RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Addendum to EHR User Manual

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Preface

The following are Indian Health Service (IHS) components in the Resource and Patient Management (RPMS) Electronic Health Record (EHR).

- Integrated Problem List (IPL)
- Medication Management
- Reproductive Factors
- Clinical Information Reconciliation Tool (CIR)
- Consolidated Clinical Document Architecture Generation (CCDA)

1.0 Integrated Problem List (IPL)

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

- Status
- Onset Date
- Date of Diagnosis
- Date Resolved
- Priority
- Provider Narrative
- Comments
- Frequency count for use as a Purpose of Visit (POV)
- 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
- If the problem is a Purpose of Visit (POV) for the current encounter
- If the problem has been marked as Non-Redisclosable (NR)
- ICD code

1.1 Orientation

At the top of the **Problem List** window of the **IPL** component (Figure 1-1) are the following features:

- Buttons
- Tabs
- Columns

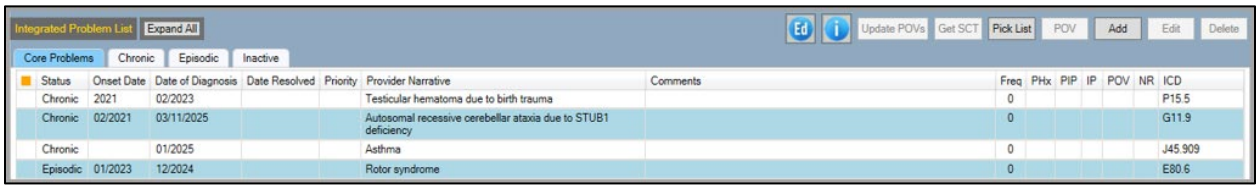


Figure 1-1: IPL Problem List main window

1.1.1 Features

- **Map Source**–Briefly hover the mouse pointer over the code in the **ICD** column to view a window of the map source advice (Figure 1-2), based on the **SNOMED CT** code.

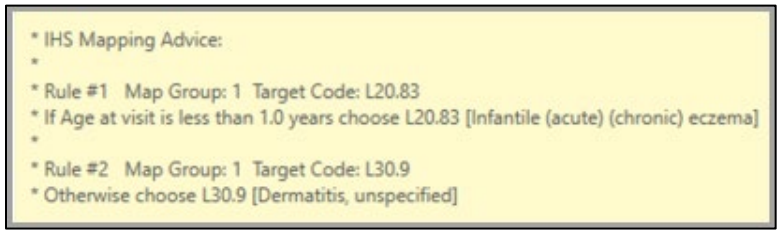


Figure 1-2: Map source window

- **Buttons Disabled**–For problems with a non-coded **SNOMED** code, the **Edit** and **POV (Purpose of Visit)** buttons are disabled.
- **Viewing Problem Details**–Double-click anywhere in a line item to view the **Problem Details** window (Figure 1-3).

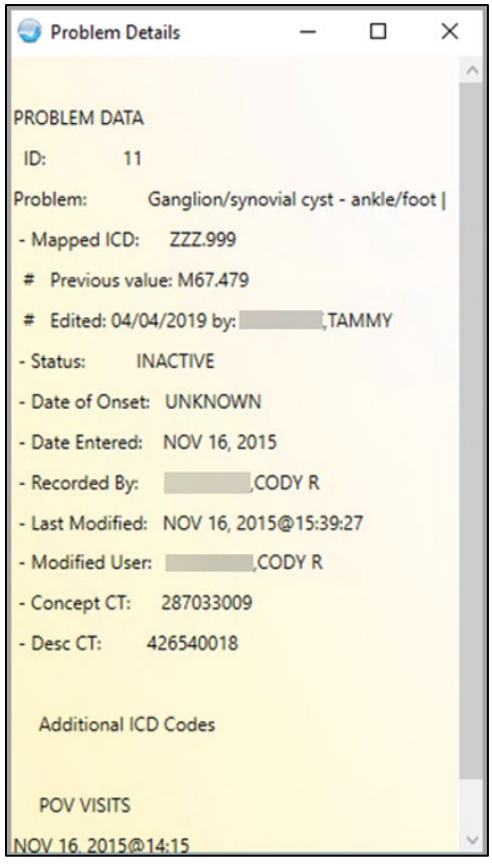


Figure 1-3: Problem Details window

- **Right-Click Menu**–Right-click anywhere on a diagnosis line to open the **Right-Click** menu (Figure 1-4).

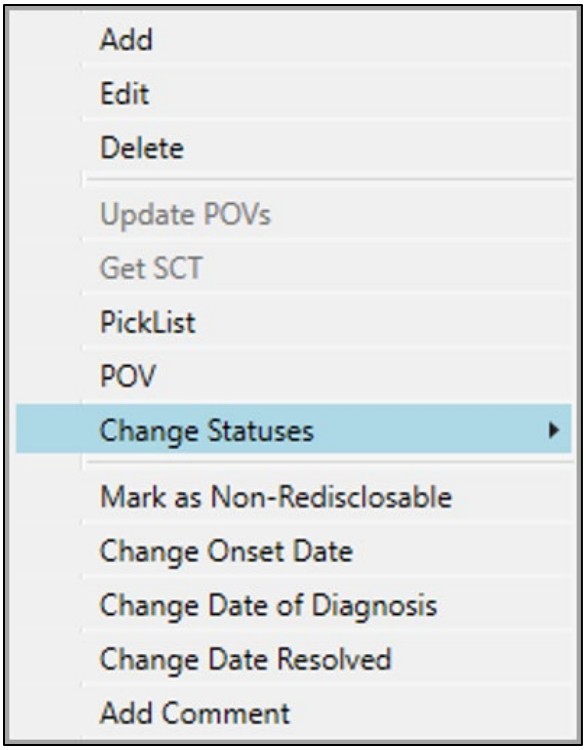


Figure 1-4: Right-click menu

- **Add:** To add a problem, refer to Section 1.8.1 for details.
- **Edit:** To edit an existing problem. Opens the **Edit Problem** dialog. Refer to Section 1.8.2 for details.
- **Delete:** To delete the selected problem. Refer to Section 1.8.4 for details.
- **Update POVs:** To update a Purpose of Visit (POV). Refer to Section 1.4 for details.
- **Get SCT:** To update a historical ICD 9 entry. Opens the **SNOMED CT Lookup** dialog. Refer to Section 1.3 topic for details.
- **Pick List:** Click the **PickList** button to select SNOMED CT descriptions by defined pick lists. Refer to Section 1.5.
- **POV:** To flag an outpatient problem as POV and to flag an inpatient problem as used for inpatient. This allows a provider to add visit, care plan, or goal activity data. Refer to Section 1.4 for details.
- **Change Statuses:** To change the status of an entry, select **Change Statuses** to display the list of available statuses.
  - Chronic
  - Episodic
  - Sub-acute
  - Personal History

- Inactive
- Social/Env
- Routine/Admin

– **Mark as Non-Redisclosable:** Places check in **NR** column and identifies information not to be disclosed to another site or provider without patient permission.

– **Change Onset Date:** Allows the Onset Date (Figure 1-5, Figure 1-6) to be changed.

- The date can be cleared.
- The date can be entered as an imprecise date (example **MMYYY**, **MM/YYYY**, or **YYYY**).
- The date can utilize **T** for today, the **Today** button.
- The date can be entered as format **mm/dd/yyyy** or use the date widget icon.

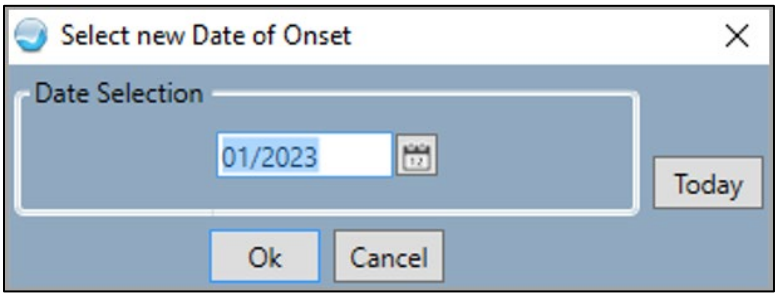


Figure 1-5: Change onset date right-click

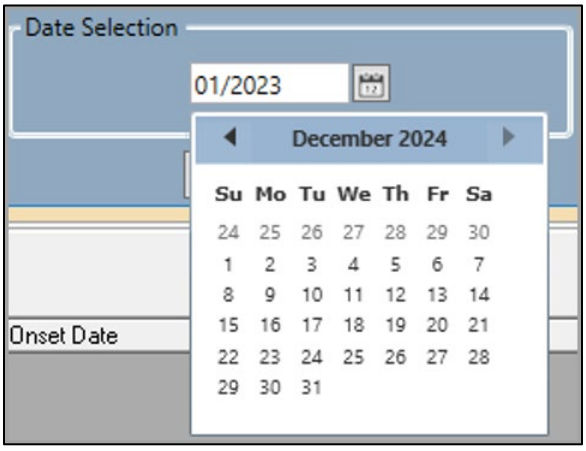


Figure 1-6: Date/Calendar selection

– **Change Date of Diagnosis:** Allows the Date of Diagnosis (Figure 1-7) to be changed. The date can be cleared,

- The date can be entered in as an imprecise date (Example **MMYYY**, **MM/YYYY**, or **YYYY**).
- The date can utilize **T** for today, the **Today** button.
- The date can be entered as format **mm/dd/yyyy** or use the date widget icon.

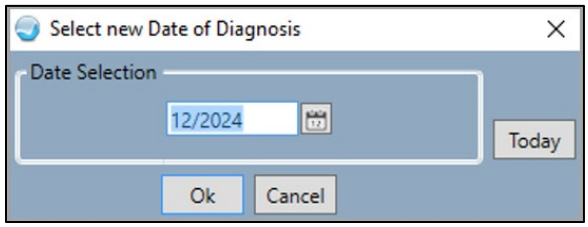


Figure 1-7: Change Date of Diagnosis right-click

– **Change Date Resolved:** Allows the Date Resolved (Figure 1-8) to be changed.

- The date can be cleared.
- The date can be entered in as an imprecise date (Example **MMYYY**, **MM/YYYY**, or **YYYY**).
- The date can utilize **T** for today, the **Today** button.
- The date can be entered as format **mm/dd/yyyy** or use the date widget icon.

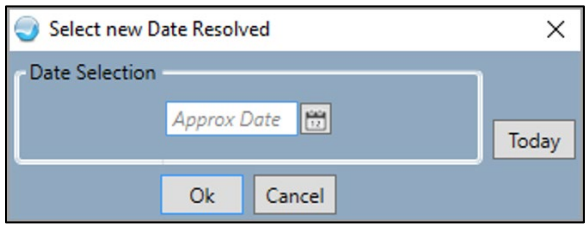


Figure 1-8: Change Date Resolved right-click

– **Add Comment:** Refer to Section 1.8.2.1 for more information.

1.1.2 Buttons

A row of buttons (Figure 1-9) are located at the top of the **IPL** window.



Figure 1-9: IPL window 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 Planning 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 to display the **Web Reference Search** dialog (Figure 1-10). Select the reference site to view from the drop-down list and click Search. Refer to the Using the Clinical Decision Support Button topic for details.

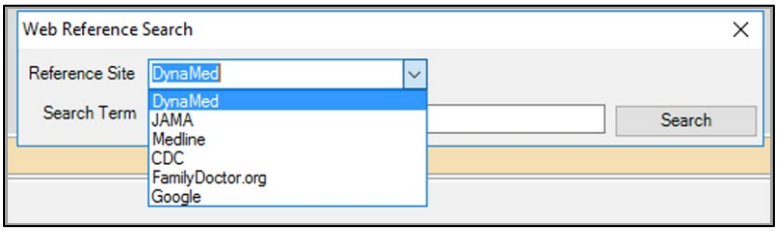


Figure 1-10: Web Reference Search dialog

- **Update POVs:** Updates any changes made to IPL POV list.
- **Get SCT button:** Click this button to look up the SNOMED CT code for an entry uncoded in SNOMED.
- **Pick List button:** Click this button to select SNOMED CT descriptions by defined pick lists.
- **POV button:** Click this button to mark the problem as the purpose of visit and to add visit, care plan, or goal activity data.
- **Add button:** Click this button to add a problem. Refer to Adding a Problem topic for details.
- **Edit button:** Click this button to edit an existing problem. Refer to Editing a Problem topic for details.
- **Delete button:** Click this button to delete a selected problem. Refer to Deleting a Problem topic for details.

1.1.3 Tabs

Select a **tab** (Figure 1-11) to filter the problem list(s) associated with that status.

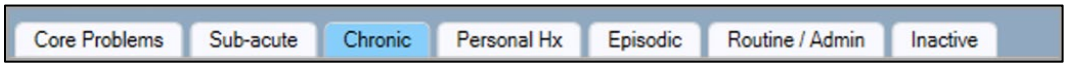


Figure 1-11: IPL tabs

> **Note:** Most tabs only display when information is included under that topic.

- **Core Problems**–(Can be configured to display several status at the same time)
- **Sub-acute**
- **Chronic**
- **Personal Hx**
- **Episodic**
- **Routine/Administrative**
- **Inactive**

1.1.4 Columns

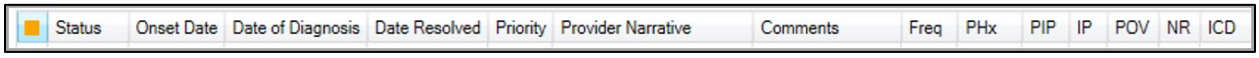


Figure 1-12: IPL columns

Columns on the main display window (Figure 1-12 and Figure 1-13) 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.

