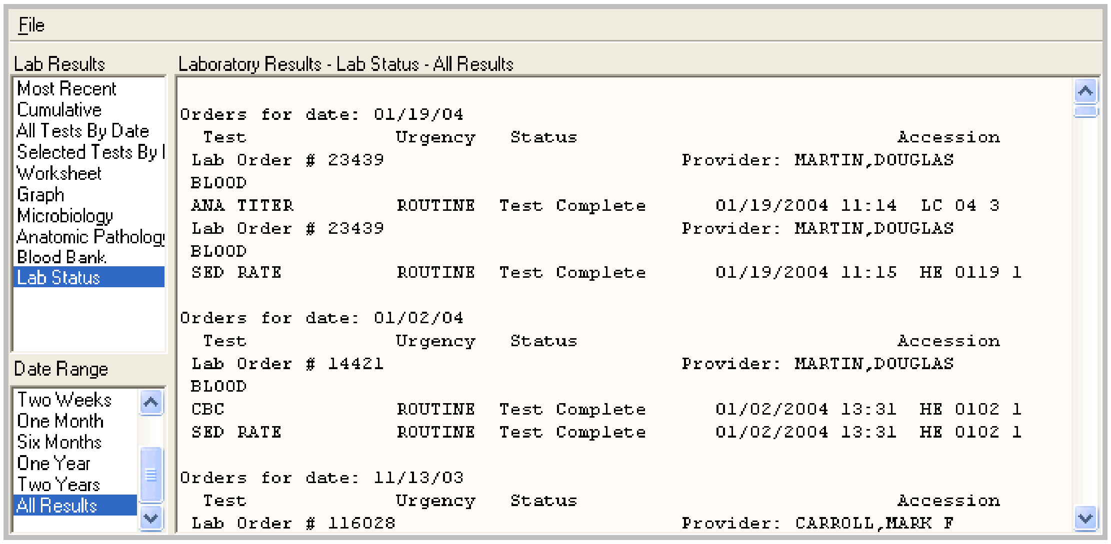


Figure 4-254: Lab Status Laboratory Results

4.8.9 Graphing

Enhanced Graphing is incorporated in the Labs and Reports tabs. This Graphing requires the Clinical Indexes, which are part of PXRM 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 4-255: Graphing Tool

4.8.10 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.

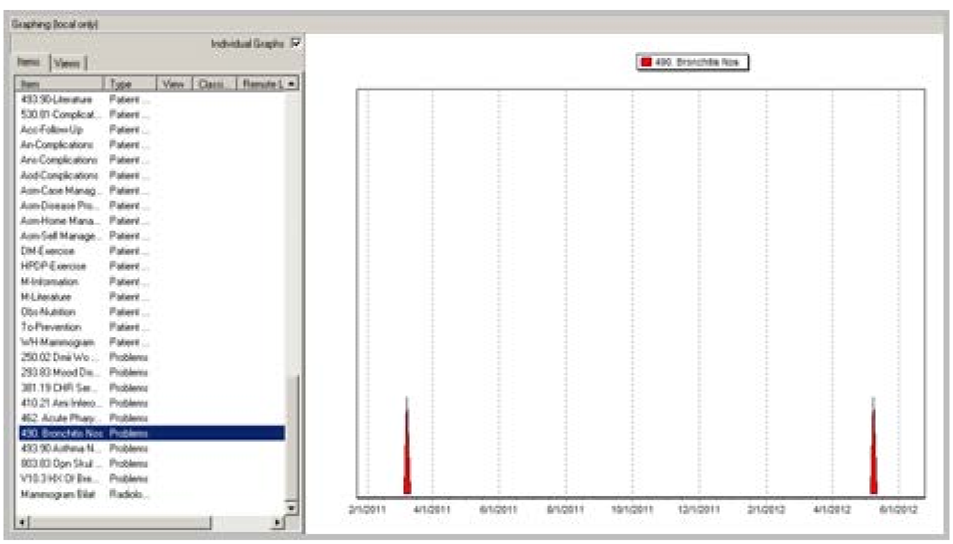


Figure 4-256: POV Graphing

4.8.10.1 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.

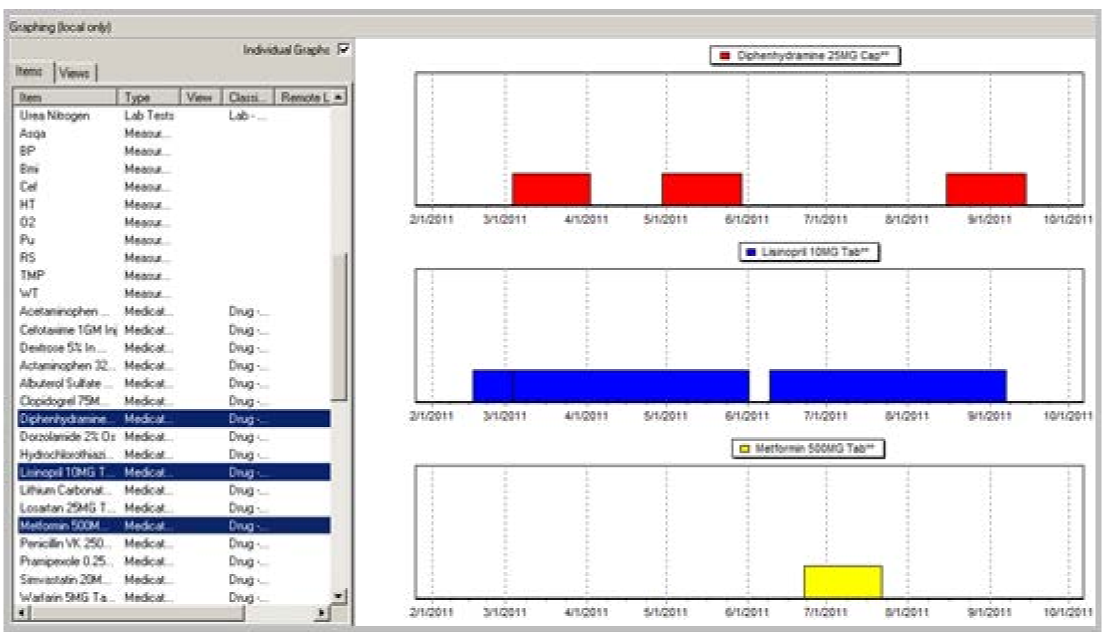


Figure 4-257.Graphing Multiple Medications

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.

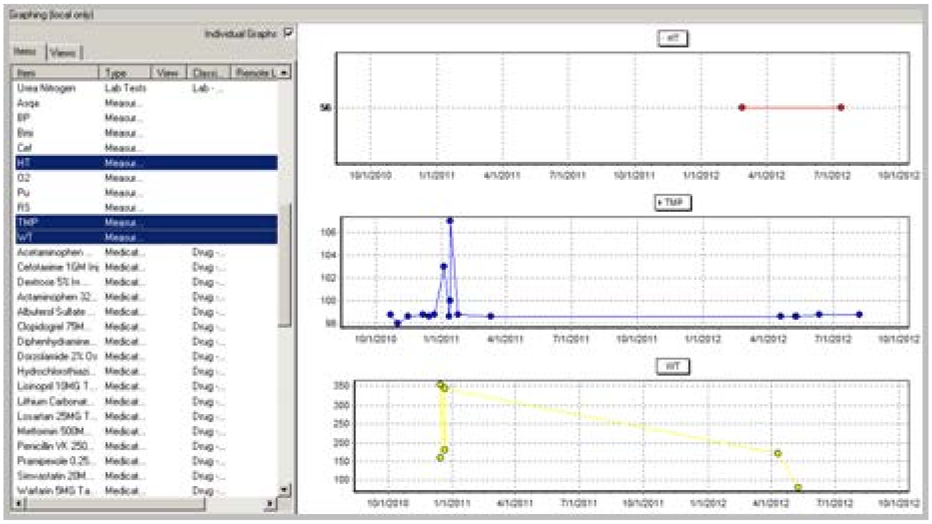


Figure 4-258: Vital Graphing

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.

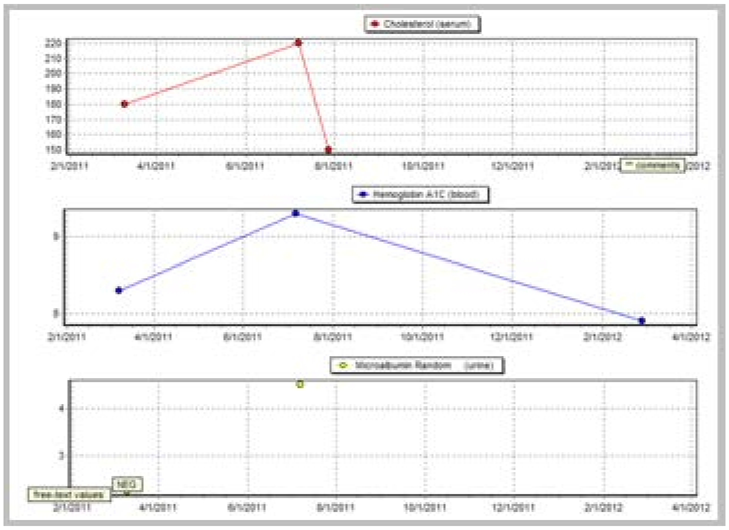


Figure 4-259: Lab Values

4.8.11 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:

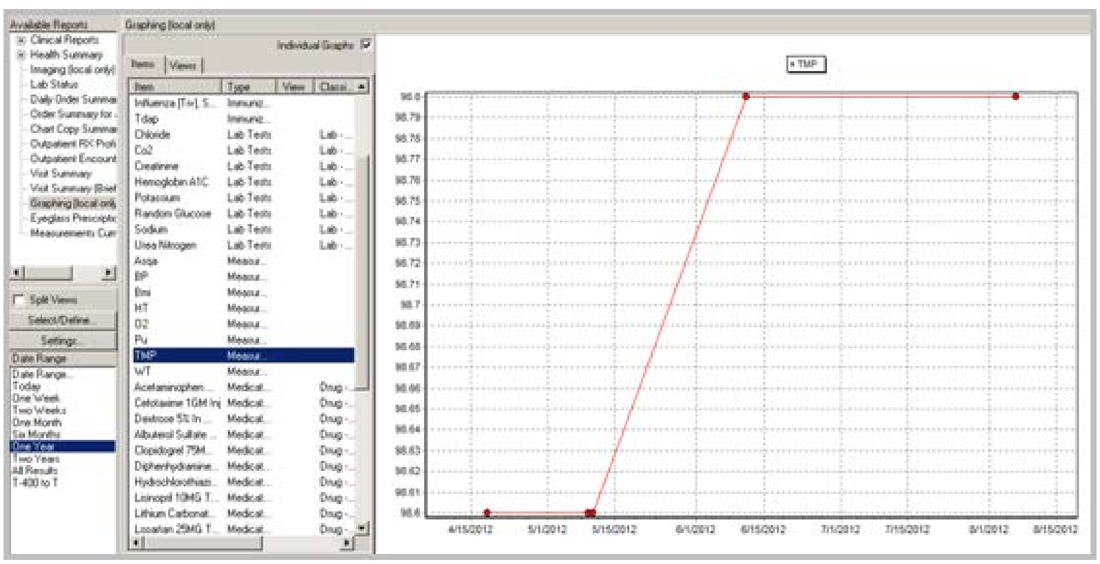


Figure 4-260: One Item

You can select multiple items to view by select an item in the selection box, holding the <Ctrl> key, and selecting other options. Next is the TMP, WT, and Pulse over one year.

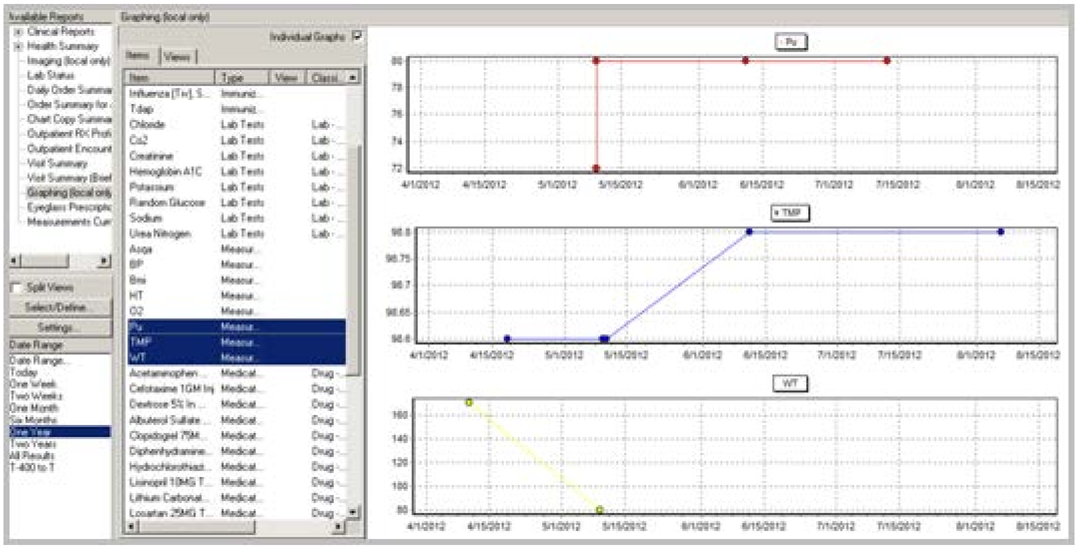


Figure 4-261: Multiple Items to Graph

You can also view them on the same graph by clearing the Individual Graphs check box at the top of the graph.

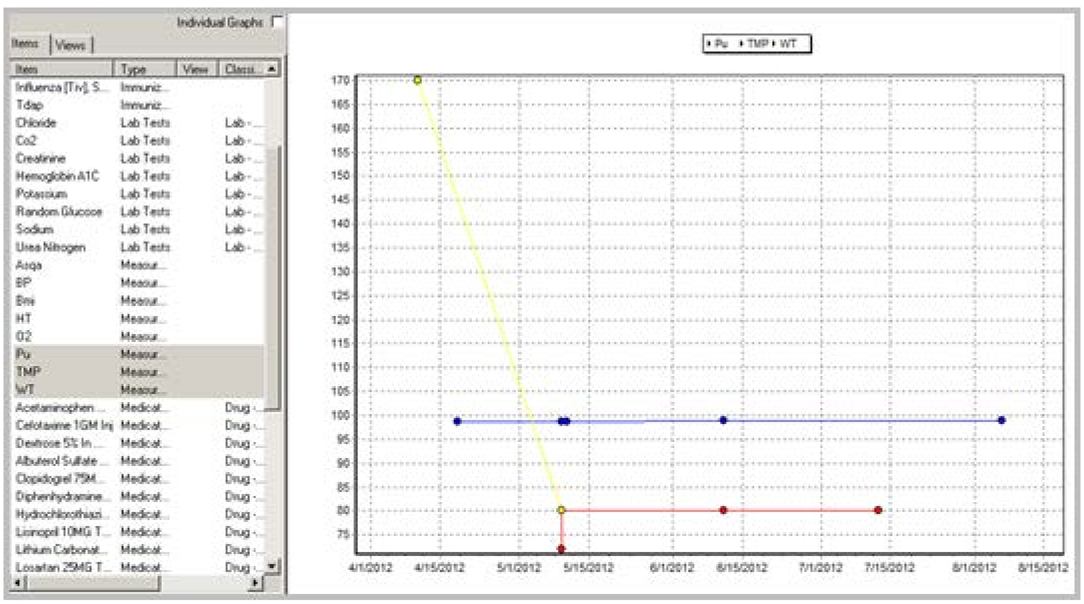


Figure 4-262: Multiple Items on the Same Graph

4.8.12 Setting Up Graphing

You can set up graphing on the Labs tab, the Reports tab, or under Options on the tool bar.

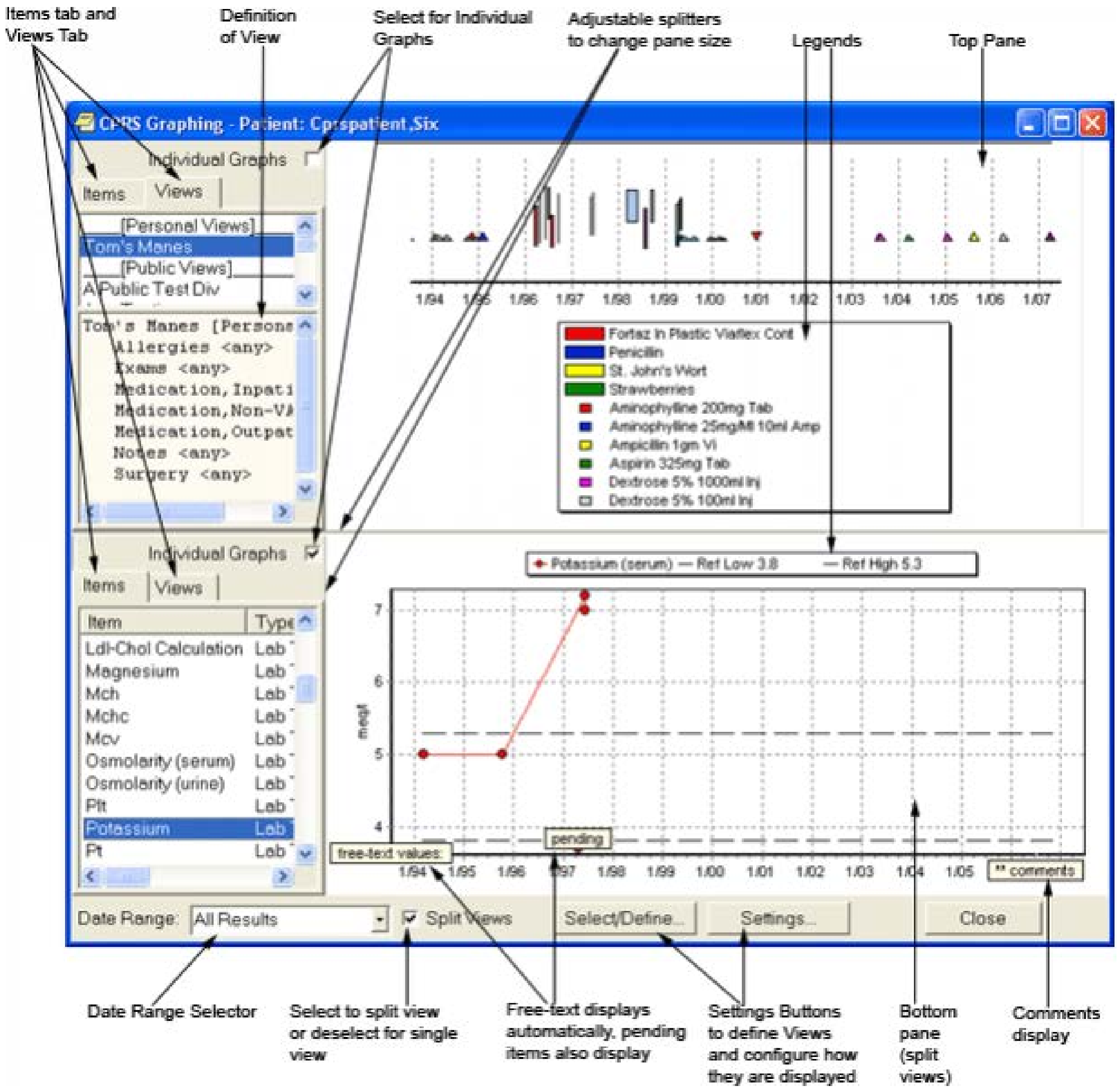


Figure 4-263: Setting Up Graphing Window

4.8.12.1 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 4-264: Settings Button

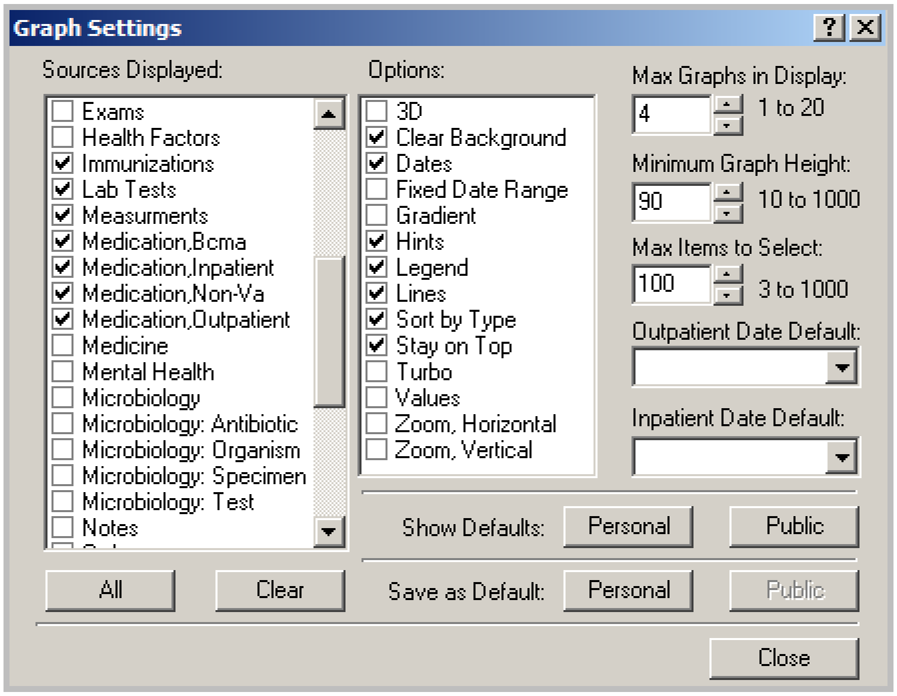


Figure 4-265: Settings Dialog

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.

   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.

4.8.12.2 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.

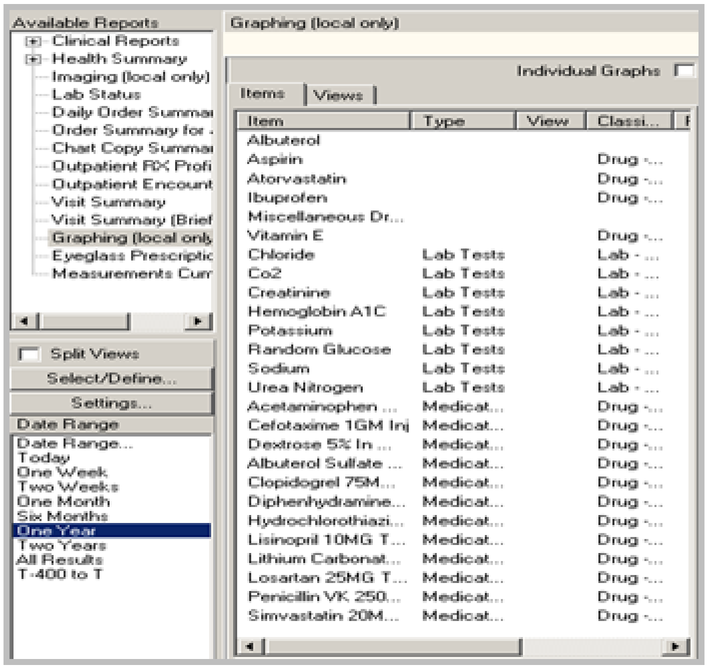


Figure 4-266: Items Tab

The Views tab includes your personal views and any laboratory worksheets that you have created and saved. There are two personal views below and three Lab groups for the user logged on.

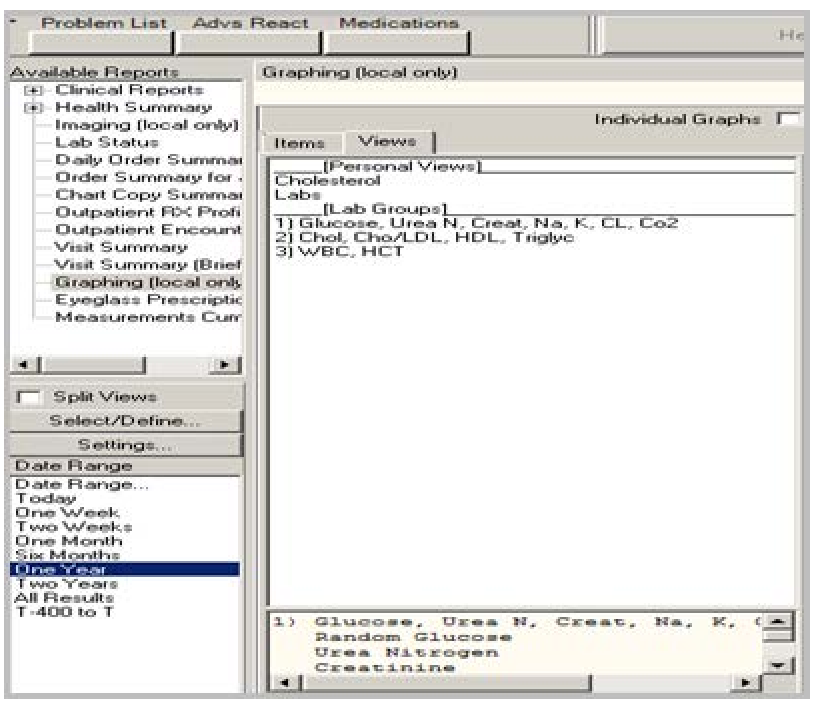


Figure 4-267: Views Tab

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 4-268: Select/Define Button

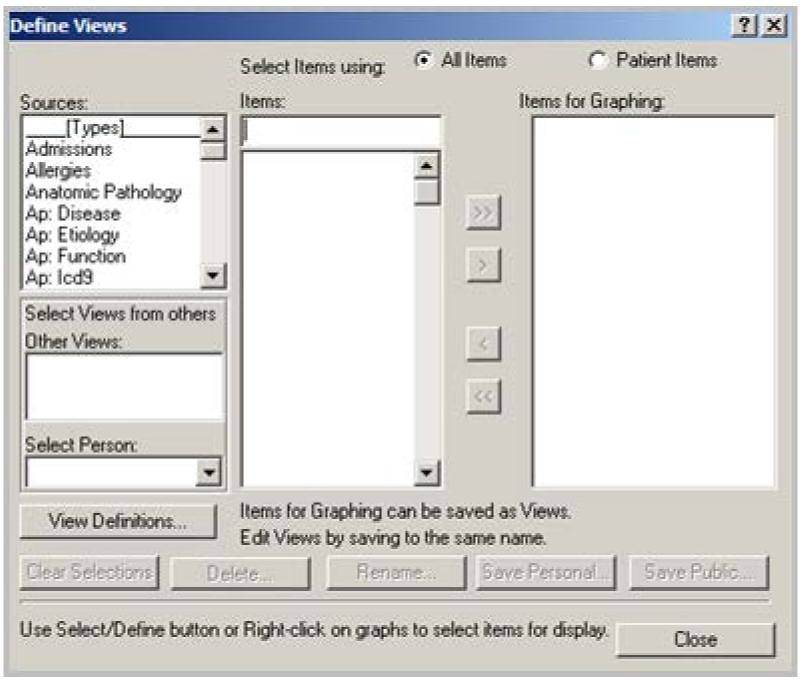


Figure 4-269: View Creation Dialog

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.

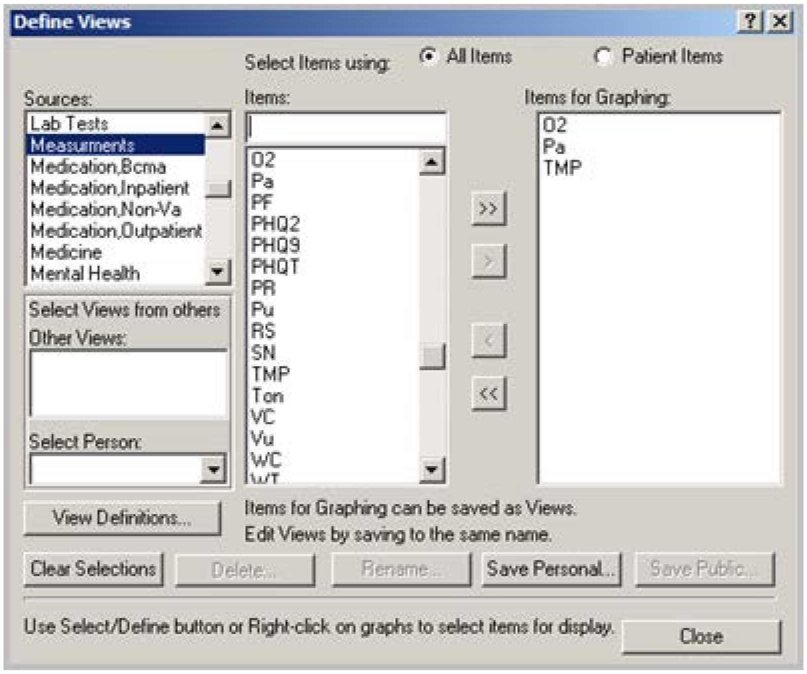


Figure 4-270: Personal View Defined

4. When finished, you can save it as a personal view by clicking the Save Personal button. However, if you have the correct security keys, it can be saved as a public view.

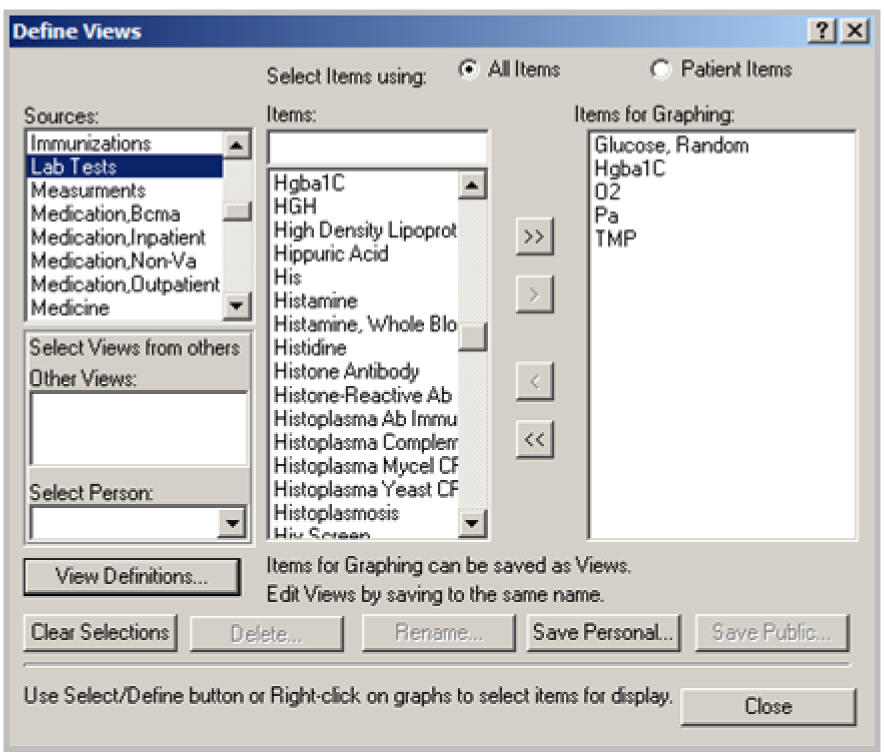


Figure 4-271: Ready to Save

5. Name the view to save it as a personal view.

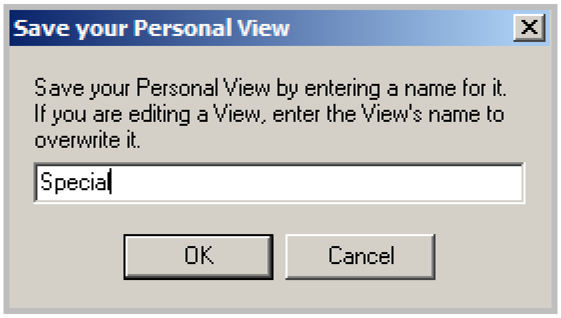


Figure 4-272: Personal View Name

6. Click the View Definitions to view a listing of what is in all the views that are available.

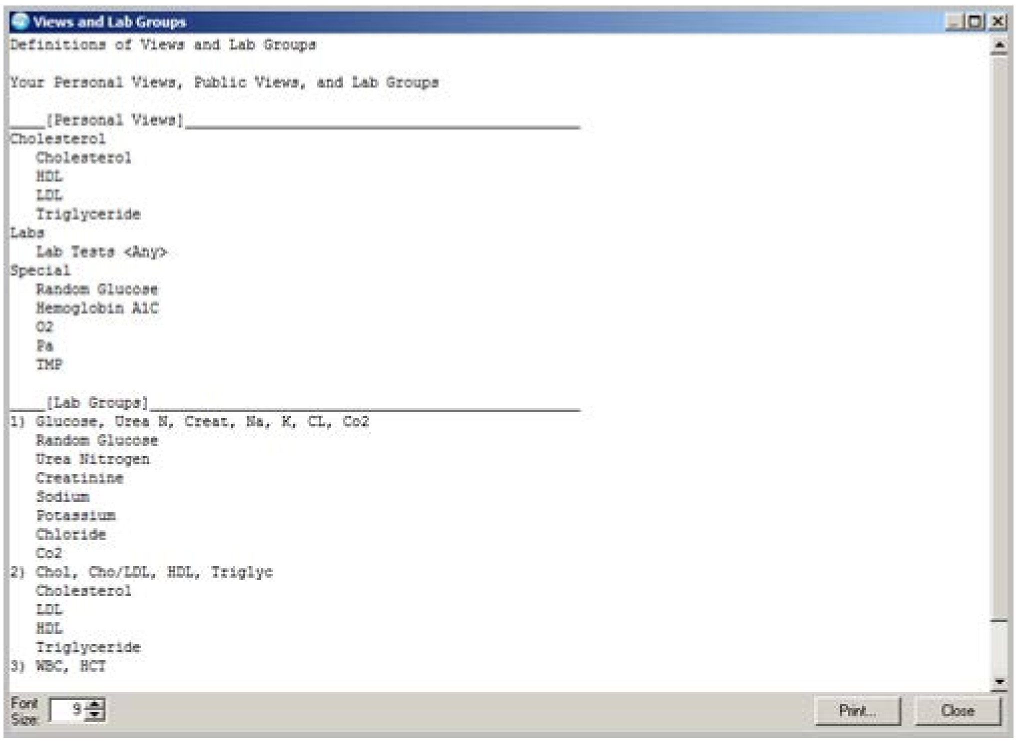


Figure 4-273.View Definitions

This view is then available to be selected.

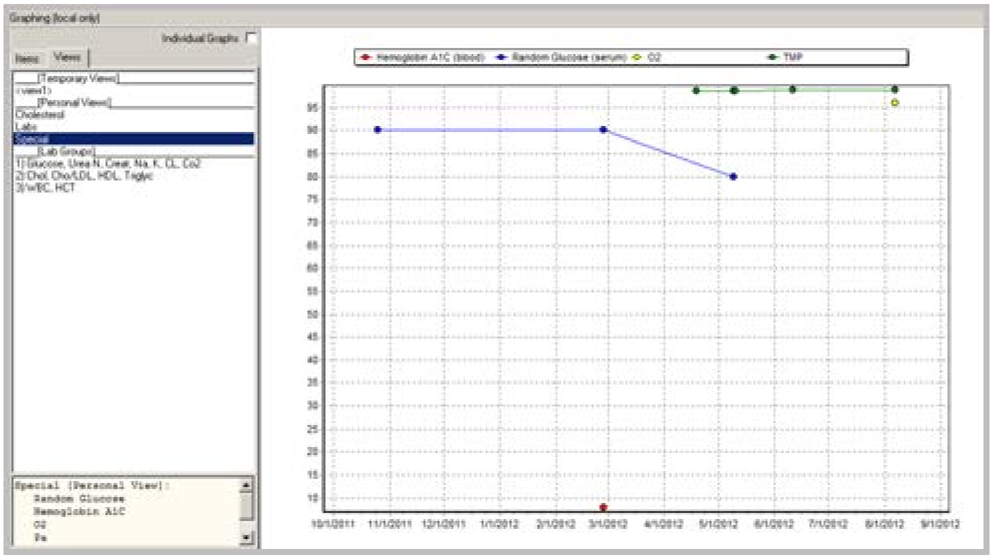


Figure 4-274: New View

Clicking the Split Views Box enables the user to see two different views at the same time.

Figure 4-275: Click Split Views

In the case below, 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.

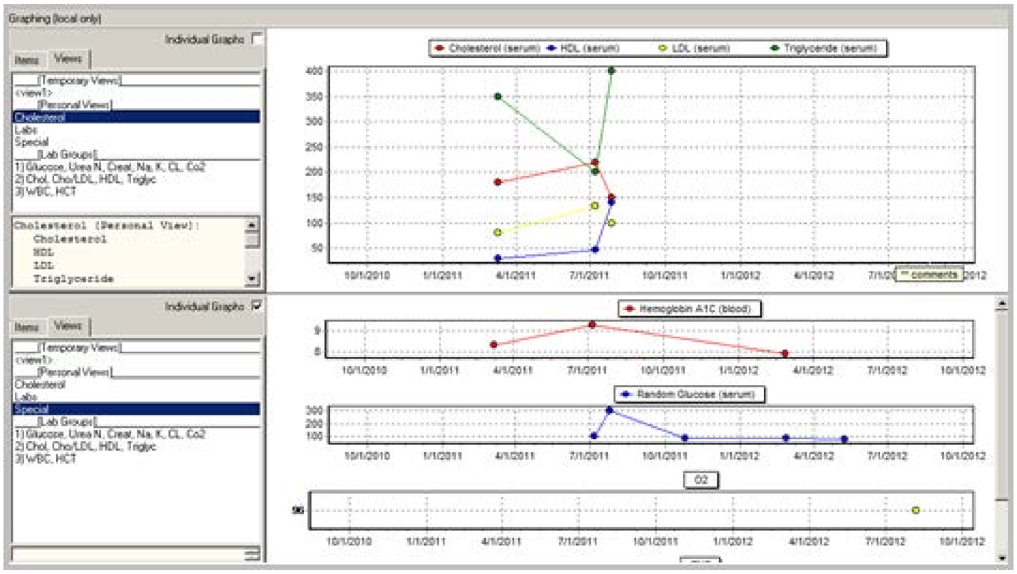


Figure 4-276: Split Views

4.8.13 Web Reference Search Function

4.8.13.1 Education Information Button

When a lab result and an active visit 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.

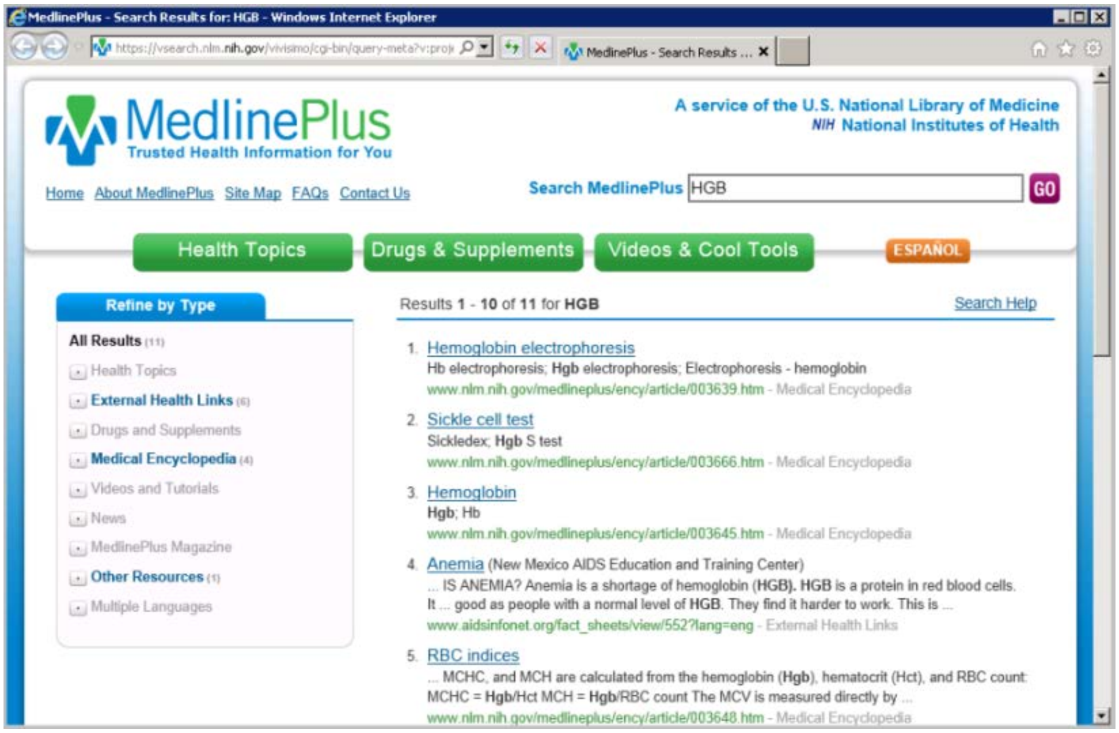


Figure 4-277: Medline Plus Web Site

If an active visit is not selected when the Education Information button is clicked, the following message appears. Click Yes to select an active visit. If No is clicked, MedlinePlus opens, but the Add Patient Education Event dialog does not open.

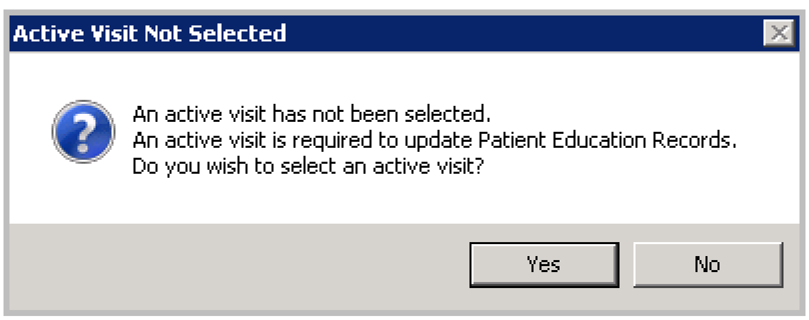


Figure 4-278: Active Visit Not Selected Information Message

4.8.13.2 Clinical Decision Support Button

When a lab result is selected from the Most Recent list, click the Clinical Decision Support button () button. This sends a call to the ClinicalKey Web site to provide information regarding the selected topic and the ClinicalKey Web site opens to the related page.

If your site is not licensed for ClinicalKey, the Web Reference Search dialog opens. After selecting a Reference Site and clicking Search, you are taken to the selected Web site for the specified term.