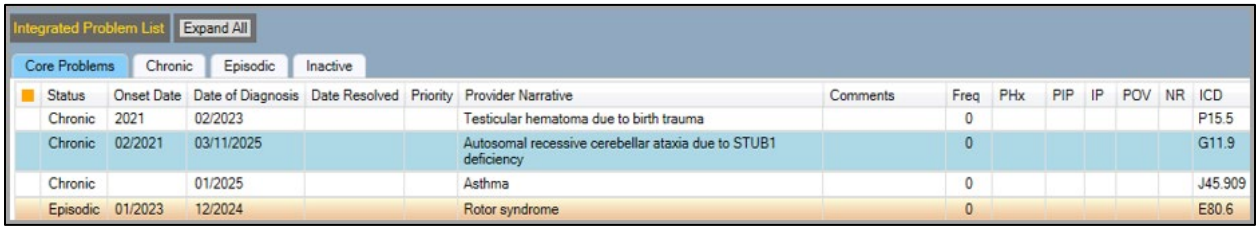


Figure 1-13: IPL columns window

Right-clicking any column header displays the list of available columns (Figure 1-14) that can be displayed.

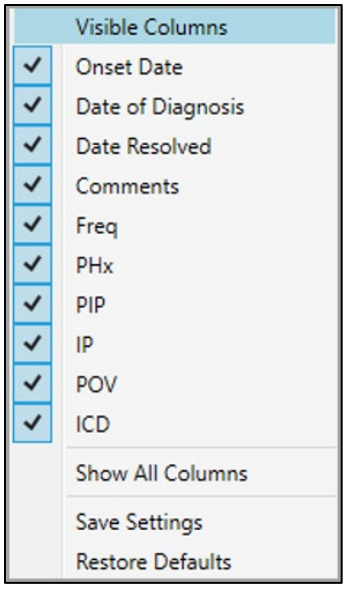


Figure 1-14: Available columns

- **Plus Sign:** Clicking this sign (Figure 1-15), which only displays when care planning has been added to a problem, opens the Care Planning information. Refer to the Care Planning Feature topic for details on using this feature.

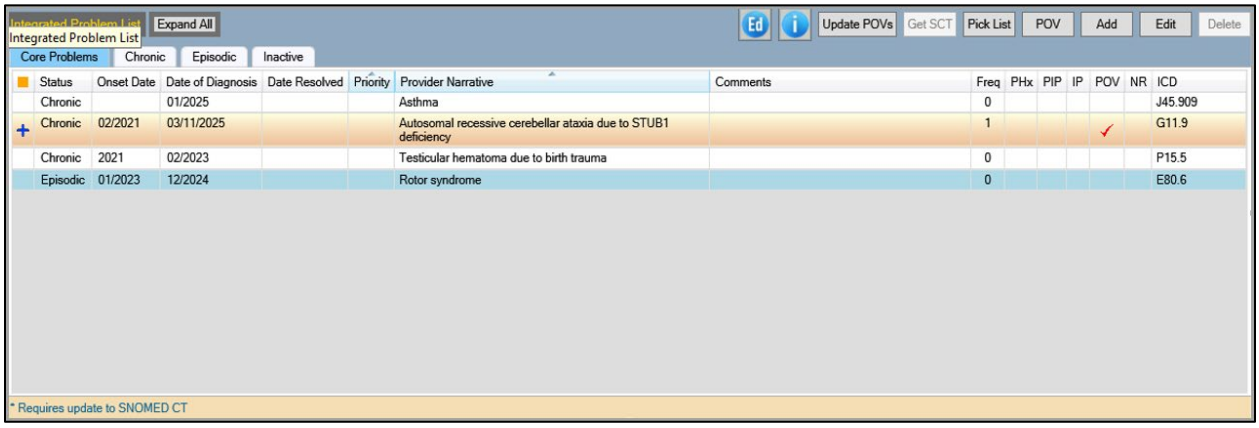


Figure 1-15: Plus sign in IPL column

- Clicking the **PRVs** button (Figure 1-16) displays the provider list (Figure 1-17) for this entry.

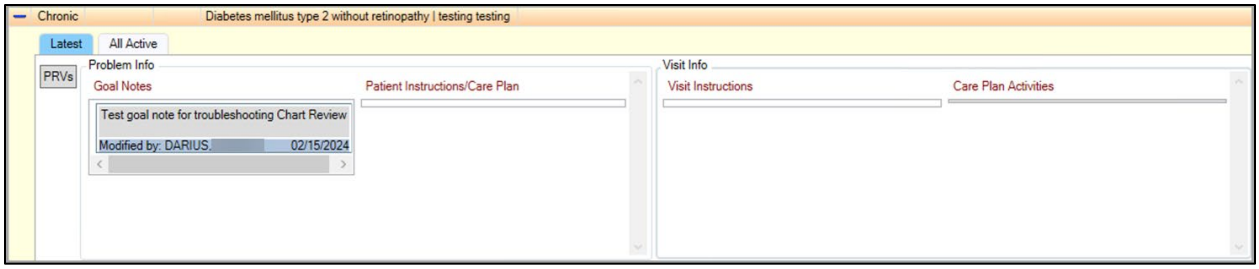


Figure 1-16: PRVs button

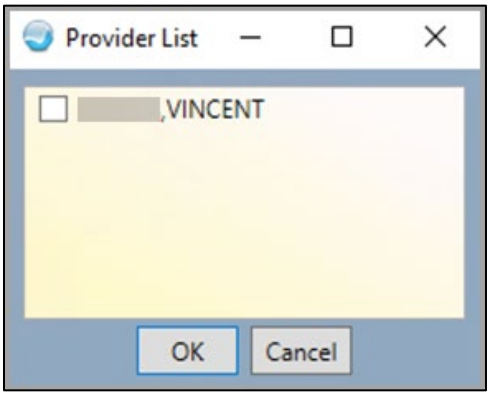


Figure 1-17: Provider List dialog

- **Status Column:** Contains one of the following statuses, as selected by the user.
  - Chronic
  - Sub-acute
  - Episodic
  - Social/Env
  - Inactive
  - Personal
  - Routine/Administrative
- **Onset Date Column:** Contains the date of the problem's onset, as input by the user (optional).
- **Date of Diagnosis Column:** Contains the date of the diagnosis for the problem (optional).
- **Date Resolved Column:** Contains the date the problem was resolved (optional). If populated, the problems status is inactive or personal history.
- **Priority Column:** Contains the priority level, as set by the user.
- **Provider Narrative Column:** Contains any data input by the user in the **Provider Text** field.
- **Comments Column:** Shows any comments typed by the user.

- **Freq Column:** Displays the frequency or number of times this problem has been used for this patient.
- **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.
- **POV Column:** If the problem is used as POV (purpose of visit) by clicking **Save as POV**, a red check mark displays in the **POV** column.
- **NR Column:** Identifies information not to be disclosed to another site or provider without patient permission. This column is always visible and cannot be removed by user preference.
- **ICD Column:** Indicates the mapped **ICD** code from the selected SNOMED term.

1.1.5 Problem Details Window

Double-click anywhere in the **IPL** window to open the **Problem Details** window for the selected problem (Figure 1-18). This dialog is informational only and provides problem data.

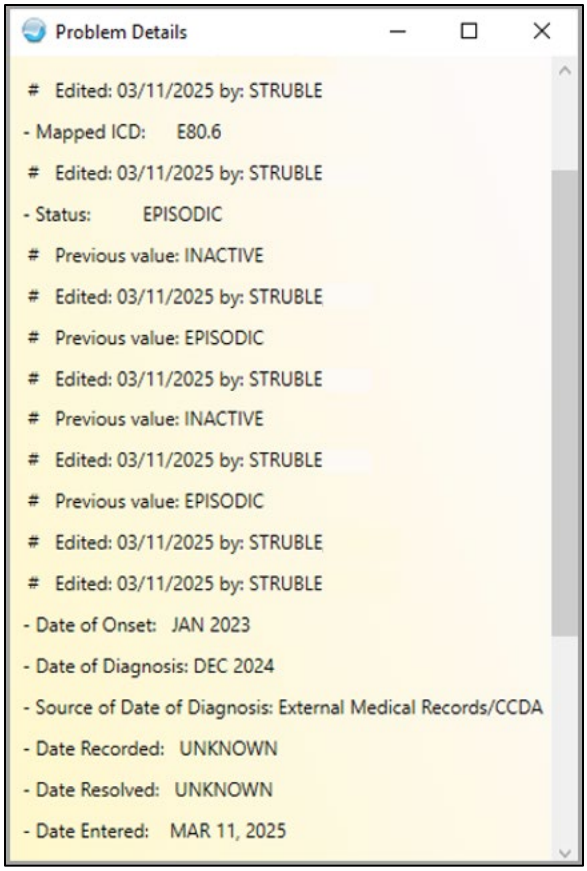


Figure 1-18: Problem Details window

1.2 Tabs

Tabs display based on the status of the patient's existing problems (Figure 1-19). For example, if a problem of Sub-acute exists in the problem list, then the **Sub-acute** tab displays. The two exceptions are the **Core Problems** and **Inactive** tabs. Those tabs always display.

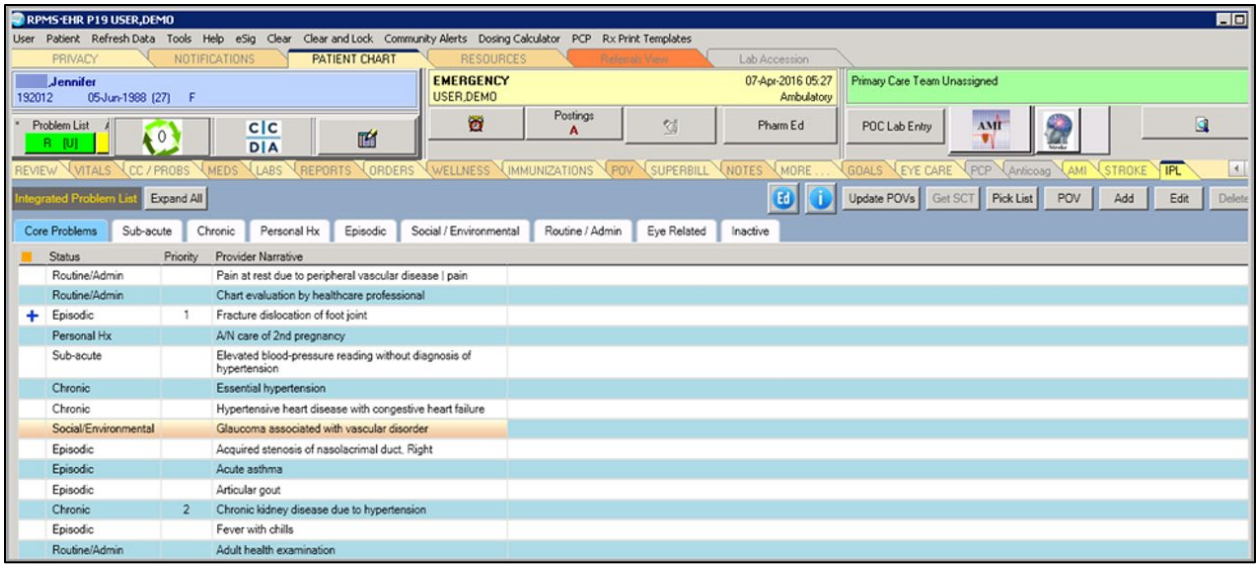


Figure 1-19: Complete list of IPL tabs

1.2.1.1 Core Tab

Users have the ability to customize the **Core** tab by selecting what status to display. Right-click the **Core** tab to view the **Customization** menu (Figure 1-20). For the EYE DX to be displayed on a separate tab, the local Informaticist must enable this parameter: **BGO IPL EYE DX**.

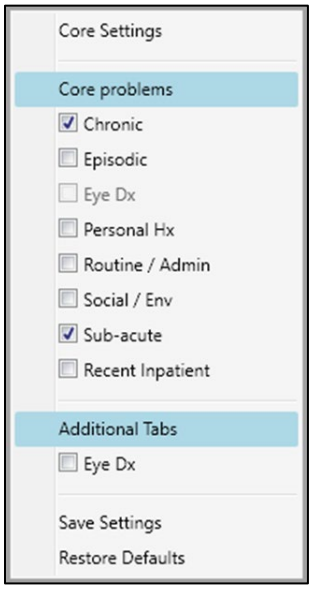


Figure 1-20: Core Settings list dialog

1.2.1.2 User Preferences for Column Display

Right-clicking any column heading (Figure 1-21) displays the **User Column Settings** dialog (Figure 1-22).



Figure 1-21: User column preference setting dialog

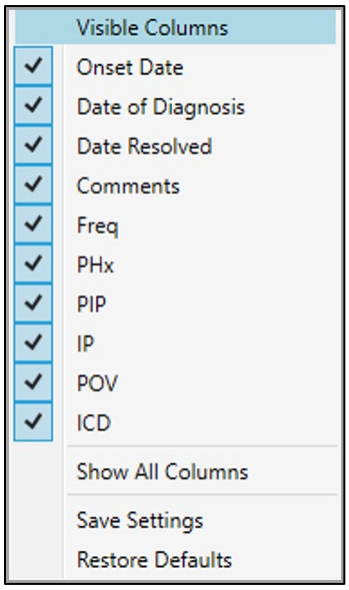


Figure 1-22: Column settings dialog

The **Column Settings** dialog enables users to customize the columns along the column bar. These settings apply to all tabs and remain in effect after the user logs off.

1.3 Using the Get SCT Button

Warning: The **Get SCT** button is no longer maintained and should not be clicked.

1.4 Using the POV Button

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

Note: An unlocked visit must be selected.

From the main window, select one or more **problem-line items**, then click the **POV** button. The **POV** dialog (Figure 1-23) opens, which shows the selected problems.

- A red triangle in the upper-right corner of a column (as in Goal Notes below) 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).

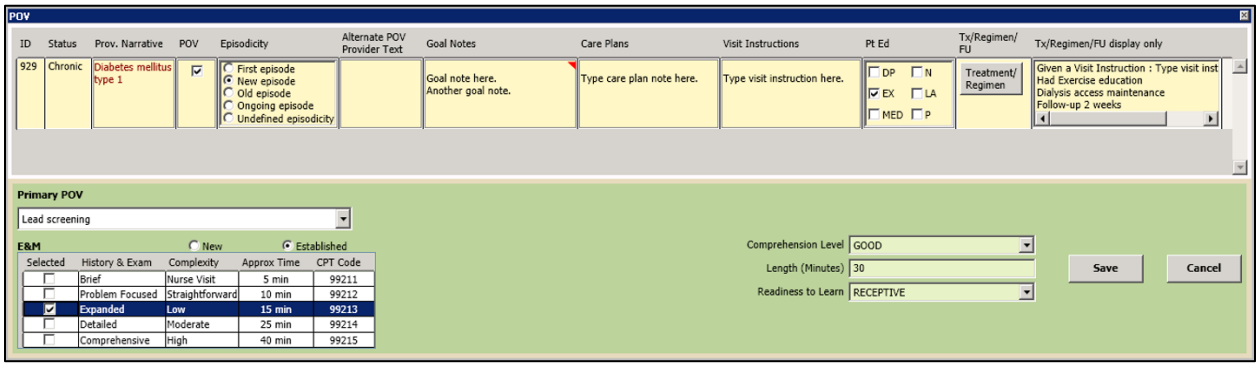


Figure 1-23: POV dialog

1.4.1 POV Dialog Columns Right-Click Menu

The following columns on the **POV** dialog have a right-click menu:

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

1. Right-click in a column to view the right-click menu (Figure 1-24) with 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.

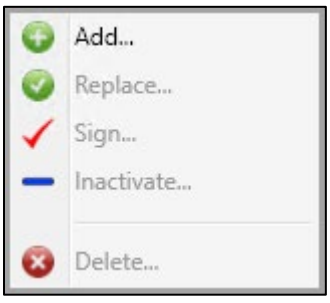


Figure 1-24: POV right-click menu

- **Add:** The **Add** dialog (Figure 1-25) opens for the column selected. Type the appropriate text and click **OK**. The text shows in the column.

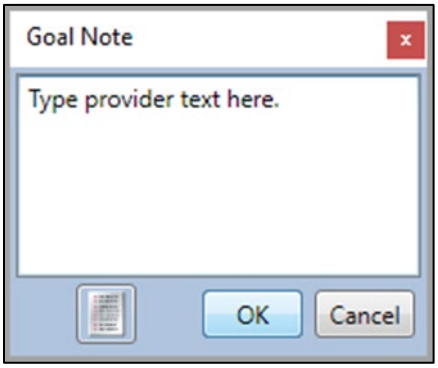


Figure 1-25: Add dialog

- **Replace:** The **Replace** function is used to edit existing text. The **Replace** dialog (Figure 1-26) showing the original text opens.

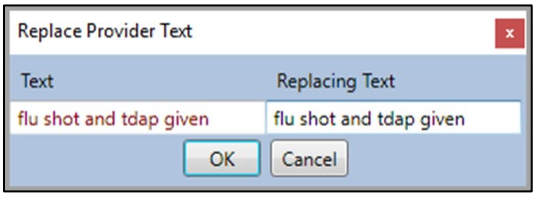


Figure 1-26: Replace dialog

2. Select the text to make it editable and surrounded by a box.
3. Type the replacement text in the **Replacing Text** field and click **OK**. The edited text displays.

- **Sign:** The **Review/Sign** dialog (Figure 1-27) opens with a list of the items added by the user to sign. Type an electronic signature, and then click **OK**.

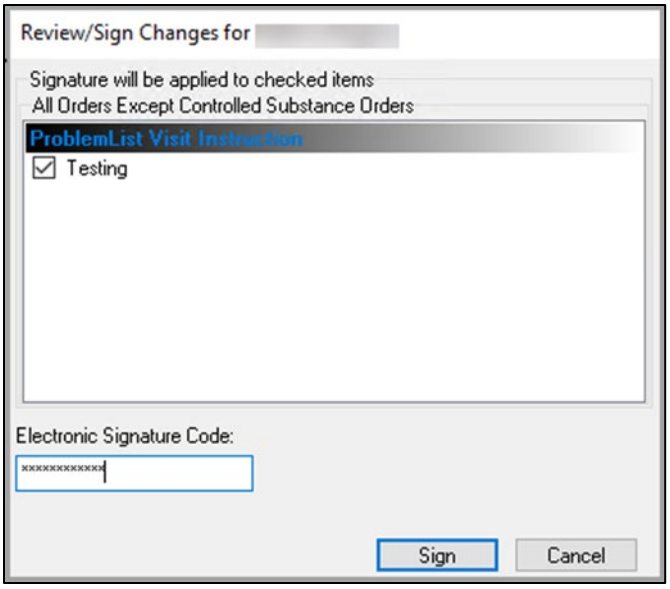


Figure 1-27: Review/Sign Changes dialog

- **Inactivate:** This functionality is intended to inactivate the existing goal or care plan and initiate a new one (Figure 1-28). Use this 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.

4. Type a **comment**, and then click **Yes**.

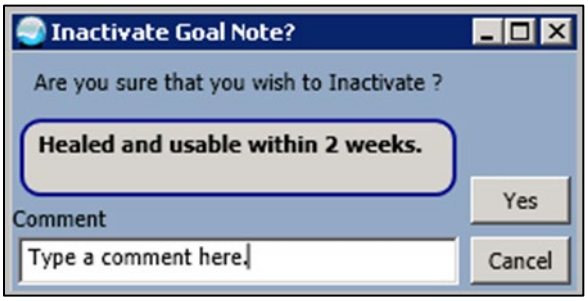


Figure 1-28: Inactivate item dialog

- **Delete:** The **Delete Care Plan** dialog (Figure 1-29 and Figure 1-30) for the column selected displays to confirm the deletion. A different dialog displays depending on whether the entry has been signed or not.

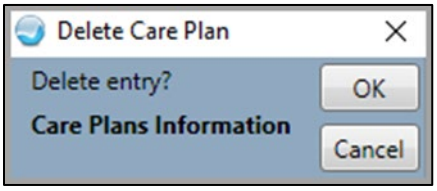


Figure 1-29: Delete confirm dialog for unsigned entry

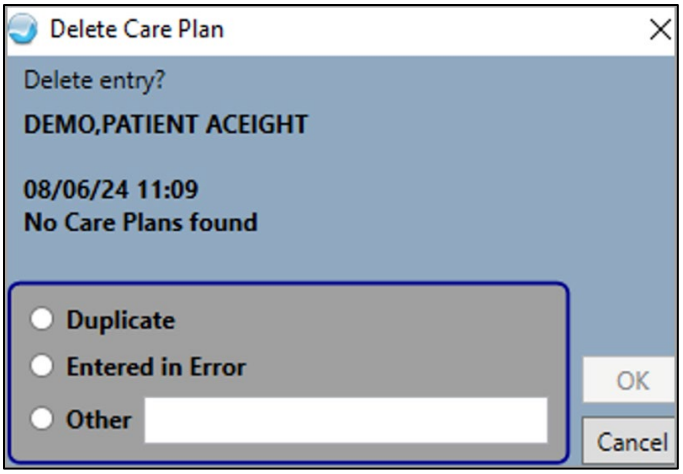


Figure 1-30: Delete confirm dialog for signed entry

1.4.2 POV Dialog Columns and Fields

1.4.2.1 ID Column

The **ID** column shows a system-generated ID.

1.4.2.2 Status Column

The **Status** column shows the selected status for the problem.

1.4.2.3 Prov. (Provider) Narrative Column

The **Prov. (Provider) Narrative** column contains SNOMED concept description and provider text.

1.4.2.4 POV or INPT Column

The next column either shows a **POV** or **INPT** column with a check box to indicate if the problem is POV or for an inpatient. Clear the check box to no longer 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.

1.4.2.5 Episodicity Column

The **Episodicity** column contains the following option buttons. Select or clear them as applicable:

- **First episode**
- **New episode**

- **Old episode**
- **Ongoing episode**
- **Undefined episodicity**

1.4.2.6 Alternate POV Provider Text Column

Add any free-text information in the **Alternate POV Provider Text** field by selecting **Add** from the right-click menu. The **Provider Text** dialog (Figure 1-31) opens:

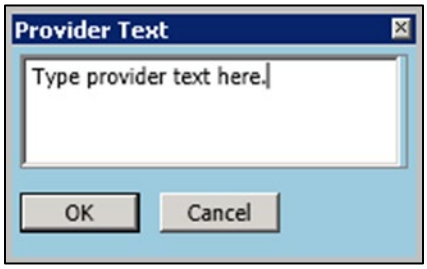


Figure 1-31: Provider text dialog

1. Type the **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.
2. Click **OK**.
3. If any provider text already exists, click **Replace…** (it will be active) in the right-click menu. The **Provider Text** dialog with the existing text and replacing text fields opens. Refer to the POV Dialog Columns Right-Click Menu for additional information.
4. Type the new **provider text** in the **Replacing Text** field.
5. Click **OK**. The change displays in the **Prov. Text** column.

1.4.2.7 Goal Notes Column

The **Goal Notes** column contains goals set for the patient to improve the problem, for example to reduce their cholesterol. Add a Goal Note by selecting **Add** from the right-click menu. The **Goal Note** dialog (Figure 1-32) opens.

- Click the **Template** button () to select a template, if needed.

  Templates must first be created on the **Notes** tab. These can be folders or individual templates. For the templates to display when the **TREG Template** button is selected, the templates must first be added by the local Informaticist using the **BGO IPL GOAL TEMPLATE** parameter.

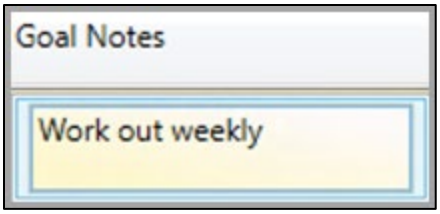


Figure 1-32: Highlighted goal note ready to replace or delete

- The user can also type over an existing Goal Note by clicking in (or selecting) the text and making the changes.

1.4.2.8 Care Plans Column

The **Care Plans** column contains instructions for the patient, for example, walk three times per week, and so on. 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. Templates must first be created on the **Notes** tab. These can be folders or individual templates. For the templates to display when the **TREG Template** button is selected, the templates must first be added by the local Informaticist using the **BGO IPL CARE TEMPLATE** parameter.

- The user can also type over an existing Care Plan by clicking in (or selecting) the text and making the changes.

1.4.2.9 Visit Instructions Column

The **Visit Instructions** column contains patient visit instructions for the selected visit. 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. Templates must first be created on the **Notes** tab. These can be folders or individual templates. For the templates to display when the **Template** button is selected, the templates must first be added by the local Informaticist using the **BGO IPL VISIT TEMPLATE** parameter.

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

1.4.2.10 Pt Ed (Patient Education) Column

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)**

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

1.4.2.11 Tx/Regimen/FU Column

The **Tx/Regimen/FU** column contains the **Treatment/Regimen** button.

1. Click the **Treatment/Regimen** button (

) to open the **Treatment/Regimen** dialog (Figure 1-33).

2. Click the **Expand** button () next to the applicable list heading to view the options.

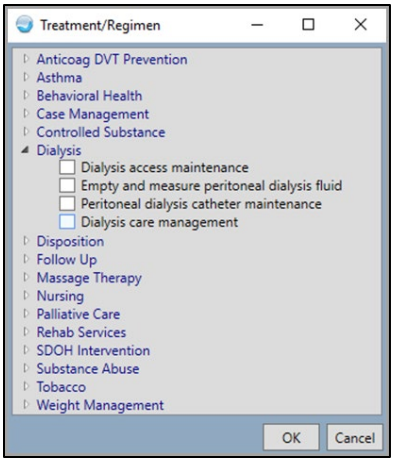


Figure 1-33: Treatment/Regimen dialog with follow up expanded

3. Select one or more check boxes to indicate the Treatment or Regimen for the patient.

4. Click **OK**. The **Tx/Regimen/FU Display Only** column updates with the selection.

1.4.2.12 Tx/Regimen/FU Display Only Column

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.