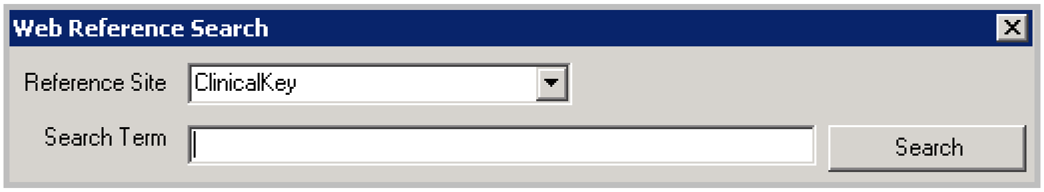


Figure 4-279: Web Reference Search Dialog

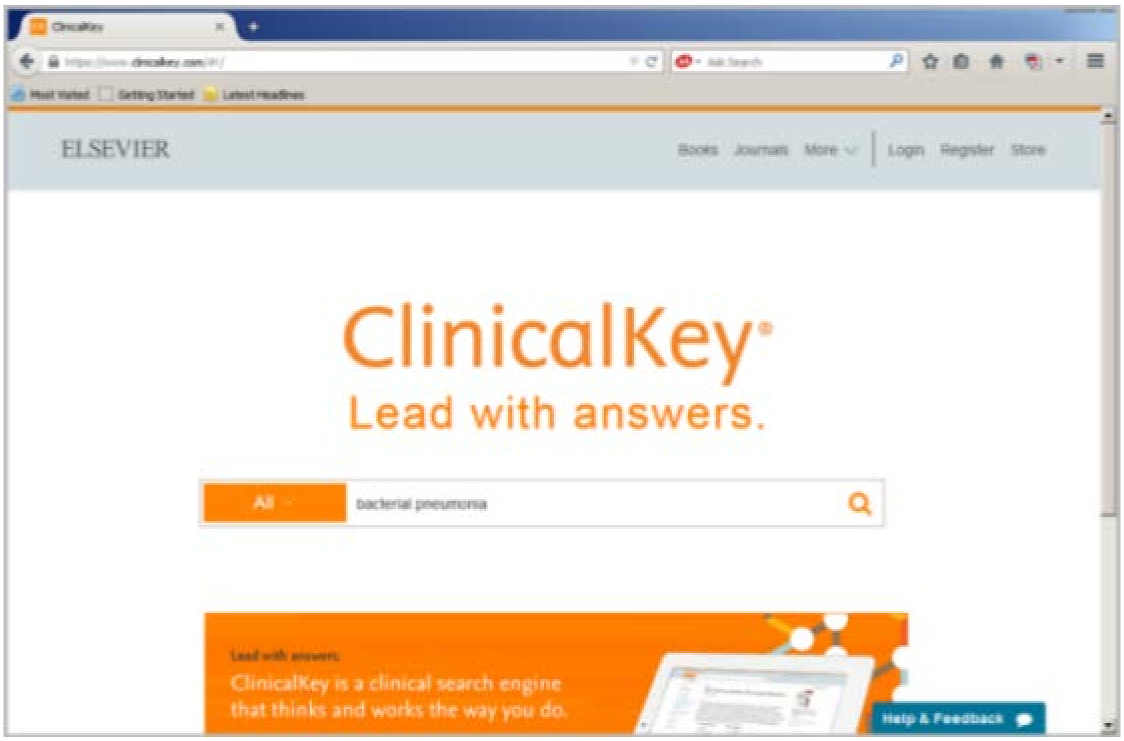


Figure 4-280: ClinicalKey Web Site

4.9 Medication Counseling Dialog

To document medication counseling by a pharmacist at the time medications are dispensed, follow these steps:

1. Select a patient, but do not select a visit. The system creates a Pharmacy visit for the current date and time, and the Medication Counseling is appended to that visit.

2. Click the Pharmacy Ed button (Pharm Ed). The Medication Counseling dialog opens.

   The patient and visit information are automatically displayed on this dialog in the Patient Context Details and Visit Context Details panes.

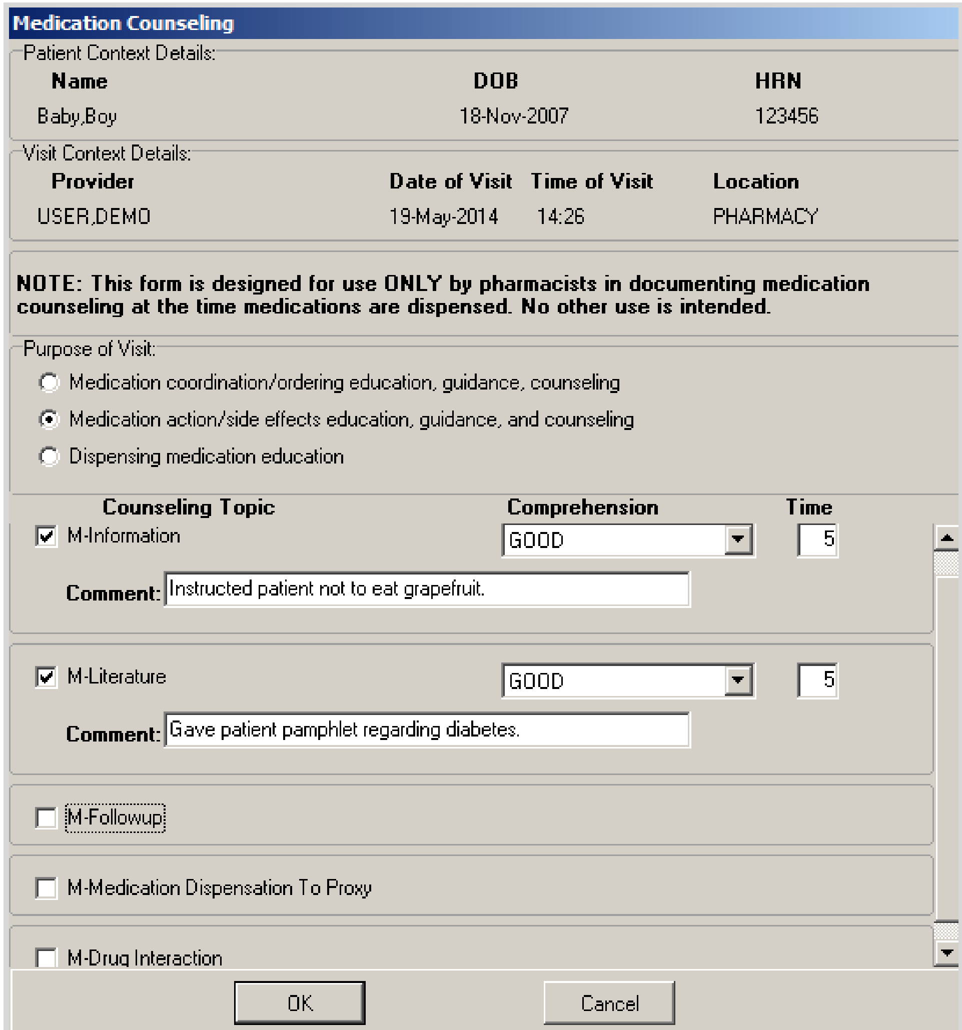


Figure 4-281: Medication Counseling Dialog

3. In the Purpose of Visit section, select a problem.

Note:	This section is site-configurable using the XPAR parameter BEHORXED. The OK button does not become active unless a Purpose of Visit is selected.

4. In the Counseling area, select the applicable Counseling Topic check box:

Note:	Multiple topics may be selected.

- M-Information
- M-Literature
- M-Follow-up

- M-Medication Dispense to Proxy
- M-Drug Interaction

5. Selecting a topic activates the Comprehension, Time, and Comment fields. Complete these fields, as necessary.

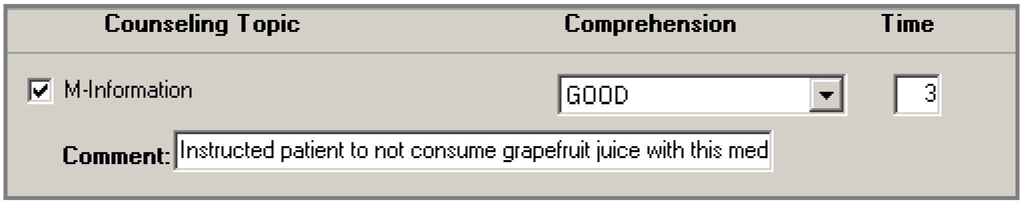


Figure 4-282: Activated Patient Education Category

- The Comprehension drop-down menu contains the Patient Education Comprehension options:
    - POOR
    - FAIR
    - GOOD (Default)
    - GROUP – NO ASSESSMENT
    - REFUSED
- The Time field is free-text. Enter a time in minutes.

Note:	Allowable entries are defined in the corresponding RPMS Patient Education file. The default is 1 and may be modified.

- The Comment field is a free-text field. It contains a right-click menu to aid in editing the text.

6. Once the dialog is complete, click OK. The Pharmacy Counseling Visit is created and the data is filed.

4.10 Medications Management

Important:	The eRx Autofinish portion of this Help is a DRAFT release. It will be updated as the application progresses.

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.

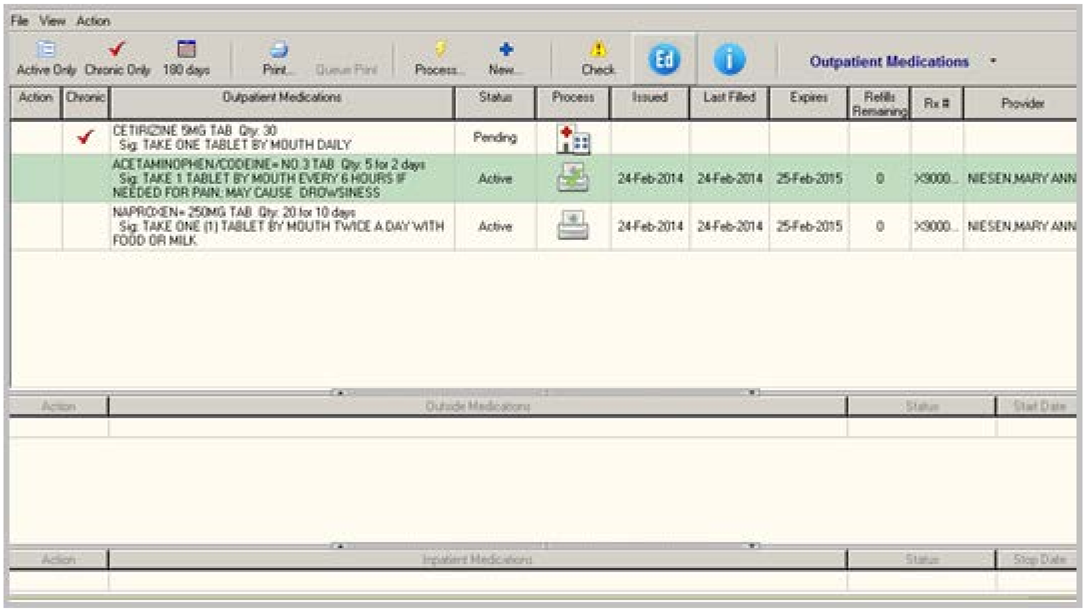


Figure 4-283: Medications Window

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.

4.10.1 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 4-284: Drop-Down List for Medication Type

4.10.2 Outpatient and Inpatient Medications Order

The process for ordering outpatient medications and inpatient medications are similar. You must have a visit selected to perform the order process.

1. Select Action → New Medication (or select the New Medication option on the right-click menu or click the New button) to display the Medication Order dialog where you select a medication.

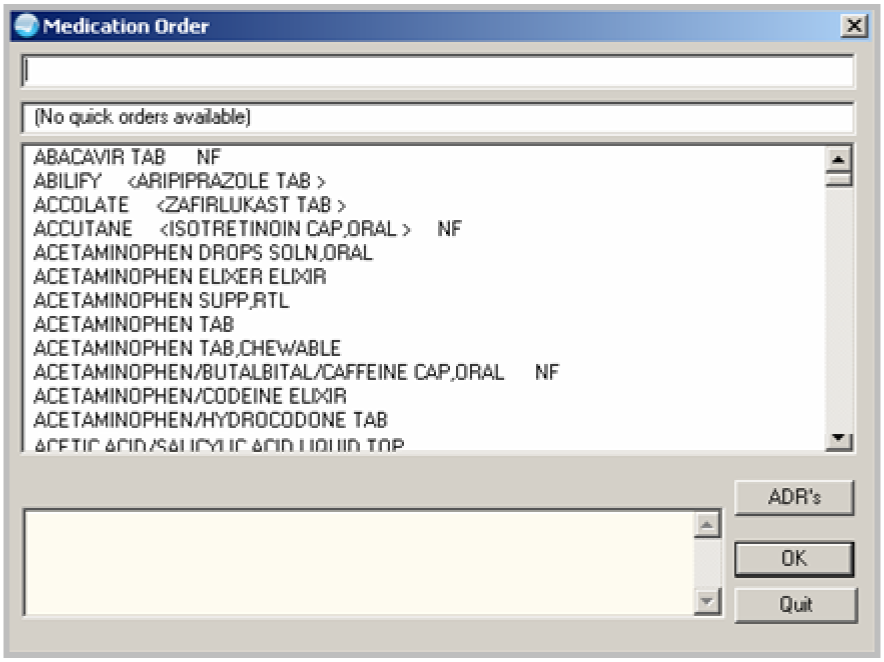


Figure 4-285: Medication Order for Selecting an Outpatient Drug

- For Inpatient status, the list contains medications designed at Unit Dose medications.
- For Outpatient status, the list contains Outpatient Medications (only).
- For Outpatient locations set up to provide Inpatient Medications, the Medications setup for Inpatient use and the Inpatient Order dialog is provided.
- For Outpatient status, the list contains Outpatient Medications (only).
- 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 pop-up.

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.

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 might need to exit the Medication Order dialog, change the provider, and then reenter the Medication Order dialog.

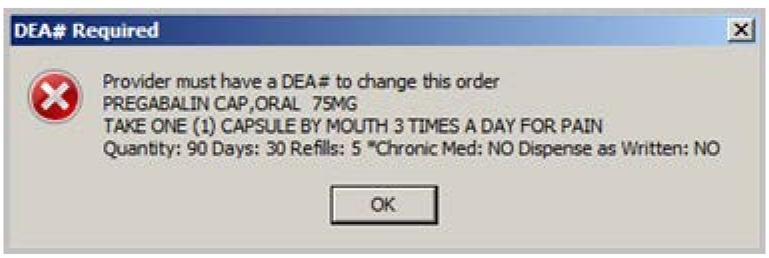


Figure 4-286: DEA# Required Warning Message

4. The ADRs button appears on many of the medication order dialoges. Click this button to show the Patient Postings information about the current patient (allergies, as well as Crisis Notes, and so on.).

4.10.3 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.

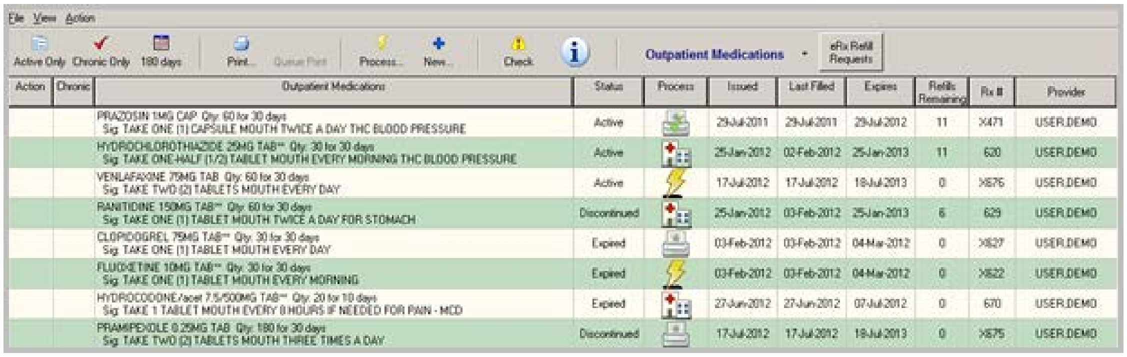


Figure 4-287: Outpatient Medications Group Box

4.10.4 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-click on any column heading. This feature assists those with smaller monitors to view only the needed information.

Figure 4-288: 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.

4.10.5 Action Menu (Outpatient Medications)

The options on the Action menu determine what actions you can take on the Outpatient Medications group box.

Figure 4-289: Options on Action Menu for Outpatient Medications Group Box

- **New Medication:** Use this option to order a new medication.
- **Change:** Enables you to change something pertaining to an already prescribed medication.
- **Copy to New Order:** Use this option to copy the selected medication to a new order.
- **Discontinue/Cancel:** Use this option to discontinue or cancel a selected medication.
- **Process:** Use this option to process the selected medication orders.
- **Transfer to Inpatient:** Use this option to transfer a selected outpatient medication to inpatient.
- **Refill:** Use this option to refill the selected medication.
- **Renew:** Use this option to renew the selected medication.
- **Chronic Medication:** Select Yes, No, or Select All from the menu.

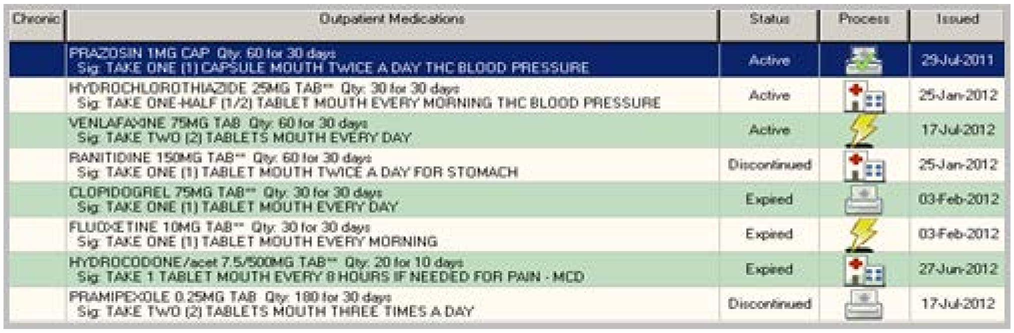
4.10.6 Icons (Outpatient Medications)

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.

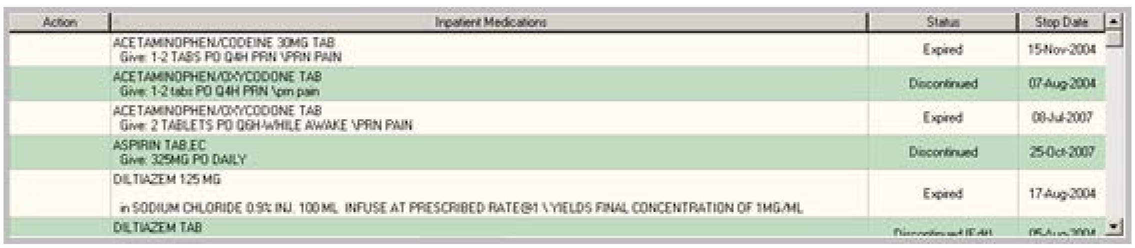


Chronic	Outpatient Medications	Status	Process	Issued
	PRAZOSIN 1MG CAP Qty: 60 for 30 days Sig: TAKE ONE (1) CAPSULE MOUTH TWICE A DAY THC BLOOD PRESSURE	Active		29-Jul-2011
	HYDROCHLOROTHIAZIDE 25MG TAB** Qty: 30 for 30 days Sig: TAKE ONE-HALF (1/2) TABLET MOUTH EVERY MORNING THC BLOOD PRESSURE	Active		25-Jan-2012
	VENLAFAXINE 75MG TAB Qty: 60 for 30 days Sig: TAKE TWO (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
	FLUOXETINE 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 TWO (2) TABLETS MOUTH THREE TIMES A DAY	Discontinued		17-Jul-2012

Figure 4-290: Example of Icons in Use

4.10.7 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 100 ML INFUSE AT PRESCRIBED RATE@1 \ YIELDS FINAL CONCENTRATION OF 1MG/ML	Expired	17-Aug-2004
	DILTIAZEM TAB	[illegible]	[illegible]

Figure 4-291: Inpatient Medications Group Box

You sort any column in the Inpatient Medications group box by clicking the heading column.

4.10.7.1 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.

4.10.7.2 Action Menu (Inpatient Medications)

The options on the Action menu determine what actions you can take on the Inpatient Medications group box.

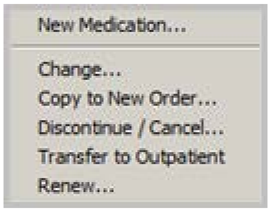


Figure 4-292: Options on Action Menu for Inpatient Medications Group Box

- **New Medication:** Use this option to order a new medication. See Outpatient and Inpatient Medications Orders for more information.
- **Change:** Enables you to change a detail pertaining to an already prescribed medication.
- **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 Discontinue/Cancel for more information.
- **Transfer to Outpatient:** Use this option to transfer a selected Inpatient Medication to an Outpatient Medication. See the Transfer to Outpatient section for more information.
- **Renew:** Use this option to renew the selected medication.

4.10.8 Outpatient and Inpatient Medications Order

The process for ordering outpatient medications and inpatient medications are similar. You must have a visit selected to perform the order process.

1. Select Action → New Medication (or select the New Medication option on the right-click menu or click the New button) to display the Medication Order dialog where you select a medication.

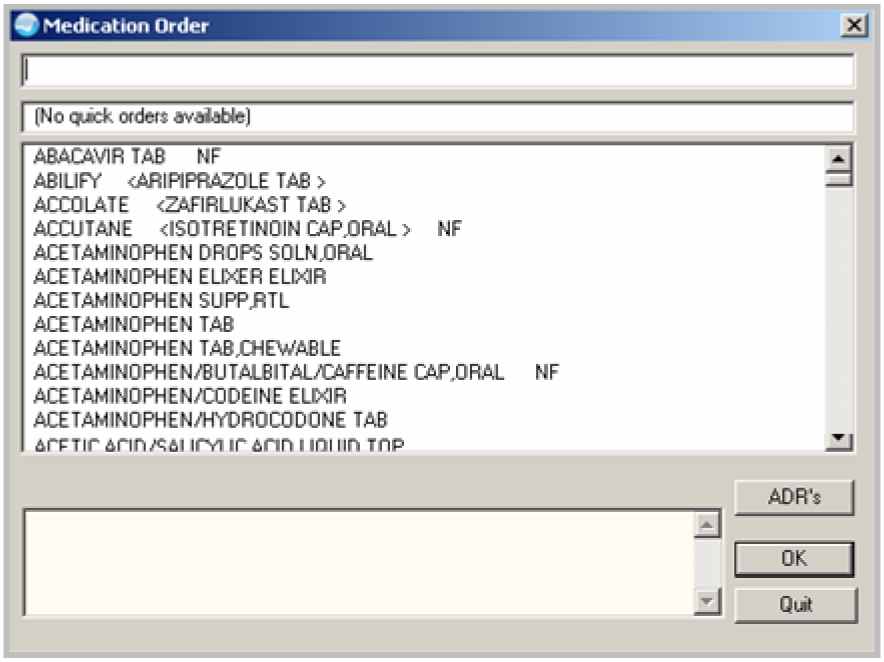


Figure 4-293: Medication Order for Selecting an Outpatient Drug

- For Inpatient status, the list contains medications designed at Unit Dose medications.
- For Outpatient status, the list contains Outpatient Medications (only).
- For Outpatient locations set up to provide Inpatient Medications, the Medications setup for Inpatient use and the Inpatient Order dialog is provided.
- For Outpatient status, the list contains Outpatient Medications (only).
- 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 pop-up.

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.

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 might need to exit the Medication Order dialog, change the provider, and then reenter the Medication Order dialog.

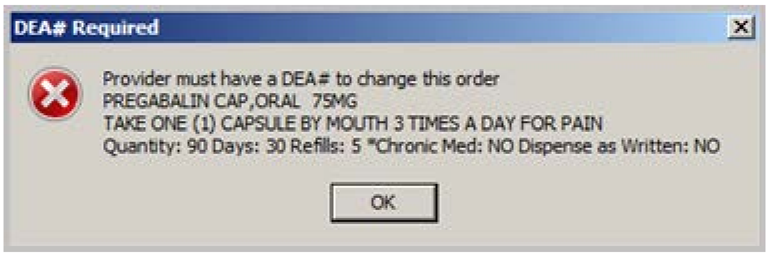


Figure 4-294: DEA# Required Warning Message

4. The ADRs button appears on many of the Medication Order dialoges. Click this button to show the Patient Postings information about the current patient (allergies, as well as Crisis Notes, and so on).

4.10.9 Simple Dose Outpatient Medication Order

To create a simple dose Medication Order:

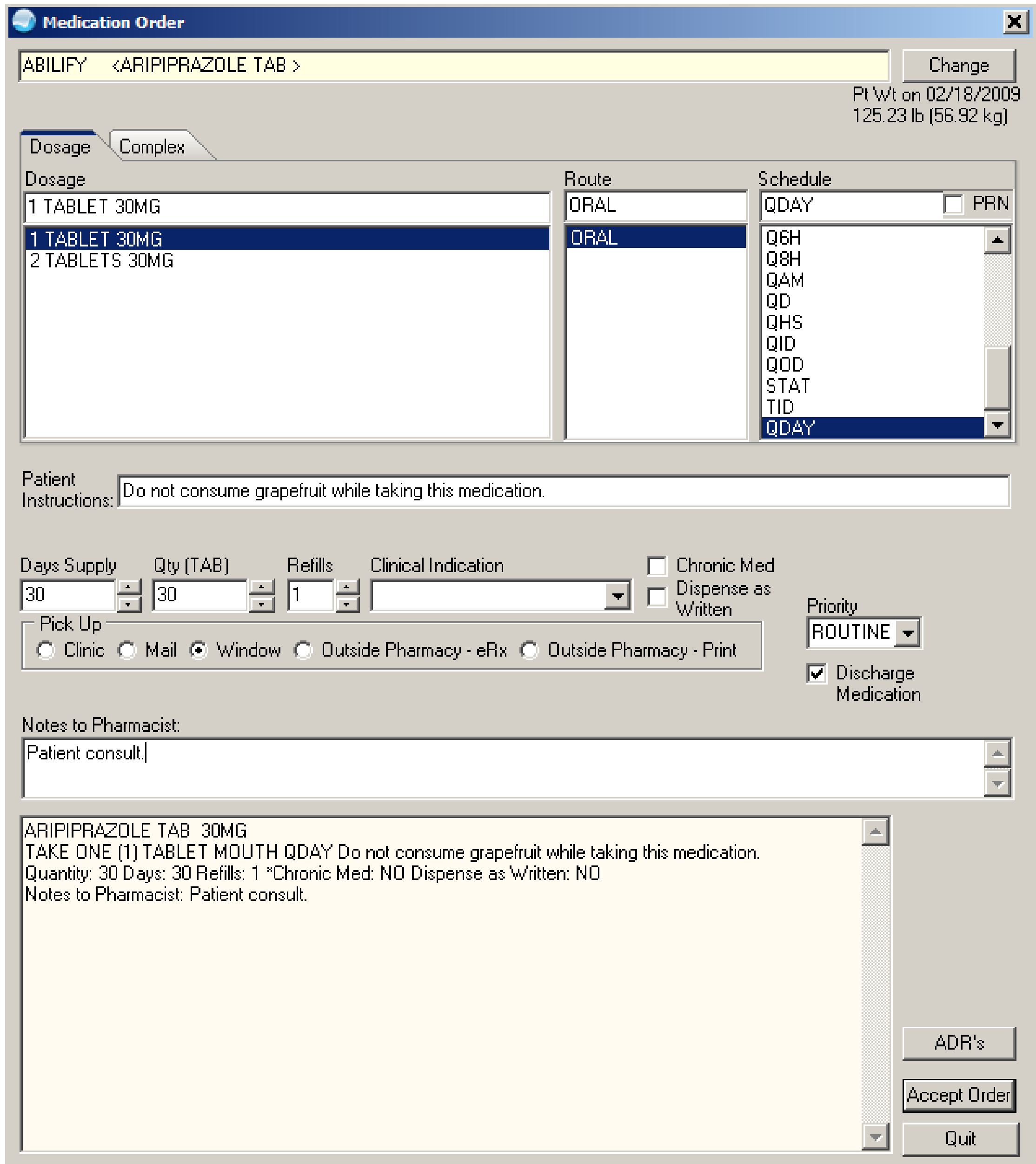


Figure 4-295: Outpatient Medication Order Dialog (Simple Dose)

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 dialoges might have the Display Restrictions/Guidelines link. Click this link to view the Restrictions/Guidelines pop-up.

a. You can print the text of the pop-up by clicking Print.

b. Click Close to dismiss the pop-up.

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.

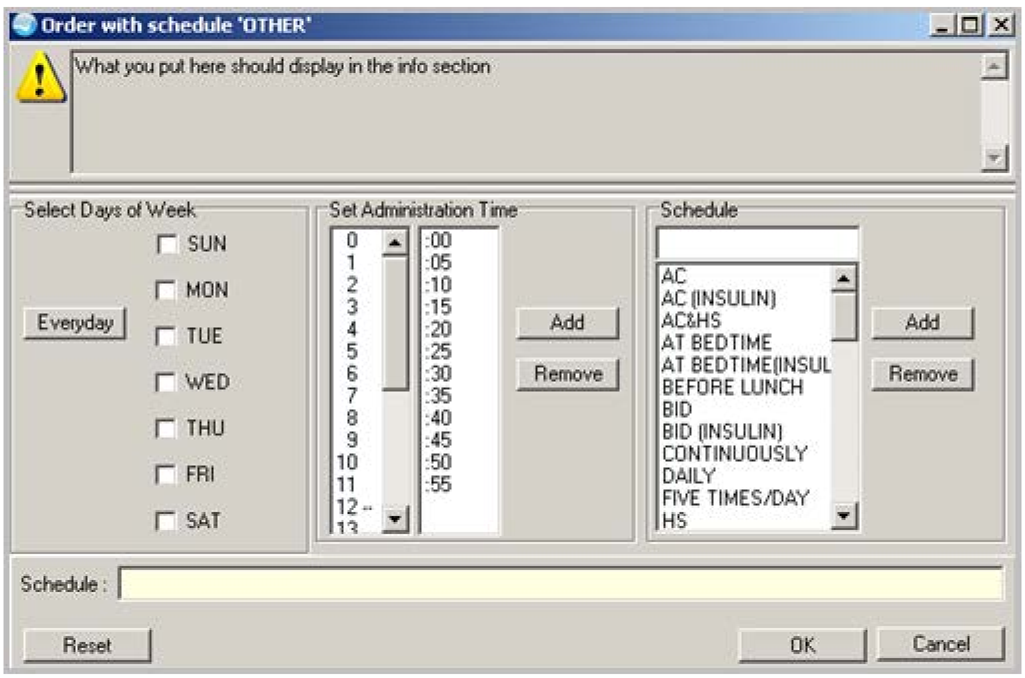


Figure 4-296: Other Dialog

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.

   - If you select OTHER from the drop-down list, the application displays the SNOMED CT Lookup dialog.

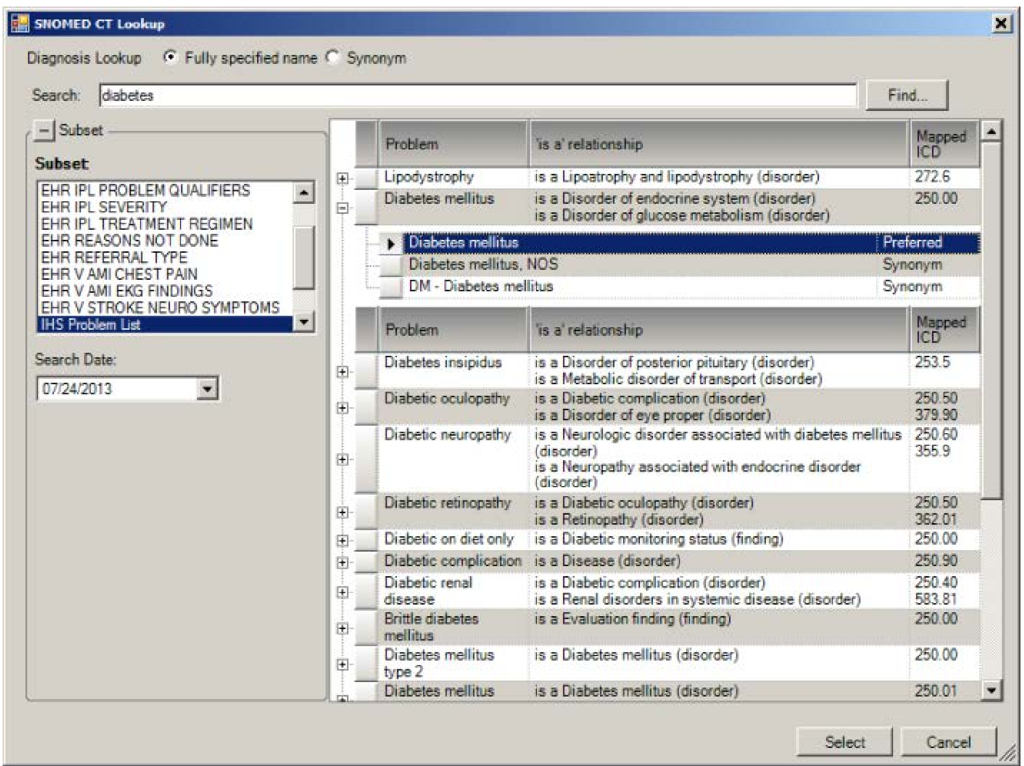


Figure 4-297: SNOMED CT Lookup Dialog

a. In the SNOMED CT Lookup dialog, in the Diagnosis Lookup section, click to select either the Fully specified name of 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.

b. In Search, type the term by which you want to search.

c. In Subset, you can select a subset in which to search, if needed.

d. 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.

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 you selected.

10. Select the Chronic Med check box for medications that are ongoing for chronic medical issues (diabetes, hypertension, etc.).

11. 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).

12. Select the location where the patient should pick up the medication from the Pick Up group box.

13. Use the Outside Pharmacy Print button to generate a paper prescription.

Figure 4-298: Print Option Buttons

After the prescription is signed, the Queue Print becomes active and the flag icon is highlighted.

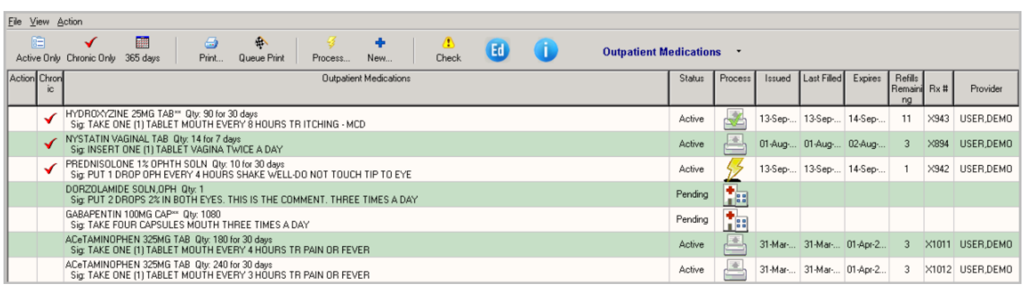


Figure 4-299: Queue Print

a. Click the flag icon to confirm that you are ready to print. A confirmation message appears.

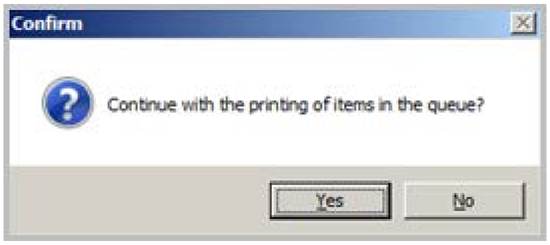


Figure 4-300: Print Confirmation Message

b. Click Yes to select the template and printer for the prescription.

Figure 4-301: Prescription Print Template Dialog

c. Sites can configure their own prescription formats. In the case above, since one of them is a narcotic, a different prescription format may have been created at the site for that type of prescription.

14. 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 4-302: Electronic Option Button and Pharmacy Field

15. 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.

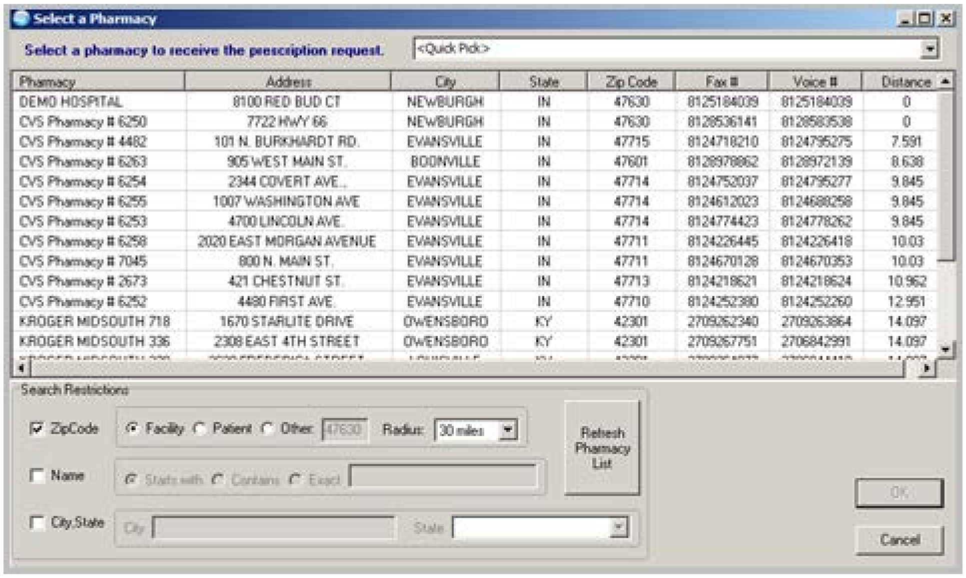


Figure 4-303: Select a Pharmacy Dialog

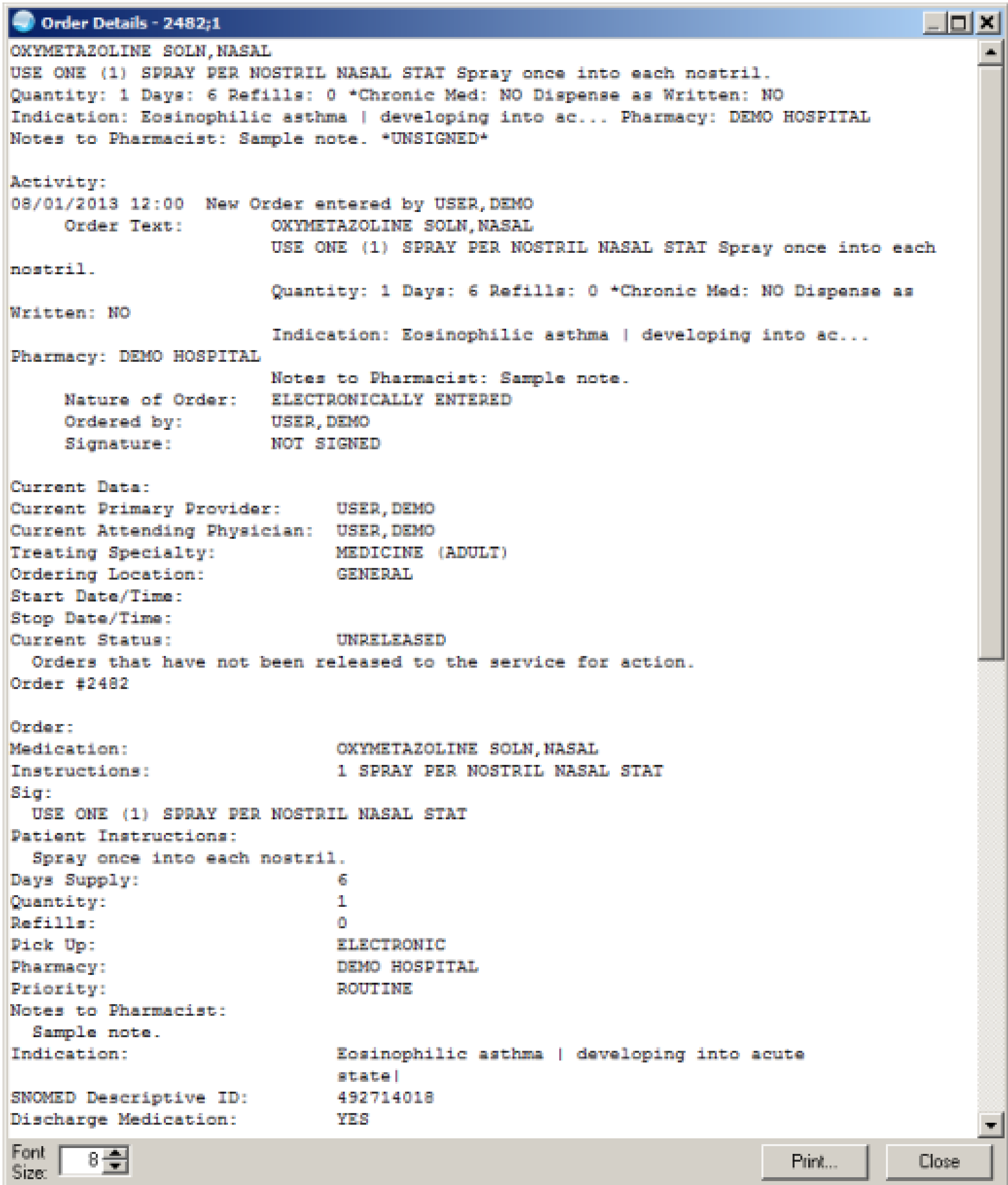
This dialog pulls entries from the new APSP PHARMACY LIST file based on a reference zip code, which can be that of the originating facility, the patient, or a manually entered one, and a defined radius.

You can sort each column by clicking on 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 4-304: Medication Details Showing Electronic Transfer

16. 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.

17. 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.

18. 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 4-305: Unable to Save Order Warning Message

19. 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.

20. 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.

21. There may be other information for you to complete on the medication order.

22. Click Accept Order.

23. 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.

4.10.10 Complex Dose Medication Order

Make sure you are on the Complex tab of the Medication Order.

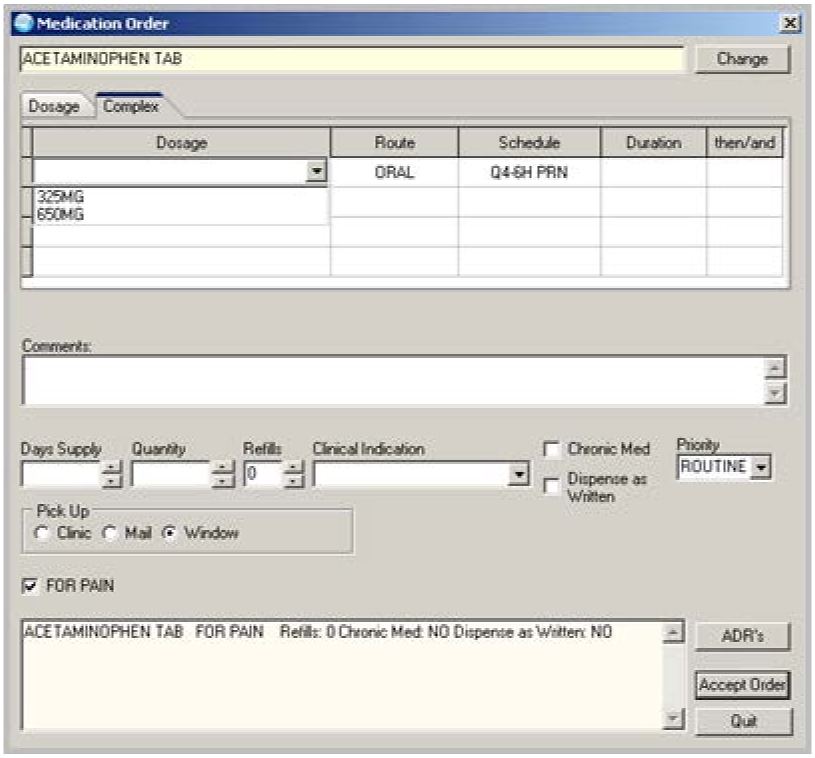


Figure 4-306: Outpatient Medication Order (Complex Dose)

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, you will lose all data on this screen. 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 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.