1.4.2.13 Primary POV

1. Highlight the **POV** to be made the **Primary** from the **IPL** list.

2. Right-click-and select **Edit** (Figure 1-34).

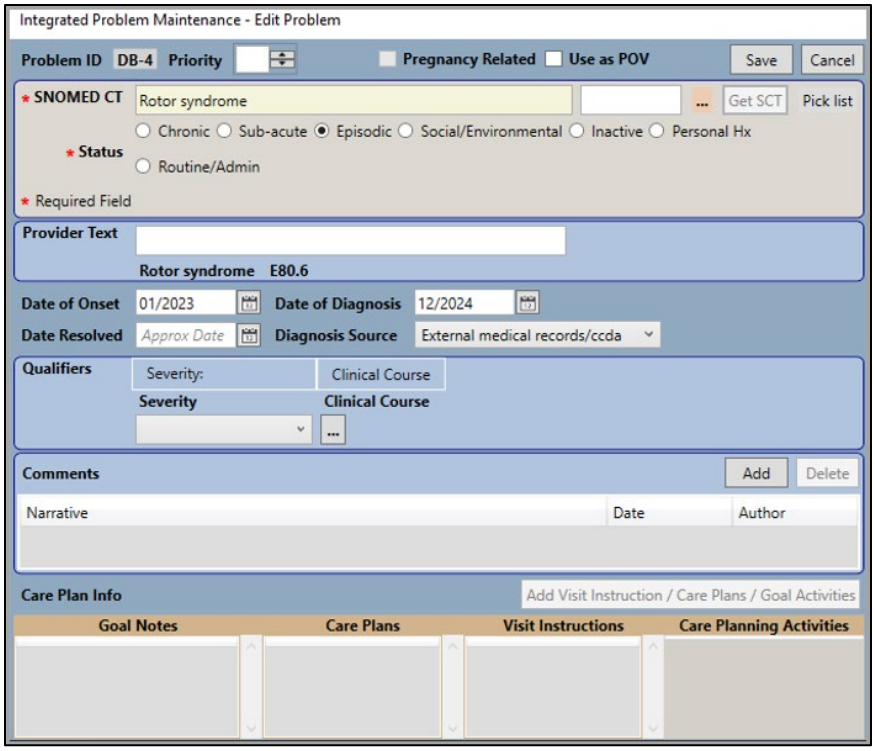


Figure 1-34: EDIT problem dialog

3. Select the **Use as POV** check box (Figure 1-35).

4. Click **Use as Primary** that only displays when the problem is used as POV.

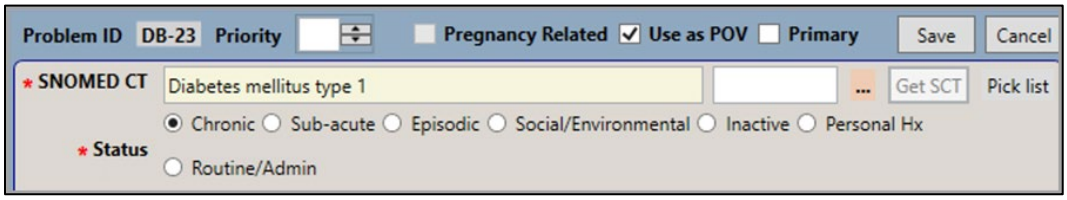


Figure 1-35: Select the Use as POV checkbox

The problem will now be saved as **Primary** in the **Visit Diagnosis** display (Figure 1-36).

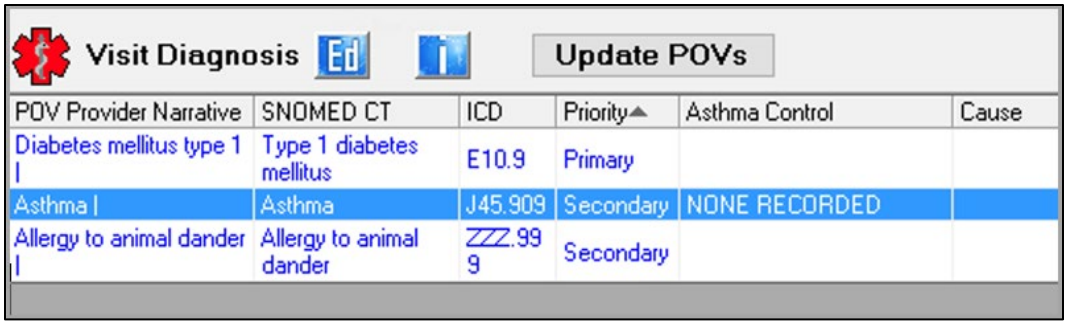


Figure 1-36: Visit Diagnosis display

1.4.2.14 E&M (Evaluation and Management) Table

The **E&M (Evaluation and Management)** table (Figure 1-37) contains all CPT codes defined for the 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 on which option button is selected, **New** or **Established**.

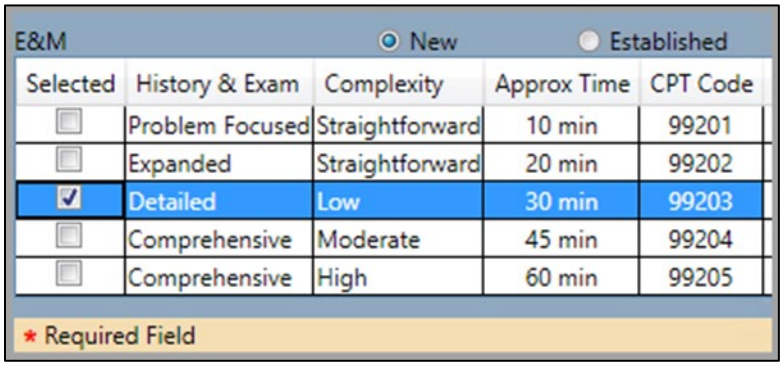


Figure 1-37: E&M table

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 the changes. If an outpatient, the **POV** shows in the **Visit Diagnosis** component.
- If the user clicks **Cancel**, the **Rollback Operations Already Executed** dialog (Figure 1-38) opens. If needed, select the **Rollback** check box to indicate that a care planning instruction was created. Click **OK**.

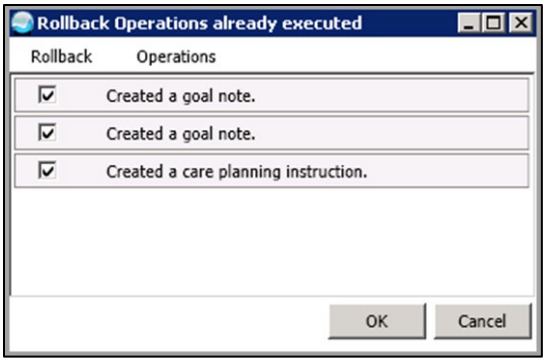


Figure 1-38: Rollback Operation already executed dialog

1.5 Using the PickList Button

These instructions are for the PickList button on the main window to update a picklist. Refer to the Adding a Problem or Editing a Problem topics for information on using the **PickList** button from the **Add Problem** or **Edit Problem** dialogs.

> **Note:** If the **PickList** button is clicked from the main **IPL** window, more than one item from a picklist can be selected. In 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.

1.5.1 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 window or from the **Add Problem** or **Edit Problem** dialogs. The **PickList Selection** dialog (Figure 1-39) opens.

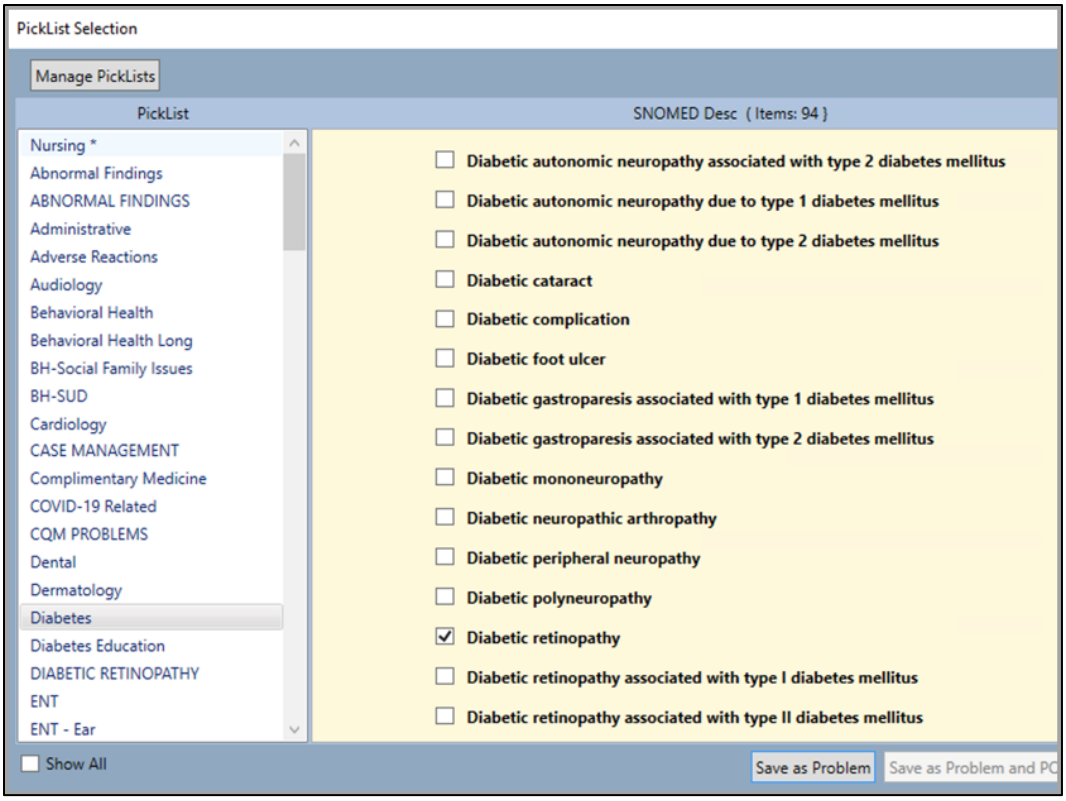


Figure 1-39: PickList Selection dialog

1.5.1.1 In the PickList Column

1. Select a **PickList**.
2. Scroll **Up** or **Down** to view the entire list, if needed.
3. Select the **Show All** check box at the lower left 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** option during configuration in managing the picklist.
   - The following message (Figure 1-40) displays when the cursor is rested on picklists with light blue shading.

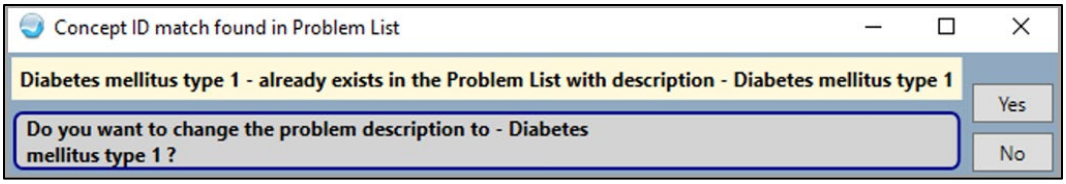


Figure 1-40: Concept ID match found in Problem List dialog

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

1.5.1.2 In the SNOMED Desc Column

- The **SNOMED Description** column refreshes with the items related to the picklists 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.
- An **Item already in Problem List (Save will Edit problem)** message displays when the cursor is rested on picklists with light blue shading.
- Problems with white shading indicate new problems for the patient and are 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.

- 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. Refer to Using the POV Button for details on completing this dialog.

1.5.2 Managing PickLists

The user can manage picklists by performing the following steps 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 (Figure 1-41) opens.

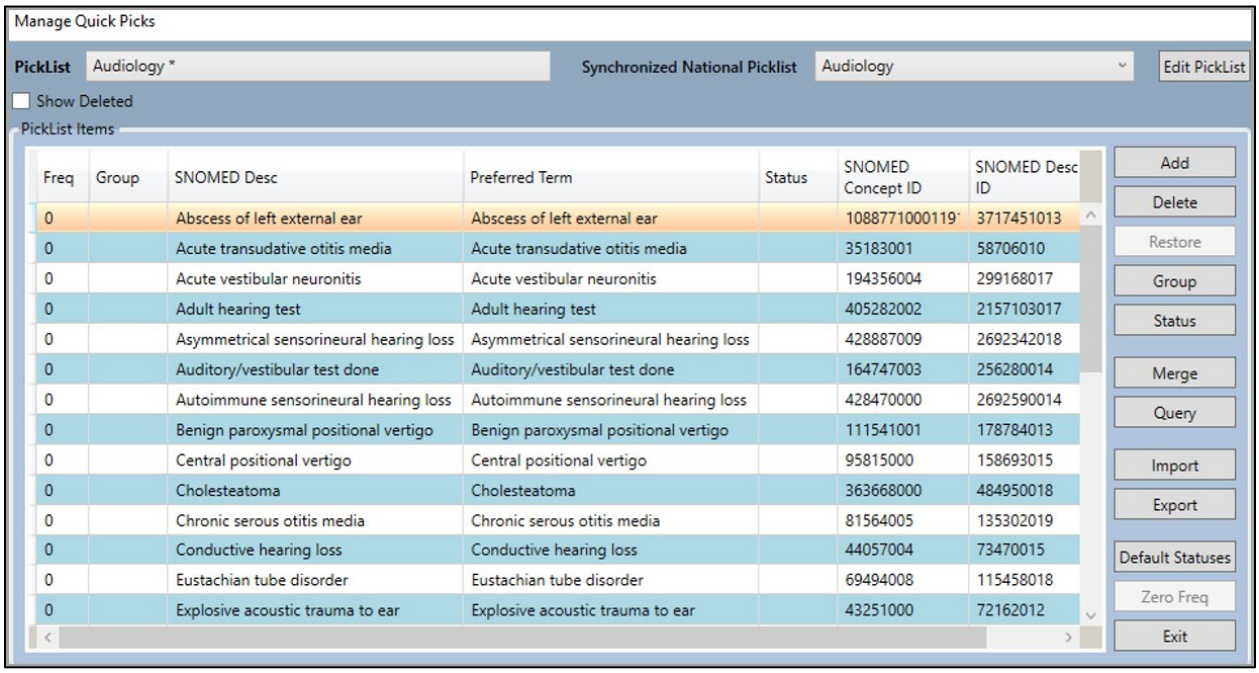


Figure 1-41: Manage Quick Picks dialog

2. From the **PickList** drop-down menu, select a **picklist** to manage. The **PickList Items** list refreshes showing 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.

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

1.5.2.1 Synchronize

1. From the **PickList** drop-down menu (Figure 1-42), select a **picklist** to manage. The **PickList Items** list refreshes showing the problems associated with that picklist.

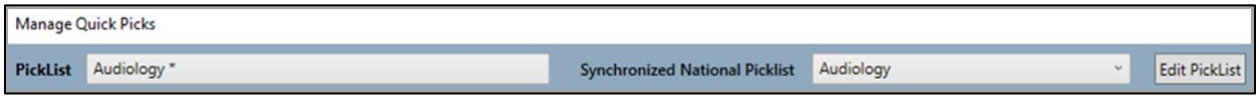


Figure 1-42: Synchronize Quick Picks problems dialog

2. From the drop-down menu **Synchronized National PickList** (Figure 1-43), select a **DTS PICK Subset** to link with the Local PickList.

The system displays the message dialog (Figure 1-43).

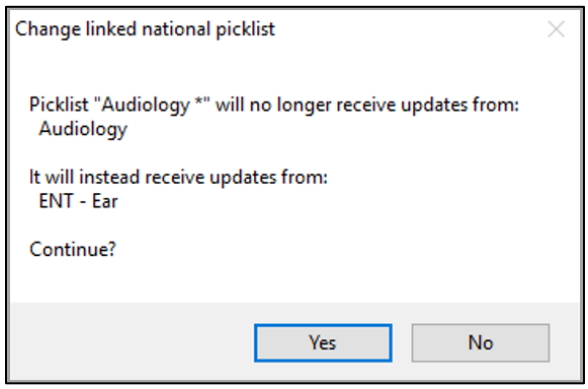


Figure 1-43: Change linked national picklist dialog

- Click **No** to close the dialog and change the existing linked **DTS Subset**.
- Click **Yes** to update the Local PickList to sync and link with the new **DTS Subset**.

1.5.2.2 Add

1. Click the **Add** button from the **Manage Quick Picks** dialog. The **SNOMED CT Lookup** dialog (Figure 1-44) opens.

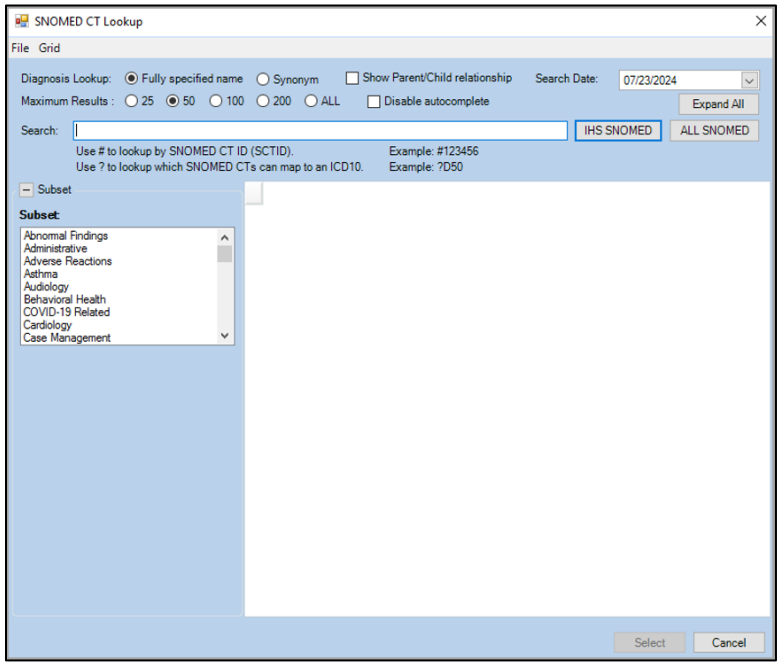


Figure 1-44: SNOMED CT Lookup dialog

2. In the **Diagnosis Lookup** section, select either the **Fully Specified Name** or **Synonym** option button.

- Fully specified name returns a collapsed list of **SNOMED CT** terms. Click the **Expand** button () next to the term to expand and view the child entries.
- Synonym returns the full list of **SNOMED CT** terms.

3. In **Maximum Results**, click one of the following option buttons to limit the number of results (or click **ALL**):
   - **25**
   - **50**
   - **100**
   - **200**
   - **ALL**
4. In **Search**, type the **term** to search.
5. In **Subset**, select a subset in which to search, if needed.
6. In **Search Date**, the field defaults to the current date. Click the **drop-down arrow** to open the calendar and select a different date to search, if needed.
7. Click either the **IHS SNOMED** or **ALL SNOMED** button. The list of **SNOMED CT** terms is populated.
8. Select a **problem** from the list and then click **Select**. The selection displays in the **PickList Items** of the **Manage Quick Picks** dialog (Figure 1-45).
   - 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.

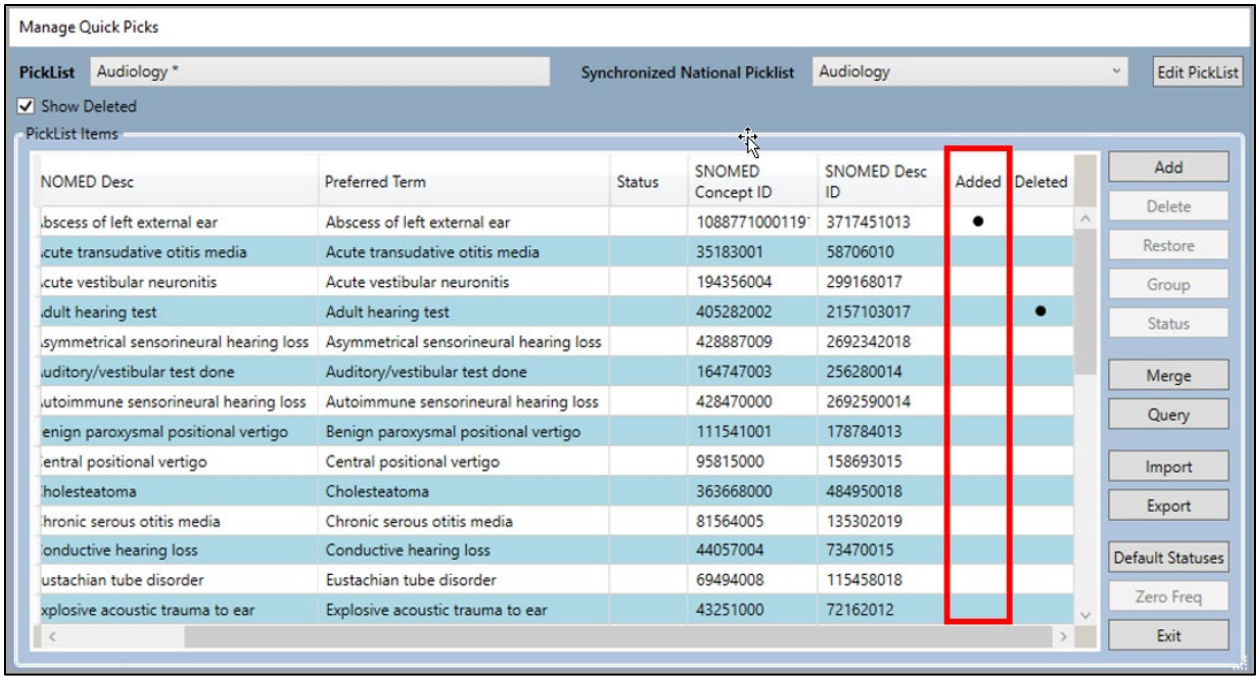


Figure 1-45: Locally added SNOMED CT not found in DTS PICK subset

9. The locally added **SNOMED CT** code will display in the table with the **Local PickList** values.

10. Scroll to the right using the horizonal scrollbar to view the **Added** column showing that the newly entered SNOMED CT has been added.

    The system displays a mouse-over tip on the column heading that states:

    A dot in this column indicates that the code is present in the Local PickList but is not present in the synchronized National PickList

1.5.2.3 Delete

1. When clicking the **Delete** button from the **Manage Quick Picks** dialog for a locally added **SNOMED CT** code. The **Delete Items** confirmation message (Figure 1-46) displays.



Figure 1-46: Delete PickList item confirmation message

- The **SNOMED CT** will be deleted and is removed from the Local PickList and display.

2. When clicking the **Delete** button from the **Manage Quick Picks** dialog for a **DTS PickList Subset SNOMED CT** code (Figure 1-47), the **Delete Items** confirmation message displays.

   - The **SNOMED CT** will be deleted and is removed from the Local PickList and display.
   - If the user selects the check box **Show Deleted**, the SNOMED CT appears back in the table.

3. Scroll to the right using the horizonal scrollbar to view the column **Deleted** showing the newly entered SNOMED CT has been added.

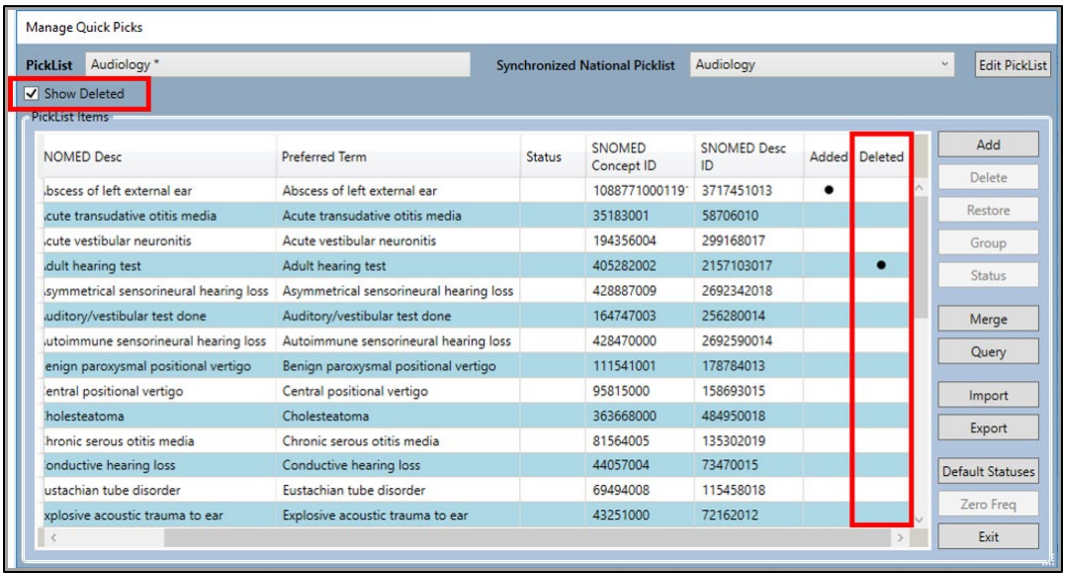


Figure 1-47: Displaying of DTS PICK subset deleted SNOMED CT

   - The system will display a mouse-over tip on the column heading Deleted that states:

     A dot in this column indicates that the code is present synchronized National PickList but has been removed from the Local PickList.

1.5.2.4 Restore

1. Select the check box **Show Deleted** and the SNOMED CT appears back in the table.

2. Select a **row** from the table with a dot in the **Deleted** column. The **Restore** button is enabled (Figure 1-48).

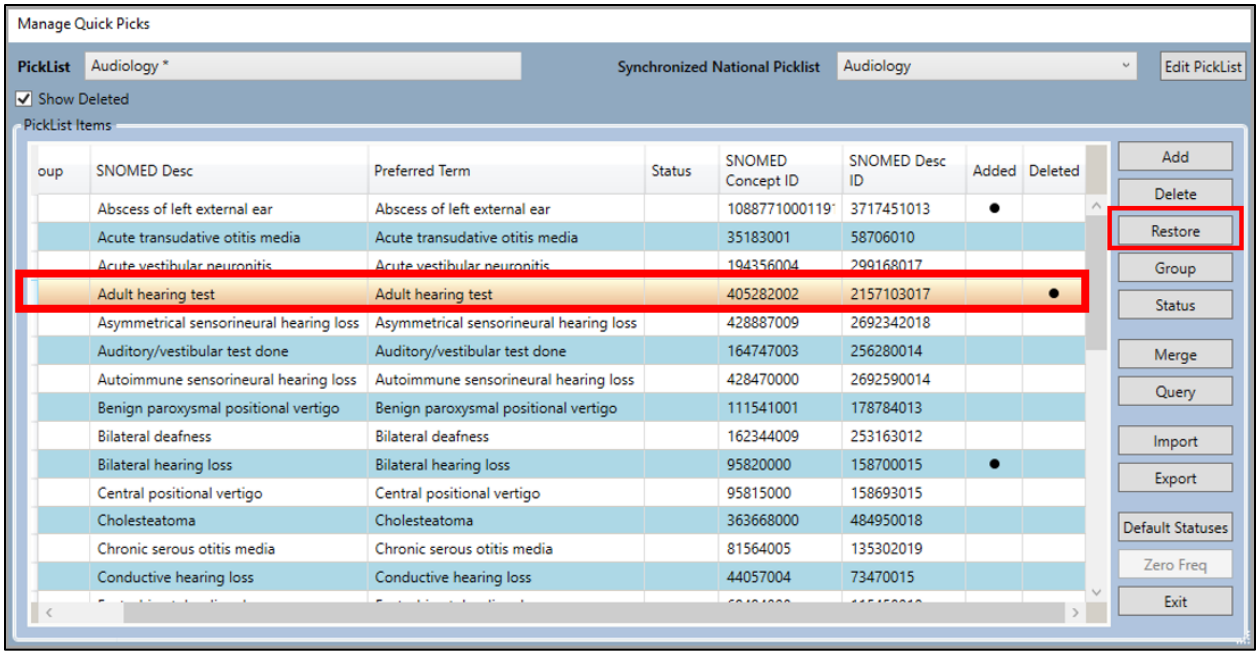


Figure 1-48: Selected and restored SNOMED CT from DTS subset

3. Click the **Restore** button.

   - The SNOMED CT is visible in the **Local PickList** table without a dot in the **Deleted** column, the code has been restored into the local picklist (Figure 1-49).