Figure 4-307: 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.)

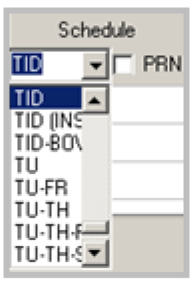


Figure 4-308: Available Selections for Schedule

If a dosing schedule is not defined when the Accept Order button is clicked, the following error message appears:

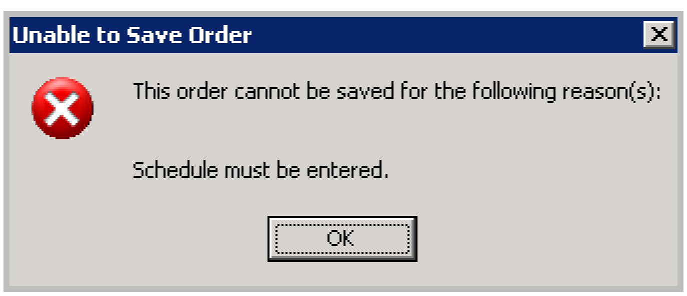


Figure 4-309: Schedule Error Message

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.

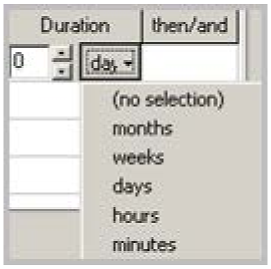


Figure 4-310: Available Selections for Duration

5. Select one of the following (appropriate) modifiers:
   - And
   - Then
   - Except (leave this cell blank for the final dose)
6. 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.

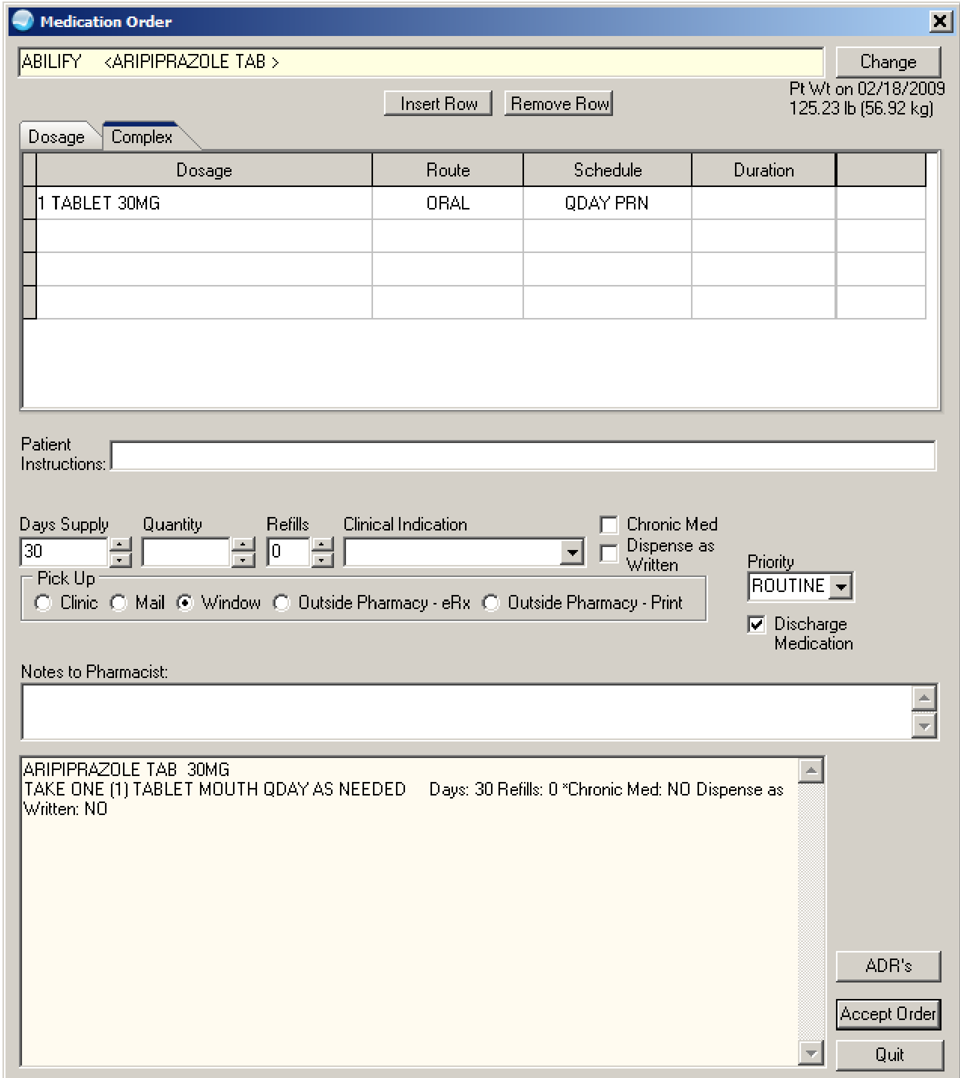


Figure 4-311: Inpatient Complex Dose

The parameter OR ADMIN TIME HELP TEXT displays information on how to change the administration times.

4.10.11 Simple Dose Inpatient Medication Order

To create a simple Inpatient-Medication order:

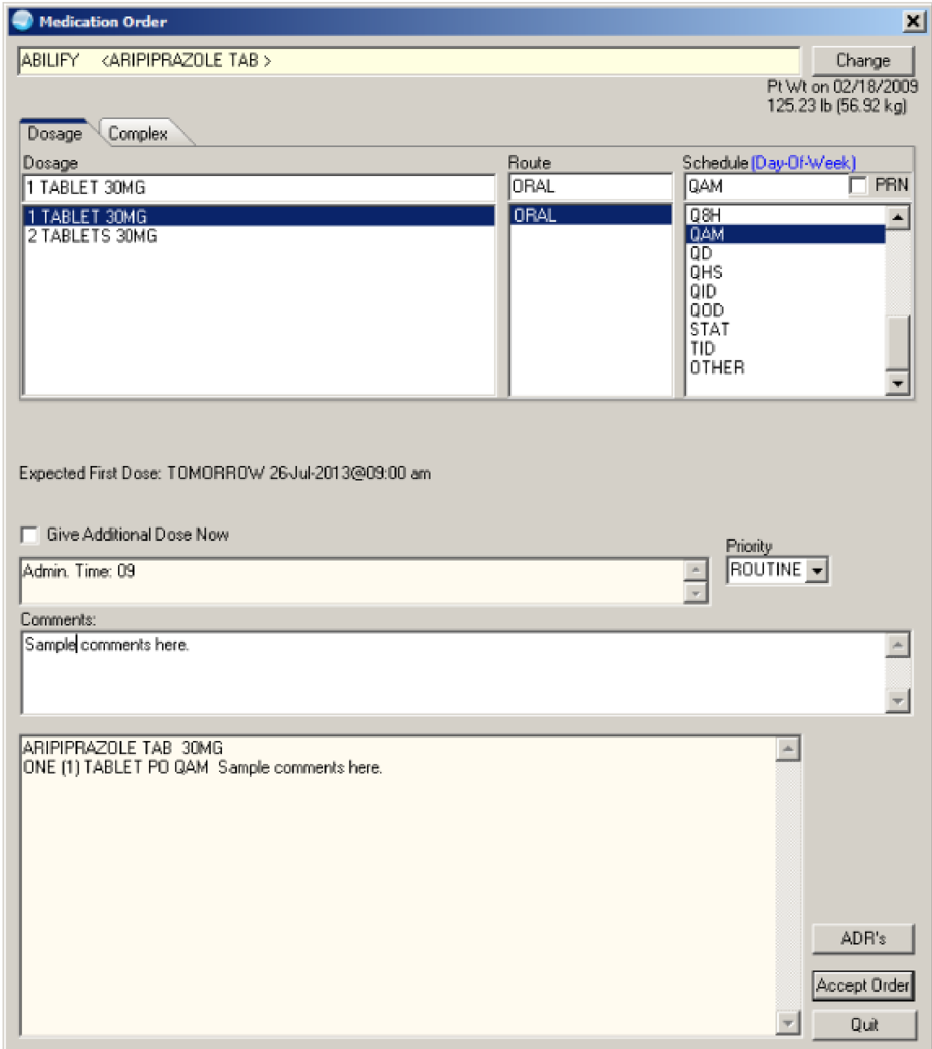


Figure 4-312: Inpatient Medication Order Dialog

1. Change the type of medication by clicking Change (if necessary).

Note:	The patient's weight and the date of the last weighing is shown below the Change button.

2. Various medication order dialoges may have the Display Restrictions/Guidelines link on them. Click this link to view the Restrictions/Guidelines pop-up.

    a. You can print the text of the pop-up by clicking Print.

    b. Click Close to dismiss the pop-up.

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 is created as below:

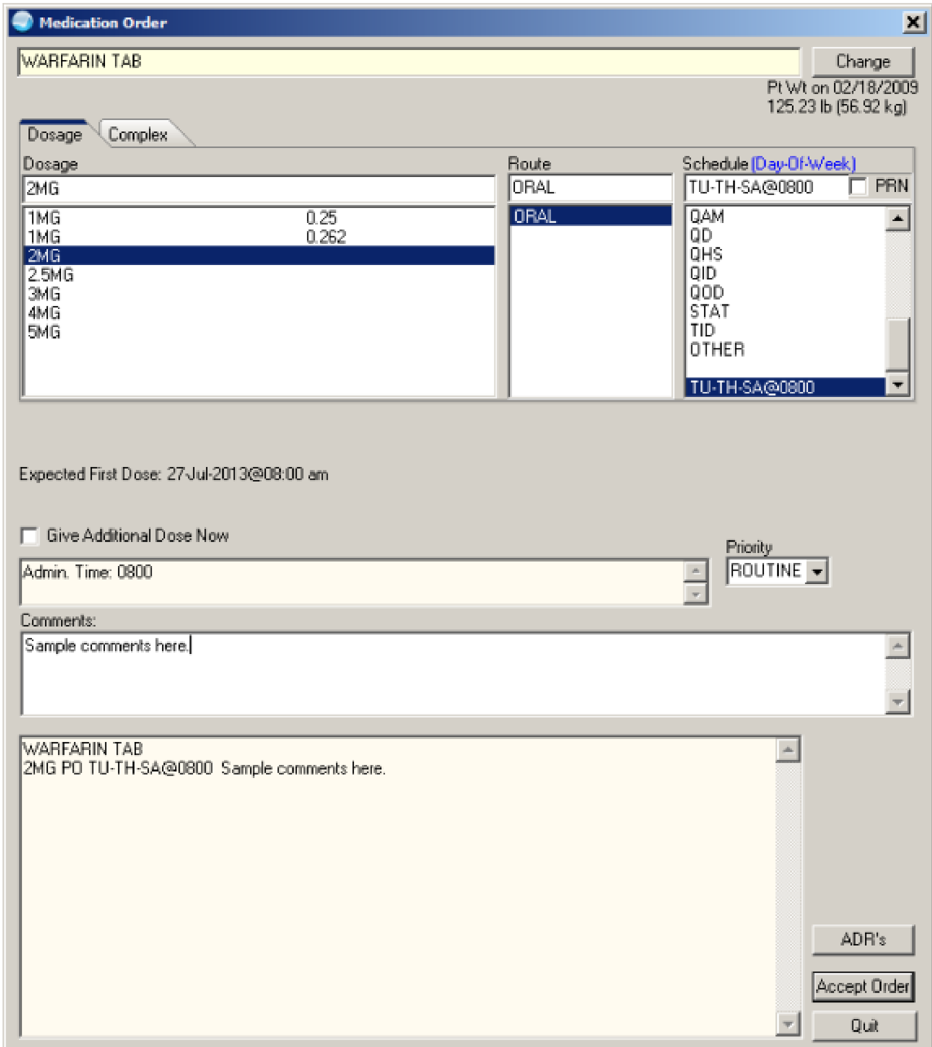


Figure 4-313: Non-Standard Schedule Selected

The following error appears:

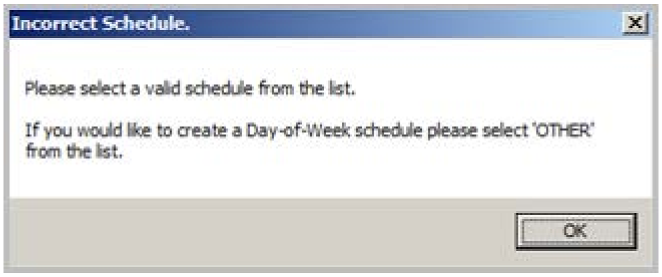


Figure 4-314: Non-Standard Error Message

6. Select OTHER from the schedule list.

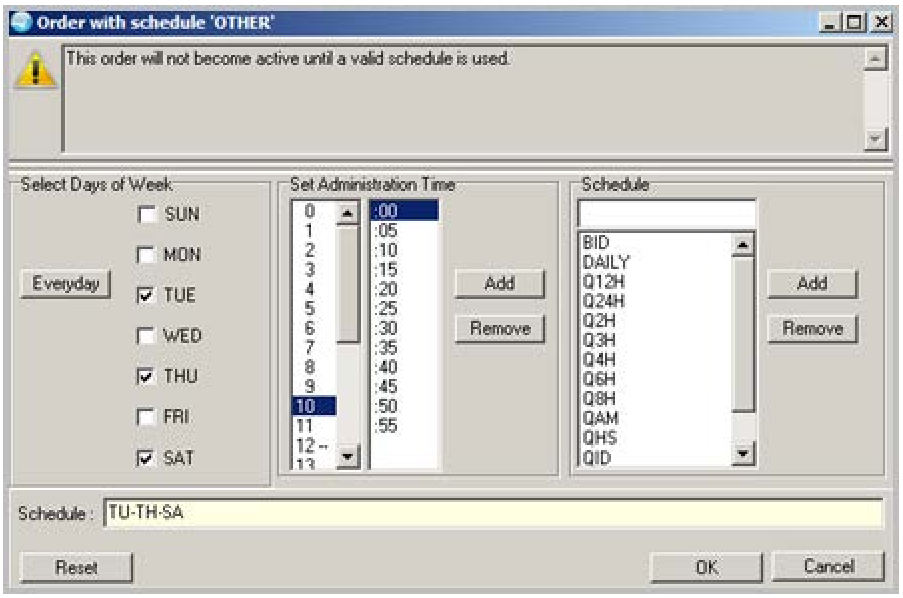


Figure 4-315: Creation a Schedule Dialog

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.

4.10.11.1 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.

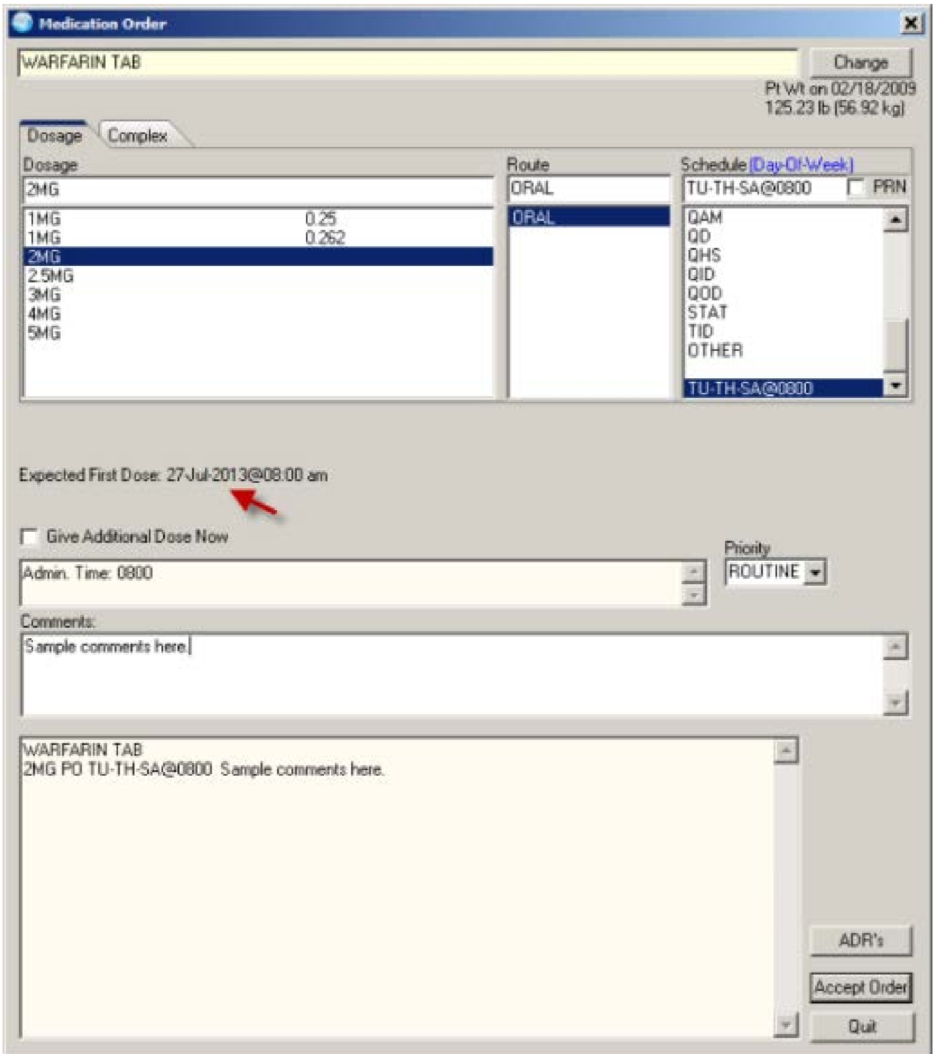


Figure 4-316: Expected First Dose

4.10.11.2 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.

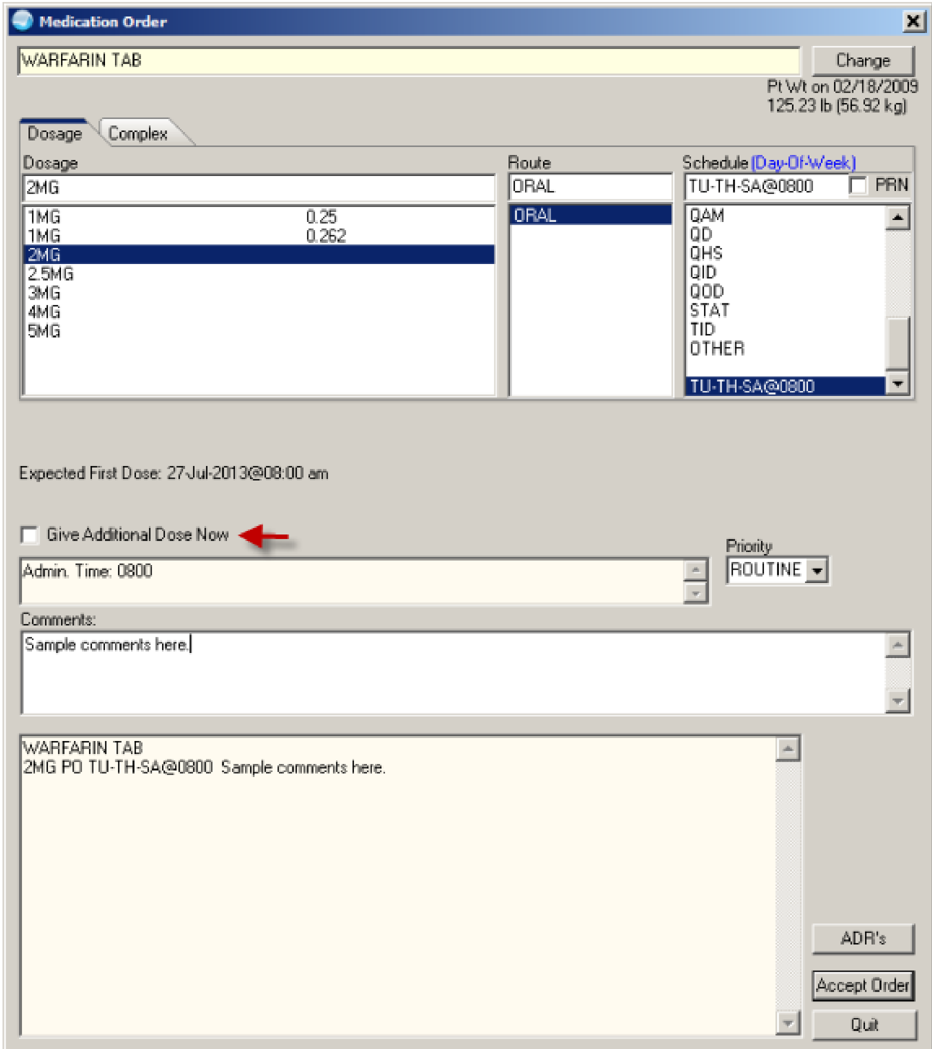


Figure 4-317: Administrative Times

4.10.12 Outside Medications

4.10.12.1 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.

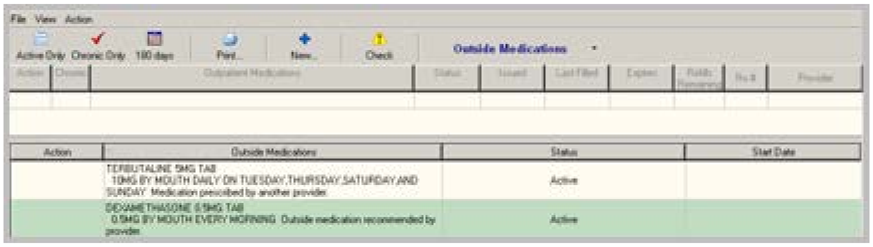


Figure 4-318: Active Outside Medications Group Box

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.

4.10.12.2 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.

4.10.12.3 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.

Also be 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).

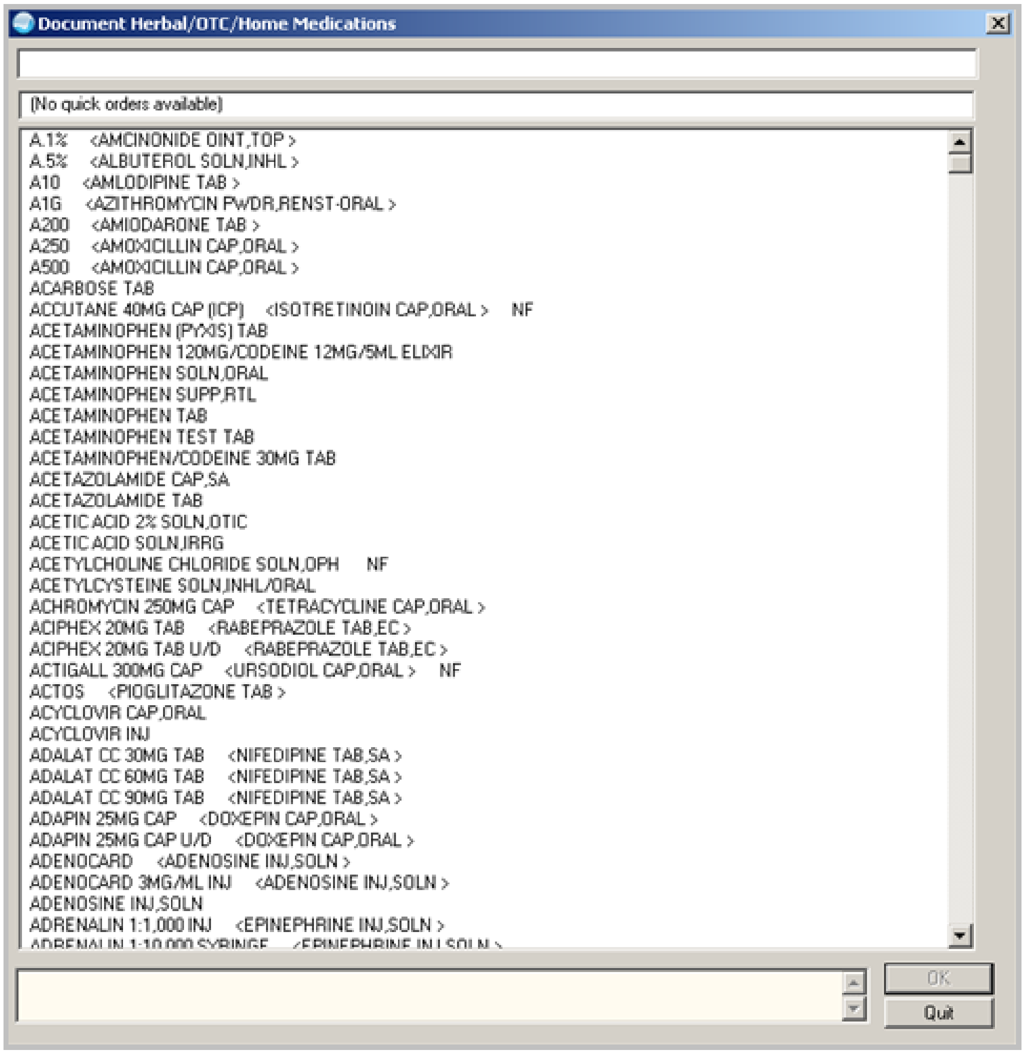


Figure 4-319: List of Drugs for Outside Medications Order

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.

4. Document the outside medication on the Document Herbal/OTC/Home Medications dialog.

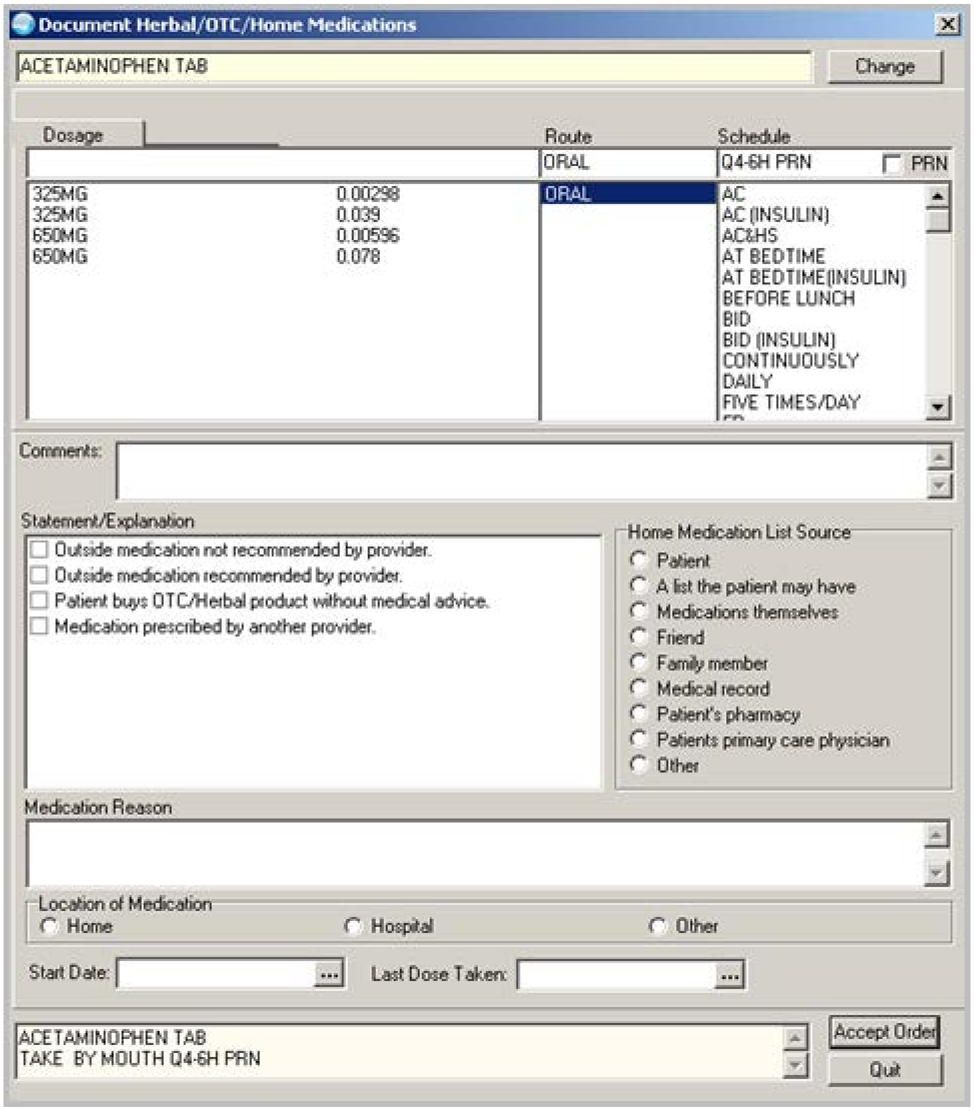


Figure 4-320: Document Herbal/OTC/Home Medications Dialog

Note:	If UNKNOWN MED MISCELLANEOUS was selected on the medication selection window, then the Dosage, Route, and Schedule fields are not required.

5. You can change the medication by clicking the Change button and then select another medication.

6. The check boxes in the Statement/Explanation group box can be configured and controlled by the ORWD NONVA REASON parameter.

7. Complete the relevant sections and click Accept Order. After all outside medications are documented, click Quit.

Important: 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.

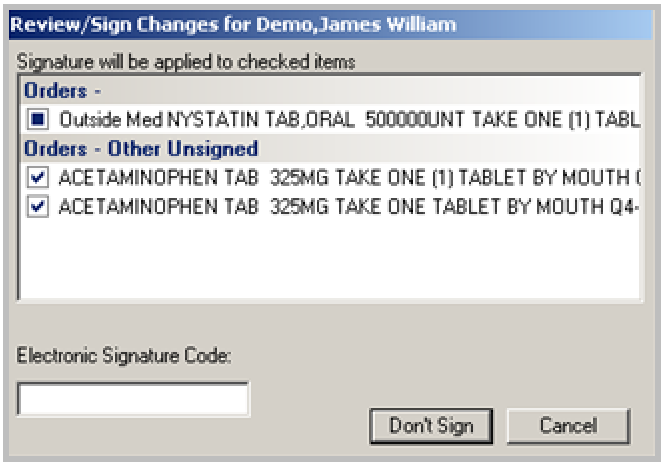


Figure 4-321: Electronic Signature Showing Outside Medications

4.10.12.4 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 pop-up. See Details for more information about this pop-up.

4.10.12.5 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.

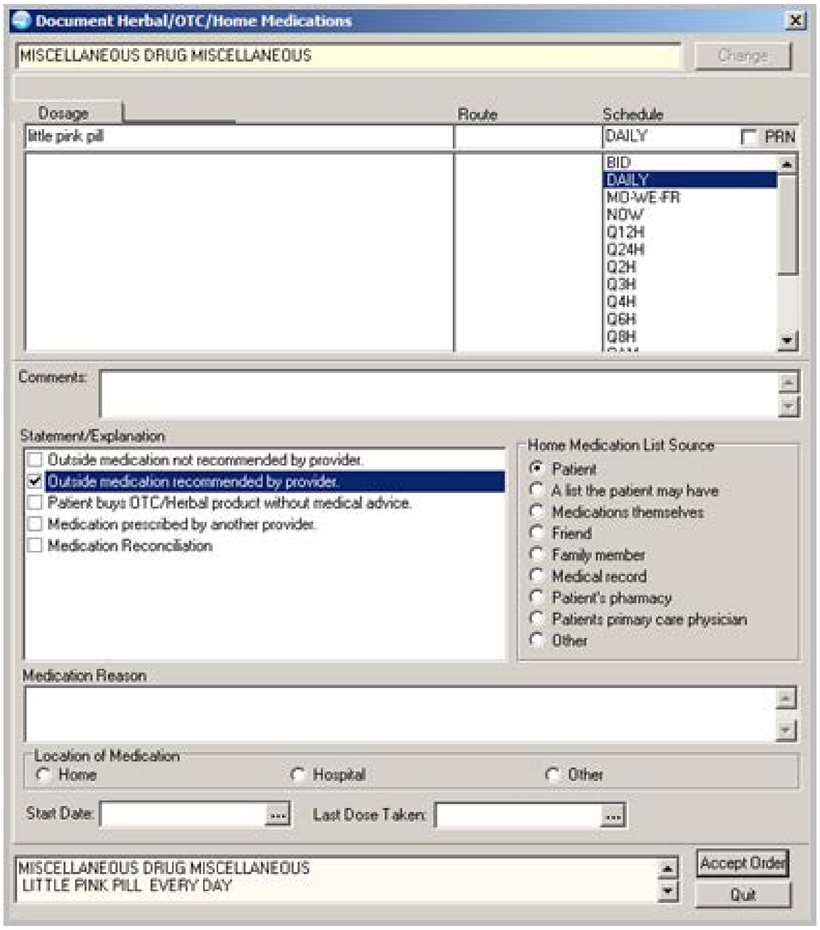


Figure 4-322: Miscellaneous Drug Dose Form

3. The medication and its description is then entered in the Dosage field.

4. Click Accept Order.

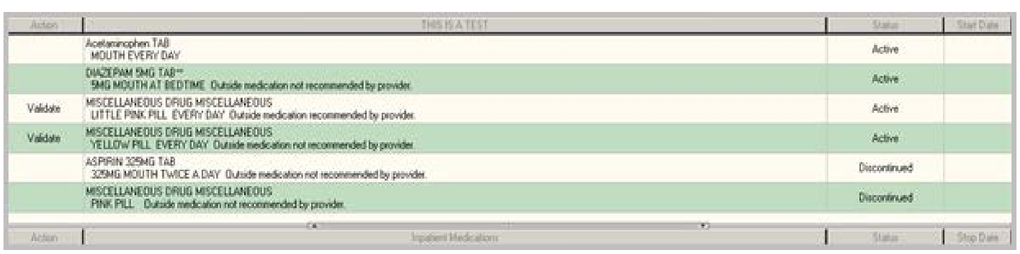


Figure 4-323: Unknown Medication for Validation

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.

4.10.12.6 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.

4.10.12.7 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.

4.10.13 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).

4.10.13.1 Active Only

The Active button appears on Outpatient, Inpatient, and Outside Medication group boxes.

Figure 4-324: 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.

4.10.13.2 Chronic Only

The Chronic Only button appears on Outpatient, Inpatient, and Outside Medication group boxes.

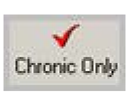


Figure 4-325: Chronic Only Button

Click the Chronic Only button to change the display to show only chronic medications for the current patient (applies to Outpatient medications only).

4.10.13.3 Restrict Medication Activity

The Restrict Medication Activity button appears on Outpatient, Inpatient, and Outside Medication group boxes.

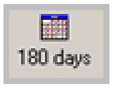


Figure 4-326: Restrict Medication Activity Button

Click the Restrict Medication Activity button to display the Restrict Medication Activity dialog.

Figure 4-327: 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.

4.10.13.4 Print

The Print button appears on Outpatient, Inpatient, and Outside Medication group boxes.

Figure 4-328: 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 4-329: Print Medications Dialog

The Prescription option button displays only after being configured in RPMS. See your Clinical Application Coordinator (CAC) about this configuration.

4.10.13.5 Report Format

This group box determines the format of the output.

Figure 4-330: 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.
- 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.

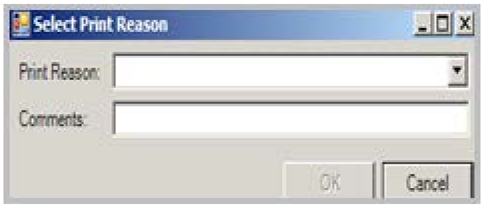


Figure 4-331: Select Reprint Reason Dialog

4.10.13.6 Inclusion Criteria

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.

Then:

1. 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.
2. Click OK on this dialog to output the information to the selected printer. (Otherwise, click Cancel to cancel the print process.)

4.10.13.7 Print Queue

The Print Queue icon is lit when there are items waiting to be printed. When clicked, the Prescription Template and Printer Selection dialog is displayed

Figure 4-332: Queue Print Button

4.10.13.8 Process

The Process button appears on Outpatient group box. This function is NOT available for Outside Medications.

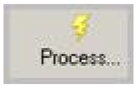


Figure 4-333: Process Button

The Process button enables you to select more than one medication order to process. The process enables you to change, refill, renew, and so on, 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.

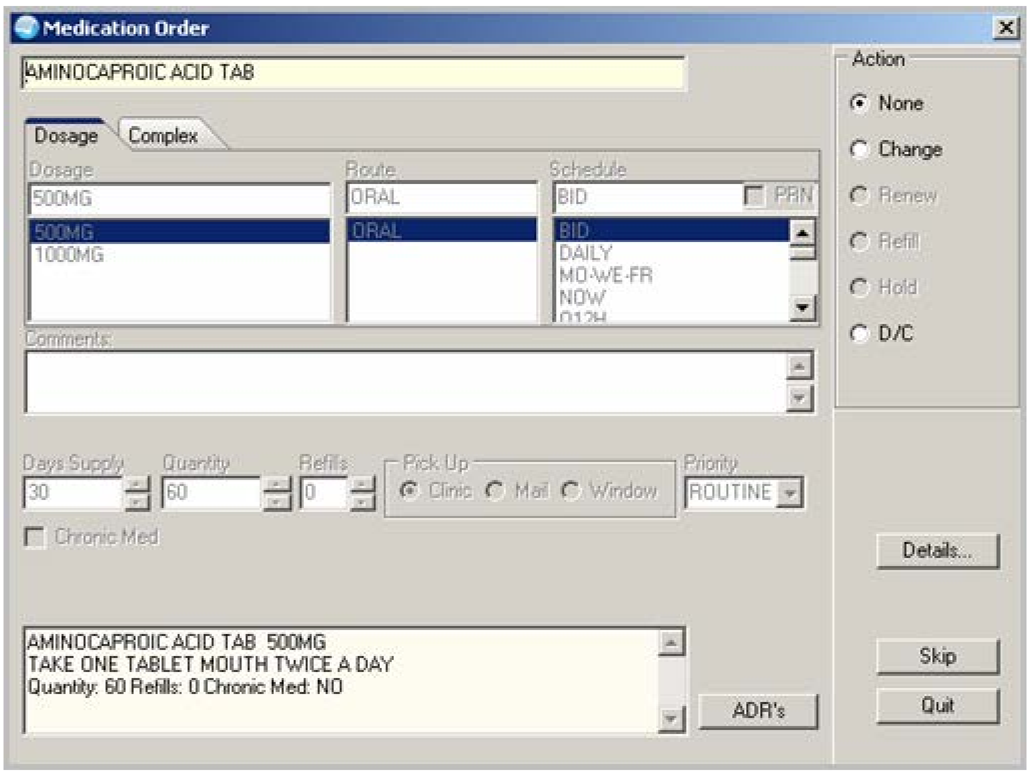


Figure 4-334: Medication Order Showing Process Actions

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 pop-up.

4.10.13.9 New

The New button appears on Outpatient, Inpatient, and Outside Medication group boxes.

Figure 4-335: 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. See Outpatient and Inpatient Medications Orders or Document Outside Medications for more information.

4.10.13.10 Check

The Check button appears on Outpatient, Inpatient, and Outside Medication group boxes.

Figure 4-336: Check Button

Click the Check button to execute on-demand order checking. This causes the Order Checks popup 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 popup in order to continue.

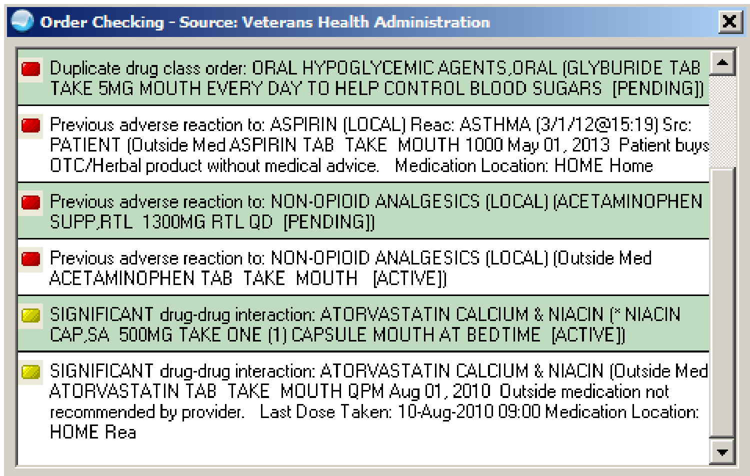


Figure 4-337: Order Checks

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.

4.10.13.11 Clinical Decision Support Button

The Clinical Decision Support button enables you to look up information on a highlighted medication order.

Figure 4-338: Clinical Decision Support Button

- If your site is not licensed for ClinicalKey, the Web Reference Search dialog opens. After selecting a Reference Site and clicking Search, you are taken to the selected Web site for the specified term.
- If your site is licensed for ClinicalKey, a search on ClinicalKey for that medication displays data for the provider.

4.10.13.12 Education Information Button

The Education Information (Ed) button (was (formerly the Information button) enables you to look up information on a highlighted medication order.

Figure 4-339: Education Information (Ed) Button

If an active visit is not selected when the Education Information button is clicked, the following message appears.

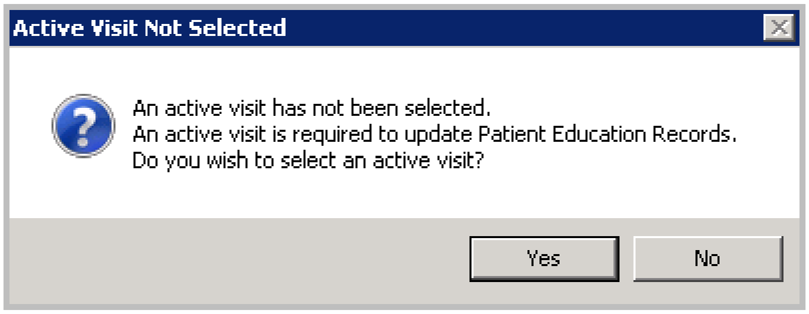


Figure 4-340: Active Visit Not Selected Information Message

Click Yes to select an active visit. If No is clicked, MedlinePlus opens, but the Add Patient Education Event dialog does not open.