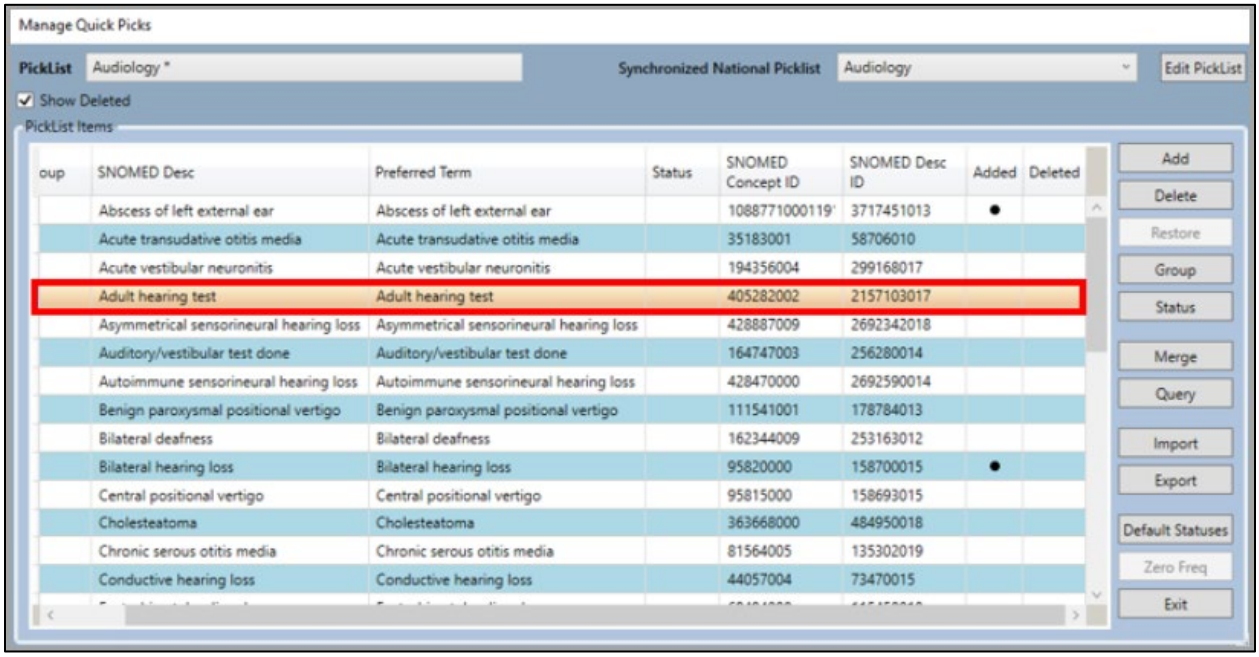


Figure 1-49: DTS subset SNOMED CT restore to local picklist

1.5.2.5 Changing Group

1. Click the **Group** button from the **Manage Quick Picks** dialog. The **Change the Group for 3** (or number selected) **PickList Item(s)** dialog (Figure 1-50) opens.

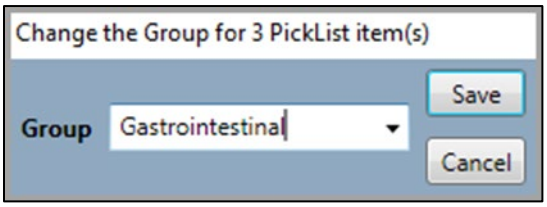


Figure 1-50: Change the Group dialog

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

1.5.2.6 Changing Status

1. Click the **Status** button from the **Manage Quick Picks** dialog. The **Change the Status for 1** (or number selected) **PickList Item(s)** dialog (Figure 1-51) opens.

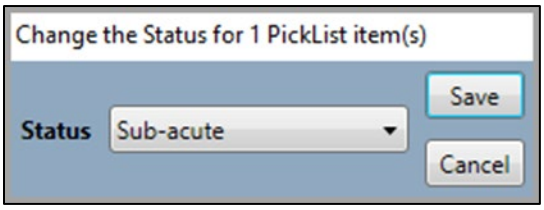


Figure 1-51: Change the Status dialog

2. In the **Status** drop-down (Figure 1-52), select a **status** to assign:

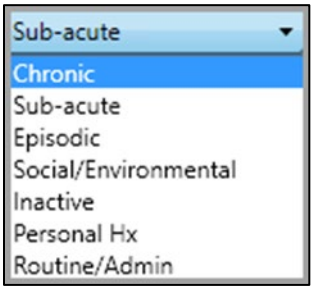


Figure 1-52: Status drop-down list

3. Click **Save**.

1.5.2.7 Merging

1. Click the **Merge** button from the **Manage Quick Picks** dialog. The **Merge PickList** dialog (Figure 1-53) opens.

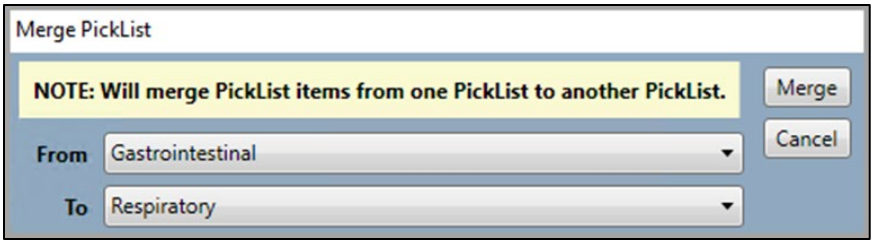


Figure 1-53: Merge PickList dialog

2. In **From**, select the **picklist** to merge the item or items from.
3. In **To**, select the **picklist** to merge the item or items to.
4. Click **Merge**. The **Merged PickList** message (Figure 1-54) displays.

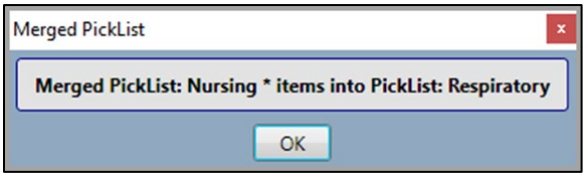


Figure 1-54: Merged PickList message dialog

1.5.2.8 Querying

1. Click the **Query** button from the **Manage Quick Picks** dialog. The **Query for PickList Items** dialog (Figure 1-55) opens.

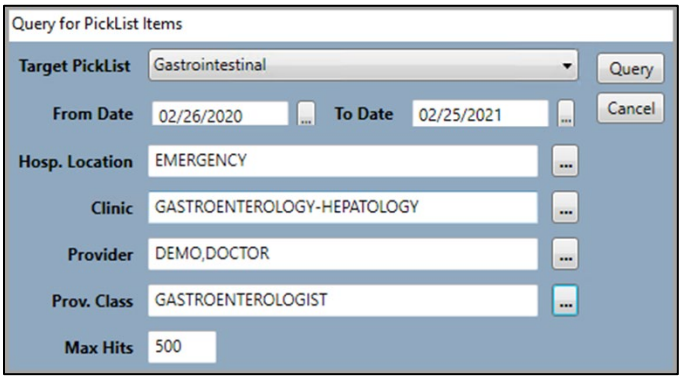


Figure 1-55: Query for PickList Items dialog

2. In **Target PickList**, select a **picklist** to query from the drop-down menu.
3. In **From Date**, click the **Ellipsis** button (…) to select a date from the calendar.
4. In **To Date**, click the **Ellipsis** button (…) to select a date from the calendar.

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

5. In **Hosp. Location**, click the **Ellipsis** button ( ) to select a location. The **Select a Location** dialog (Figure 1-56) opens.

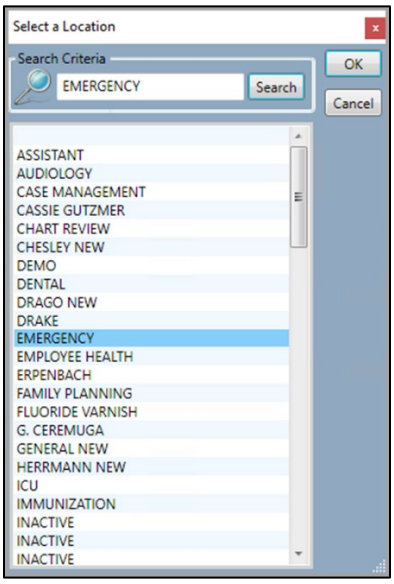


Figure 1-56: Select a Location dialog

6. In **Search Value** begin typing the first few letters of the location name. The list refreshes the location.

7. Click to select the location, and then click **OK**. The selection is populated in the **Hosp. Location** field.

8. In **Clinic**, click the **Ellipsis** button ( ) to select a clinic. The **Select a Clinic** dialog (Figure 1-57) opens.

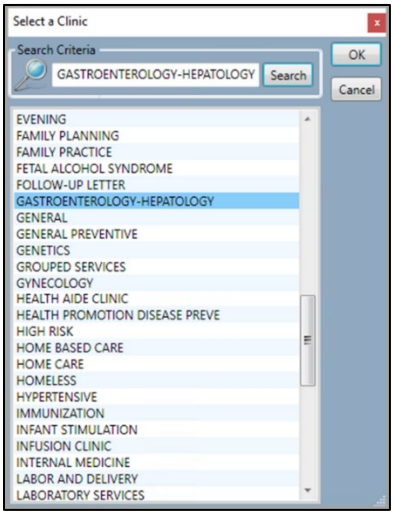


Figure 1-57: Select a Clinic dialog

9. In **Search Value**, begin typing the first few letters of the clinic name. The list refreshes with the clinic name.

10. Click to select the **clinic**, and then click **OK**. The selection is populated in the **Clinic** field.

11. In **Provider**, click the **Ellipsis** button (...) to select a provider. The **Select a Provider** dialog (Figure 1-58) opens.

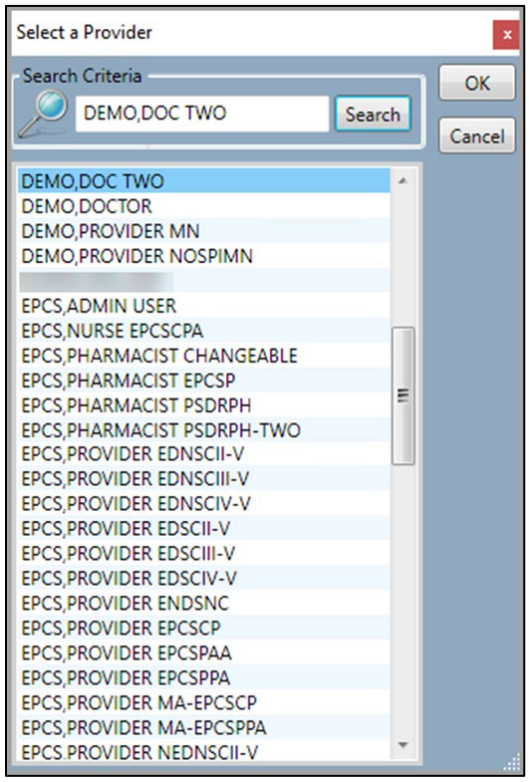


Figure 1-58: Select a Provider dialog

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

13. Click to select the **provider**, and then click **OK**. The selection is populated in the **Provider** field.

14. In **Prov. Class**, click the **Ellipsis** button (...) to select a provider class. The **Select a Provider Class** dialog (Figure 1-59) opens.

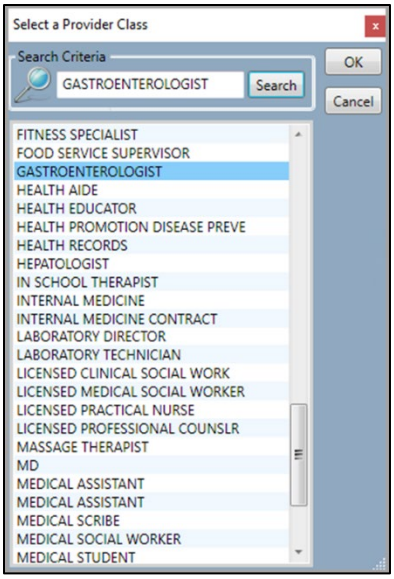


Figure 1-59: Select a Provider Class dialog

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

16. Click to select the **Provider Class**, and then click **OK**. The selection is populated in the **Prov. Class** field.

17. In **Max hits**, **500** is the default. Type a **number of hits** to return (Figure 1-60) in order to change the number of hits returned.



Figure 1-60: Max Hits field

18. Click **OK** on the **Query for PickList Items** dialog. An information message (Figure 1-61) displays showing the number of returned records.

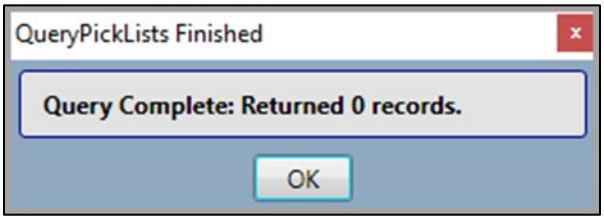


Figure 1-61: Query PickLists Finished information message

1.5.2.9 Importing

1. Click the **Import** button from the **Manage Quick Picks** dialog. The **Import SNOMED PickLists** dialog (Figure 1-62) opens.

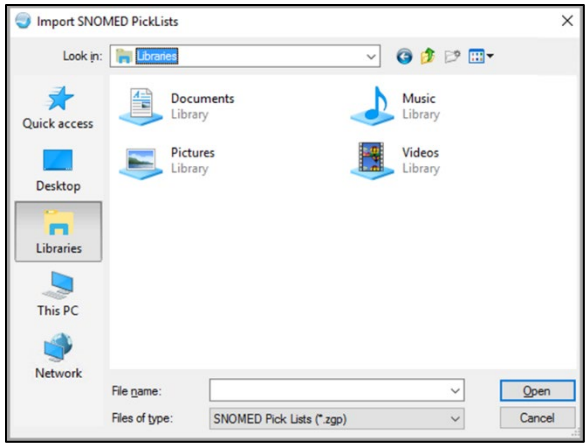


Figure 1-62: Import SNOMED PickLists dialog

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

1.5.2.10 Exporting

1. Click the **Export** button from the **Manage Quick Picks** dialog. The **Save As** dialog (Figure 1-63) opens.

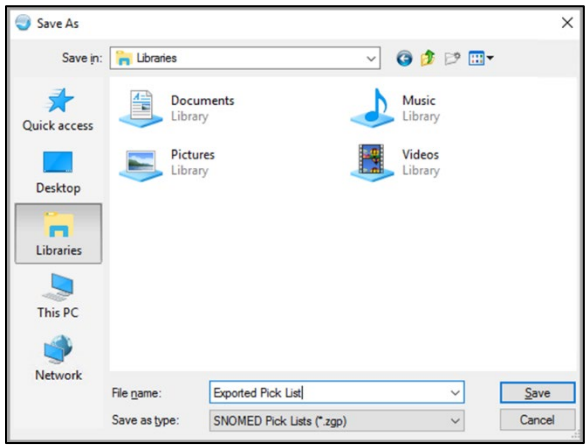


Figure 1-63: Save As (Export PickList) dialog

2. Select a **location** to save, type a **file name**, and then click **Save**. The SNOMED picklist is saved as **.zgp** file type, ready for exporting.