Once an active visit and a medication are selected, a search is created on MedlinePlus for that medication and displays data for the provider.

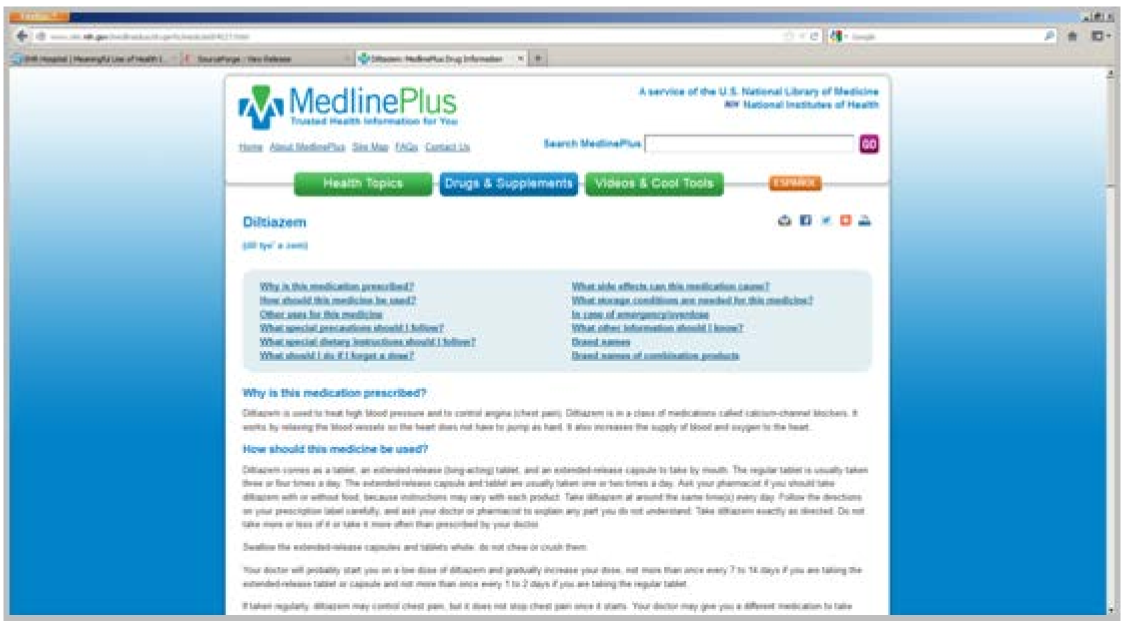


Figure 4-341: MedlinePlus Web Site

Note:	The Add Patient Education Event dialog also opens, where you can add patient education information. Refer to the Patient Education Online Help for details on completing this dialog.

4.10.14 Options on Right-Click Menu

4.10.14.1 Details

This option appears on the Outpatient, Inpatient, and Outside Medication group boxes. Use this option to display the Medication Details pop-up window.

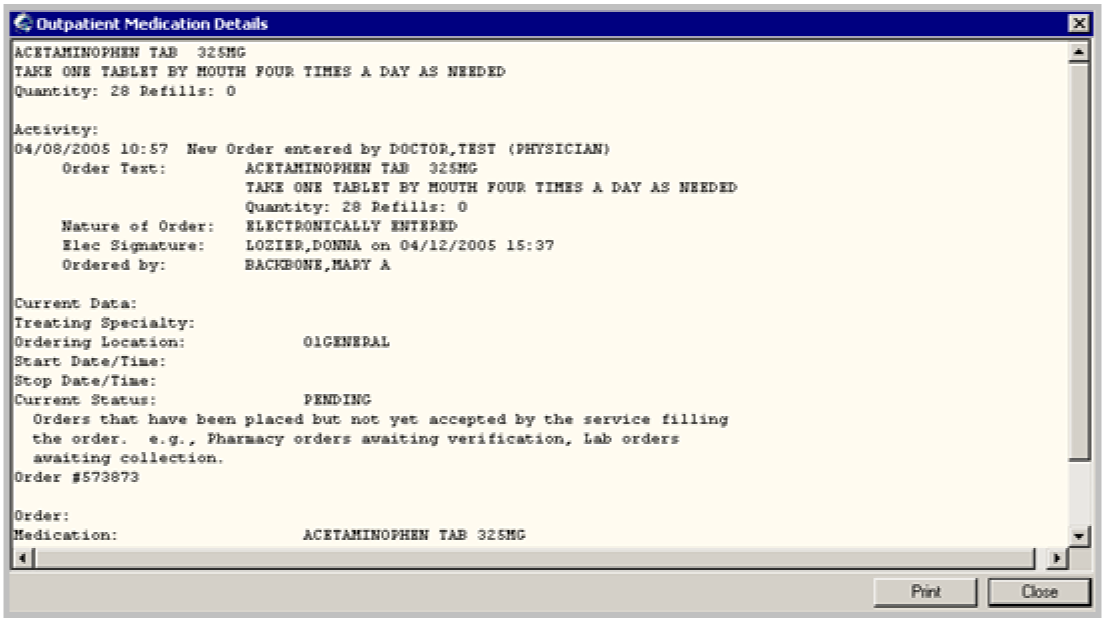


Figure 4-342: Medication Detail Window

4.10.14.2 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 pop-up window displays.

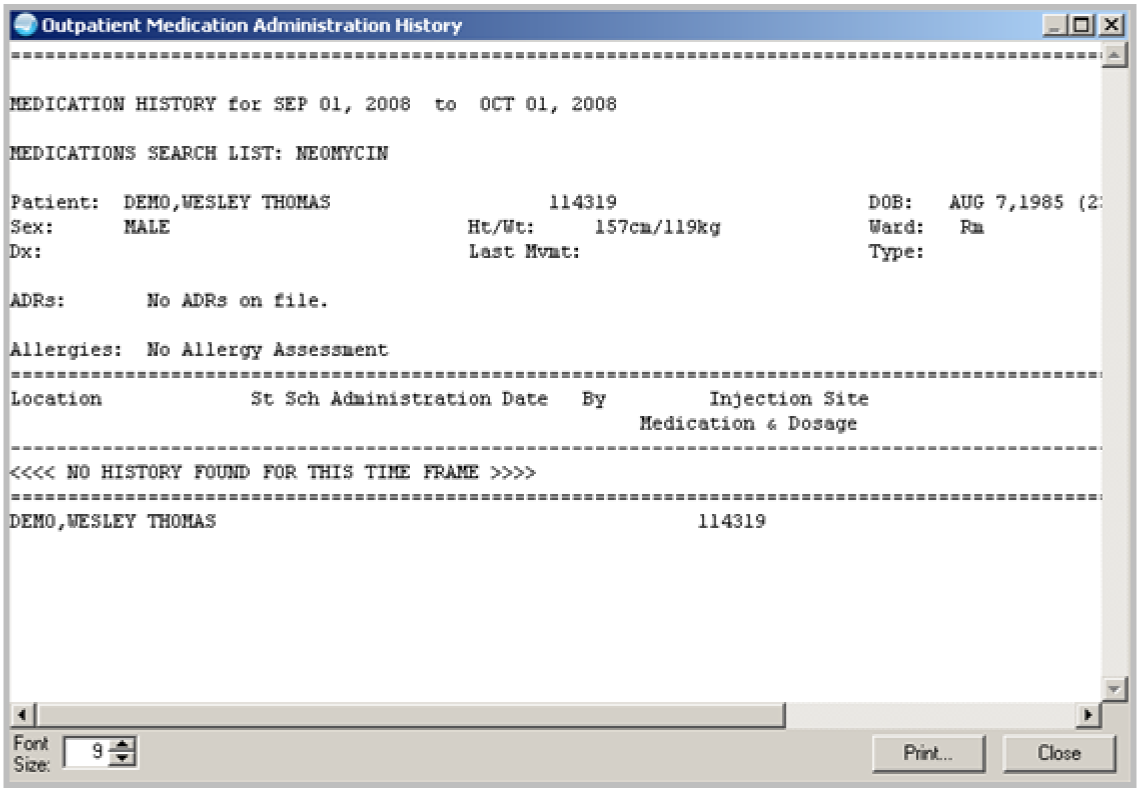


Figure 4-343: Administrative History Pop-Up Window

Each pop-up window that displays by using the Details or Administration History option allows you to change the font size of the text displayed in this pop-up 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 pop-up 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 pop-up 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 pop-up.

4.10.14.3 Medication

This option appears on the Outpatient, Inpatient, and Outside Medication group boxes.

4.10.14.4 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.

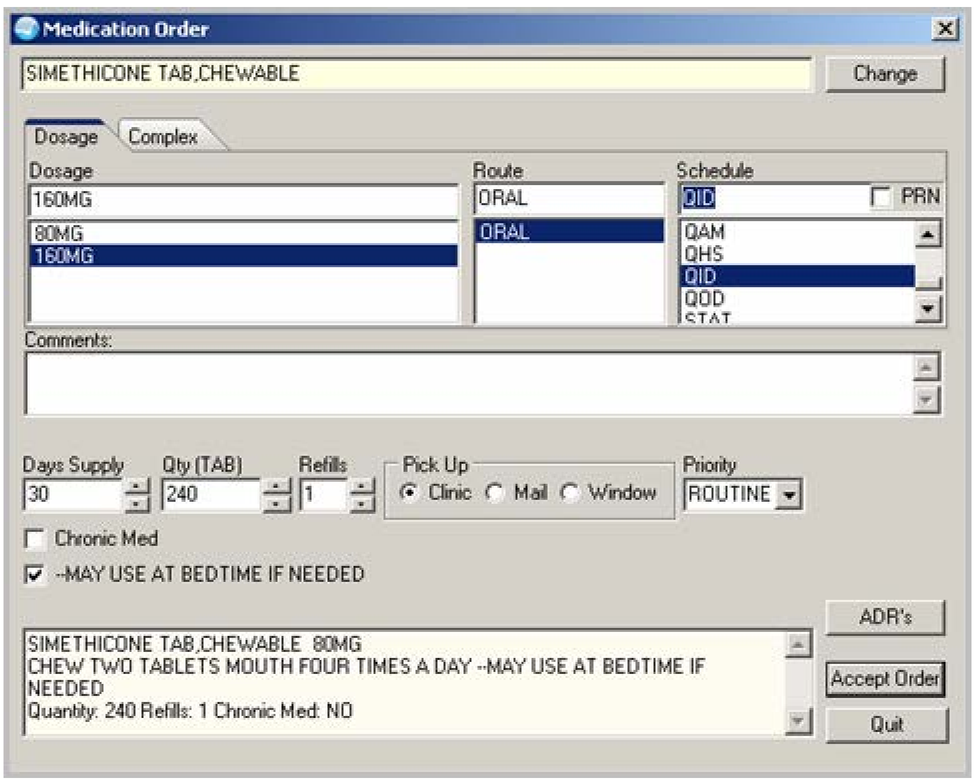


Figure 4-344: Medication Order to Change

3. Complete the changes as appropriate on the Medication Order dialog. See Outpatient and Inpatient Medications 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.

4.10.14.5 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.

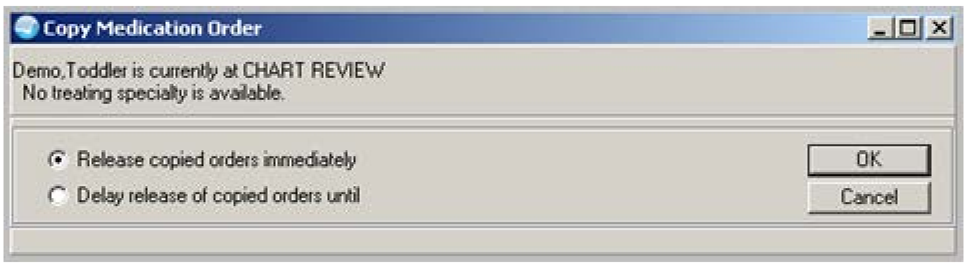


Figure 4-345: Copy Medication Order Dialog

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.

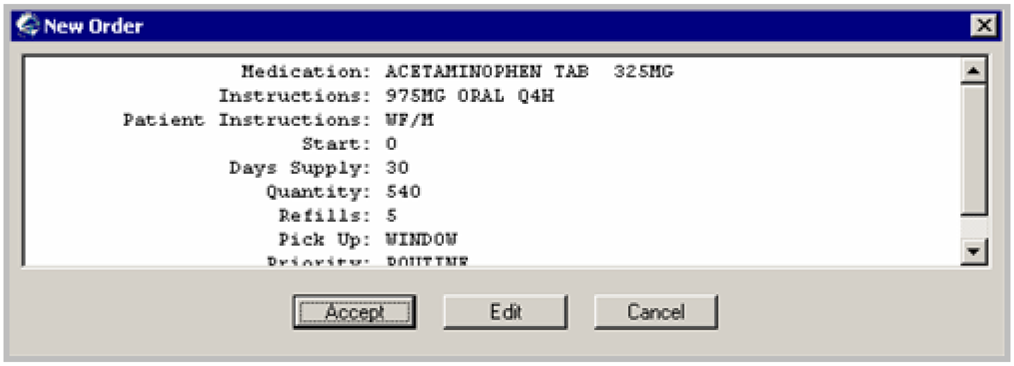


Figure 4-346: New Order Dialog

a. If you click Edit, you get the Medication Order dialog for the particular medication. See Outpatient and Inpatient Medications Orders for completing the dialog.

b. 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.

4.10.14.6 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.

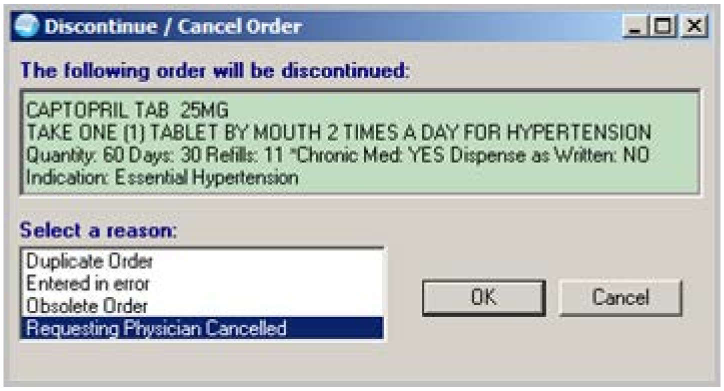


Figure 4-347: Discontinue/Cancel Orders Dialog

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 will have DC in the Action column.

4.10.14.7 Hold

This option appears on the Outpatient and Inpatient group boxes.

Only active orders can be placed on hold. Orders placed on hold continues 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.

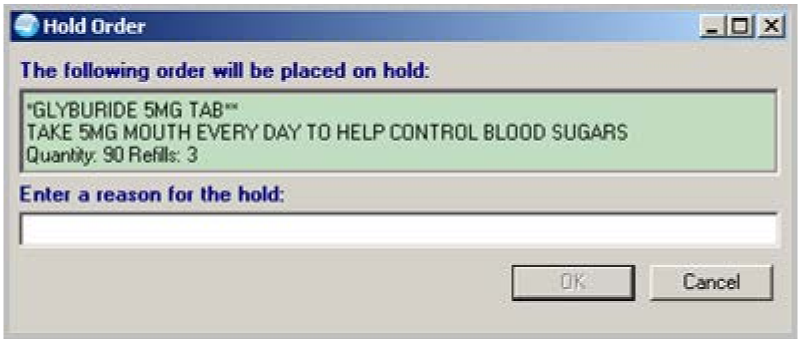


Figure 4-348: Hold Order Dialog

3. Enter a reason in the free text field (required).
4. Click OK.
5. The word Hold appears in the Order column for the selected order and the Status = Unreleased.
6. You must sign the Hold order now or later. After signing, the Status = Hold.
7. 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.

Note: 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 put in place 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.

4.10.14.8 Process

This option appears on the Outpatient and Inpatient group boxes. See Process for more information about this option.

4.10.14.9 Refill

This option appears on the Outpatient Medications group box. You can only refill outpatient medications that are active and have refills available (and NOT a medication that has been renewed).

Important: 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.

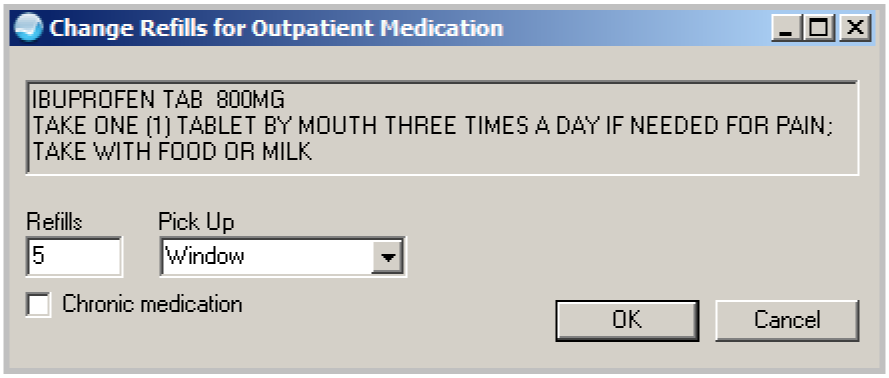


Figure 4-349: Change Refills for Outpatient Medication Dialog

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.

4.10.14.10 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 4-350: 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 4-351: 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:

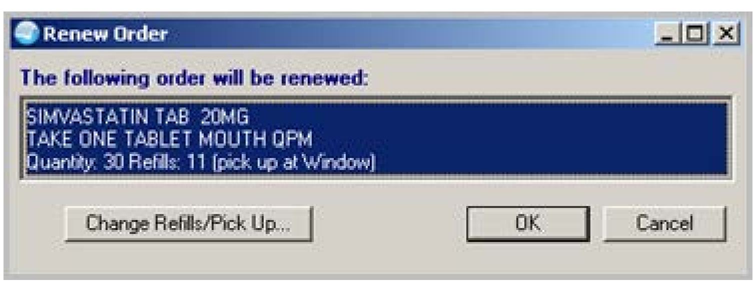


Figure 4-352: Renew Order Dialog with Changed Button Label

   a. Click the Change Refill/Pick Up button to display the Change Refills dialog.

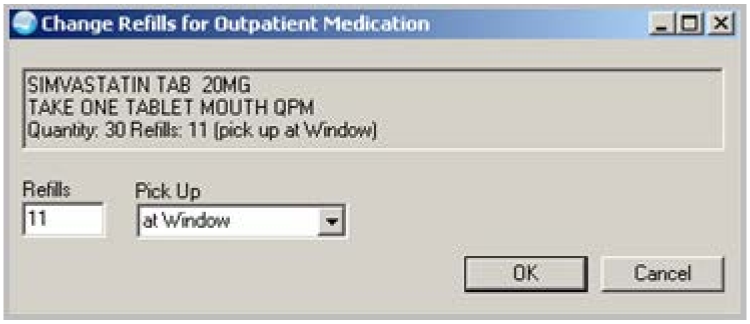


Figure 4-353: Change Refills Dialog

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.

4. Click OK on the Renew Order dialog. (Otherwise, click Cancel.) The specified medication shows Status = Unreleased and Action = Renew.

5. After signing the order, this changes the order to have Status = Pending.

4.10.14.11 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:

1. Select the Outpatient Medication you want to transfer (you can select more than one, if needed).

2. 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.

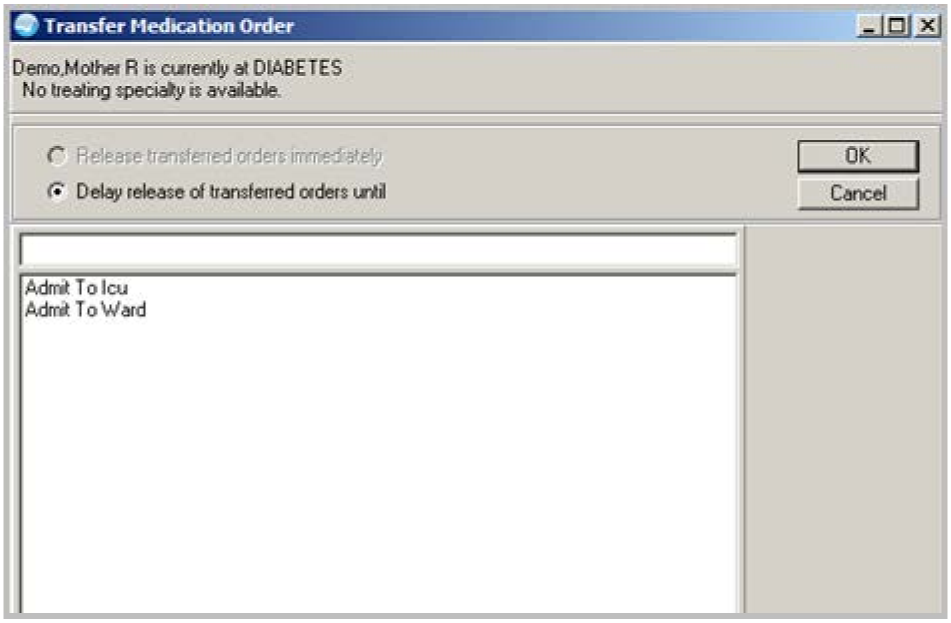


Figure 4-354: Transfer Medication Order Dialog

3. Select one of the options in the lower field, such as Admit to Ward.
4. Click OK to display the Admit Patient dialog.

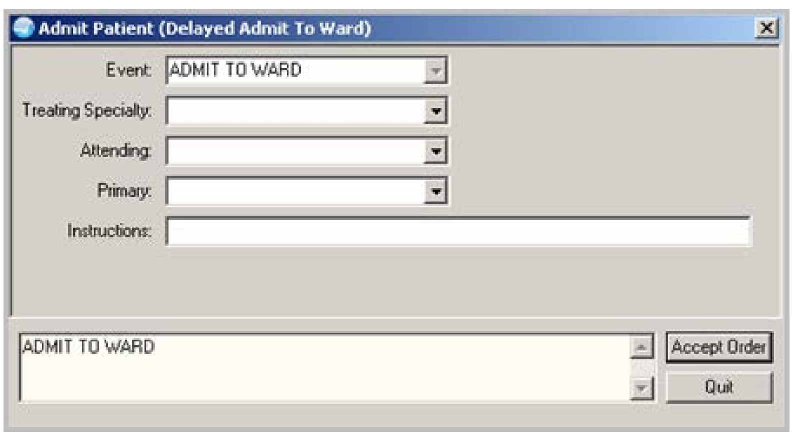


Figure 4-355: Admit Patient Dialog

5. 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.
6. Click Accept Order to display the Medication Order.

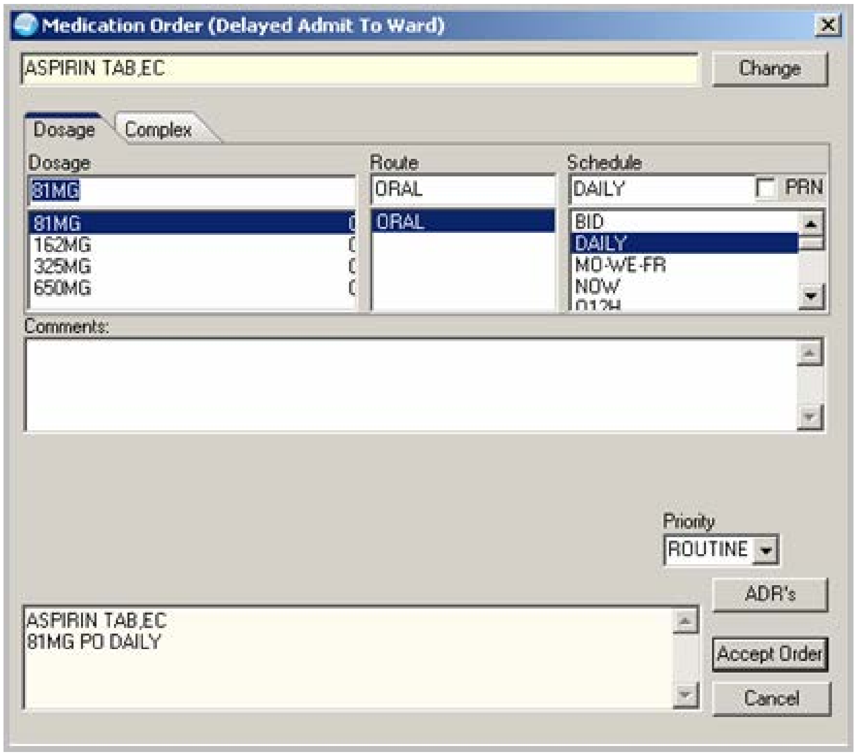


Figure 4-356: Sample Outpatient Medication Order

7. Complete the medication order and click Accept Order. See Outpatient and Inpatient Medications 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 medication selected must have been set up to be an inpatient medication.

   After you sign the order, the Status becomes Pending.

4.10.14.12 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.

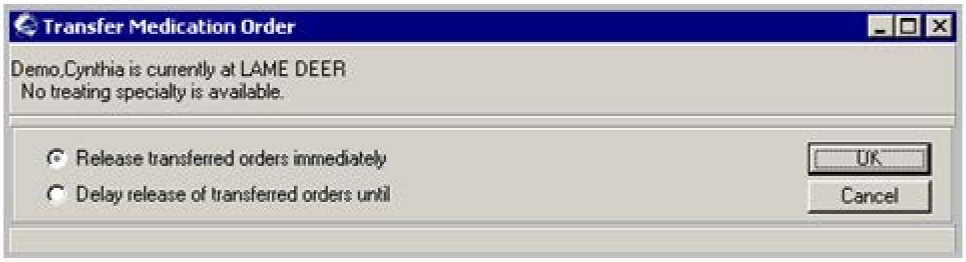


Figure 4-357: Transfer Medication Order Dialog

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.

5. The selected medication order appears in the Outpatient Medications group box with New in the Action column.

6. After you sign the order, the Status becomes Pending.

4.10.14.13 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:

1. 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.

2. Select Chronic Medication → Yes on the right-click menu. The selected medications show a check mark (✓) in the Chronic column.

3. 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.

4.11 Orders

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.

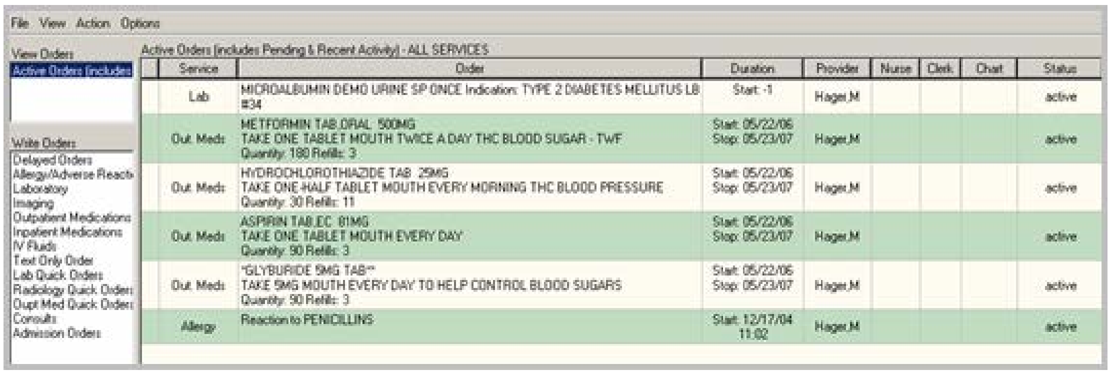


Figure 4-358: Orders Window

The Orders window displays information about each order, such as 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.

4.11.1 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):

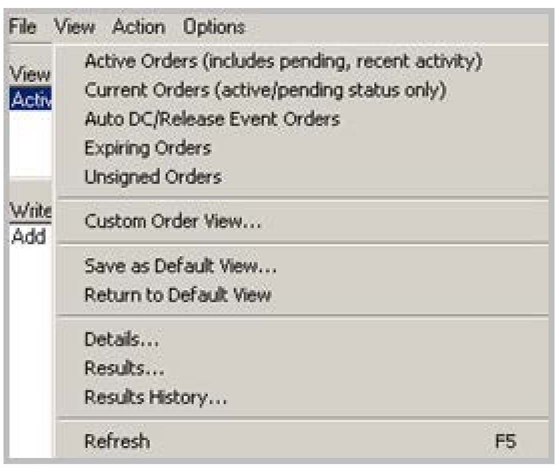


Figure 4-359: View Menu Options

   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.

4.11.1.1 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.

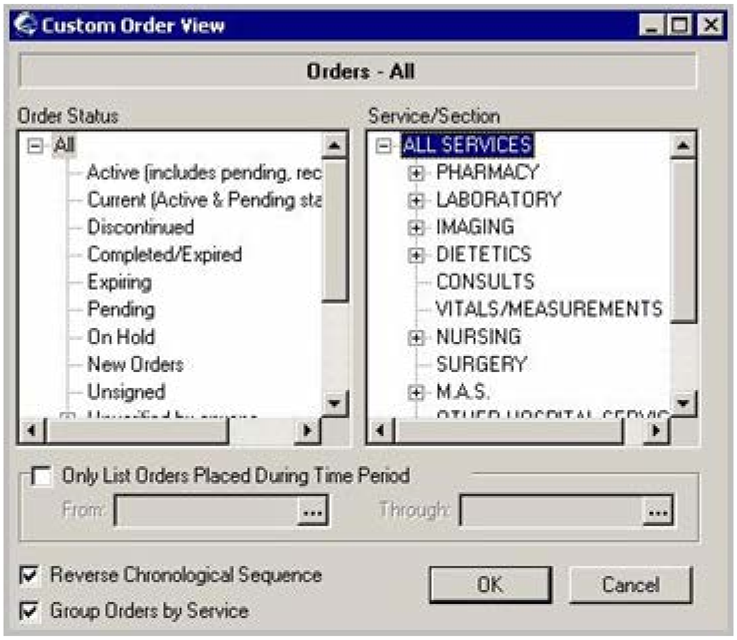


Figure 4-360: Custom Order View Dialog

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.

    The 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 4-361: 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 Clinical Applications Coordinator (CAC) sets the number of hours.

4.11.1.2 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.

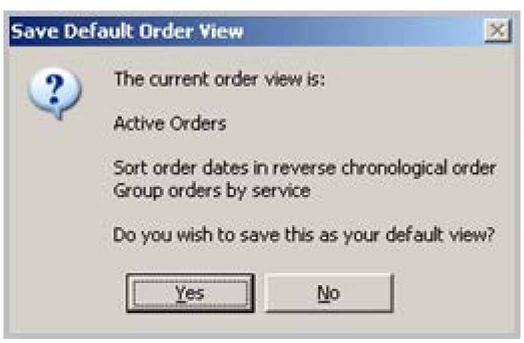


Figure 4-362: Save Default Order View Information Message

3. Click Yes to save the view as your default view. (Otherwise, click No.)
4. If you are in another view on the Orders window, you can return to your default view by selecting View → Return to Default View.

4.11.2 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 pop-up.

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. Refer to the online Help for the Medications window for more information.

4.11.2.1 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).

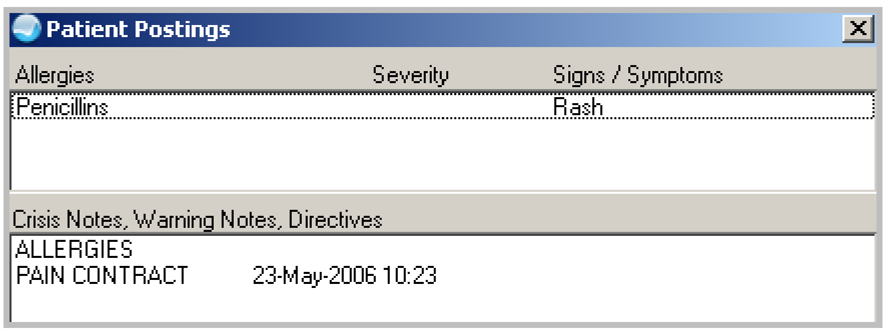


Figure 4-363: Patient Postings Information

4.11.2.2 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.

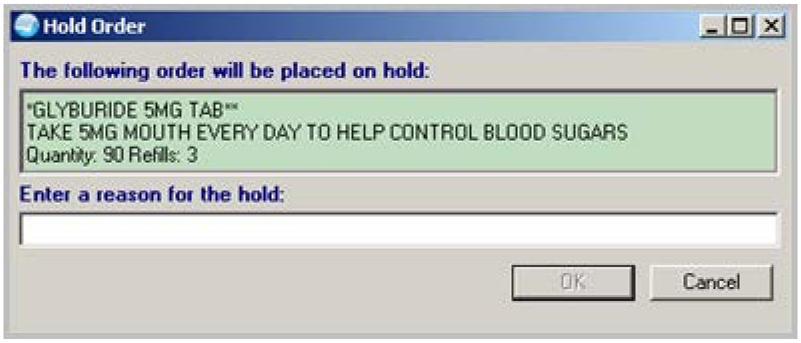


Figure 4-364: Hold Order Dialog

The Enter a reason for the hold field is a required, free-text field.

3. Click OK.

The pharmacy order now has Status = Hold on the Orders window. You can sign the order now or later.

4.11.2.3 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.

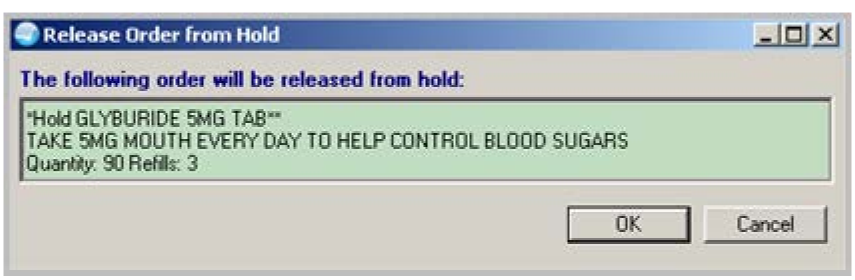


Figure 4-365: Release Order from Hold Dialog

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.

4.11.2.4 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 above) 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. To renew a medication:

1. Make sure a visit is selected.

2. Select the pharmacy order to be renewed. You can select more than one order.

3. Select Action → Renew (or select Renew on the right-click menu) to display the Renew Orders dialog.

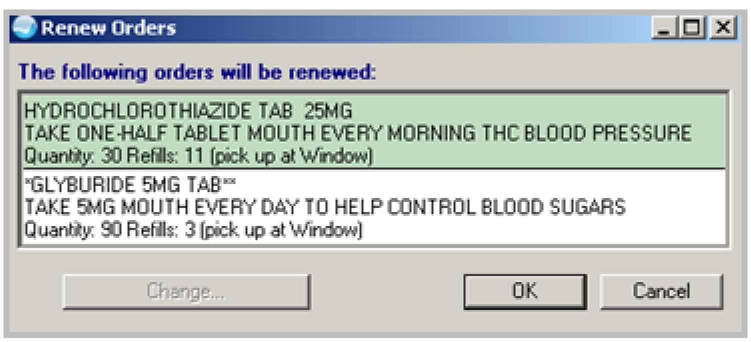


Figure 4-366: Renew Order Dialog for Two Orders

4. To change the Refill/Pick Up information, select the order's text in the Renew Orders dialog and the button label changes:

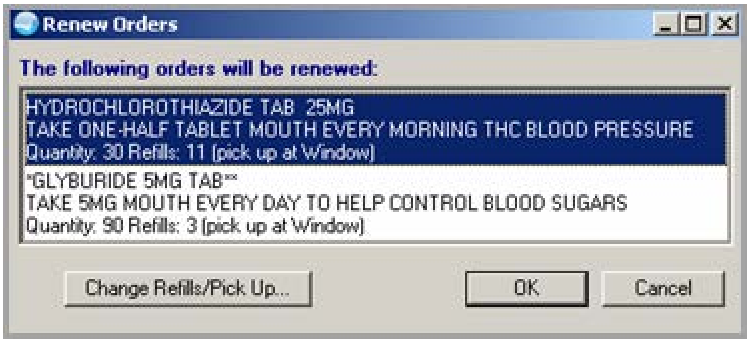


Figure 4-367: Renew Order with Change Refills/Pick Up Button

5. Click the Change Refills/Pick Up button to display the Change Refills dialog.

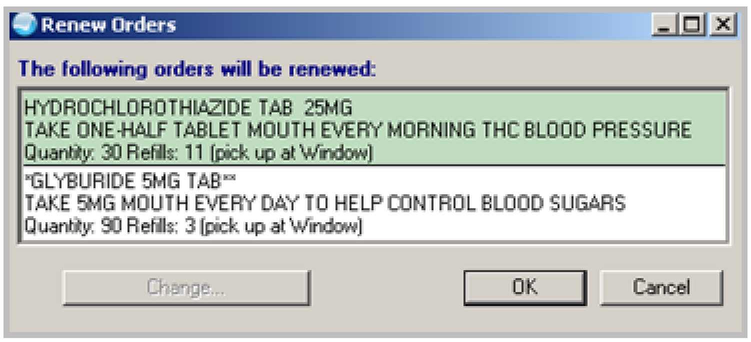


Figure 4-368: Change Refills Dialog

6. You can manually change the number of refills and can change the Pick Up information by selecting from the drop-down list.

7. Click OK on the Change Refills dialog to return to the Review Orders dialog.

8. You can repeat the above 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 the Using the SNOMED CT Lookup Dialog if the Other option is selected in the Clinical Indication field.

9. 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 = Renewed.

4.11.3 Ordering Infusions

IV infusions can only be ordered on the Orders tab.

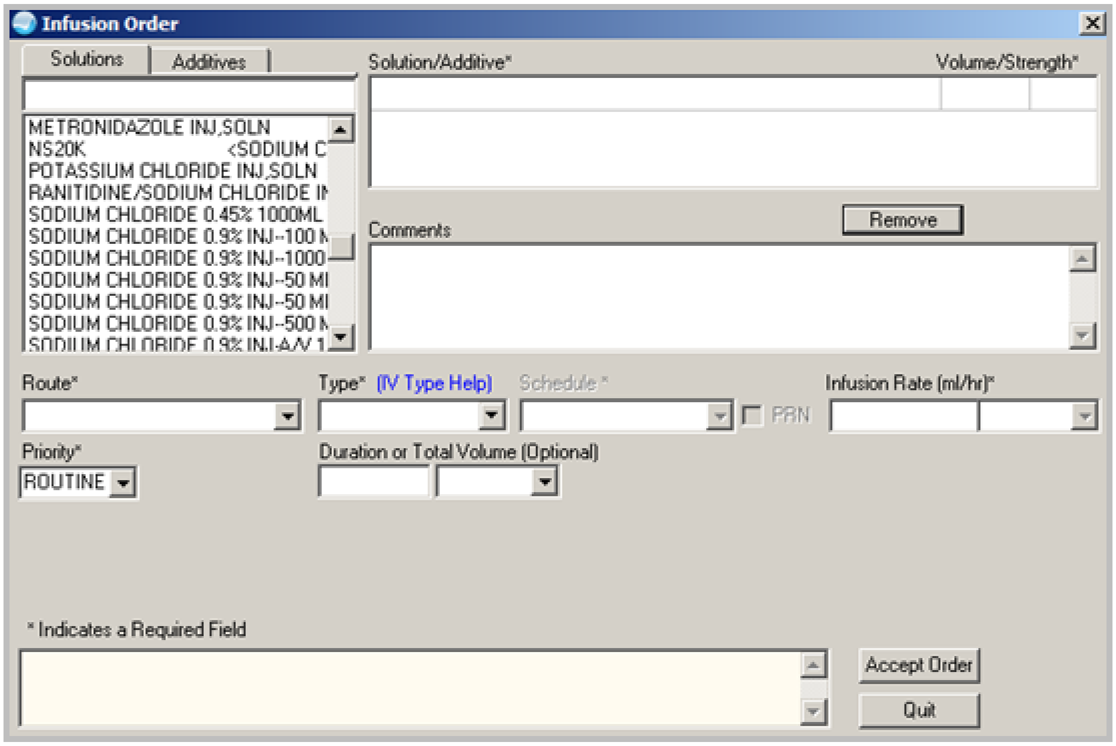


Figure 4-369: Infusion Dialog

1. 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.

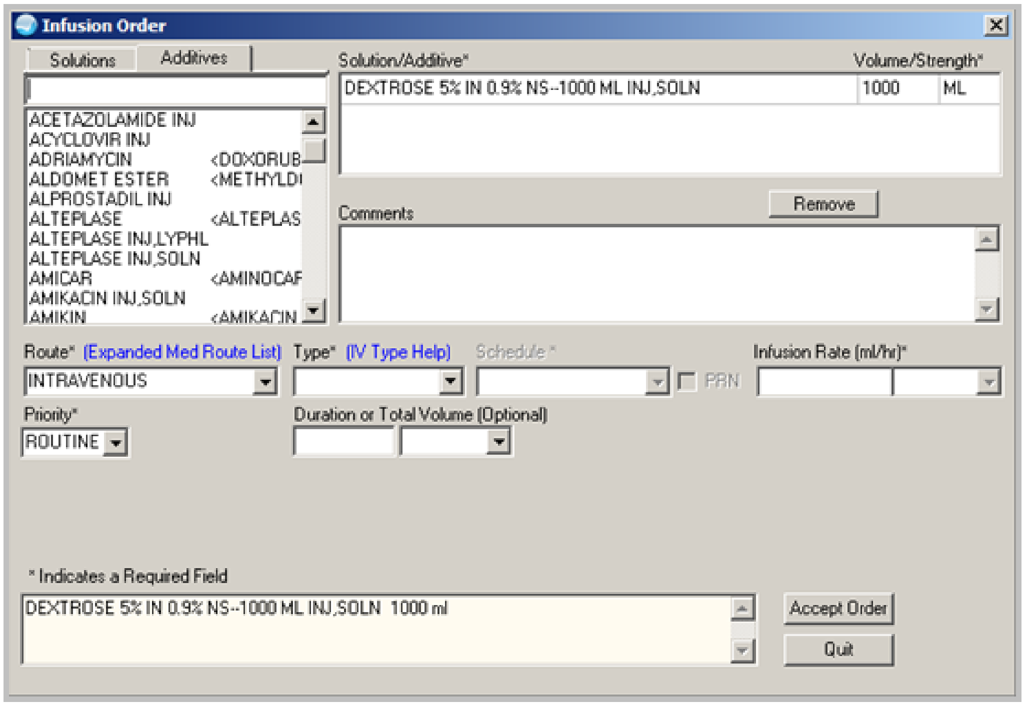


Figure 4-370: Solution Selected

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.

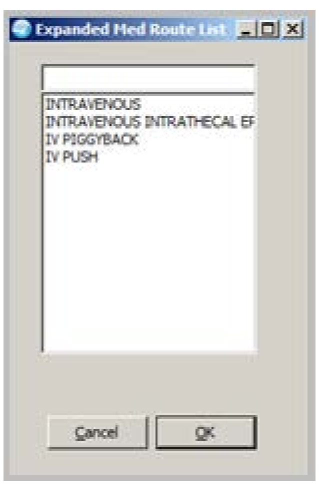


Figure 4-371: Other IV Med Routes

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.

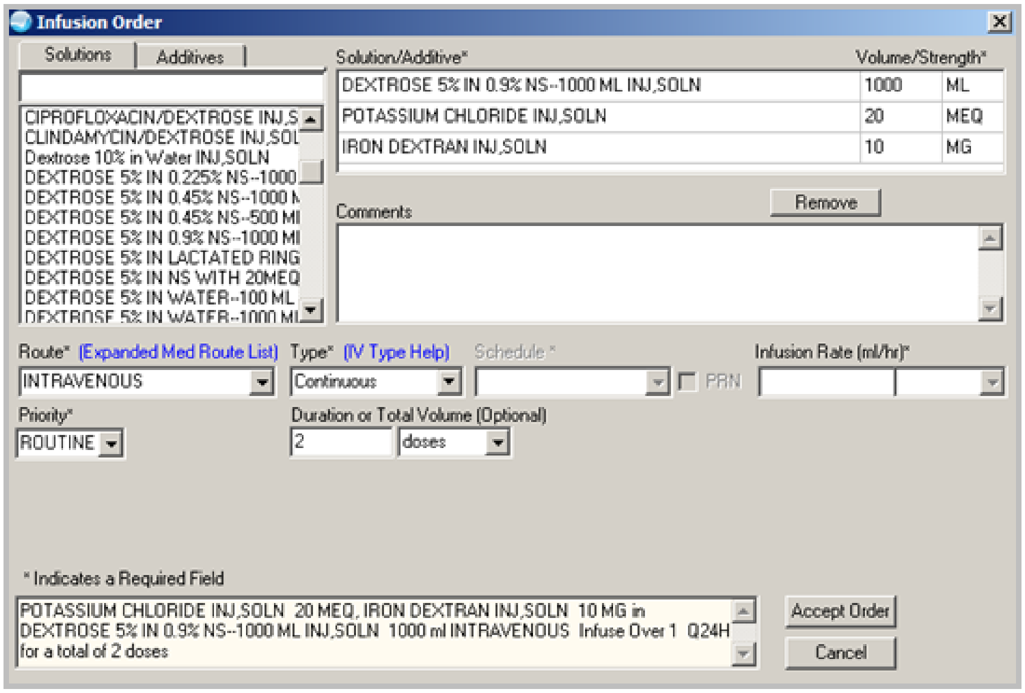


Figure 4-372: Continuous Type

- The Duration or Total Volume fields are optional.
- The Comments field is optional for comments to the pharmacist or nursing staff.

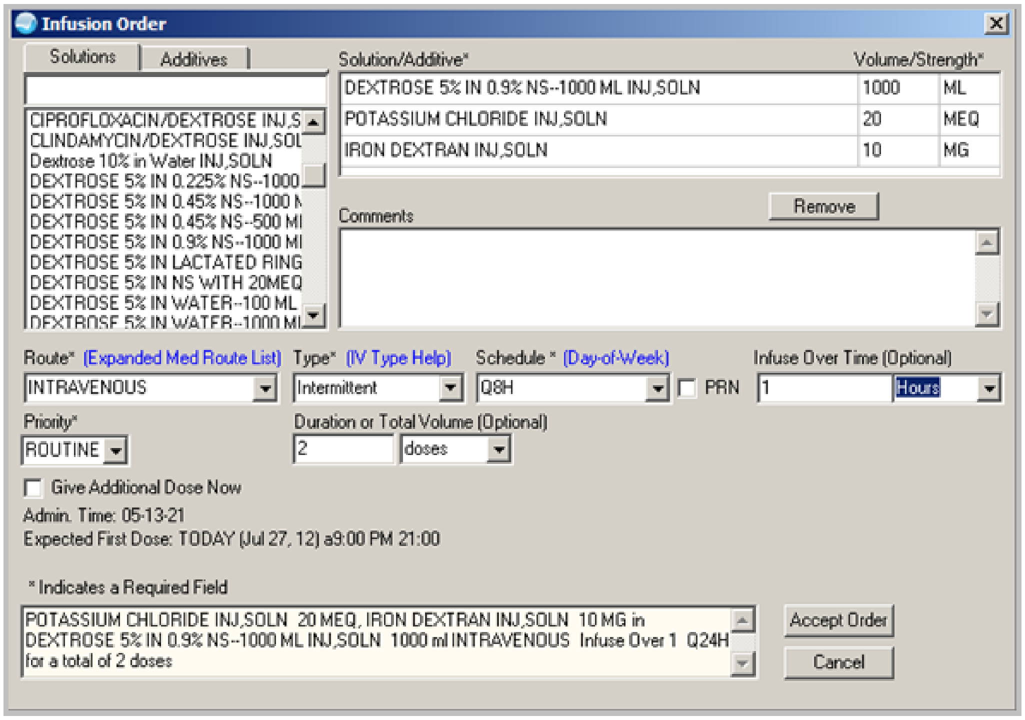


Figure 4-373: Completed Infusion Order Dialog

6. Click Accept Order when finished.

4.11.4 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):

1. Select the Lab Tests function on the Orders window. The Order a Lab Test dialog displays.

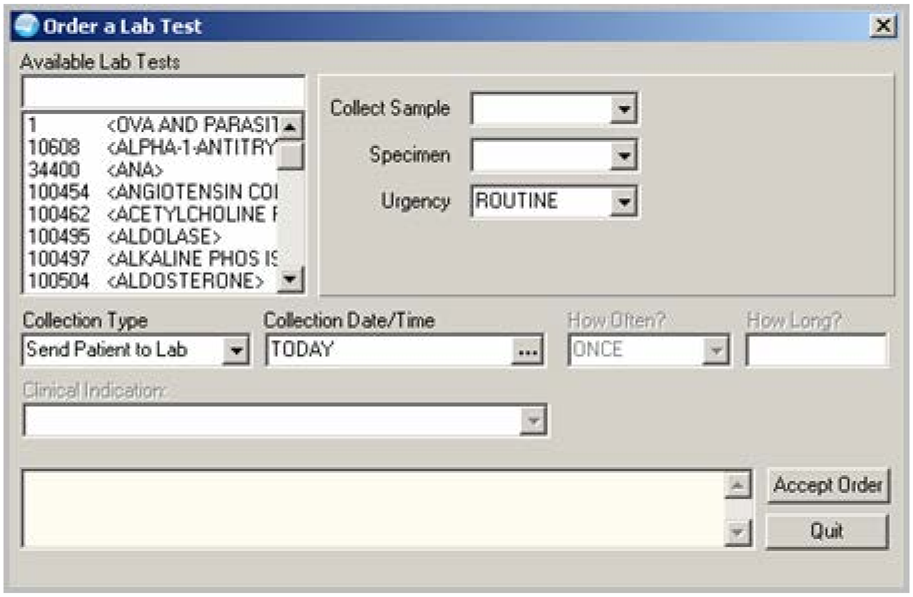


Figure 4-374: Order a Lab Test Dialog

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.

2. 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.)

3. Select the desired lab test in the Available Lab Tests list box.

Note:	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).

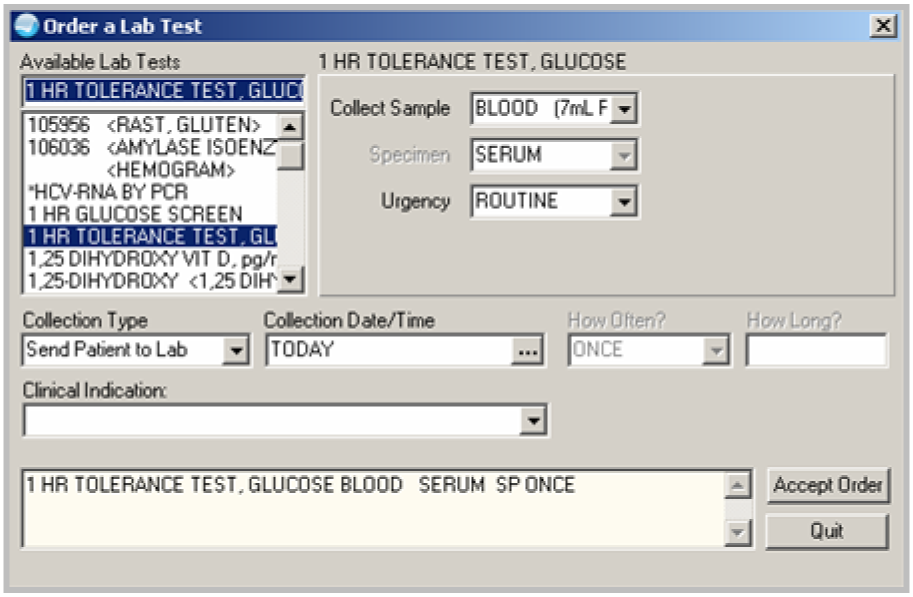


Figure 4-375: Lab Order Showing Information in Lower Part of Dialog

In some cases, a warning message displays in the lower part of the dialog. (Click outside the message to dismiss it.)

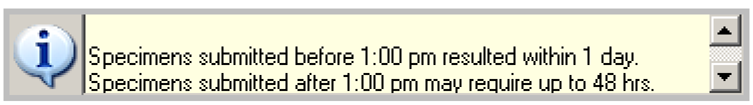


Figure 4-376: Warning Message for Lab Order

4. 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.

5. 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.

6. Manually change the Collection Date/Time (cannot be earlier than the Current Date/Time). Otherwise, click the Ellipsis button to select from a calendar.

    - The How Often? field displays the lab administration scheduled. This is set up in the Laboratory application.

    - The How Long? field indicates a time. For example, 3 = 3 days, or occurrence 3X = 3 times.

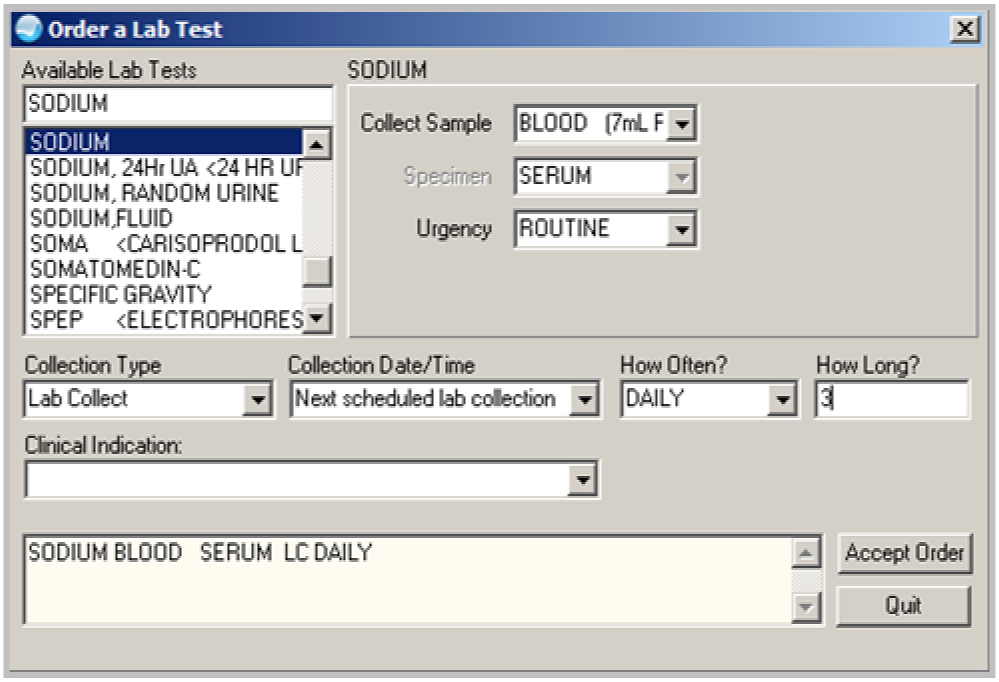


Figure 4-377: Lab Collect for Inpatients

A response in the Clinical Indication field is required to be able to save.

7. 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.

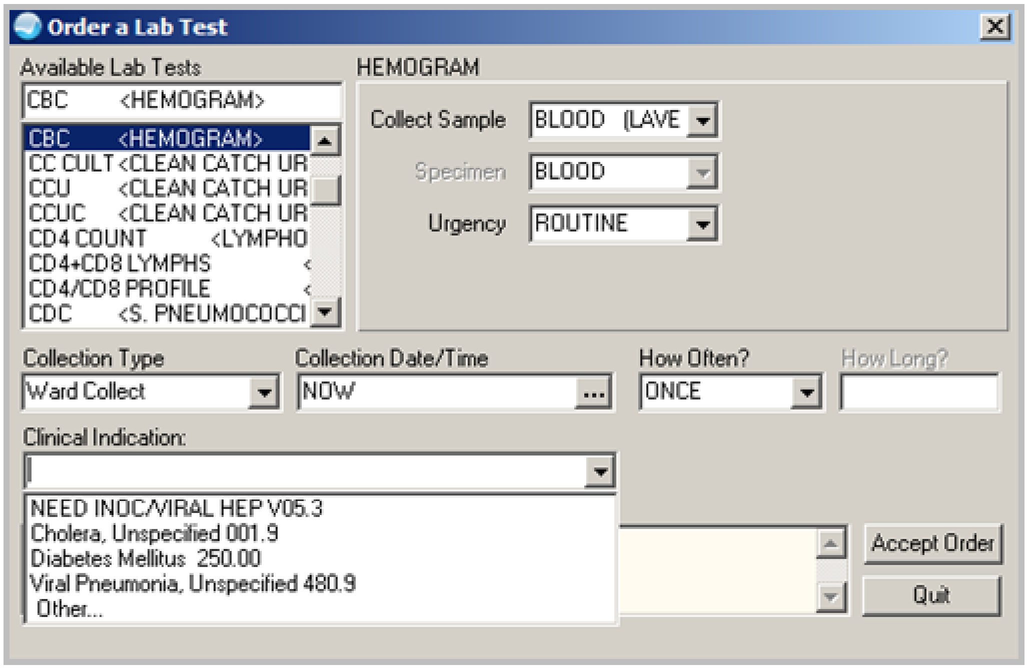


Figure 4-378: Problem List as Clinical Indication

If you select Other in the Clinical Indication field, the SNOMED CT Lookup dialog displays for you to select a problem. After selecting a SNOMED CT code, the Clinical Indication field becomes populated with the selected problem.

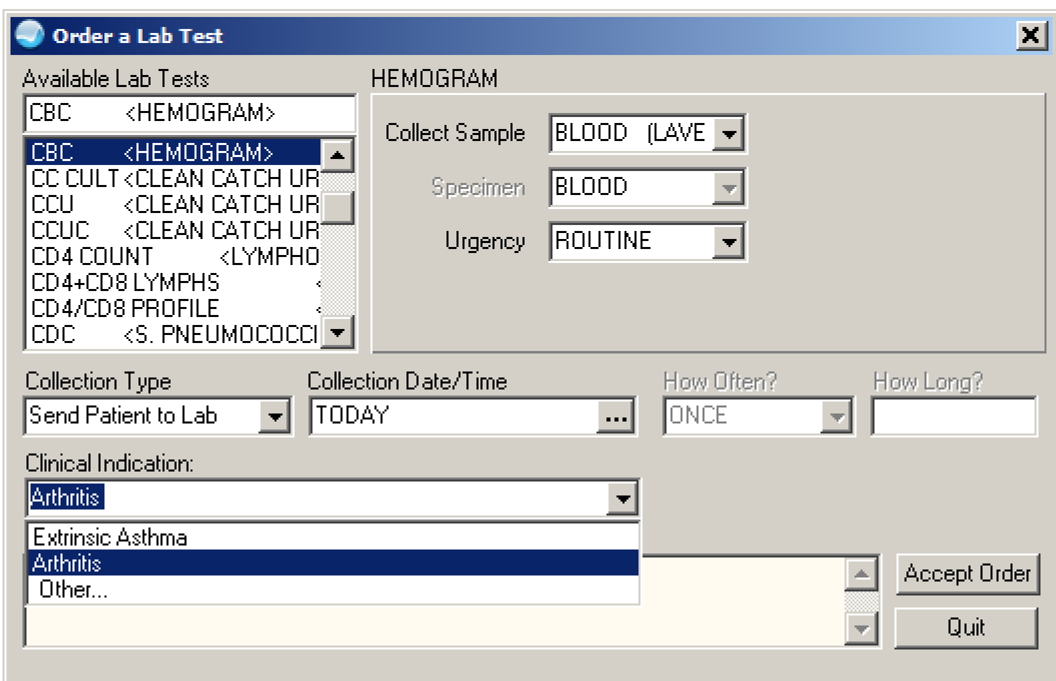


Figure 4-379: Clinical Indication Field

8. Click Accept Order.

9. 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.

4.11.5 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.

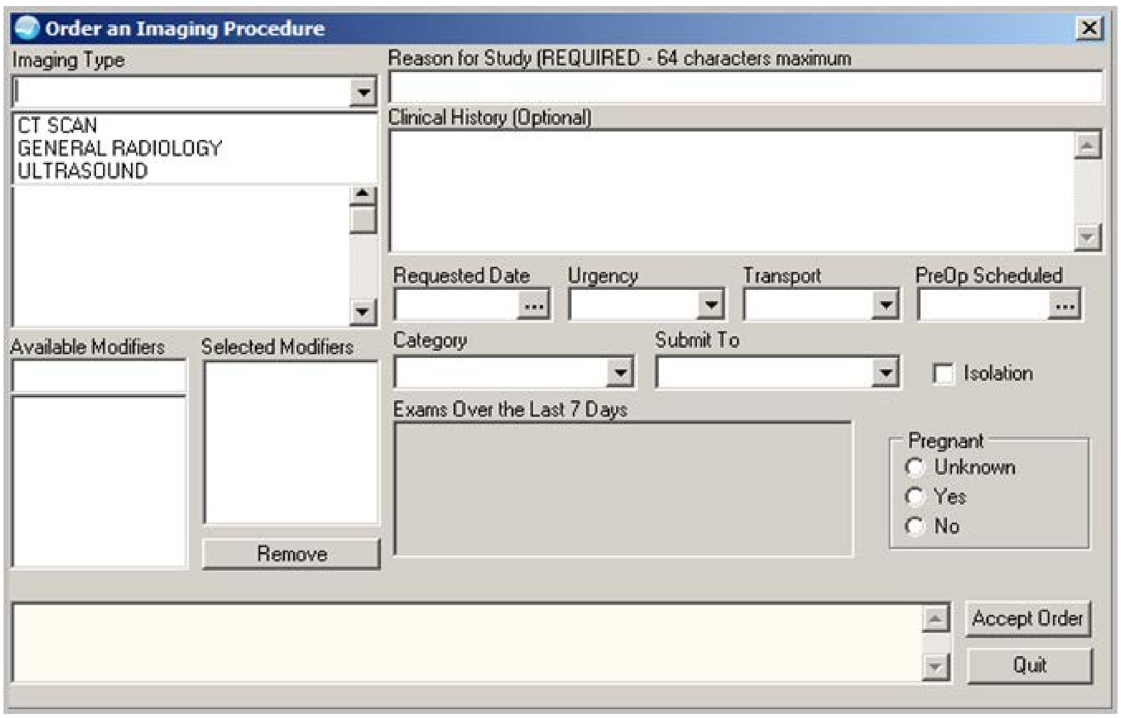


Figure 4-380: Order an Imaging Procedure Dialog

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.

4.11.6 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.

4.11.6.1 Entering Text Orders

A visit must be selected, and the current view must be 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.

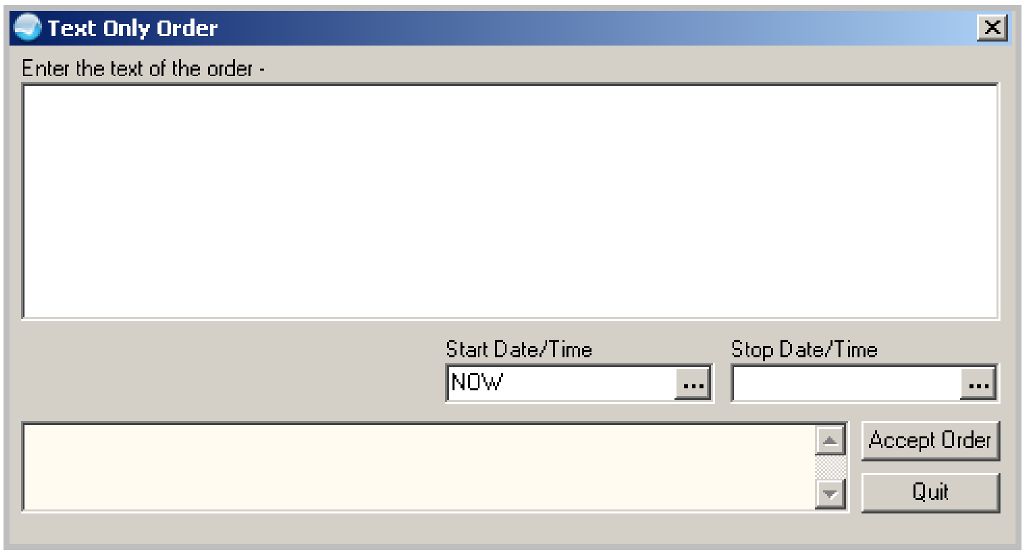


Figure 4-381: Text Only Order Dialog

2. Complete the text for the order in the top field. The field has a right-click menu to aid in editing the text. See Right-Click Menu to Edit Text for more information.

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.

4.11.6.2 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 4-382: Complete Order Dialog

3. Enter your electronic signature and click OK. The text order is dropped from the Active Order list. (Otherwise, click Cancel).

4.11.7 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.

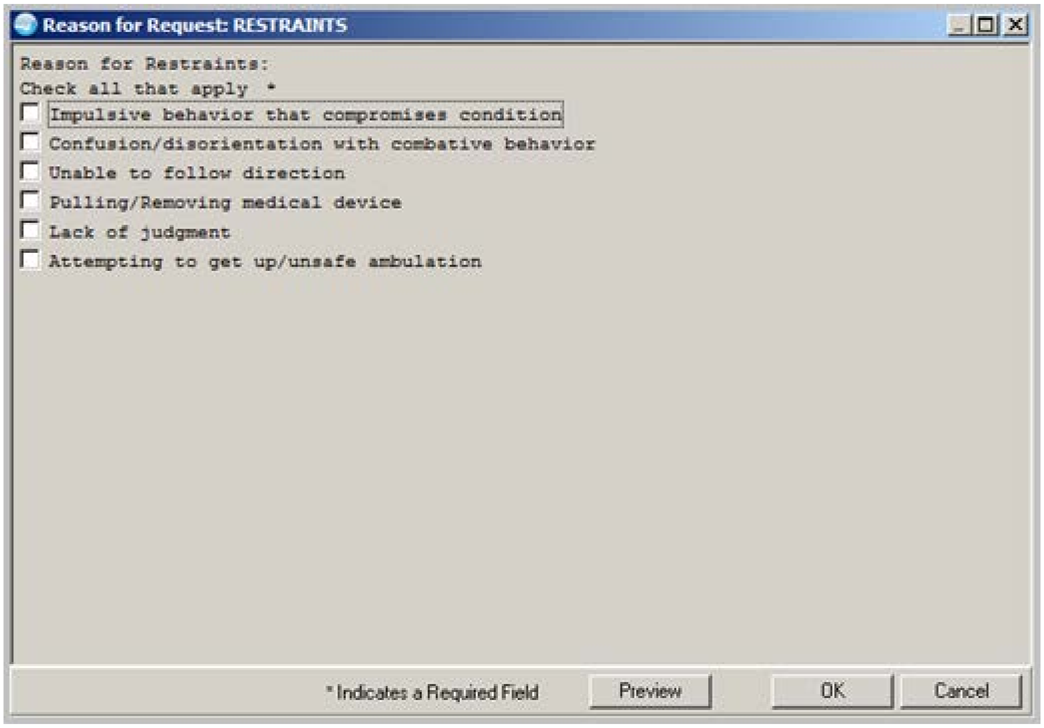


Figure 4-383: Generic Order with TIU Template Field

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.

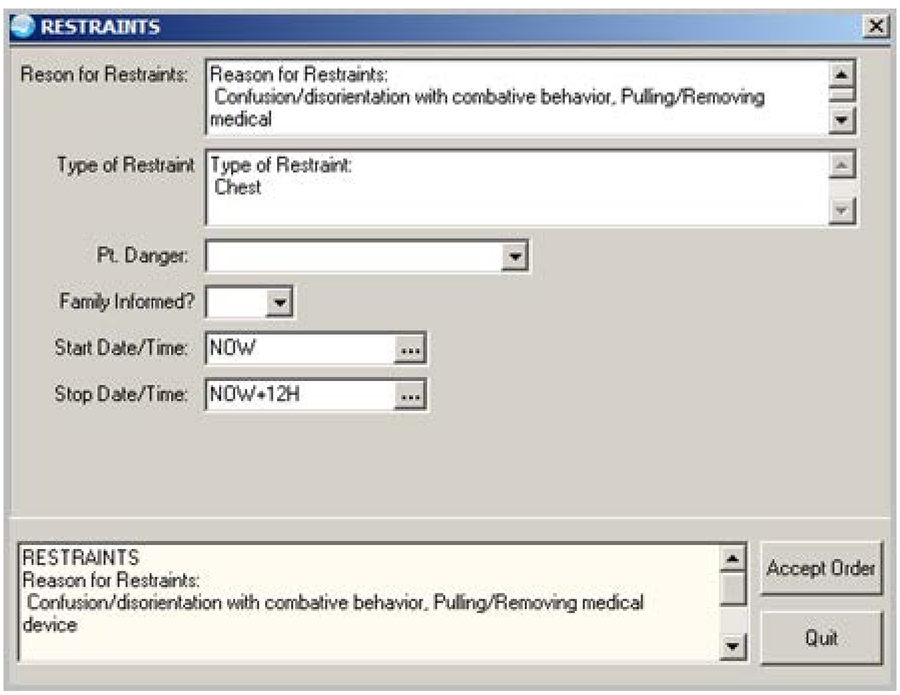


Figure 4-384: Generic Order with Multiple Fields Including Drop-Downs

4.11.8 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.

Below are some examples of quick orders.

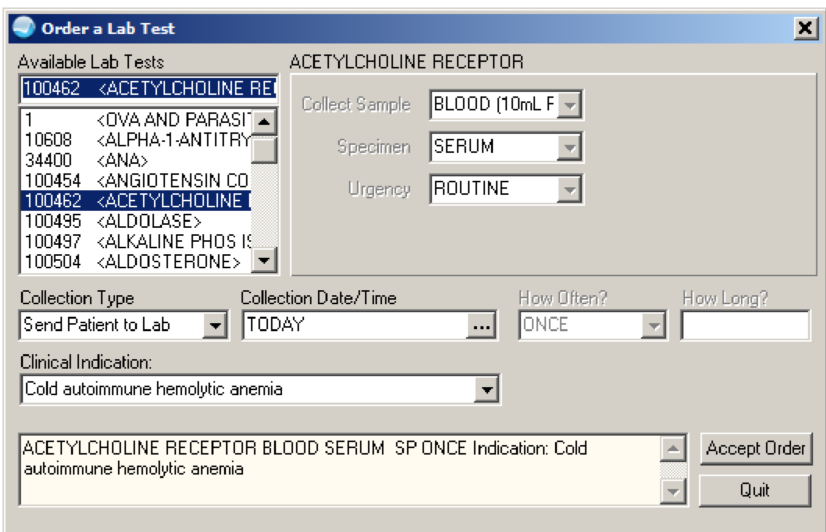


Figure 4-385: Lab Quick Order with Clinical Indication Completed

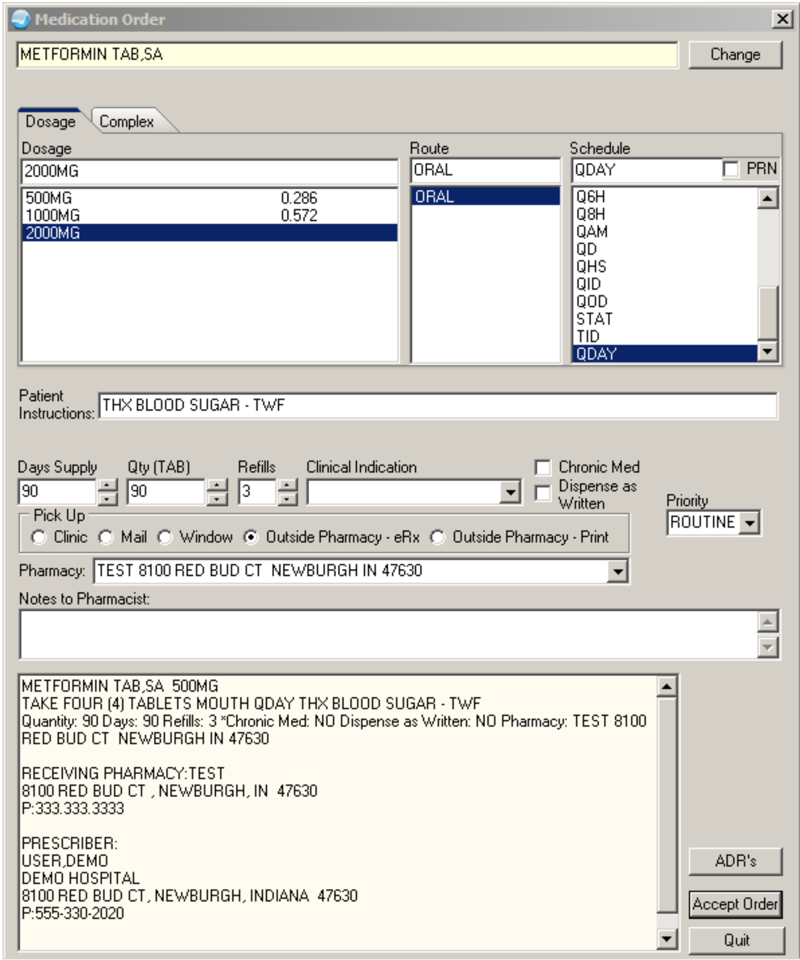


Figure 4-386: Output Med Quick Order

4.11.9 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.

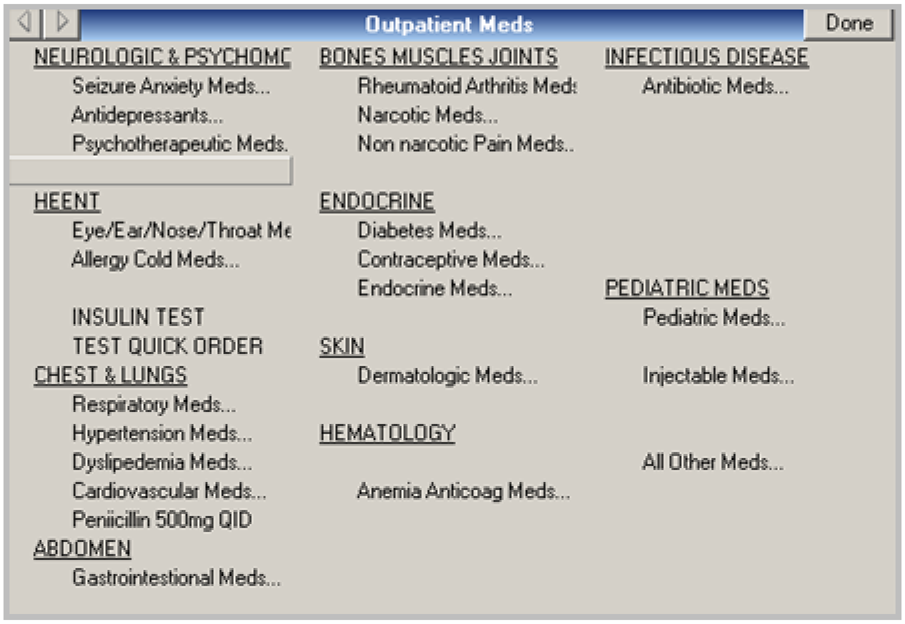


Figure 4-387: Menu with Sub-Menu

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.

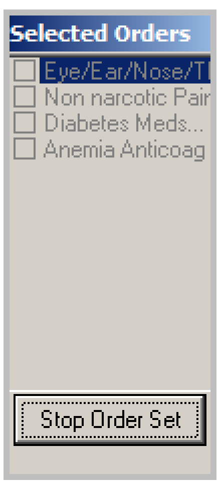


Figure 4-388: Start of Multiple Order Selection

The Stop Order Set button allows the user to quit ordering. Otherwise, it progresses through each item in the list until finished.

If any of the items you selected contain a menu, you can then select items from that menu.

Clicking Next indicates you are moving on from that menu.

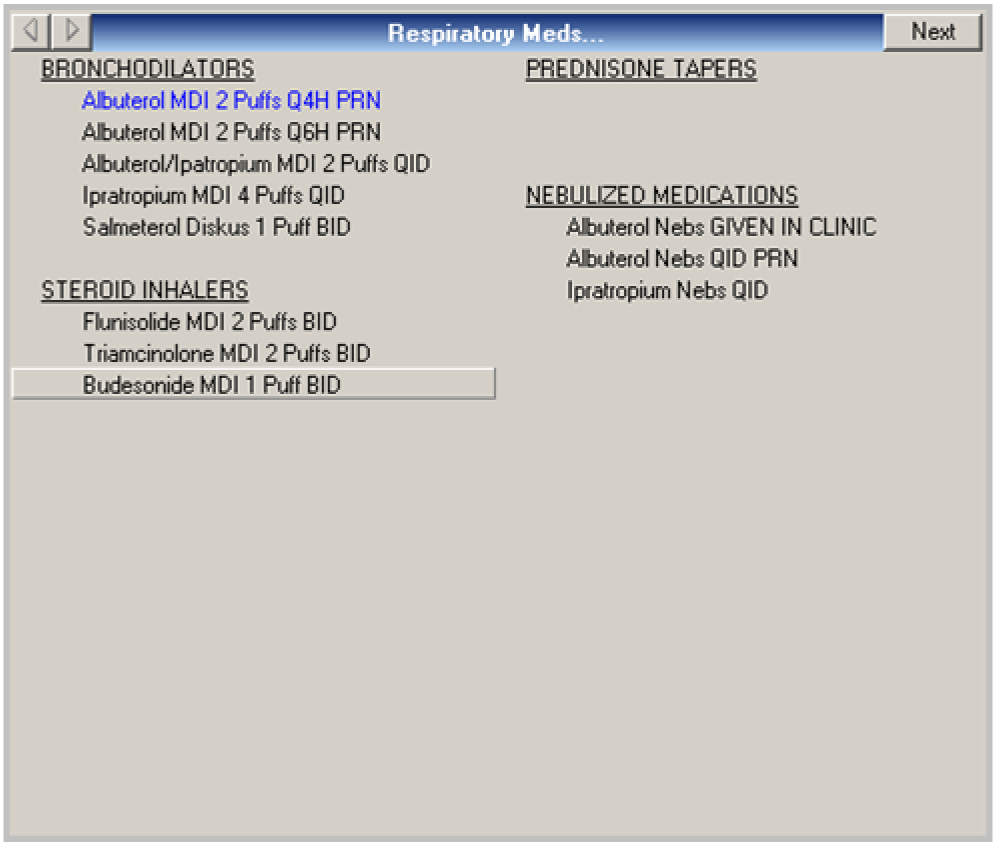


Figure 4-389: Next Button on Respiratory Meds Dialog

As you progress through the items, the finished items contain a check box.

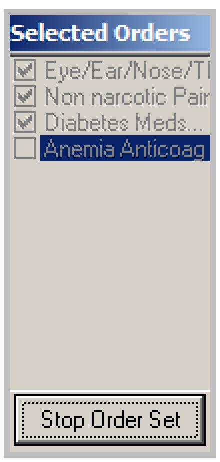


Figure 4-390: Order Selection in Progress

4.11.10 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 Clinical Applications Coordinator (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.

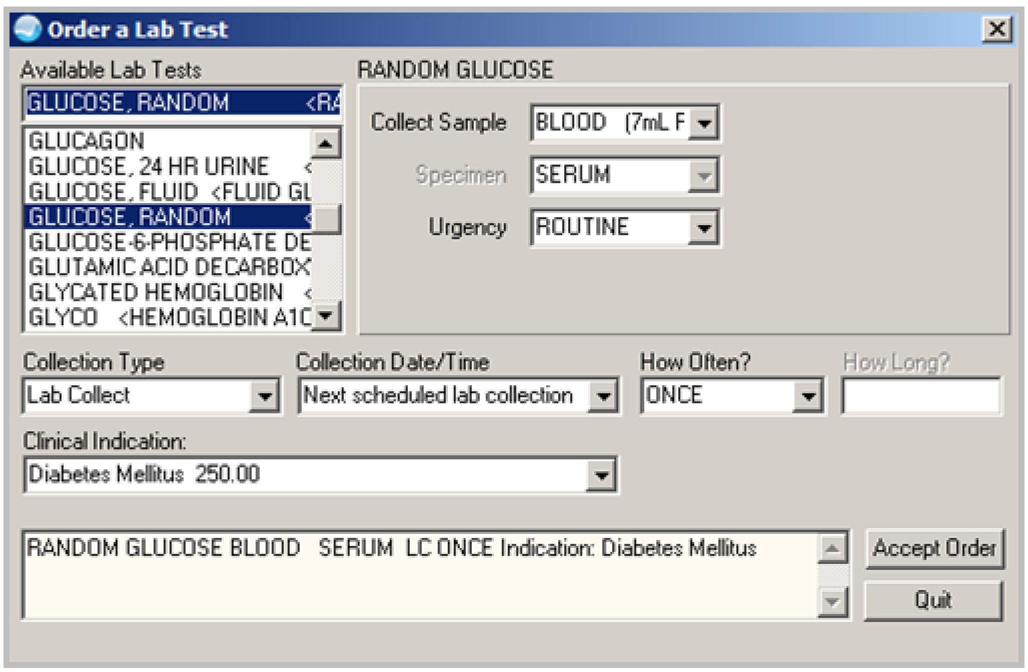


Figure 4-391: Making a Personal Quick Order

2. Select Options → Save as Quick Order.

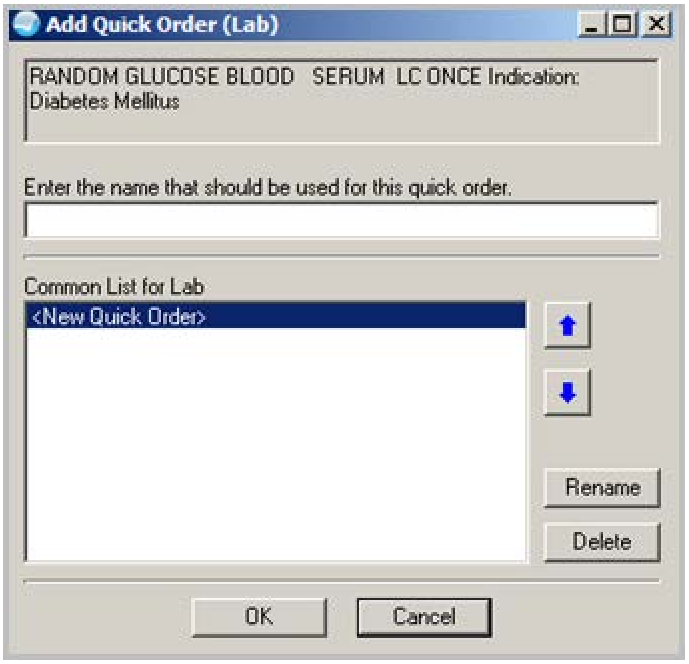


Figure 4-392: Add Quick Order (Lab) Dialog

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.

4.11.11 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.

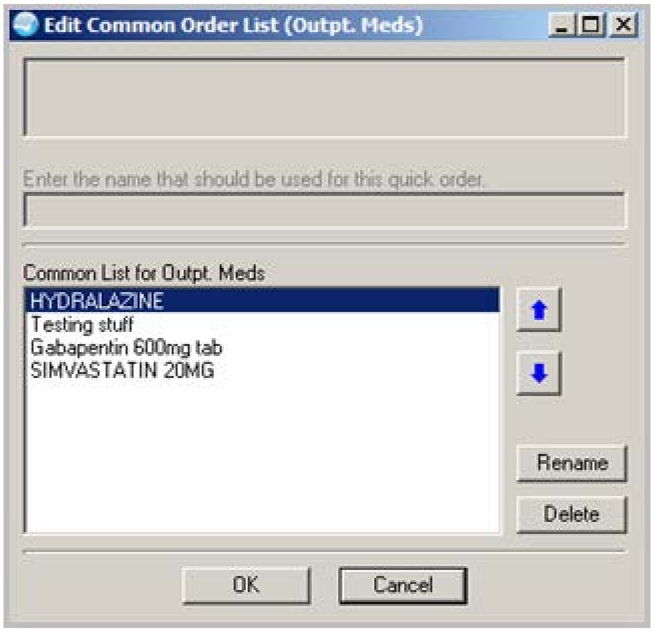


Figure 4-393: Editing Personal Quick Orders

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.

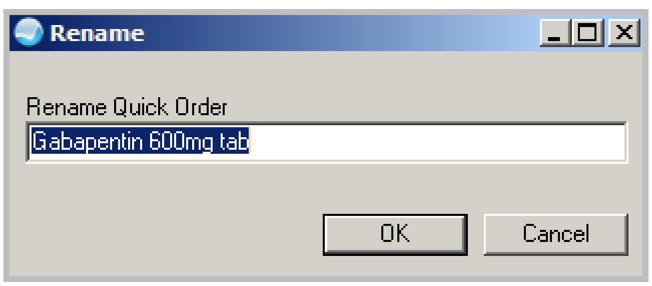


Figure 4-394: Renaming a Personal Quick Order

4.11.12 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.

   You can sign the changed order now or later.

4.11.13 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.

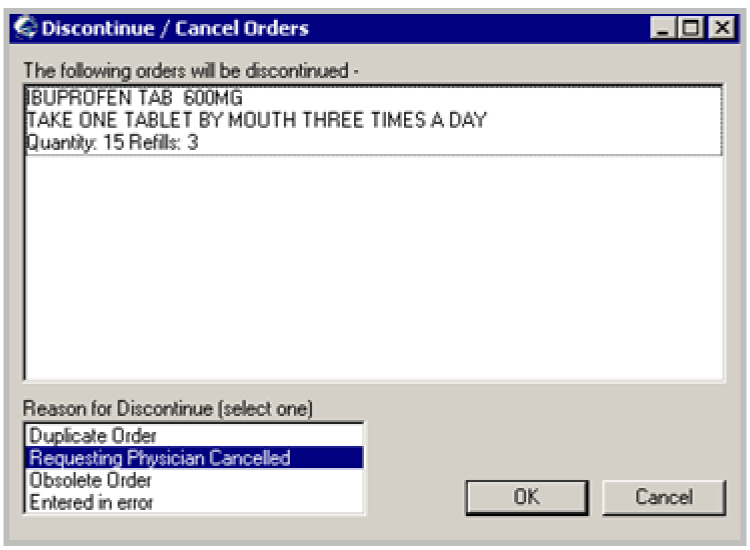


Figure 4-395: Discontinue/Cancel Orders Dialog

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).