1.5.2.11 Default Statuses

1. Click the **Default Statuses** button from the **Manage Quick Picks** dialog (Figure 1-41). The **Default the status of all items** dialog displays (Figure 1-64).

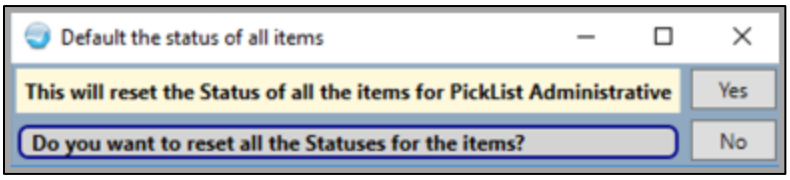


Figure 1-64: Default the status of all items dialog

2. Click **Yes** to reset the status of all the items for the particular picklist. Click **No** to return to the **Manage Quick Picks** dialog (Figure 1-41).

1.5.2.12 Marking Zero Freq(uency)

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

2. Click **Exit** to close the **Manage Quick Picks** dialog (Figure 1-41).

1.5.3 Edit PickList Button

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

1. Click the **Edit PickList** button (

). The **Edit PickList** dialog (Figure 1-65) opens.

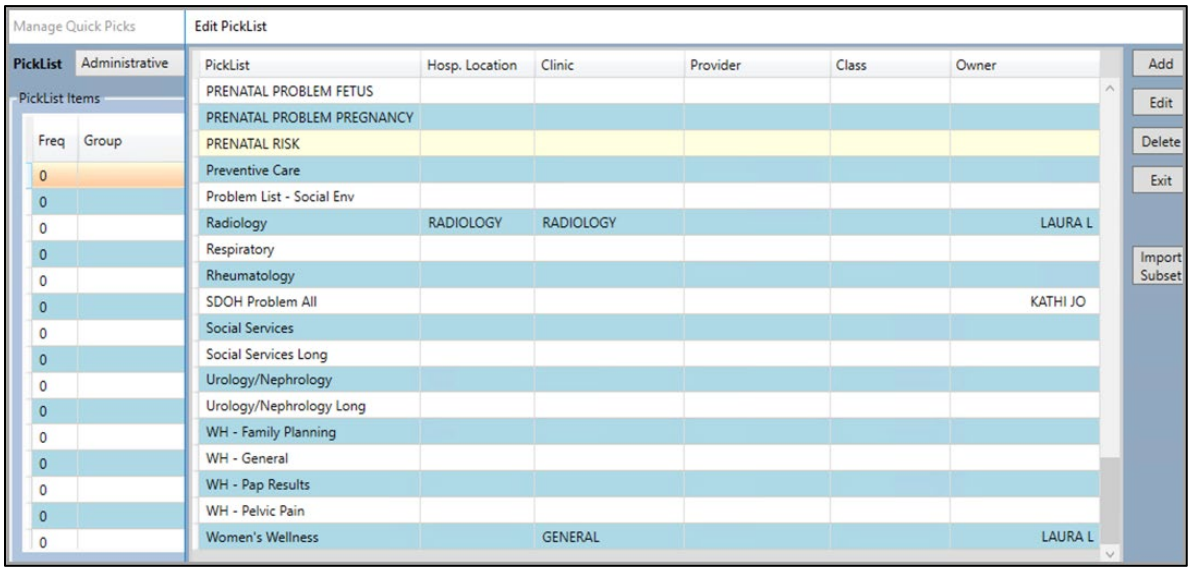


Figure 1-65: Edit PickList dialog

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

1.5.3.1 Add Button

1. Click **Add** from the **Manage PickLists** dialog. The **Add PickList** dialog (Figure 1-66) opens.

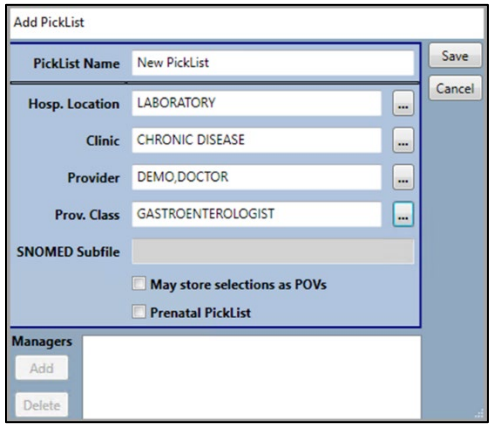


Figure 1-66: Add PickList dialog

2. In **PickList Name**, type a **name** for the picklist.

3. In **Hosp. Location**, click the **Ellipsis** button (...) to select a location. The **Select a Location** dialog (Figure 1-67) opens.

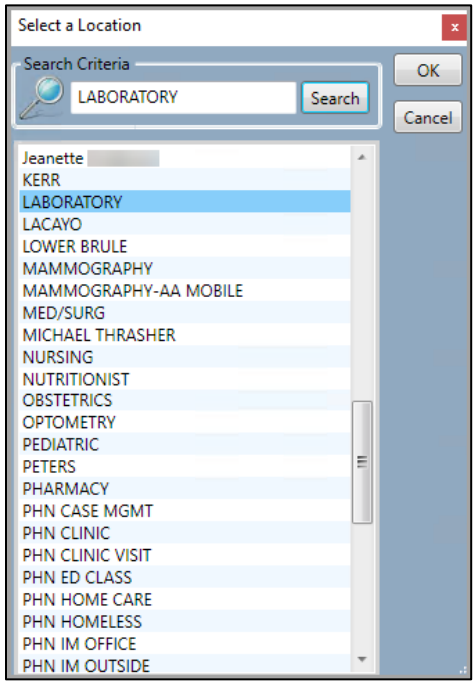


Figure 1-67: Select a Location dialog

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

5. Click to select **location**, then click **OK**. The selection is populated in the **Hosp. Location** field.

6. In **Clinic**, click the **Ellipsis** button (...) to select a clinic. The **Lookup Clinic** dialog (Figure 1-68) opens.

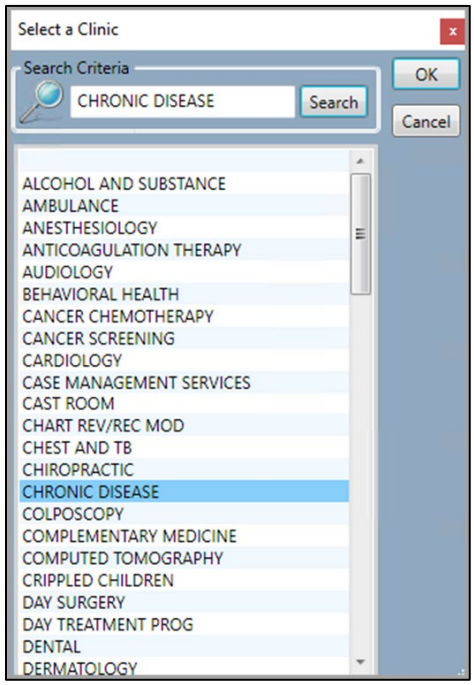


Figure 1-68: Lookup Clinic dialog

   a. In **Search Value**, begin typing the first few letters of the clinic name. The list refreshes with the clinic.

   b. Click to select the **clinic**, and then click **OK**. The selection is populated in the **Clinic** field.

7. In **Provider**, click the **Ellipsis** button (...) to select a provider. The **Lookup Provider** dialog (Figure 1-69) opens.

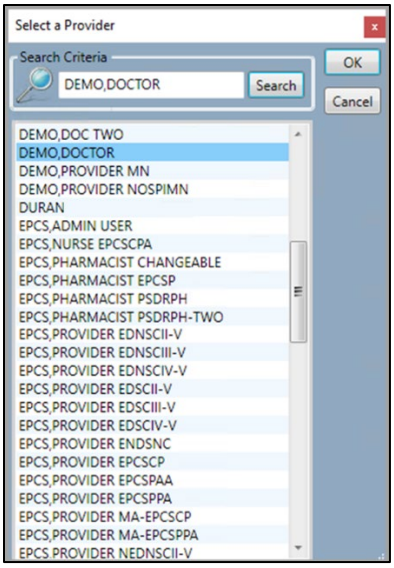


Figure 1-69: Lookup Provider dialog

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

b. Click to select the **provider**, and then click **OK**. The selection is populated in the **Provider** field.

8. In **Prov. Class**, click the **Ellipsis** button () to select a provider class. The **Lookup Provider Class** dialog (Figure 1-70) opens.

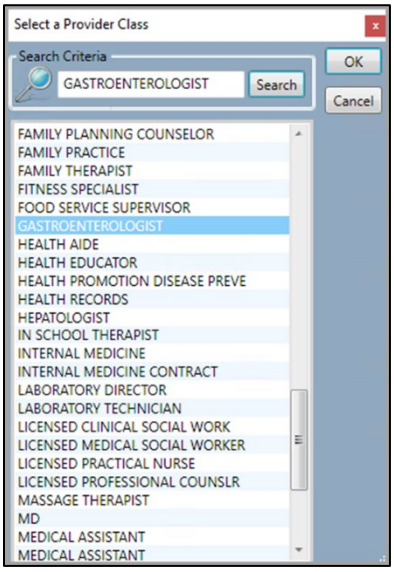


Figure 1-70: Lookup Provider Class dialog

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

b. Click to select the **provider class**, and then click **OK**. The selection is populated in the **Prov. Class** field.

9. The **SNOMED Subfile** field (Figure 1-71) is not editable, but shows the file that the list is based from. For example, if a subset was imported, that subset shows in the **SNOMED Subfile** field.



Figure 1-71: SNOMED Subfile field

The **Managers Section** dialog (Figure 1-72) is inactive until a picklist is created and edited. Refer to the **Edit** button.



Figure 1-72: Managers Section dialog

- If applicable, select the May store selections as **POVs** check box. 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. Refer to the Selecting Problems from a PickList section, above.
- If applicable, select the **Prenatal PickList** check box.

10. Click **Save**. The entries show in the **Manage PickLists** dialog.

1.5.3.2 Edit Button

1. Click to select a **picklist** to edit from the **Manage PickList** dialog. The **Edit PickList** dialog (Figure 1-73) opens.

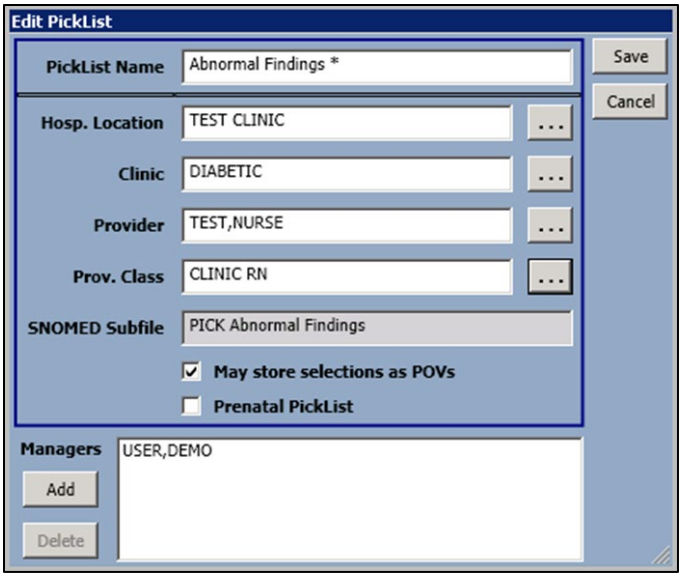


Figure 1-73: Edit PickList dialog

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

3. If applicable, click the **Add** button in the **Managers** section to add a **PickList** manager. The **Select a Manager** dialog (Figure 1-74) opens.

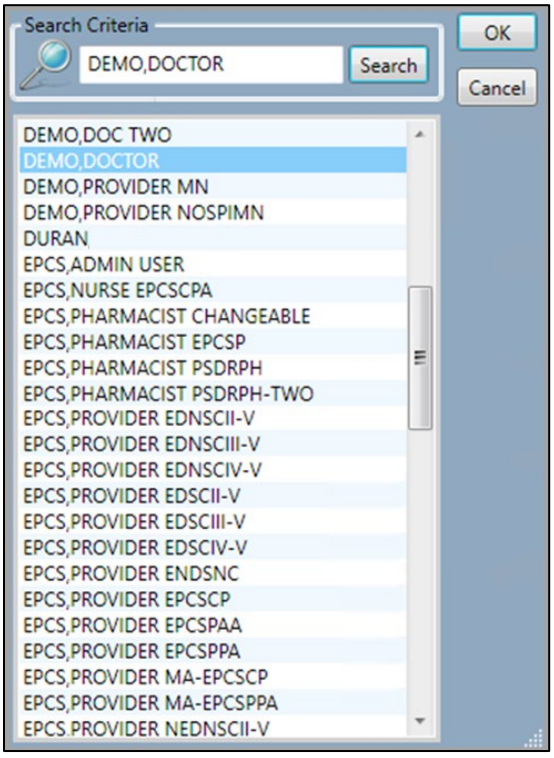


Figure 1-74: Select a Manager dialog

4. In **Search Criteria**, begin typing the first few letters of the person's name. The list refreshes with the selection.
5. Select the **name**, then click **OK**. The **Managers** field populates with the entry.
6. Click **Save** on the **Edit PickList** dialog.