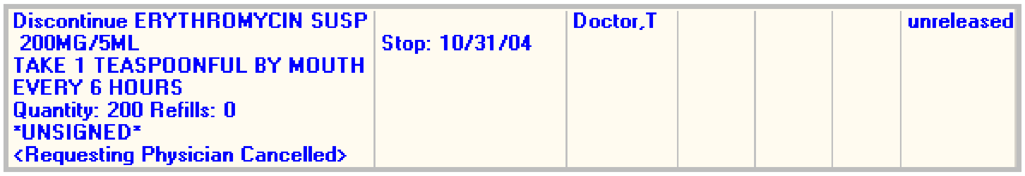


Figure 4-396: Discontinued Medication Order

Other types of orders, like imaging, have Status = Discontinue and the reason appears in the Order column.

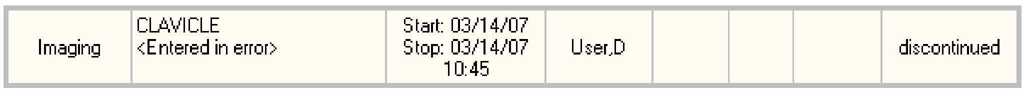


Figure 4-397: Discontinue Imaging Order

4.11.14 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.

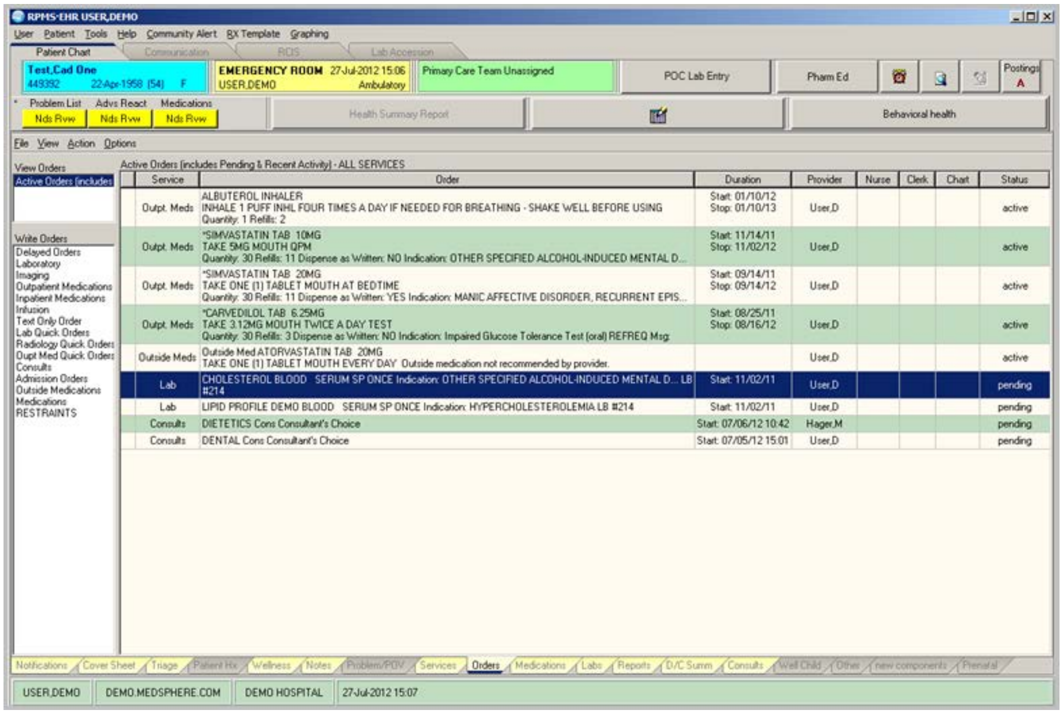


Figure 4-398: Delayed Orders in Write Orders Window

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.

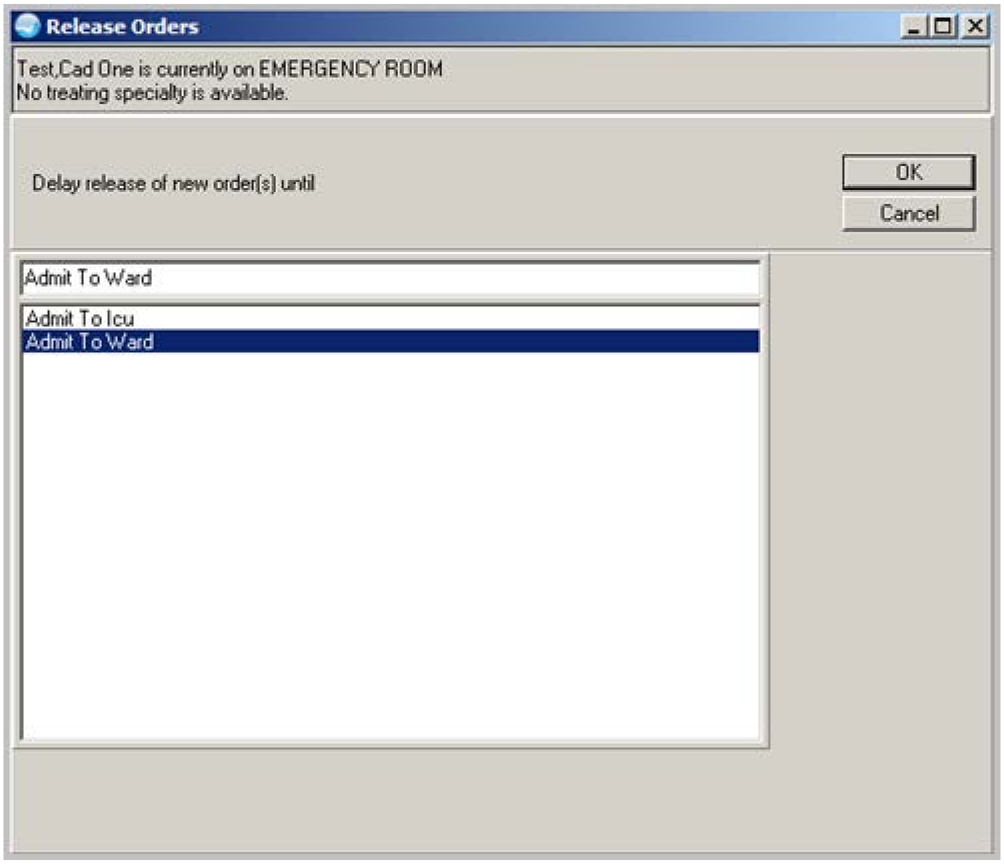


Figure 4-399: Admission Delayed Orders

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.

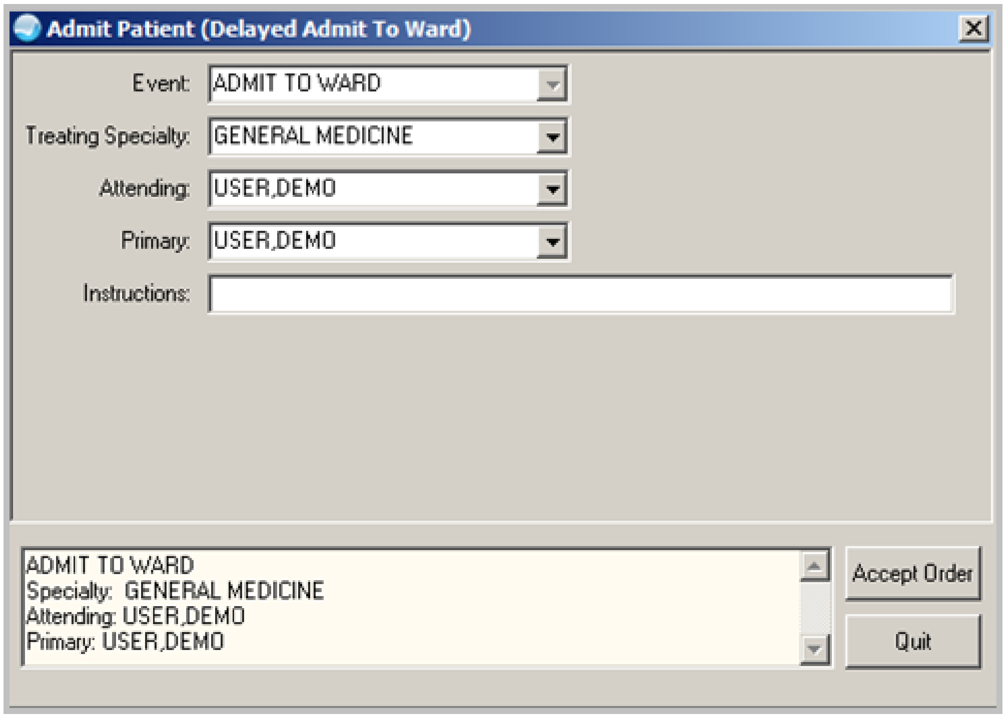


Figure 4-400: Admit Patient Delayed Admit to Ward

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.

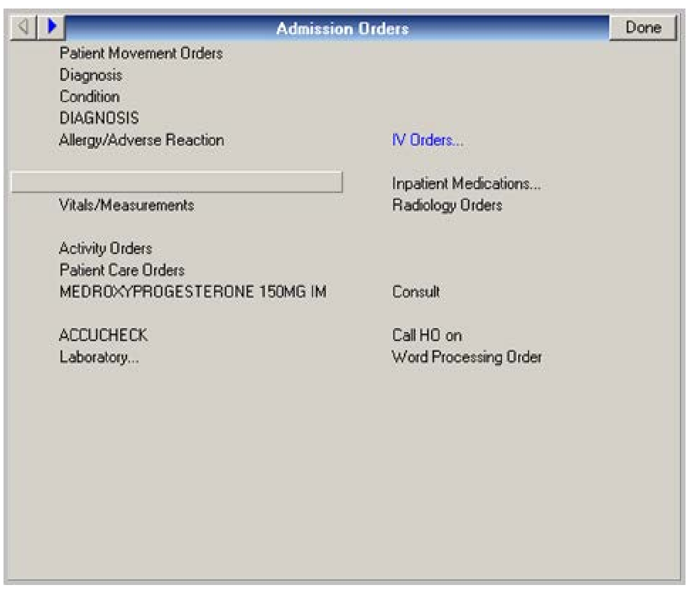


Figure 4-401: Delayed Order Done

The Event Delayed Orders are highlighted in the View Orders window.

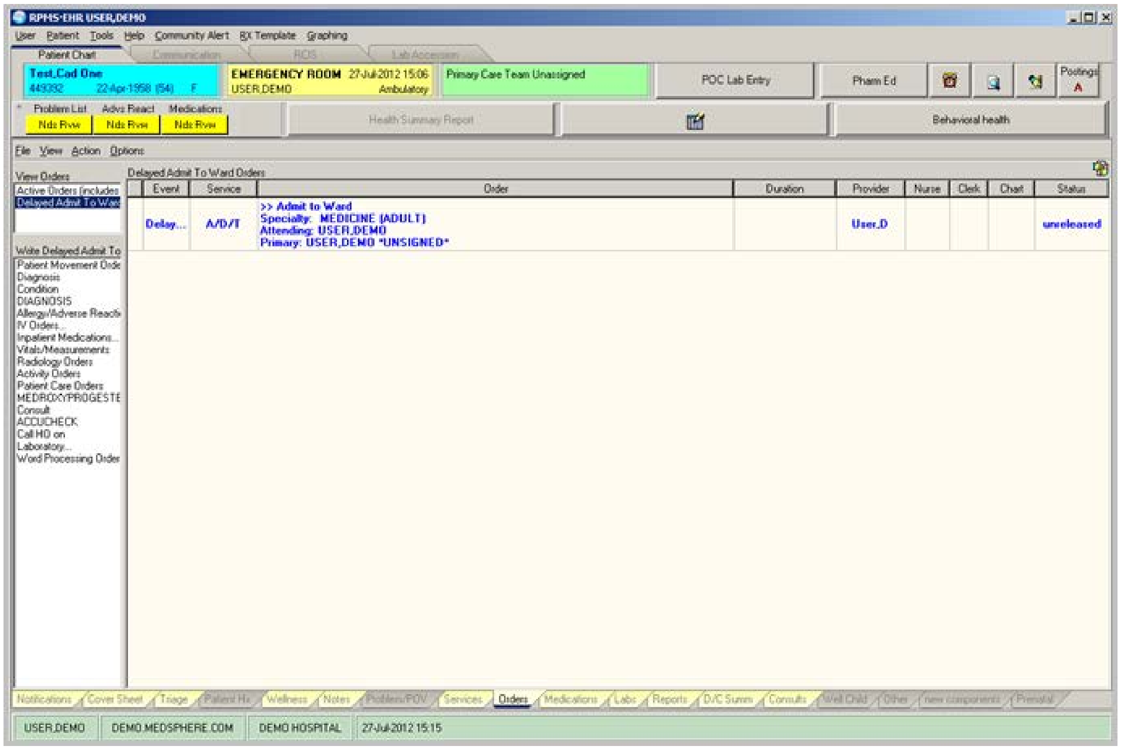


Figure 4-402: Event Delayed Order in View Orders Window

The provider is notified they are writing Delayed Orders. Medication orders are for Inpatient medications. These orders appear as delayed.

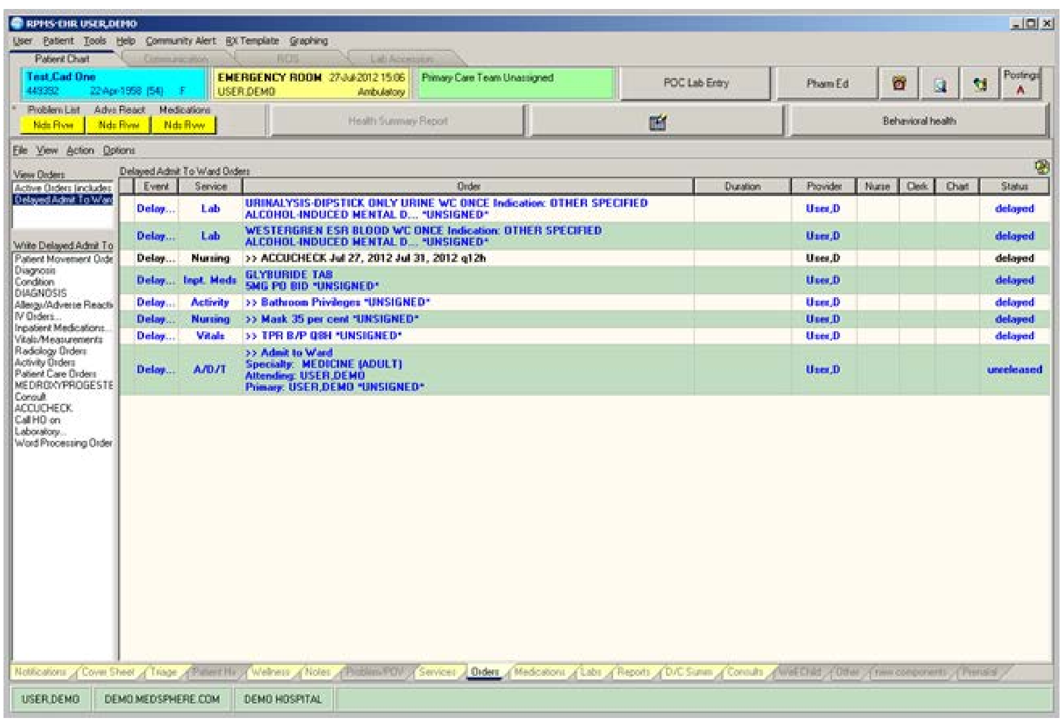


Figure 4-403: Unsigned Delayed Orders

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.

4. Select Action and look for Release Delayed Orders. This option only appears if there are unreleased orders.

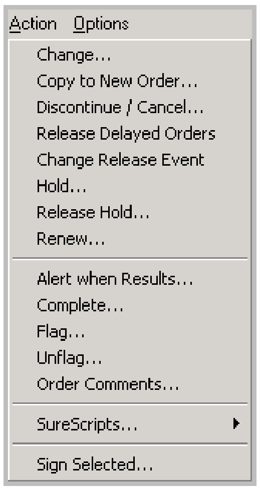


Figure 4-404: Manual Release

Under View →Auto DC/Release Event, users can also review which orders were auto-DC'd or released in ADT action. Selecting an action from the list brings up all of the orders that were affected by that action.

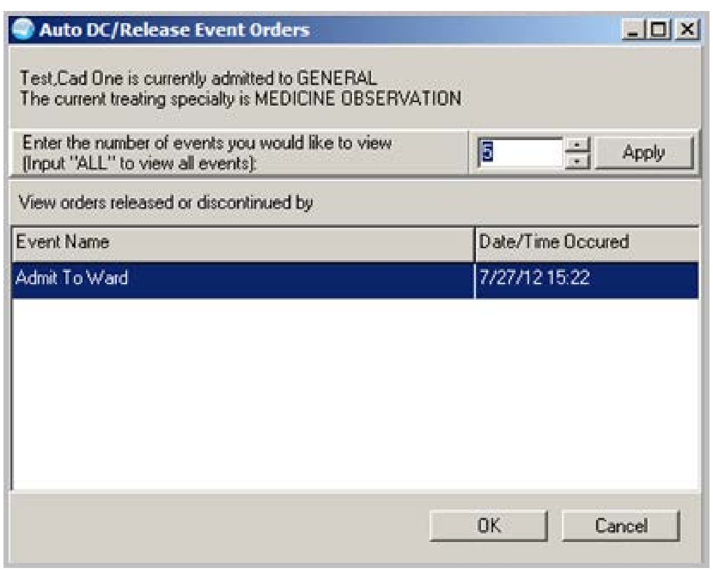


Figure 4-405: Auto DC/Release Event Orders

4.11.15 Copy to New Order

You can copy an existing order to a new order. This process lets you:

- Copy the exact elements of the existing order to create a new order

  –or–

- Change the order elements to create a new order

1. Make sure a visit is selected.
2. Select the order to be copied.
3. Select Action → Copy to New Order (or select Copy to New Order on the right-click menu) to display the Copy Orders dialog.

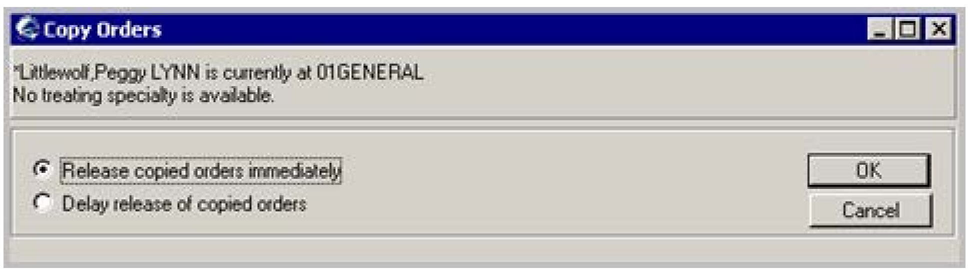


Figure 4-406: Copy Orders Dialog

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 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.

4. Make sure the Release copied orders immediately option button is selected. (The Delay release of copied orders option button is used for inpatients only.
5. Click OK. The New Order dialog displays.

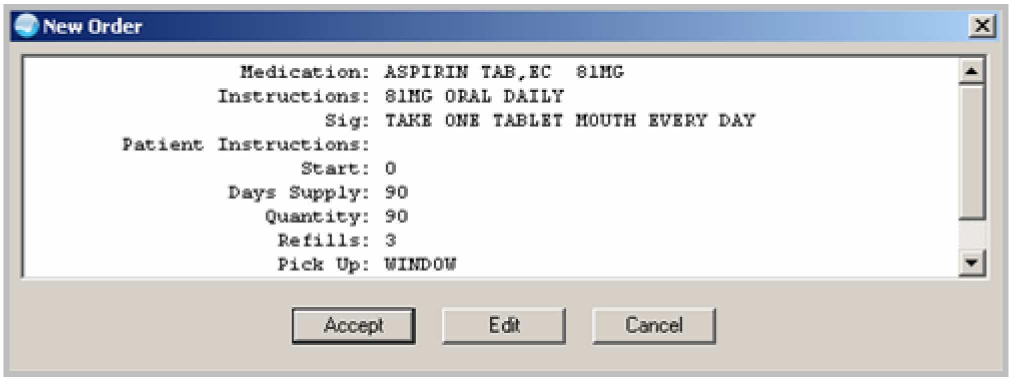


Figure 4-407: New Order Dialog

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.

6. You can sign the order now or wait until later.

4.11.16 Order Comments

This function allows you to add comments to an order. The comments appear on the Order Details pop-up.

1. Make sure a patient is selected. To add order comments:
2. Select the order to which you want to add comments.
3. Select Action → Order Comments to display the Comments for Order dialog.

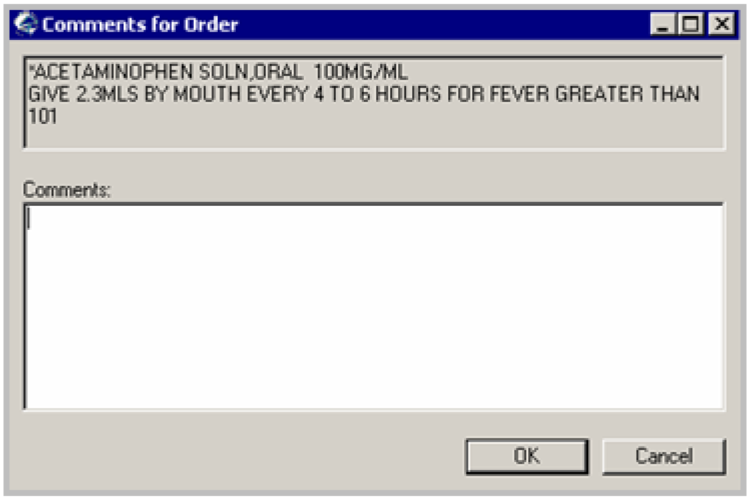


Figure 4-408: Comments for Order Dialog

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.

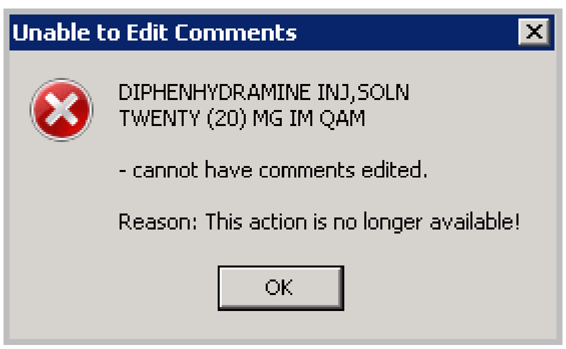


Figure 4-409: Unable to Edit Comments

4. Enter the comments in the Comments field.

Note:	There is a right-click menu to aid in editing the text. See Right-Click Menu to Edit Text for more information.

5. Click OK when the dialog is complete.

   You can view the comments on the details for the order.

4.11.17 Order Details

Order Details enables you to view information about an 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 patient data, including height and weight at last measurement, whether the medication is a discharge medication, and any comments.

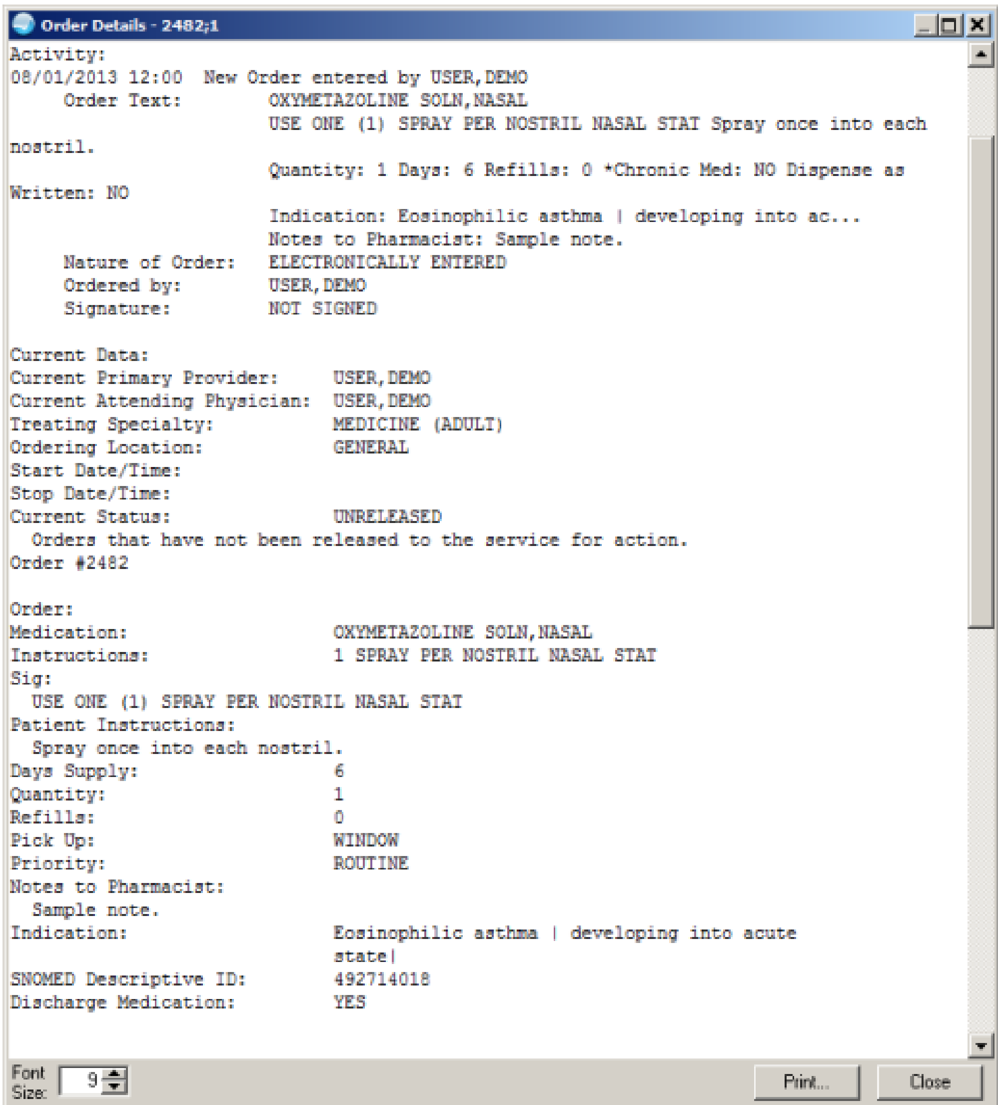


Figure 4-410: Order Details Pop-up

3. You can change the font size of the text displayed in this pop-up 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 pop-up 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).

4. Click Print to choose a printer and to output the (entire) contents of this pop-up to the specified printer.

Note:	The Print button may be available. It is according to how your application is configured.

5. Click Close to dismiss the pop-up.

4.11.18 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. To print the text of the results, click Print.

4.11.19 Miscellaneous Ordering Features

4.11.19.1 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.

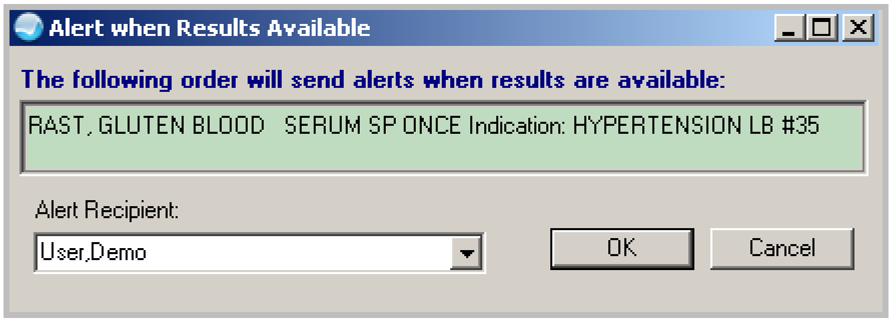


Figure 4-411: Alert when Results Available Dialog

3. Choose an alert recipient from the Alert Recipient: drop-down list.
4. Click OK.

4.11.19.2 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.

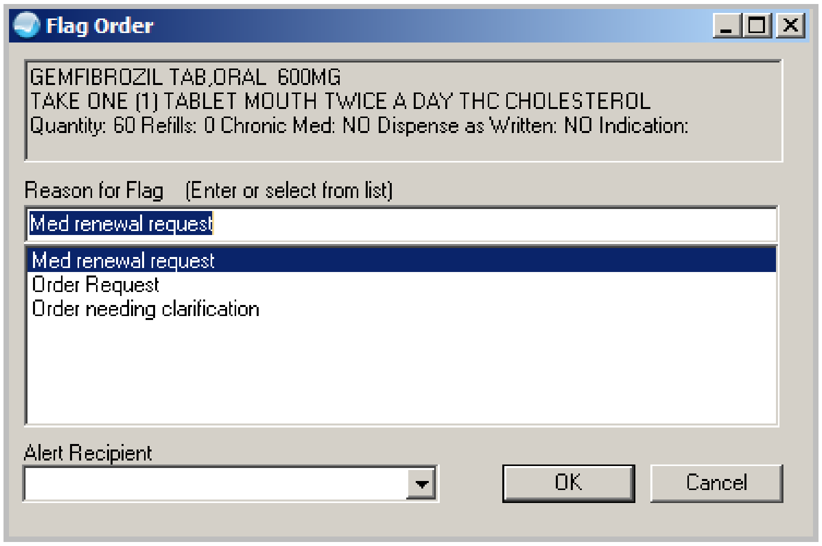


Figure 4-412: Flag Order Dialog

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:

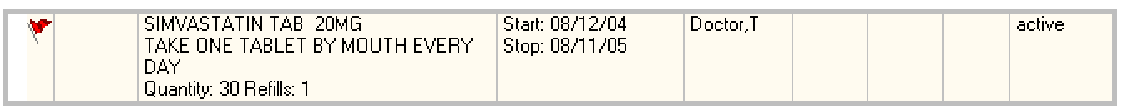


Figure 4-413: Flagged Order on Orders Window

4.11.19.3 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.

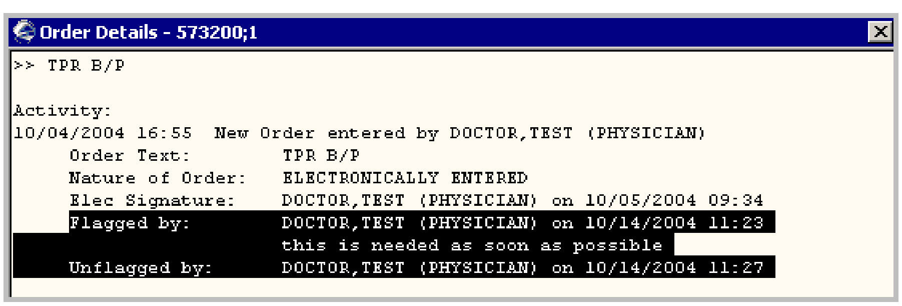


Figure 4-414: Order Detail Showing Flag and Unflag Information

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.

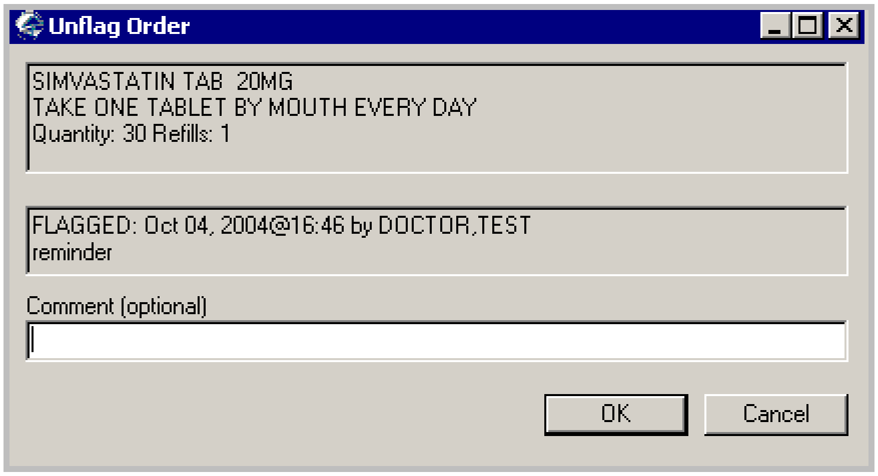


Figure 4-415: Unflag Order Dialog

3. Enter a comment, if desired. See Right-Click Menu to Edit Text for more information about editing the text.

4. Click OK to complete the unflagging order process.

4.11.19.4 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.

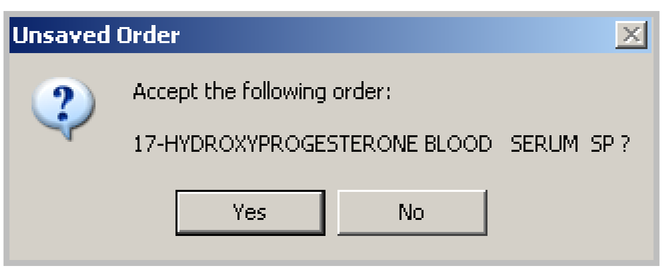


Figure 4-416: Information Message After Clicking Quit

- Click Yes to save the order and exit the order dialog.

–or–

- Click No to not save the order and exit the order dialog.

4.11.19.5 Sign Selected

When you have unsigned orders (appears in bold, blue lettering) on the Orders window, you can sign it. Follow these steps:

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.

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.

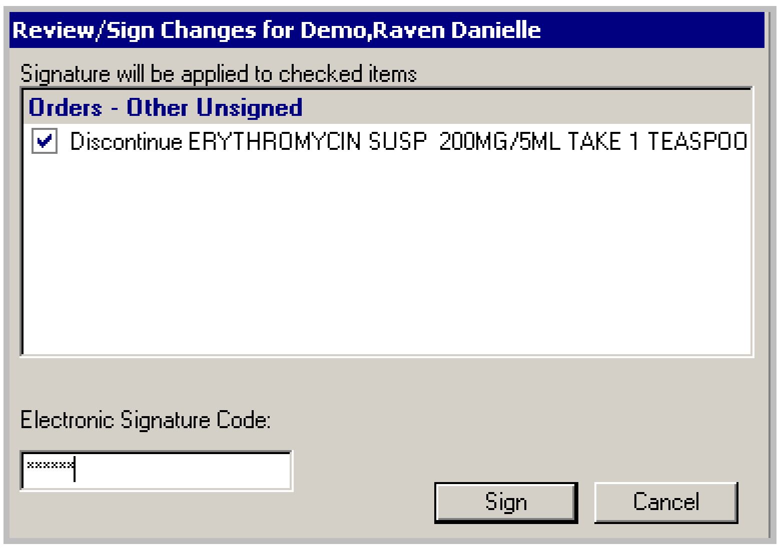


Figure 4-417: Review/Sign Changes Dialog

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.)

4.11.19.6 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.

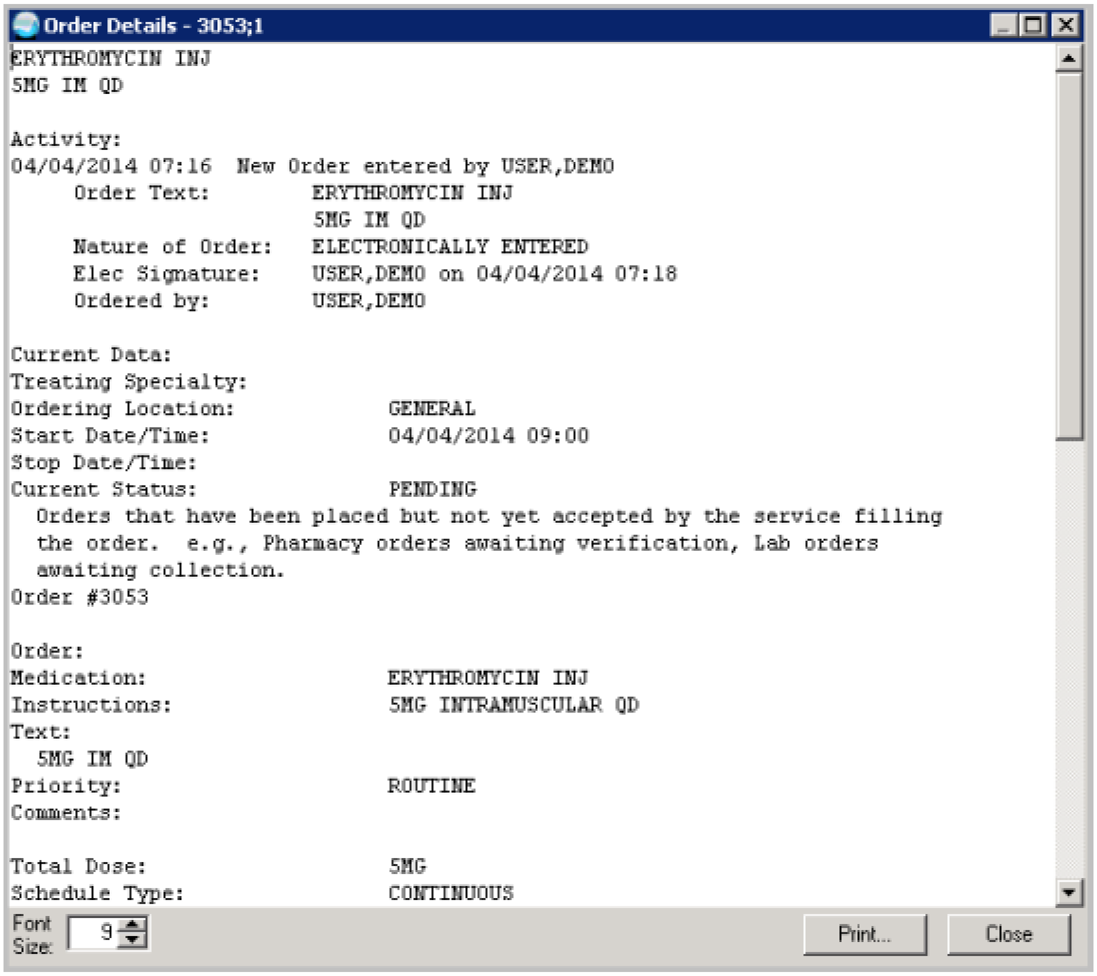


Figure 4-418: Inpatient Medication Order Details

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.

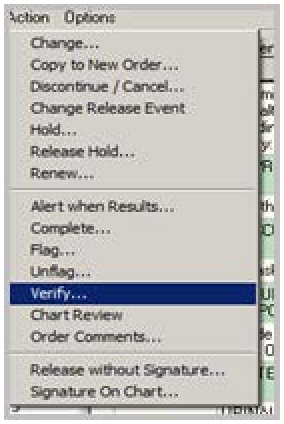


Figure 4-419: Verify Action

The nurse or clerk can select the orders they want to verify and then select the Verify action.

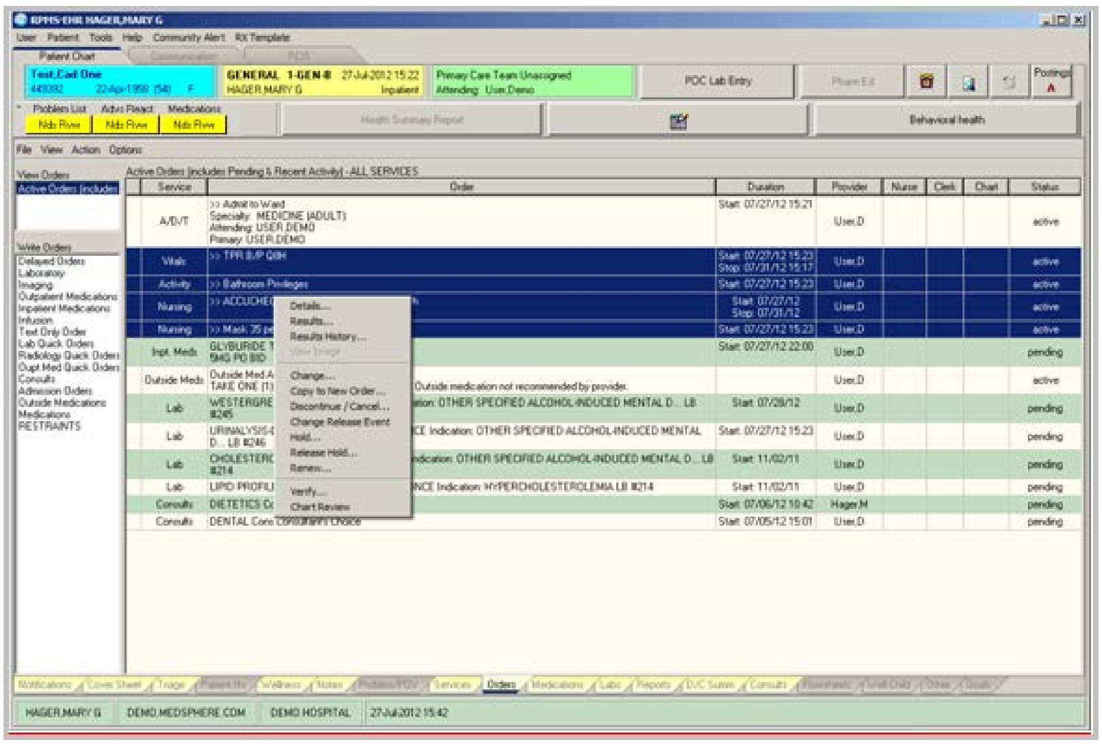


Figure 4-420: Nurse Verify Action

The action is then reviewed and signed.

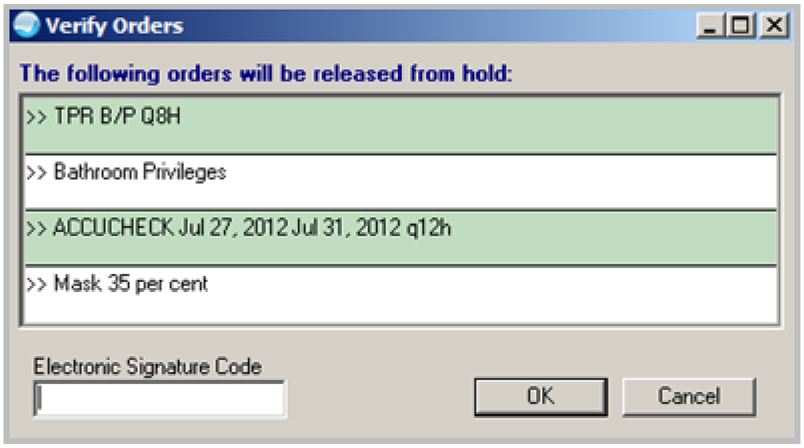


Figure 4-421: Review and Sign

The nurse's initials appear in the Nurse column.

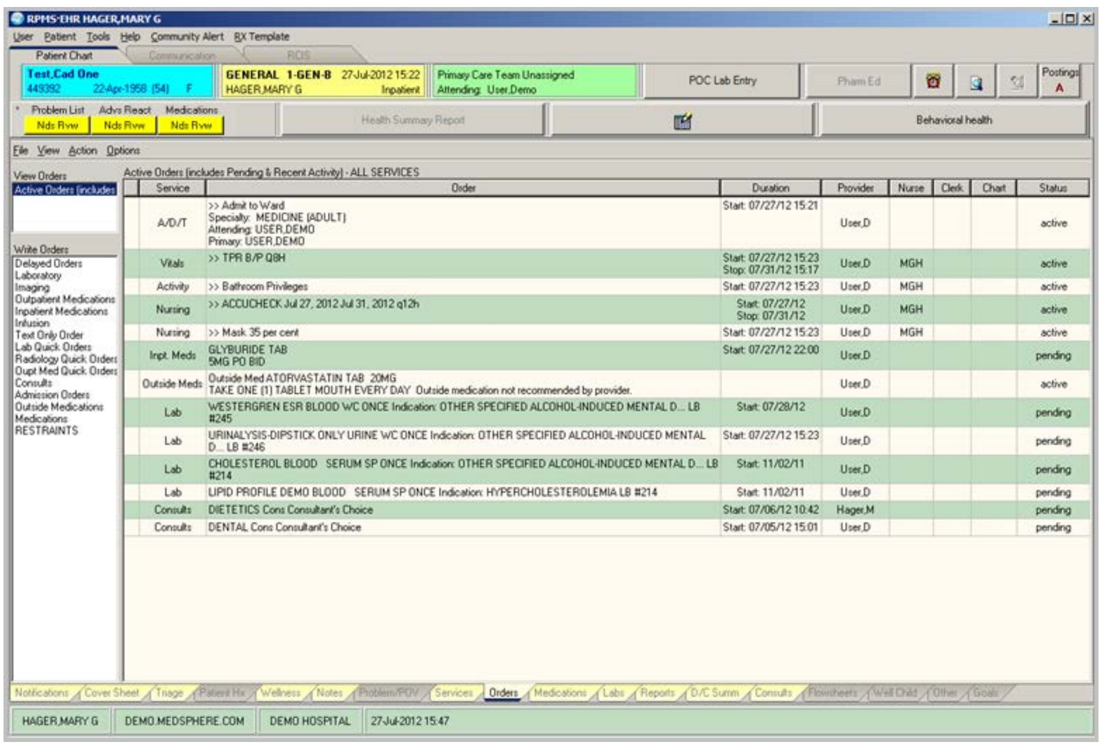


Figure 4-422: Nurse Initials in Nurse Column

4.11.19.7 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.

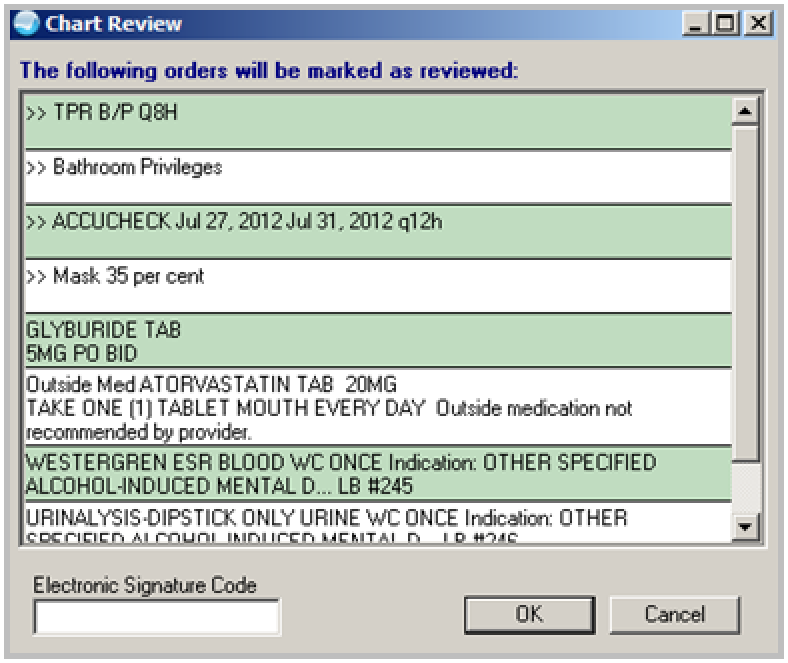


Figure 4-423: Chart Review Dialog

4.11.19.8 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.

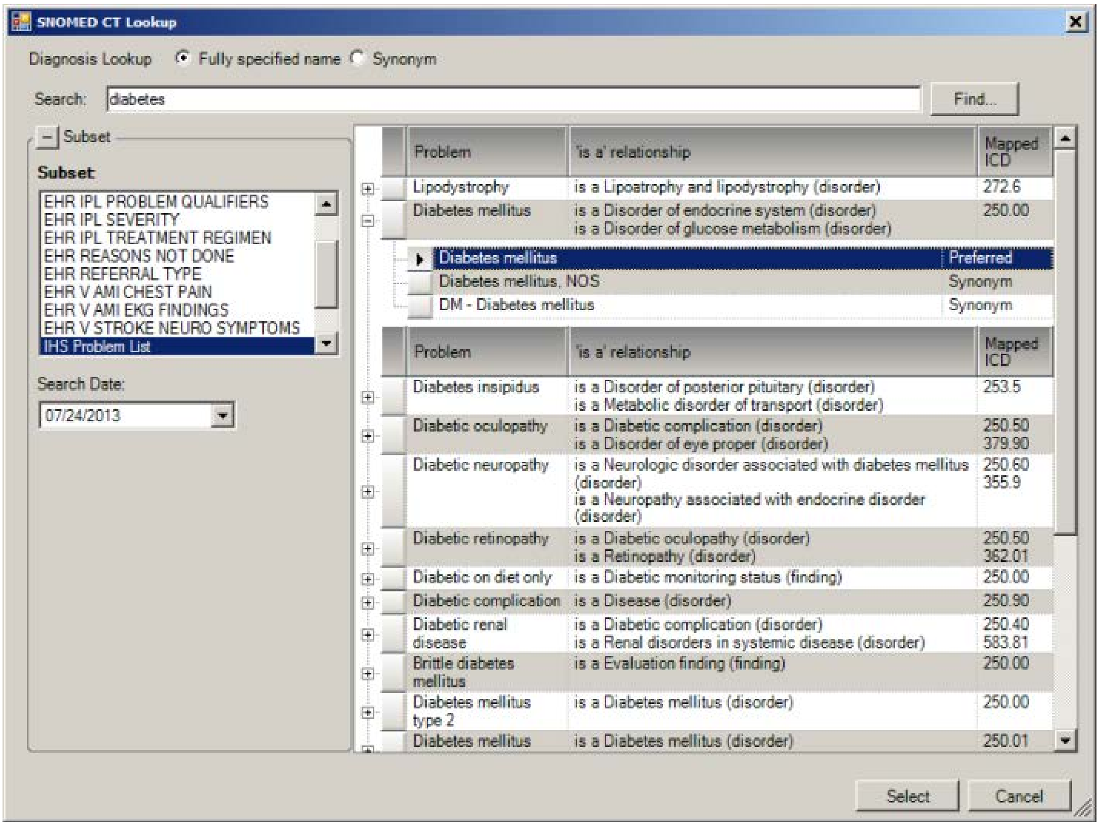


Figure 4-424: SNOMED CT Lookup Dialog

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. Click and highlight a term, and then click the Select button. The Clinical Indication field refreshes with the selected SNOMED CT term you selected.

4.11.20 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.

4.11.20.1 Severity Levels and Source of Information

Order Check dialoges 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 4-425: 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.

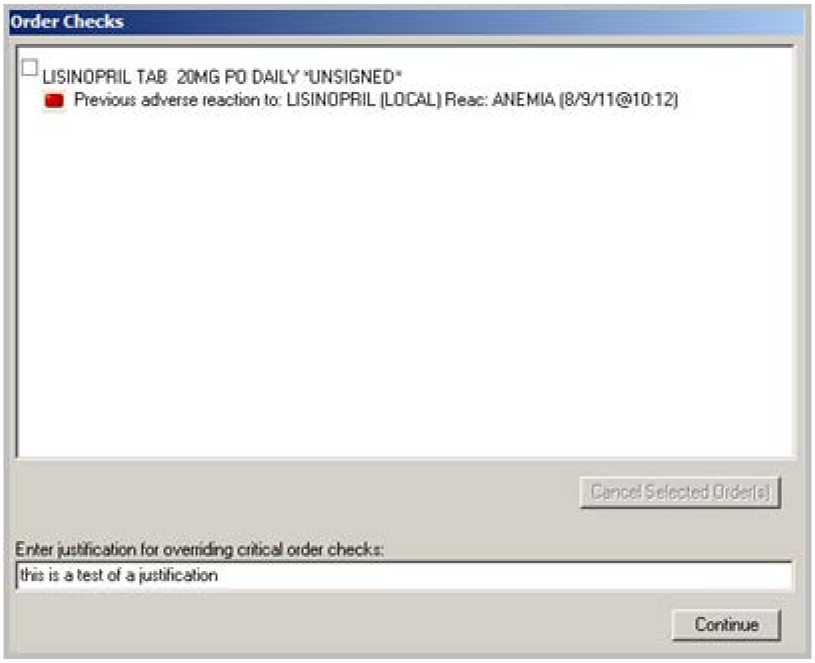


Figure 4-426: Order Check Justification

The justification remains with the order and is available in the order details.

4.11.20.2 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.

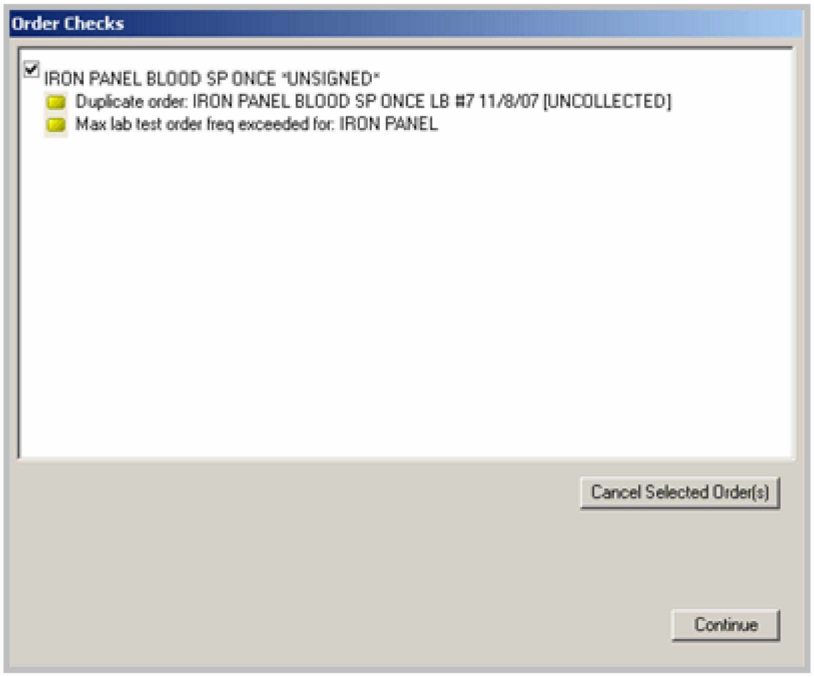


Figure 4-427: Order Checks Dialog

1. Select the order you want to delete.
2. Click the Cancel Selected Order(s) button. The application displays the Cancel Order information message.

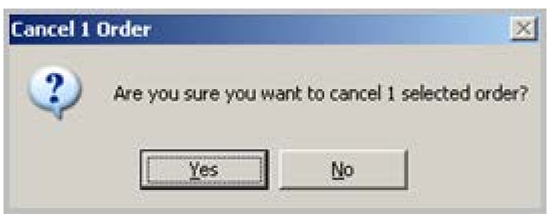


Figure 4-428: Cancel Order Information Message

3. Click Yes to cancel the selected order. The order then is removed from the Order window. (Otherwise, click No to not cancel the order.)

If you do not select the order and click the Continue button, you return to the Order window with both orders remaining on the list of orders.

4.11.20.3 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.

4.11.20.4 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.
2. Click the Order Checks tab.

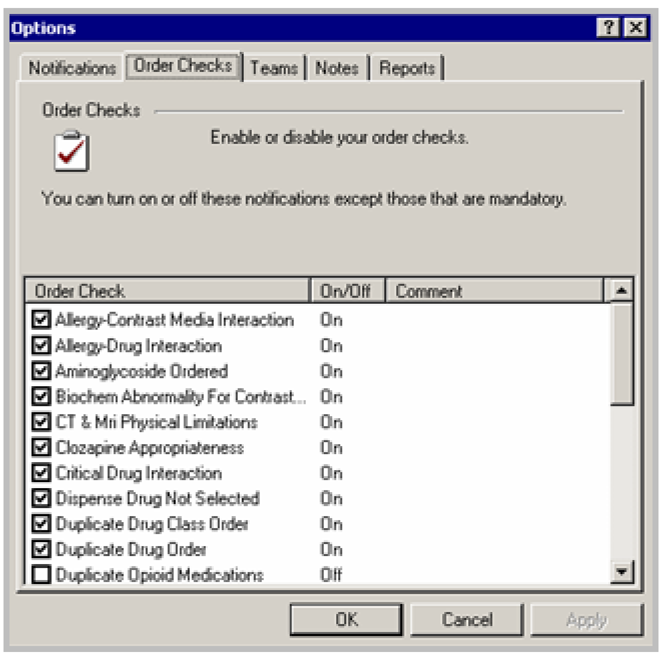


Figure 4-429: Order Checks Tab of Options Dialog

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.

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.

4.11.21 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. See Printer Setup for more information.

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 4-430: 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. You must check at least one check box in order 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.

4. 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.

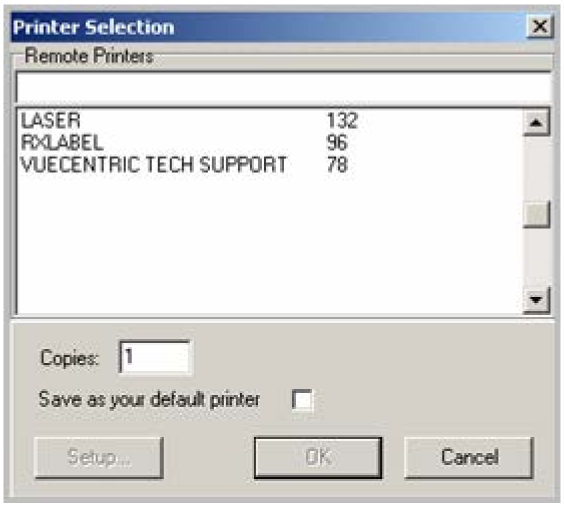


Figure 4-431: Printer Selection Dialog

5. 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.

6. You can change the number of copies by changing the value in the Copies field.

7. 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.

8. After the Printer Selection dialog is complete, click OK. (Otherwise, click Cancel.)

9. 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.

4.12 Reproductive Factors

The Reproductive Factors application is available for female patients only. After selecting a female patient, the application displays the most recent reproductive factors information, if available.

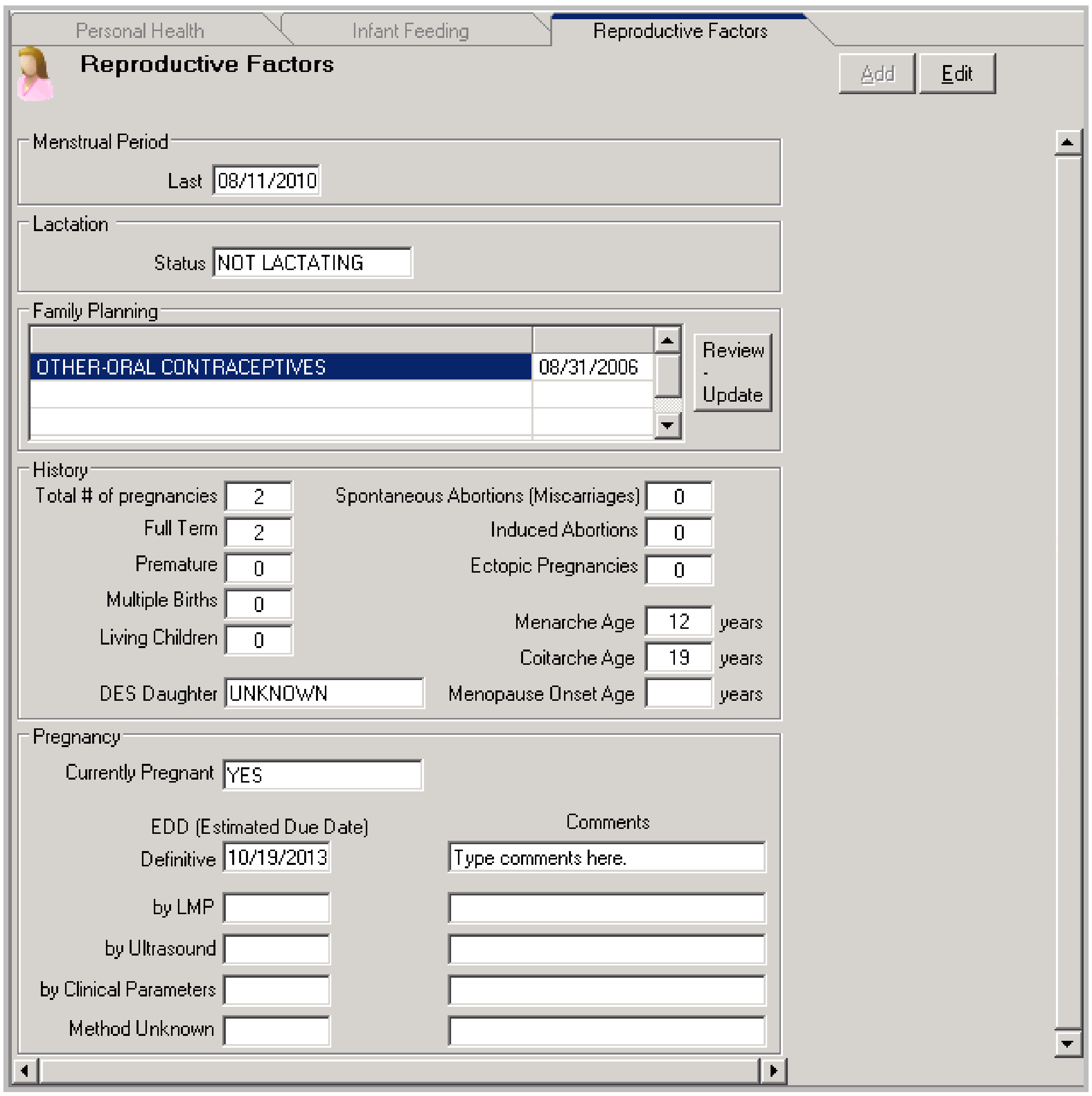


Figure 4-432: Reproductive Factors Data for Female Patient

A visit does not need to be selected. The Reproductive Factors application is used for populating PCC data in RPMS.

4.12.1 Add/Edit Reproductive Factors

Use the Add or Edit button on the Reproductive Factors dialog to add or update reproductive factors.

To Add Reproductive Factors:

1. Click Add on the Reproductive Factors dialog. The Update Reproductive Factors dialog opens.

Note:	If a patient currently has an entry for Reproductive Factors, only the Edit button is active. The Add button is grayed out. Refer to the next section for editing instructions.

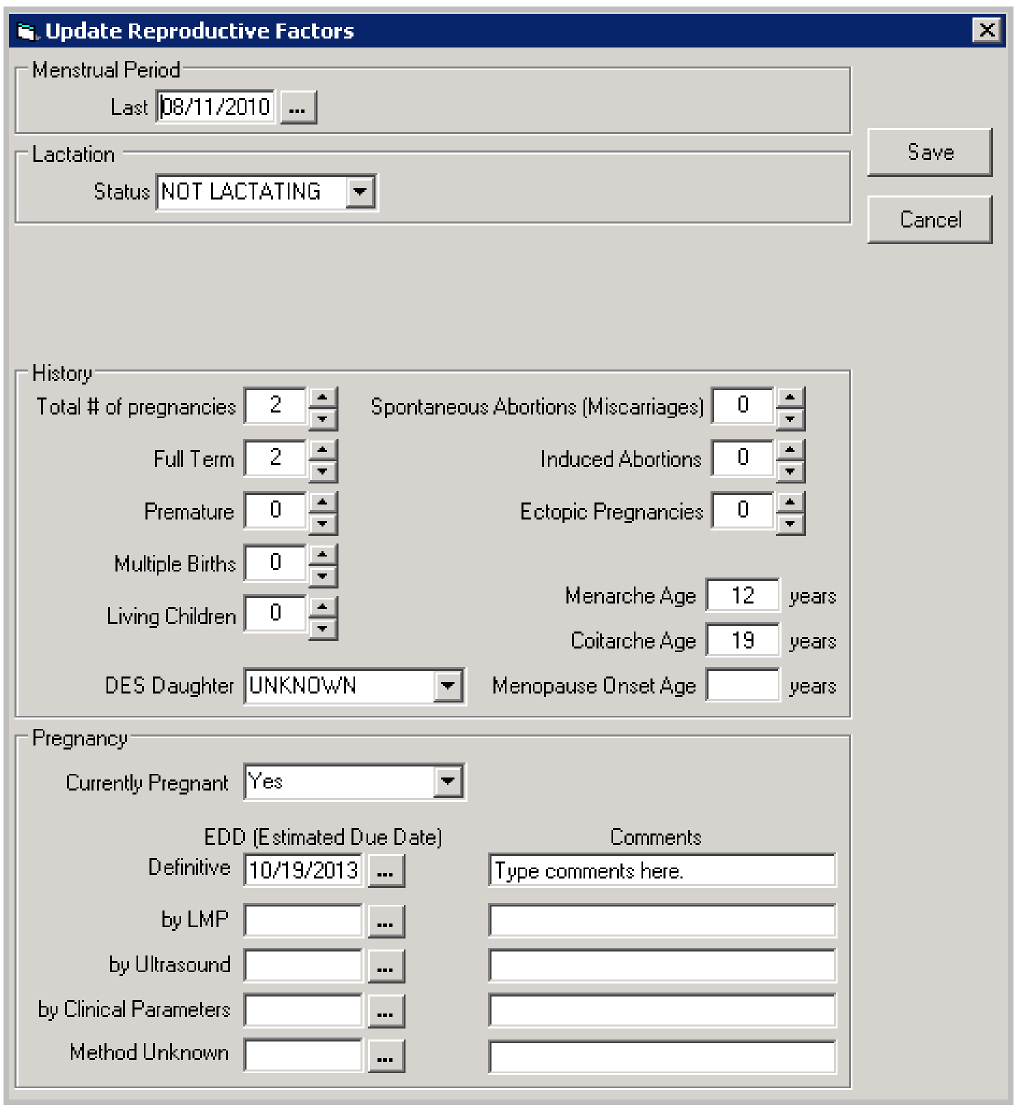


Figure 4-433: Add/Edit Reproductive Data Dialog

2. Provide the date of the patient's last menstrual period. This cannot be a future date. If you enter a future date, the application displays an Invalid Date alert message. Acceptable date entries are:

   - A date selected by clicking the Ellipsis button and clicking a date on the calendar
   - A date typed in the MM/DD/YYY format, such as 01/23/1999
   - A format that omits the precise day, such as 01/1957
   - A date with the year omitted so the application uses the current year
   - Using a two-digit year assumes no more than 20 years in the future or 80 years in the past

3. Enter whether or not the patient is lactating by selecting one of the following from the drop-down menu:

   - Not Lactating
   - Lactating
   - Unknown

4. In the History section, complete the fields as applicable:

Note: Zero is an acceptable entry for the numeric fields.

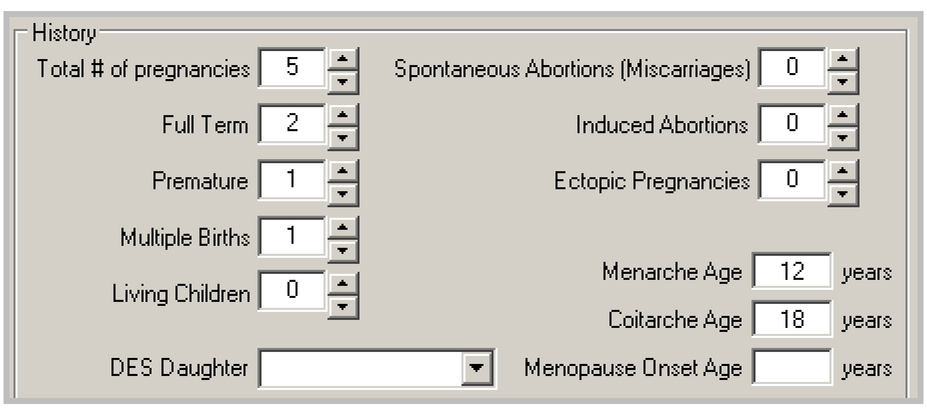


Figure 4-434: Reproductive History Fields

   a. Click the Up and Down arrows to indicate historic pregnancy and birth data.
   b. Type a number for Menarche, Coitarche, and Menopause ages.
   c. Select an entry for DES Daughter from the drop-down menu:

  - o Yes
  - o No
  - o Unknown
  - o Refused to Answer

5. In the Pregnancy section, complete the pregnancy information:
6. In Currently Pregnant, select one of the following:
   - Yes
   - No
   - Unknown
   - Refused to Answer

Note:	The fields in this section only become active if Yes is selected.

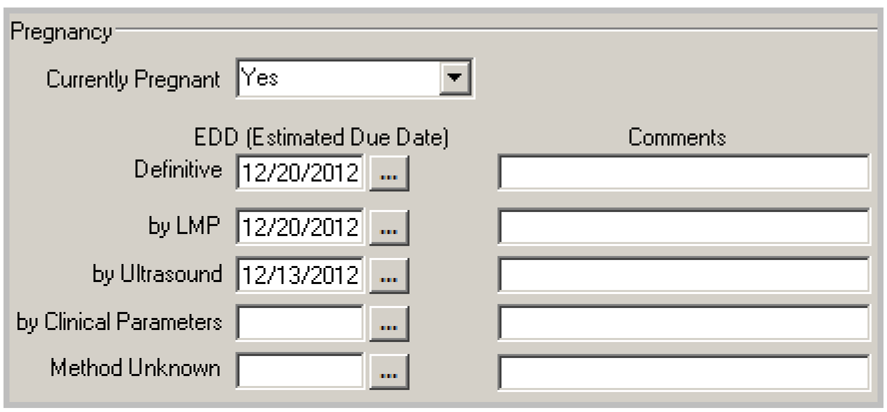


Figure 4-435: Pregnancy Data

Note:	If dates and comments are entered, and the Currently Pregnant drop-down menu is changed to No, the fields are cleared.

   - In the date fields, type a date or click the Ellipsis button to select the due dates from the calendar for the patient. All fields do not need to be entered.

Note:	The Definitive Due Date is required if the site wants to use the prenatal application.

   - In the Comments fields, type any notes, as needed.

7. Click Save at the top of the Update Reproductive Factors dialog.

4.12.1.1 To Edit Reproductive Factors

1. Click Edit on the Reproductive Factors dialog. The Update Reproductive Factors dialog opens.
2. Make any changes or updates, as necessary.
3. Click Save at the top of the Update Reproductive Factors dialog to save the changes.

4.12.2 Add/Edit Family Planning

Active family planning entries appear in the Reproductive Factors dialog. The Review/Update button on this dialog is used to review and update family planning.

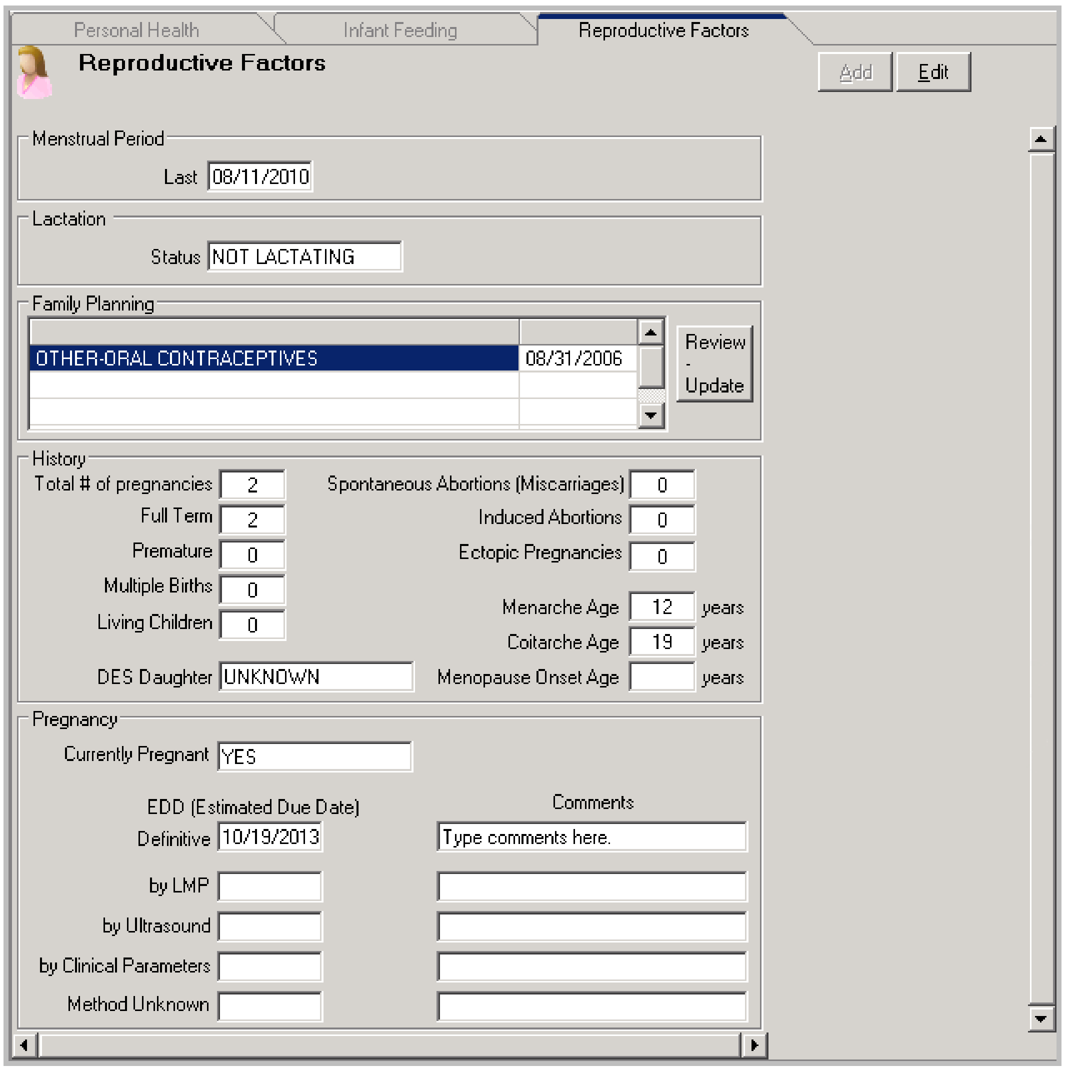


Figure 4-436: Reproductive History Review Dialog

Click the Review/Update button. The Review/Update of Family Planning Methods dialog opens.

4.12.2.1 To Add a New Family Planning Method

1. Click New to add a new family planning method. Entry fields appear in the Edit Method Information section at the bottom of the dialog.

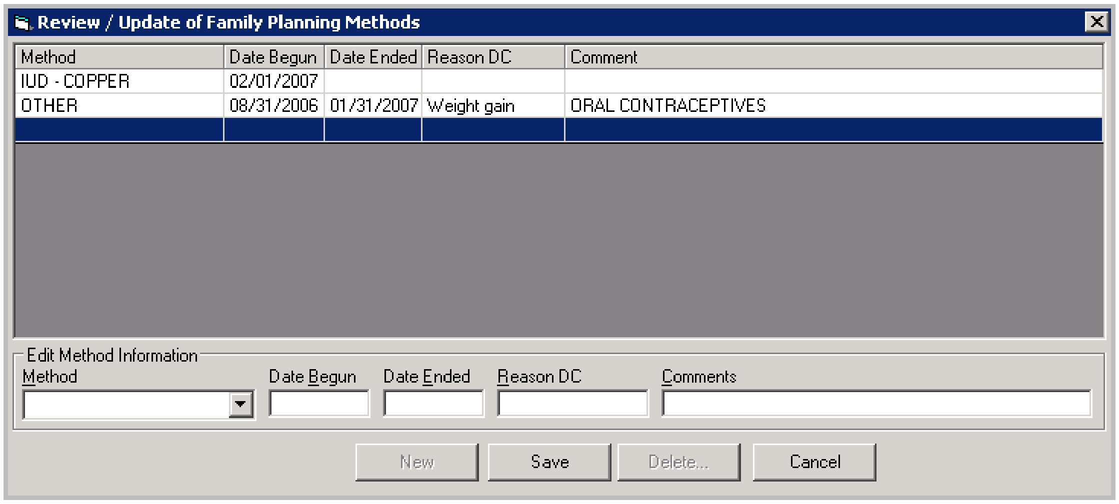


Figure 4-437.New Birth Control Method Dialog

2. In Method, select a birth control method from the drop-down menu.

3. In Date Begun, type the date the patient started using the method.

4. In Date Ended type the date the patient stopped using the method, if doing a historical entry.

Note: The following date formats can be used: T, T-n, M/D, M/D/YY, or M/D/YYYY.

5. In Reason DC, type the reason the patient stopped using the method.

6. In Comments, type a note, as needed.

7. Click Save. Your entry appears in the list.

4.12.2.2 To Edit an Existing Family Planning Method

1. Select an existing method to edit. The Edit Method Information section fields appear with the current information populated.

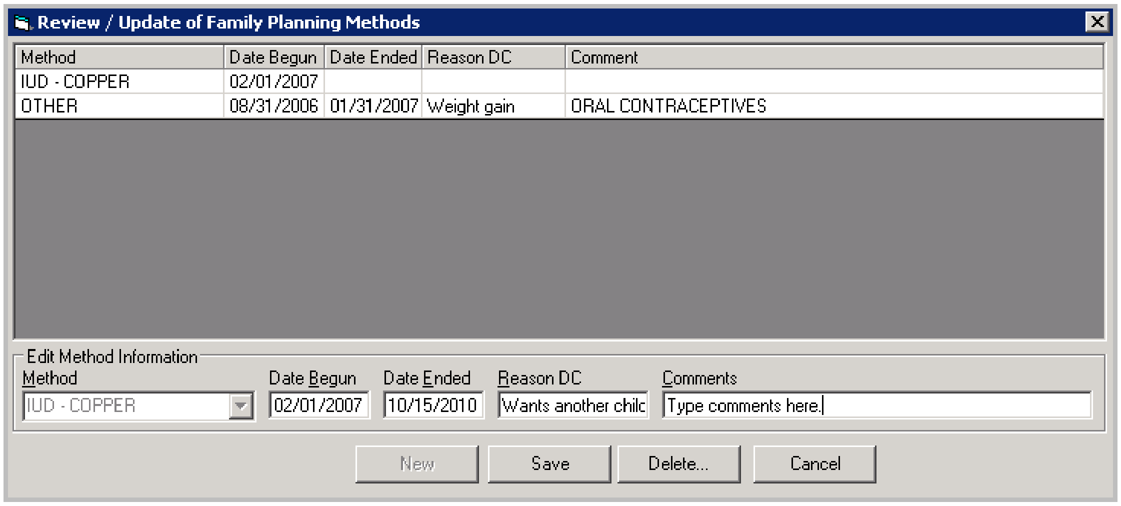


Figure 4-438: Edit Existing Birth Control Method Dialog

Note: The Method field is not accessible when editing a family planning method.

2. In Date Begun, type the date the patient began using the method, or edit the current date.

3. In Date Ended, type the date the patient stopped using the method, or edit the current date.

4. If a Date Ended was entered, type a reason for stopping the family planning method in the Reason DC field.

5. In Comments, type a note, as needed.

6. Click Save. The changes update in the list.

4.12.2.3 To Delete an Existing Family Planning Method

1. Select an existing method to edit.

2. Click the Delete button. The Reason for Deletion dialog opens.

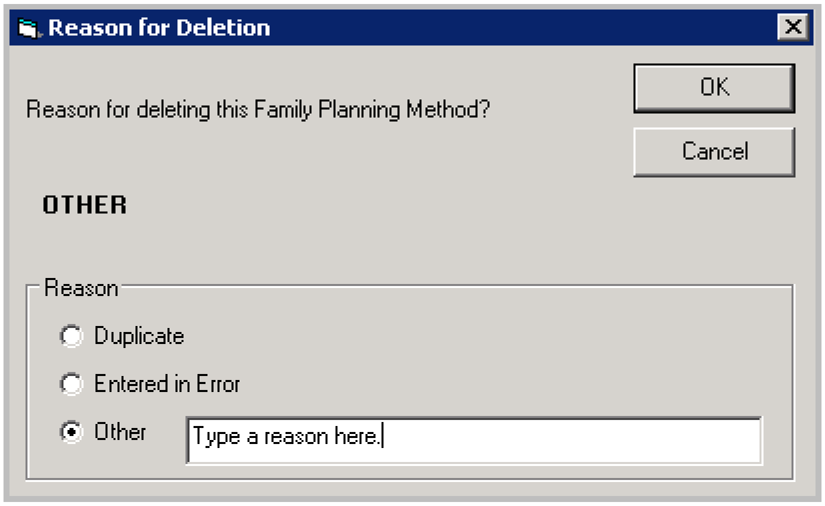


Figure 4-439: Reason for Deletion Dialog

3. Select one of the following reason option buttons:

    - Duplicate
    - Entered in Error
    - Other
        - If Other is selected, a reason must be typed in the field. If no reason is given, the following information message appears. Click OK to dismiss the message and provide a reason.

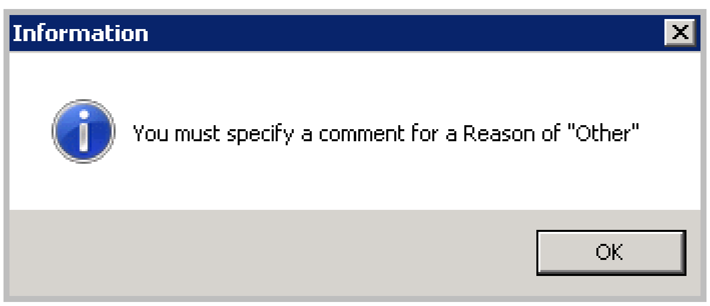


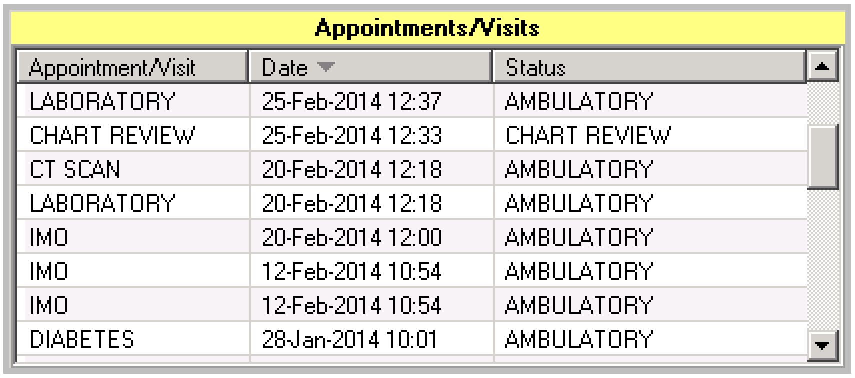
Figure 4-440: Other Delete Information Message

4. Click OK. The entry is deleted.

4.13 Visits

4.13.1 Appointments and Visits

The Appointments and Visits panel lists the appointments for the current patient. The list includes future appointments created through scheduling where no visit currently exists.



Appointments/Visits

Appointment/Visit	Date	Status
LABORATORY	25-Feb-2014 12:37	AMBULATORY
CHART REVIEW	25-Feb-2014 12:33	CHART REVIEW
CT SCAN	20-Feb-2014 12:18	AMBULATORY
LABORATORY	20-Feb-2014 12:18	AMBULATORY
IMO	20-Feb-2014 12:00	AMBULATORY
IMO	12-Feb-2014 10:54	AMBULATORY
IMO	12-Feb-2014 10:54	AMBULATORY
DIABETES	28-Jan-2014 10:01	AMBULATORY

Figure 4-441: Appointments and Visits Panel

The date range of appointments that appear on this panel is controlled by a parameter that is setup by the Clinical Applications Coordinator (CAC).

The default sort is by date, with the newest at the top. Any column can be sorted by clicking the heading.

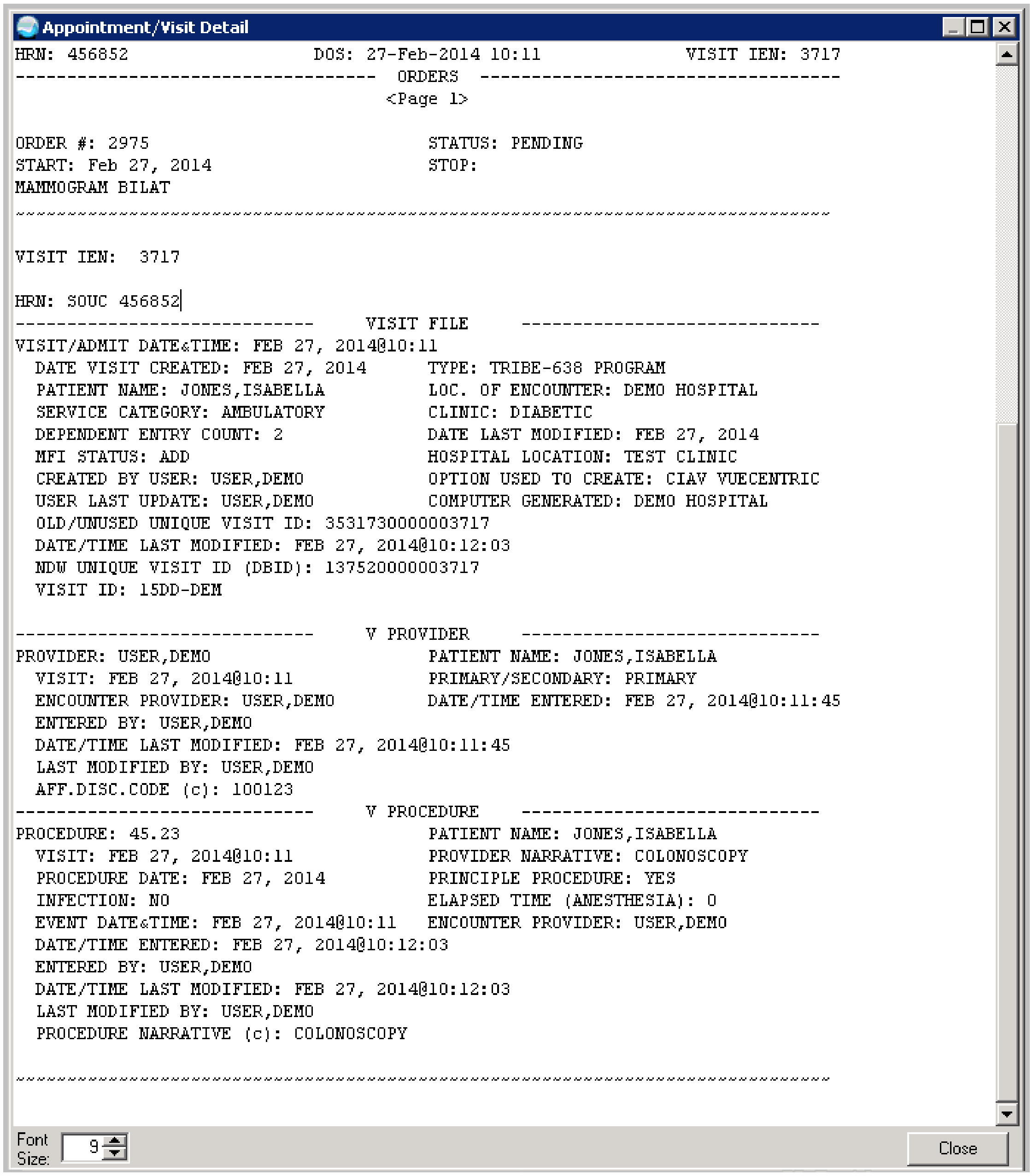
Select Refresh from the right-click menu to re-display the patient’s information to show recent changes.

4.13.2 Appointment/Visit Detail

If your application is configured for a pop-up window, the Appointment/Visit Detail (contents of the Visit File) displays when a table entry is selected.

Note: If a visit dated prior to the implementation date is selected, ICD-9 codes are shown. If a visit dated on or after the implementation date is selected, ICD-10 codes are shown.

Visit Detail Prior to Implementation



Appointment/Visit Detail

```
HRN: 456852                  DOS: 27-Feb-2014 10:11            VISIT IEN: 3717
-----------------------------------  ORDERS  -----------------------------------
                                  <Page 1>

ORDER #: 2975                           STATUS: PENDING
START: Feb 27, 2014                     STOP:
MAMMOGRAM BILAT
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

VISIT IEN:  3717

HRN: SOUC 456852
-----------------------------     VISIT FILE     -----------------------------
VISIT/ADMIT DATE&TIME: FEB 27, 2014@10:11
  DATE VISIT CREATED: FEB 27, 2014      TYPE: TRIBE-638 PROGRAM
  PATIENT NAME: JONES,ISABELLA          LOC. OF ENCOUNTER: DEMO HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: DIABETIC
  DEPENDENT ENTRY COUNT: 2              DATE LAST MODIFIED: FEB 27, 2014
  MFI STATUS: ADD                       HOSPITAL LOCATION: TEST CLINIC
  CREATED BY USER: USER,DEMO            OPTION USED TO CREATE: CIAV VUECENTRIC
  USER LAST UPDATE: USER,DEMO           COMPUTER GENERATED: DEMO HOSPITAL
  OLD/UNUSED UNIQUE VISIT ID: 3531730000003717
  DATE/TIME LAST MODIFIED: FEB 27, 2014@10:12:03
  NDW UNIQUE VISIT ID (DBID): 137520000003717
  VISIT ID: 15DD-DEM

-----------------------------     V PROVIDER     -----------------------------
PROVIDER: USER,DEMO                     PATIENT NAME: JONES,ISABELLA
  VISIT: FEB 27, 2014@10:11             PRIMARY/SECONDARY: PRIMARY
  ENCOUNTER PROVIDER: USER,DEMO         DATE/TIME ENTERED: FEB 27, 2014@10:11:45
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: FEB 27, 2014@10:11:45
  LAST MODIFIED BY: USER,DEMO
  AFF.DISC.CODE (c): 100123
-----------------------------     V PROCEDURE    -----------------------------
PROCEDURE: 45.23                        PATIENT NAME: JONES,ISABELLA
  VISIT: FEB 27, 2014@10:11             PROVIDER NARRATIVE: COLONOSCOPY
  PROCEDURE DATE: FEB 27, 2014          PRINCIPLE PROCEDURE: YES
  INFECTION: NO                         ELAPSED TIME (ANESTHESIA): 0
  EVENT DATE&TIME: FEB 27, 2014@10:11   ENCOUNTER PROVIDER: USER,DEMO
  DATE/TIME ENTERED: FEB 27, 2014@10:12:03
  ENTERED BY: USER,DEMO
  DATE/TIME LAST MODIFIED: FEB 27, 2014@10:12:03
  LAST MODIFIED BY: USER,DEMO
  PROCEDURE NARRATIVE (c): COLONOSCOPY

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Font Size: 9 Close

Figure 4-442: Appointment/Visit Detail Prior to Implementation

Visit Detail After Implementation

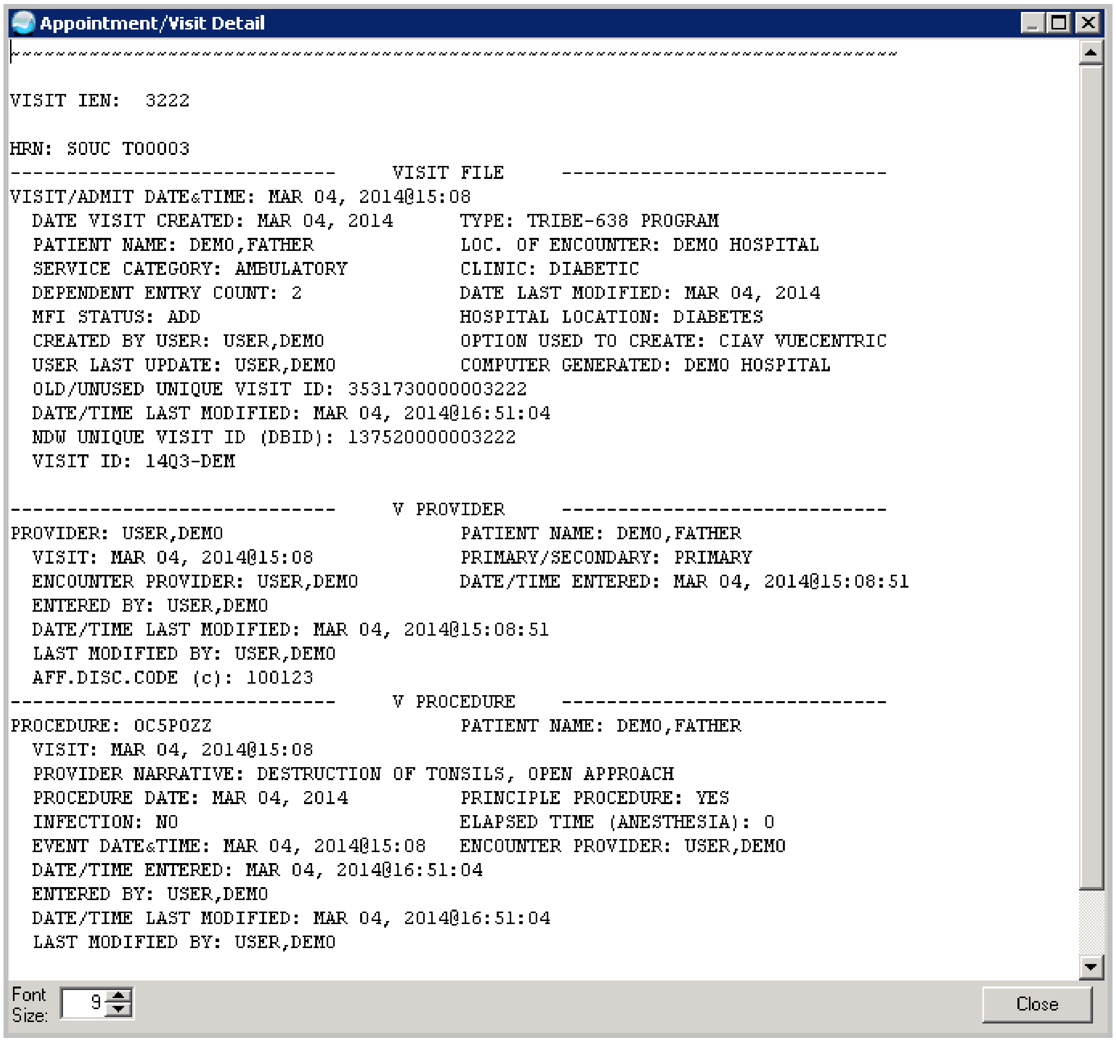


Figure 4-443.Appointment/Visit Detail After Implementation

The font size of the text displayed can be changed by adjusting the size in the Font Size field (enter manually or use the Up and Down arrows). This does not change the size of the text on the output when you print.

1. Click Print to choose a printer and to output the entire contents of this pop-up window to the specified printer. The Print button appears depending on how your application is configured.

   There is 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 such as MS Word.

2. Click Close to dismiss the pop-up window.

4.14 Visit Services

The Visit Services application displays the procedures that have been selected for the patient visit. Service listed in this panel can be added, edited, or deleted using buttons located at the top of the panel, by right-clicking anywhere in the panel and selecting an option, or by right-clicking and selecting the item you want to edit or delete.

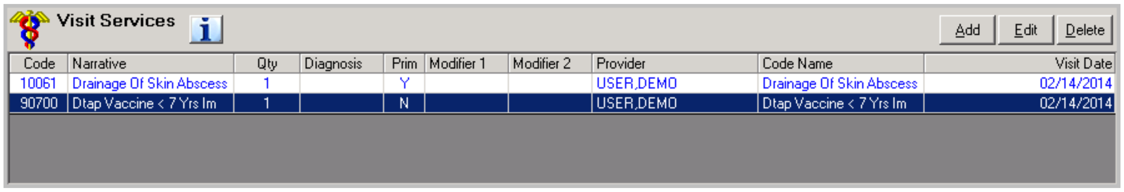


Figure 4-444: Visit Services Panel

4.14.1 Right-Click Menu

The Visit Services application right-click menu contains the following options:

- Add New Procedure
- Edit Procedure
- Delete Procedure
- View Visit Detail
- Web References

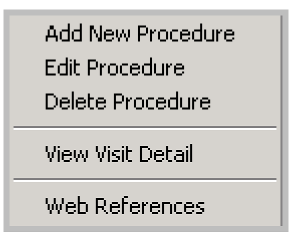


Figure 4-445: Visit Services Right-Click Menu

Select an existing record and select the View Visit Detail option on the right-click menu to display visit information in a pop-up window.

4.14.2 Adding a Visit Service Record

4.14.2.1 Adding a Visit Service Record Using CPT Code

A visit must be selected to add a visit service record.

Note:	Holders of the BGOZ VCPT EDIT security key are able to add Visit Services records. Holders of the BGOZ VIEW ONLY security key can only view Visit Services records.

Follow these steps to add a new visit procedure using CPT Code:

1. Click the Add button or select Add New Procedure on the right-click menu. The Add Procedure for Current Visit dialog opens.

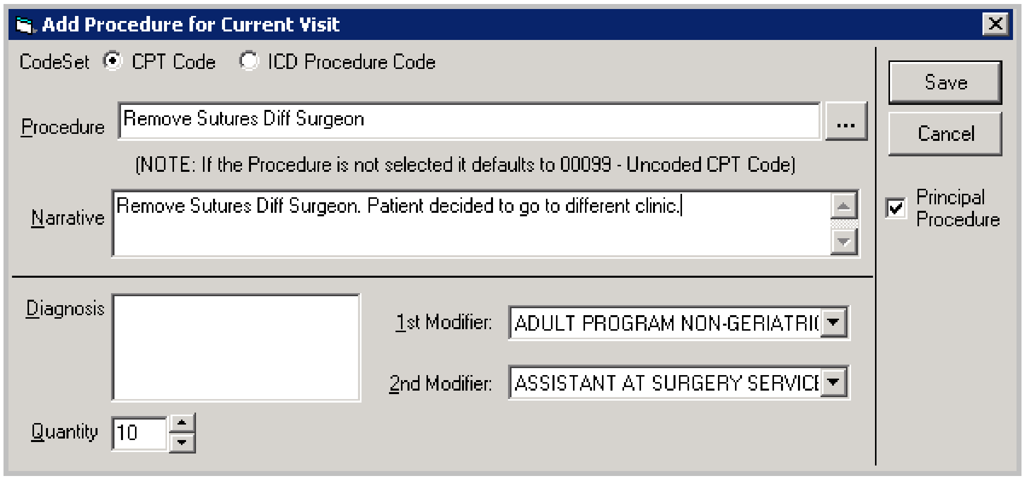


Figure 4-446: Add Procedure for Current Visit Dialog

2. Click the CPT Code option button.

3. In the Procedure field, type the name of the procedure and click the Ellipsis button or just press Enter. The Procedure Lookup dialog opens.

4. In the Procedure field, type the name of the procedure, then click the Ellipsis button. Or simply click the Ellipsis button and the Procedure Lookup dialog opens.

Note:	The Procedure field must be completed. A Failed to Save Procedure information message appears if you attempt to save with a blank Procedure field.

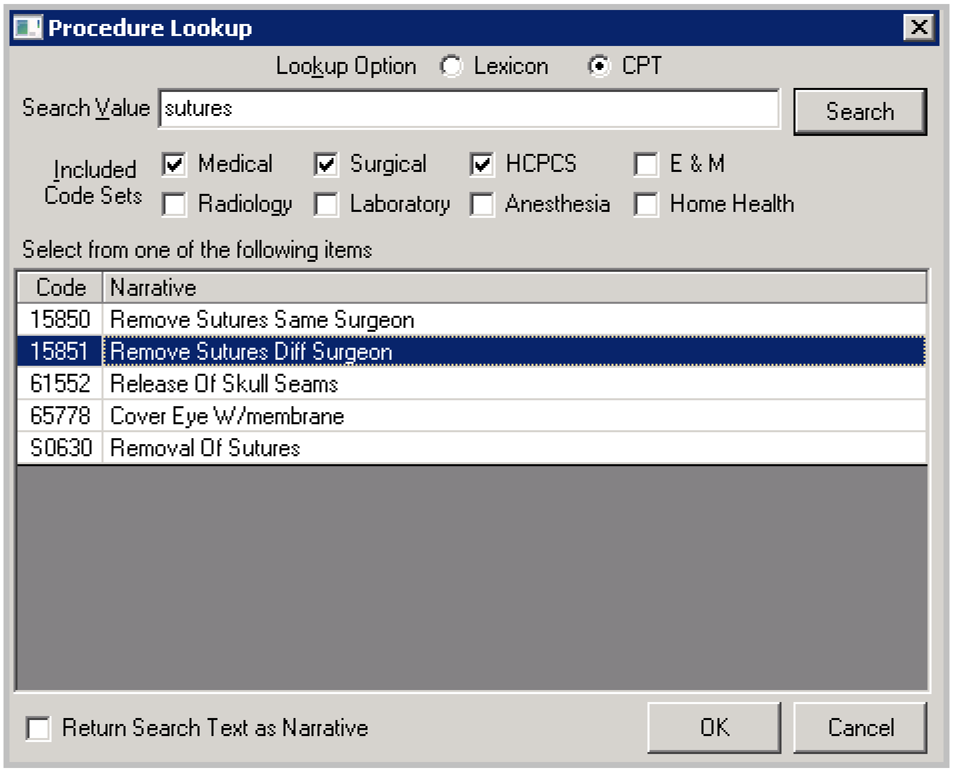


Figure 4-447: Procedure Lookup Dialog

a. In the Procedure Lookup dialog in Lookup Option, click the Lexicon or CPT option button to select a search option.

b. In Search Value, type a search term if one was not already entered.

c. In Included Code Sets, select one or more of the following check boxes:

- Medical (default)
- Surgical (default)
- HCPCS (default)
- E&M
- Radiology
- Laboratory
- Anesthesia
- Home Health

d. If needed, select the Return Search Text as Narrative check box.

e. Click Search. A list of matching Codes and Narratives is returned.

f. Select an item and click OK. Your selection is populated in the Procedure field of the Add Procedure dialog. The Narrative field also populates with the narrative of the code selected.

   The Narrative field is required. This field is limited to 160 characters. If a narrative is longer than 160 characters, the Narrative Too Long information message displays when you click Save on the Add Procedure for Current Visit dialog.

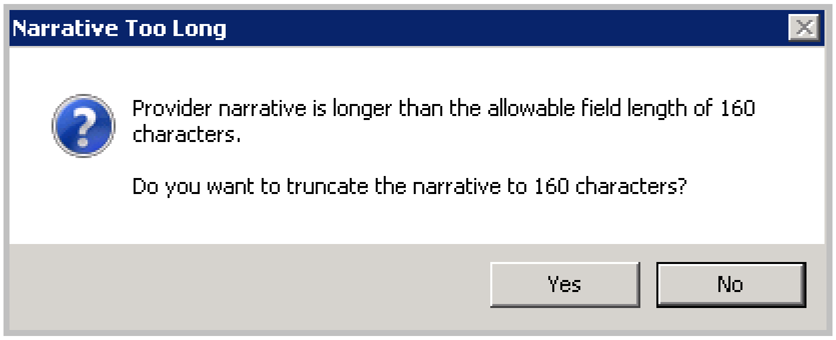


Figure 4-448: Information Message for Narrative Too Long

- Click Yes to have the application truncate the text of the Narrative field to 160 characters.
- Click No to close the information message. Return to the Narrative field and edit the text. The Narrative field has a right-click menu to aid in editing the text.

5. In Diagnosis, the selections in this field come from the purpose of visit. Select one or more of the appropriate selections in the Diagnosis selection panel, if needed.
6. The Principal Procedure check box indicates whether or not the procedure you are adding is the primary one for the visit. When selected, it indicates that this is the procedure to bill. Also, when selected, the Prim cell on the grid will contain Y; when not selected, the Prim cell will contain N.
7. The Quantity field applies to the selected diagnosis. For example, enter the number of sutures removed. If applicable, type (or select using the Up and Down arrows) the quantity of the item used in the Quantity field.
8. In the 1st Modifier field, click the arrow to open a drop-down list where a modifier can be selected. The modifiers are used to reflect the status of the procedure as of this visit.
9. In the 2nd Modifier, click the arrow to open a drop-down list where a second modifier can be selected.

> **Note:** The selections checked in the Diagnosis and the items in the Modifier fields might influence subsequent billing activity for the visit.

10. Click Save. The add process generates a record in the Visit Services and Historical Services components. The New records are in blue lettering.

    If you delete one of these new records (for example, the record for Visit Services), the other record is also deleted.

4.14.2.2 Adding a Visit Service Using ICD Procedure Code

A visit must be selected to add a Visit Service record.

> **Note:** Holders of the BGOZ VCPT EDIT security key are able to add Visit Services records. Holders of the BGOZ VIEW ONLY security key can only view Visit Services records.

> **Note:** If a visit dated prior to the implementation date is selected, ICD-9 codes are retrieved. If a visit dated on or after the implementation date is selected, ICD-10 codes are retrieved.

Follow these steps to add a new visit procedure using ICD Procedure Code:

1. Click the Add button or select Add New Procedure on the right-click menu. The Add Procedure for Current Visit dialog opens.

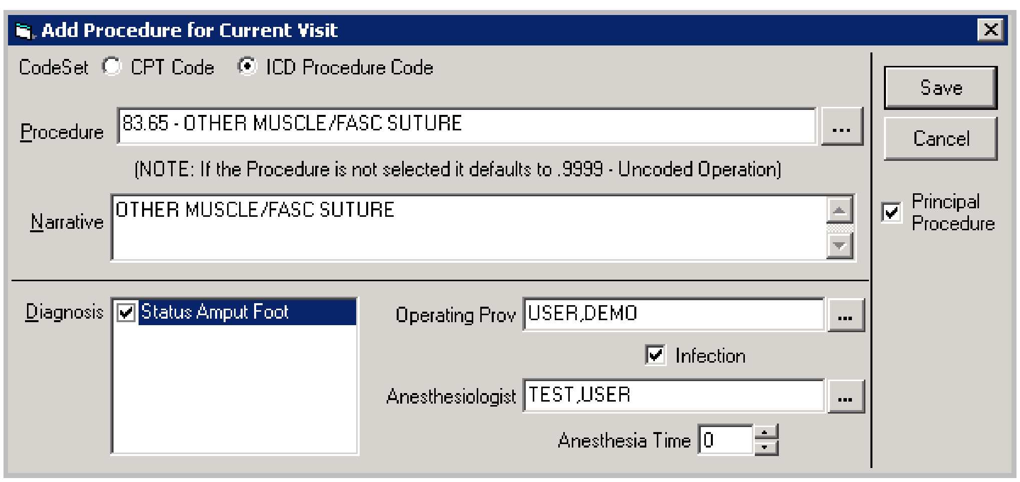


Figure 4-449: Add Procedure for Current Visit Dialog

2. Click the ICD Procedure option button.

3. In the Procedure field, type the name of the procedure, then click the Ellipsis

button. Or simply click the Ellipsis button and the Lookup ICD Procedure dialog opens.

> **Note:** The Procedure field must be completed. A Failed to Save Procedure information message appears if you attempt to save with a blank Procedure field.

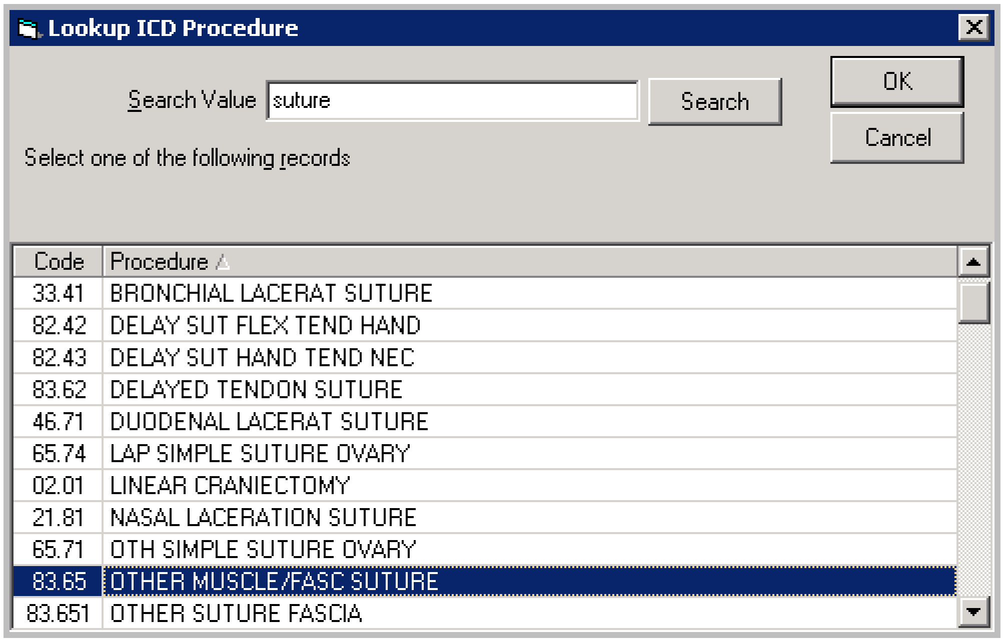


Figure 4-450: Lookup ICD Procedure Dialog

a. In the Lookup ICD Procedure dialog in Search Value, type the term to search for if one was not already entered.

b. Click the Search button. A list of matching Codes and Narratives is returned.

c. Select an item and click OK. Your selection is populated in the Procedure field of the Add Procedure dialog. The Narrative field also populates with the narrative of the code selected.

   The Narrative field is required. This field is limited to 160 characters. If it is longer than 160 characters, the Narrative Too Long information message displays after you click Save on the Add Procedure for Current Visit dialog.

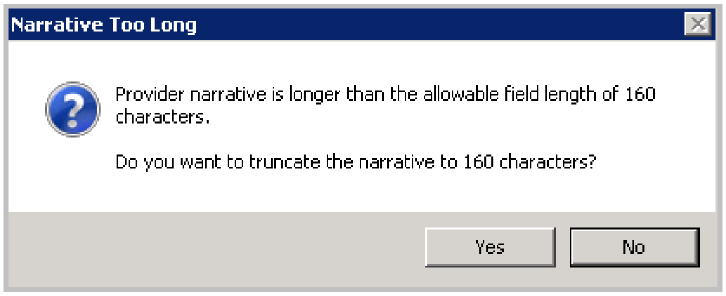


Figure 4-451: Sample Information Message for Narrative Too Long

- Click Yes to have the application truncate the text of the Narrative field to 160 characters.
- Click No to close the information message. Return to the Narrative field and edit the text. The Narrative field has a right-click menu to aid in editing the text.

4. In Diagnosis, the selections in this field come from the purpose of visit. Select one or more of the appropriate selections in the Diagnosis selection panel, if needed.
5. The Principal Procedure check box indicates whether or not the procedure is the primary one for the visit. When checked, this means this is the procedure to bill.
6. In the Operating Prov field, type the name of the operating provider or click the Ellipsis button to open the Lookup Provider dialog.

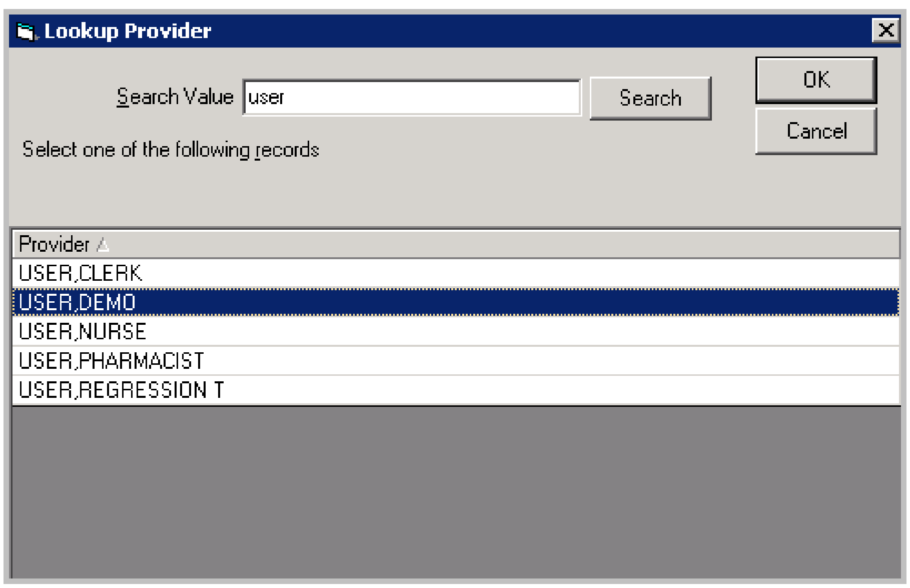


Figure 4-452: Lookup Provider Dialog

   a. In Search Value, type a name.
   b. Click Search. The Lookup Provider dialog refreshes with a list of matching names.
   c. Select a name from the list and click OK. Your selection populates in the Operating Prov field of the Add Procedure for Current Visit dialog.

7. If applicable, click the Infection check box.
8. In the Anesthesiologist field, type the name of the anesthesiologist or click the Ellipsis button to open the Lookup Provider dialog. Follow the same steps to populate the Anesthesiologist field as in step 6, above.
9. In the Anesthesia Time field, use the Up and Down arrows to indicate the number of minutes the patient was under anesthesia.
10. Click Save. The add process generates a record in the Visit Services and Historical Services components. The New records are in blue lettering.

> **Note:** If you delete one of these new records (for example, Visit Services), the other record is also deleted.

4.14.3 Editing the Visit Service Record

You must have a visit selected.

> **Note:** Holders of the BGOZ VCPT EDIT security key are able to edit Visit Services records. Holders of the BGOZ VIEW ONLY security key can only view Visit Services records.

Follow these steps to edit an existing visit service:

1. Select the procedure you want to edit in the Visit Services panel and click Edit or select Edit Procedure on the right-click menu. The Edit Procedure for Current Visit dialog displays, showing the existing information.

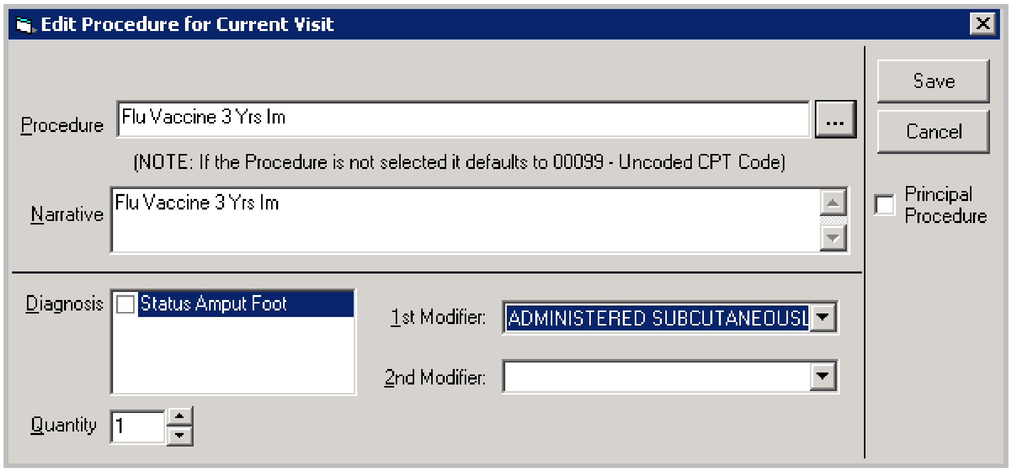


Figure 4-453: Edit Procedure for Current Visit

2. You can edit any of the fields on the dialog. See Adding a Visit Service Record for more information about how to complete the fields.

3. When the edits are complete, click Save to save your edits.

4.14.4 Deleting a Visit Service

You must have a visit selected. Follow these steps to delete a visit service:

1. Select the visit service you want to delete in the Visit Services panel, and then click Delete or select Delete Procedure on the right-click menu. The Delete Entry? information message opens.

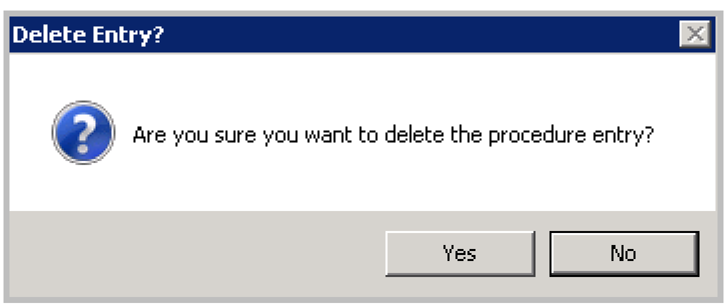


Figure 4-454: Delete Entry Information Message

2. Click Yes to remove the visit service from the Visit Services panel.

4.14.5 Web Reference Search

The Web Reference Search for the Visit Services panel depends on if any records are present or not.

- **Condition 1:** If there are records present, select one and click the Information button ( ), or select Web Reference on the right-click menu to go to the MedlinePlus Reference Web site for the topic associated with the selected record.

- **Condition 2:** If there are no records present, click the Information button ( ), or select Web Reference on the right-click menu to display the Web Reference Search dialog.

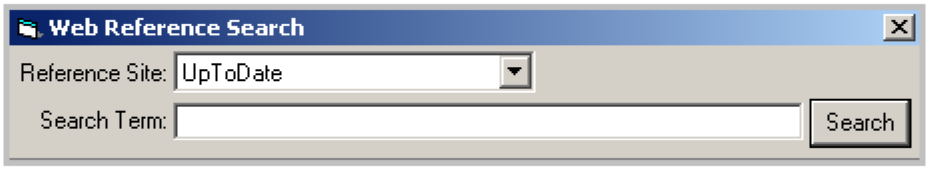


Figure 4-455: Web Reference Search Dialog

a. In the Reference Site field, select a Reference Web site from the drop-down menu.

b. In Search Term, type a term and click Search. You are taken to the selected Reference Web site for the specified term.

Appendix A: Fixing GetItem Error in EHRP14

Read through these instructions prior to set up to become oriented with procedures that must be completed.

Users receive a GetItem Error when using a CPT code that has a high frequency. The problem occurs if the frequency count for an item in the PickList is greater than an int16 can handle.

This appendix provides instructions on running the report from FileMan to fix the error.

> **Note:** Change the frequency of the CPT codes that are above 25,000. In the example report below, the NURSING CPT code 94760 frequency is at 54,534. Reset the frequency to 200 as the new value in FileMan. The frequency should never get to 32768. If it exceeds 32768, the user receives the GetItems error.

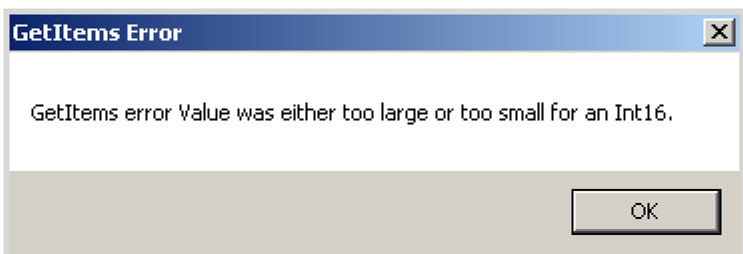


Figure 4-456: GetItems Error Message

A.1 FileMan Search

FileMan search instructions (VA FileMan 22.0) are as follows:

1. Select OPTION: 3 SEARCH FILE ENTRIES.
2. At OUTPUT FROM WHAT FILE:, enter BGO CPT PREFERENCES//.
    a. At -A- SEARCH FOR BGO CPT PREFERENCES FIELD:, enter CPT (multiple).
    b. At -A- SEARCH FOR BGO CPT PREFERENCES CPT SUB-FIELD:, enter FREQUENCY.
    c. At -A- CONDITION:, enter an amount GREATER THAN, 32767.
    d. At -A- GREATER THAN:, enter 100 (enter your large number).
    e. At -B- SEARCH FOR BGO CPT PREFERENCES CPT SUB-FIELD:,

press Enter.

f. At -B- SEARCH FOR BGO CPT PREFERENCES FIELD:, press Enter.

3. IF:, select A// BGO CPT PREFERENCES FREQUENCY GREATER THAN "100."
4. At DO YOU WANT THIS SEARCH SPECIFICATION TO BE CONSIDERED TRUE FOR CONDITION -A-:

   1) WHEN AT LEAST ONE OF THE 'CPT' MULTIPLES SATISFIES IT

   2) WHEN ALL OF THE 'CPT' MULTIPLES SATISFY IT

   CHOOSE 1-2:, enter 1//
5. Store the results of the search in the template.
6. At SORT BY:, enter NAME// CPT (multiple).
7. At CPT SUB-FIELD:, enter FREQUENCY.
8. At START WITH FREQUENCY:, enter FIRST// 100 (your large number).
9. At GO TO FREQUENCY:, enter LAST//.
   a. At WITHIN FREQUENCY, SORT BY:, press Enter.
10. At FIRST PRINT FIELD:, enter .01 NAME.
11. At THEN PRINT FIELD:, enter CPT (multiple).
    a. At THEN PRINT CPT SUB-FIELD:, enter .01 CPT.
    b. At THEN PRINT CPT SUB-FIELD:, enter .03 FREQUENCY.
    c. At THEN PRINT CPT SUB-FIELD:, press Enter.
12. At THEN PRINT FIELD:, press Enter.
13. At Heading (S/C):, enter BGO CPT PREFERENCES SEARCH Replace.
14. Store the print logic in the template.
15. At START AT PAGE:, enter 1//.
16. At DEVICE:, enter CONSOLE.

a. At Right Margin:, enter 80//.

The following appears: EXCUSE ME, HOLD ON.

```
BGO CPT PREFERENCES SEARCH                     APR  7,2015  16:32
PAGE 1
NAME
    CPT                             FREQUENCY
----------------------------------------------------------------------

OPTOMETRY
    92015                                118
OPTOMETRY
    92014                                149
OPTOMETRY
    92012                                300
ANURSE SUPERBILL
    94760                                356
DRESSING-WOUND CARE
    29580                                999

                          5 MATCHES FOUND
```

17. To edit, logon to FileMan and enter/edit.
18. At Select OPTION:, select 1 ENTER OR EDIT FILE ENTRIES.
19. At INPUT TO WHAT FILE:, enter BGO CPT PREFERENCES//.
20. At EDIT WHICH FIELD:, enter ALL// CPT (multiple).
    a. At EDIT WHICH CPT SUB-FIELD:, enter ALL// FREQUENCY.
    b. At THEN EDIT CPT SUB-FIELD: press Enter.
    c. At THEN EDIT FIELD:, press Enter.
21. At Select BGO CPT PREFERENCES NAME:, enter OPTOMETRY (Enter the name from the search output).
22. At Select CPT:, enter 92081// 92015 DETERMINE REFRACTIVE STATE (enter the CPT from the search output).
    a. At DETERMINATION OF REFRACTIVE STATE OK? Yes//, enter Y (Yes).
    b. At FREQUENCY:, enter 118// (change the frequency).

A.2 Example of Report Returned from FileMan

```
BGO CPT PREFERENCES SEARCH           APR 14,2015  10:10
PAGE 1
```

NAME	CPT	FREQUENCY
NURSING	96366	100
PTSUPPLIES	E0112	101
BH SUPERBILL	90836	102
PROCEDURES	12002	104
PT	97018	106
PT	97018	106
SUPPLIES	A6216	107
PODIATRY	11040	110
GYN	57455	120
NURSING	J3030	120
PROCEDURES	20553	121
KEWA-EYE	92285	131
NURSING	J1950	131
PT	11719	133
PT	97760	137
AUDIOLOGY CPT	92591	140
P T	97760	143
PODIATRY	90772	146
KEWA-EYE	92132	147
PROCEDURES	17110	147
PHN PROCEDURES	S9446	148
IMMUNIZATIONS	90660	149
GYN	J7302	155
GENERAL PROCEDURES	93010	155
PT	11721	155
KEWA - PHN	90471	156
PAIN	20553	157
BH SUPERBILL	90833	158
NURSING	J7620	159
NURSING	J9260	161
PODIATRY	11721	163
PROCEDURES	12001	163
KEWA BH	T1016	164
NURSING	J1631	167
PT	97116	167
GYN	S0610	176
PODIATRY	11719	178
AUDIOLOGY CPT	92590	179
KEWA BH	90834	180
AUDIOLOGY CPT	92556	182
BH SUPERBILL	90837	185
AUDIOLOGY CPT	92553	191
NURSING	J1815	197
NON - OB ULTRASOUND	90471	197
DIABETES MELLITUS	93000	198
PODIATRY	64450	204
NURSING	J1070	205
BH SUPERBILL	90792	205
PHN PROCEDURES	S9445	205
BH SUPERBILL	99441	213
BH SUPERBILL	98967	215
AUDIOLOGY CPT	92587	218
PHN PROCEDURES	T1001	224
GYN	58301	235
PAIN	20552	237
IMMUNIZATIONS	90657	248
GYN	57160	249
PT	97014	249
PROCEDURES	20550	263

```
PODIATRY                          11730                                265
PT                                97140                                281
FOOT DEVICES                      94760                                288
P T                               97014                                297
PROCEDURES                        10060                                305
GYN                               58100                                321
P T                               97033                                321
PT                                97033                                321
NURSING                           J0881                                323
BH SUPERBILL                      90846                                328
BH SUPERBILL                      99242                                339
PT                                97597                                344
NURSING                           96372                                345
BH SUPERBILL                      96101                                353
PROCEDURES                        20552                                364
GYN                               Q0111                                373
PT                                97112                                375
NURSING                           94640                                377
NURSING                           96374                                379
OBSTETRICS                        76805                                384
KEWA BH                           90837                                386
P T                               97032                                407
PT                                97032                                407
P T                               97112                                414
PT                                97002                                419
AUDIOLOGY CPT                     92552                                430
PSYCHIATRY                        90832                                434
PT                                97530                                439
NUTRITION                         97803                                449
PSYCHIATRY                        90834                                453
DIABETES MELLITUS                 83036                                480
ANTICOAG                          99607                                499
BH SUPERBILL                      90832                                502
BH SUPERBILL                      90889                                533
NURSING                           96365                                536
FOOT DEVICES                      36415                                547
DIABETES MELLITUS                 36415                                553
NURSING                           96361                                558
GYN                               58300                                571
AUDIOLOGY CPT                     92593                                595
BH SUPERBILL                      98968                                606
NURSING                           J0561                                610
GYN                               57452                                617
PROCEDURES                        20610                                627
NURSING                           J1050                                645
NURSING                           93000                                652
NURSING                           J7610                                688
EYE GLASSES                       92370                                728
PT                                97116                                729
P T                               97116                                752
ANTICOAG                          99364                                774
ANTICOAG                          85610                                796
OBSTETRICS                        76801                                823
KEWA-EYE                          92134                                828
OBSTETRICS                        59426                                835
AUDIOLOGY CPT                     92557                                877
PT                                97001                                884
NURSING                           J2270                                909
NURSING                           J0696                                956
PROCEDURES                        90472                                958
BH SUPERBILL                      99241                               1001
```

BH SUPERBILL	90885	1018
BH SUPERBILL	90834	1029
KEWA-EYE	92133	1030
NUTRITION	97802	1030
AUDIOLOGY CPT	92592	1041
KEWA-EYE	92002	1066
GYN	76830	1138
AUDIOLOGY CPT	92567	1162
ANTICOAG	99606	1174
NURSING	96360	1189
BH SUPERBILL	90847	1195
PT	97002	1217
NURSING	J2550	1321
KEWA-EYE	92012	1332
P T	97002	1346
NON - OB ULTRASOUND	94760	1419
PT	97602	1435
ANTICOAG	36416	1502
PT	97110	1795
IMMUNIZATIONS	90658	1896
EYE GLASSES	92341	1923
EYE GLASSES	92342	1924
KEWA-EYE	92083	1955
NURSING	J1885	1985
PT	97035	1988
P T	97035	2034
OBSTETRICS	59425	2055
GYN	Q0091	2059
NURSING	J3420	2089
KEWA-EYE	92014	2171
PT	97001	2285
P T	97001	2415
DIABETES MELLITUS	36416	2764
KEWA-EYE	92004	2944
PT	97140	3077
PROCEDURES	90471	3196
P T	97140	3305
NURSING	36416	3896
GYN	S0612	3968
EYE GLASSES	92340	4942
KEWA-EYE	92015	6060
GENERAL PROCEDURES	94760	6608
URGENT CARE PROCEDURES	94760	7001
PT	97110	8495
P T	97110	9115
NURSING	36415	9595
PROCEDURES	94760	13923
NURSING	94760	54534

168 MATCHES FOUND

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