1.5.3.3 Delete Button

1. Select a **picklist** to delete.
2. Click the **Delete** button. A **Delete PickList** information message (Figure 1-75) displays.

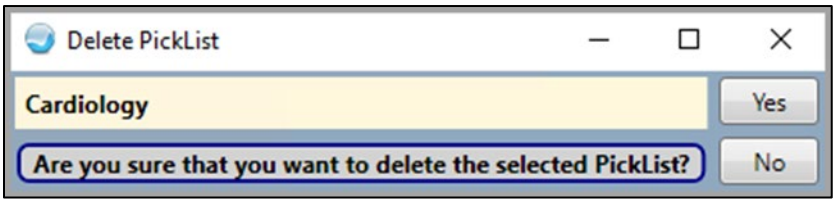


Figure 1-75: Delete PickList information message

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

1.5.3.3.1 Import Subset Button

1. Select a **picklist**, then click the **Import Subset** button. The **Import Subset** dialog (Figure 1-76) opens.

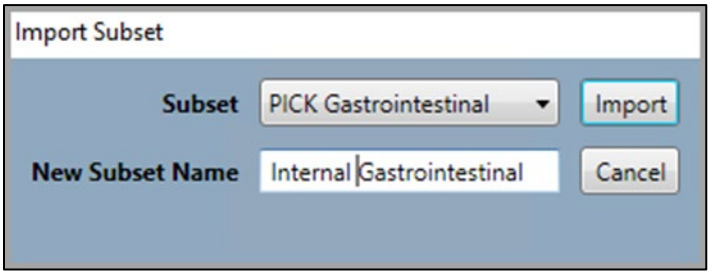


Figure 1-76: Import Subset dialog

2. In **Subset**, select a **subset** to import from the drop-down menu. The **New Subset Name** field populates with the selection.
3. Click **Import**.
4. Click **Exit** to exit the **Manage PickLists** dialog.

1.5.4 Updating a PickList

There is an option available to authorized individuals to update all picklists (Figure 1-77) with statuses defaulted for SNOMED terms DTS.

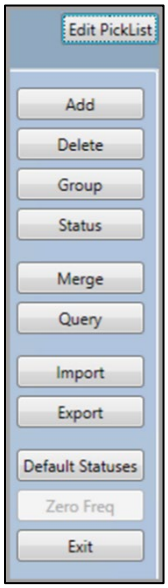


Figure 1-77: Updating the Edit PickList drop-down list

1.6 Using the Education Information Button

The **Education Information** search enables the user 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 (Figure 1-78) displays.

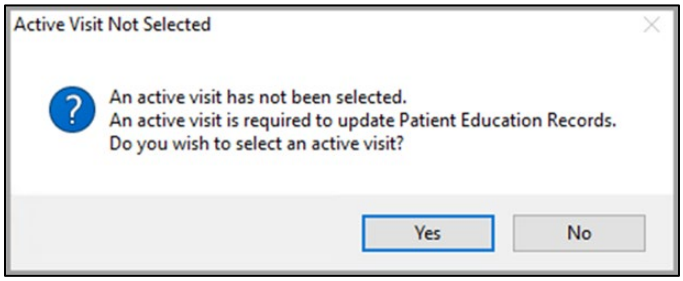


Figure 1-78: Active Visit Not Selected information message

- Click **Yes** to select an active visit.
- If **No** is clicked, **MedlinePlus** opens, but the **Add Patient Education Event** dialog does not open.

The search depends on 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** website (Figure 1-80) 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 1-79).

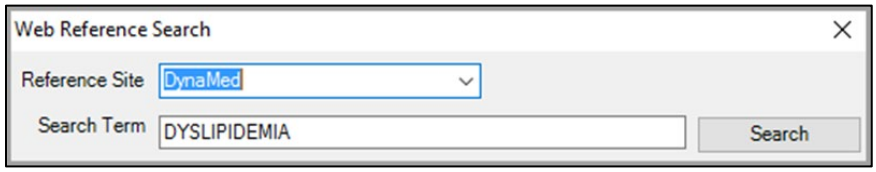


Figure 1-79: Web Reference Search dialog

Select a **Reference Site**, if needed. The default is the **ClinicalKey** site. After entering a term and clicking **Search**, the user is taken to the selected website (example Figure 1-80) 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.



Figure 1-80: MedlinePlus website

1.7 Using the Clinical Decision Support Button

The **Clinical Decision Support** search depends on whether any records are present or not.

- **Condition 1:** If there are records present, select one and click the **Clinical Decision Support** button ( ). The **Web Reference Search** dialog (Figure 1-81) displays. The default is the **DynaMed** website (Figure 1-83) 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 (Figure 1-81).

> **Note:** This dialog will also display if the site is not licensed for DynaMed.

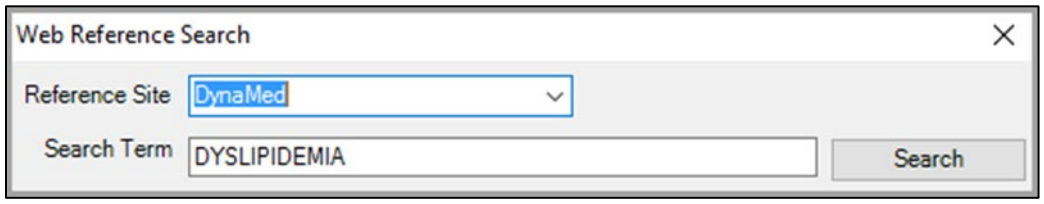


Figure 1-81: Web Reference Search dialog

There is a drop-down list (Figure 1-82) to select a different Reference Site if needed. The default is the **DynaMed** website (Figure 1-83).

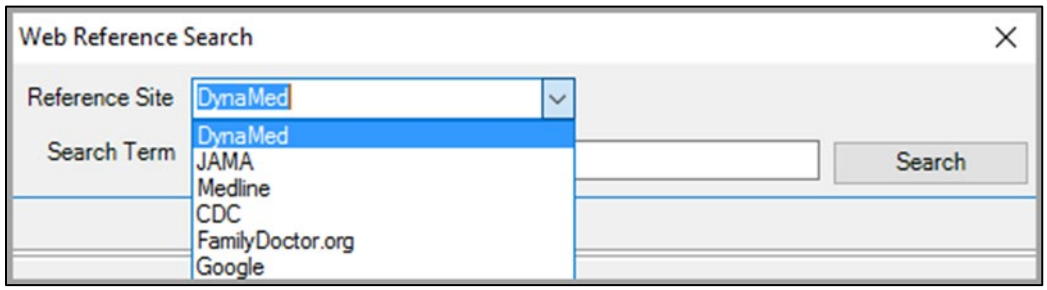


Figure 1-82: Reference Site drop-down list

After entering a term and clicking **Search**, the user is taken to the selected website (Figure 1-83) for the specified term.

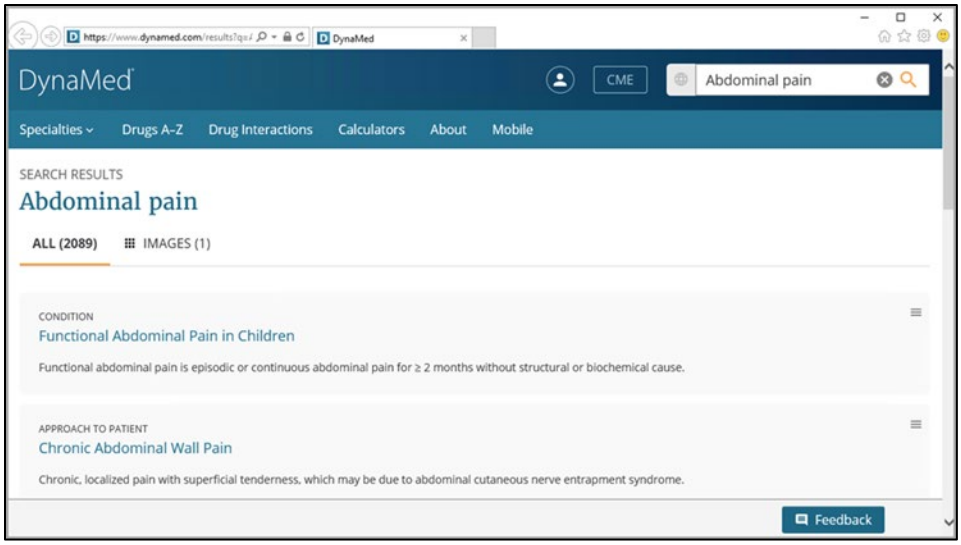


Figure 1-83: DynaMed website example

Change to another website by selecting from the **Reference Site** drop-down list (Figure 1-82). The drop-down list for the **Reference Site** field on the **Web Reference Search** dialog can be configured.

1.8 Completing Integrated Problem List (IPL) Tasks

Tasks can be completed in the **Integrated Problem List** module by clicking the **Add**, **Edit**, or **Delete** buttons from the main window.

1.8.1 Adding a Problem

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

1. On the main **IPL** window, click the **Add** button. The **Add Problem** dialog (Figure 1-84) opens.



Figure 1-84: Initial Add Problem dialog

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

2. Populate the **SNOMED CT** field using one of the following methods.

3. After the user populates the **SNOMED CT** code, the **Add Problem** dialog (Figure 1-87) expands with additional fields. Choose a **SNOMED** by one of the following options.

1.8.1.1 SNOMED CT Field

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

2. If the user wants 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 (Figure 1-85) opens.

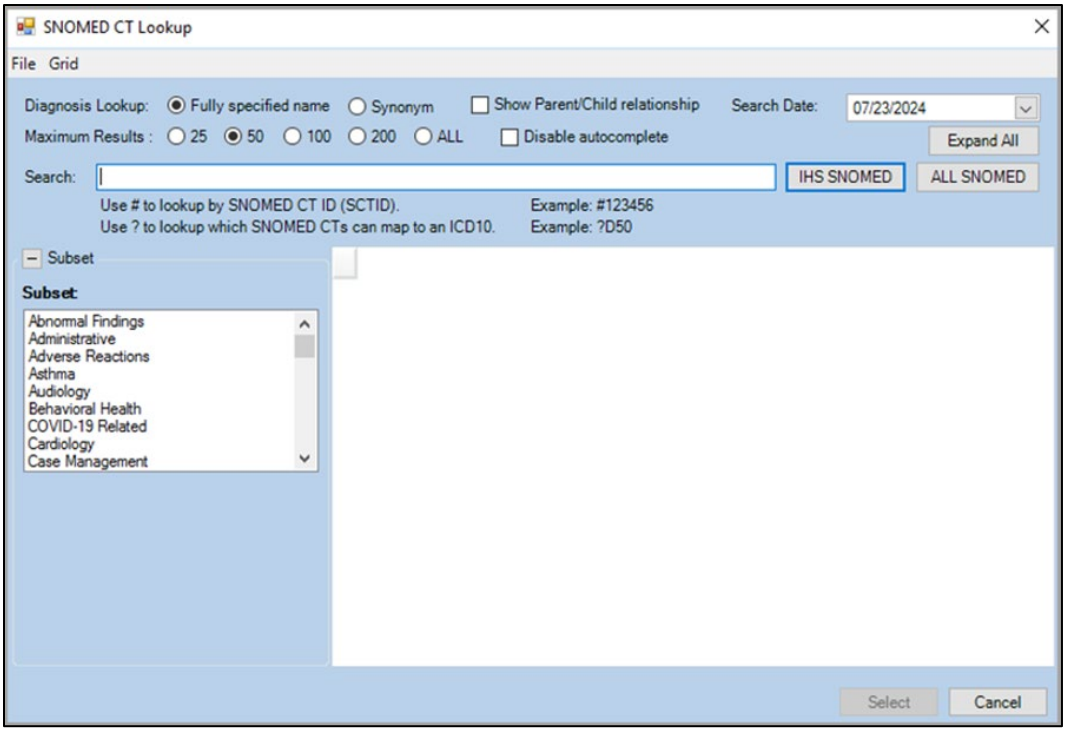


Figure 1-85: SNOMED CT Lookup dialog

3. 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.
   - **Show Parent/Child Relationships** displays detail of value to coders.

- **Disable Autocomplete** disables autocompletion of entries.

4. In **Maximum Results**, click one of the following option buttons to limit the number of results (or click **ALL**):
   - **25**
   - **50**
   - **100**
   - **200**
   - **ALL**
5. In **Search**, type the term to search.
6. In **Subset**, the user can select a subset to search for, if needed.
7. 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.
8. Click either the **IHS SNOMED** or **ALL SNOMED** button. The list of **SNOMED CT** terms is populated.
9. Select and highlight a term, and then click the **Select** button. The **SNOMED CT** field of the **Add Problem** dialog refreshes with the **SNOMED CT** term the user selected.

   If the user attempt to assign the same **SNOMED CT** code as an existing problem, the **Duplicate SNOMED CT Code** error message (Figure 1-86) displays.

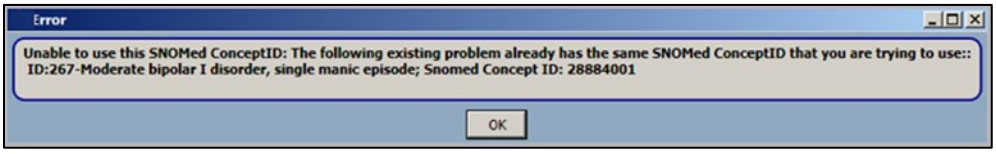


Figure 1-86: Duplicate SNOMED CT Code error message

10. Click **OK** and select a different **SNOMED CT** code from the **SNOMED CT Lookup** dialog.

1.8.1.2 Get SCT Button

Warning: The **Get SCT** button is no longer maintained and should not be clicked.

1.8.1.3 Pick List Button

1. Click the **Pick List** button to open the **Pick List** dialog. Refer to Section 1.5 for details on completing this dialog.

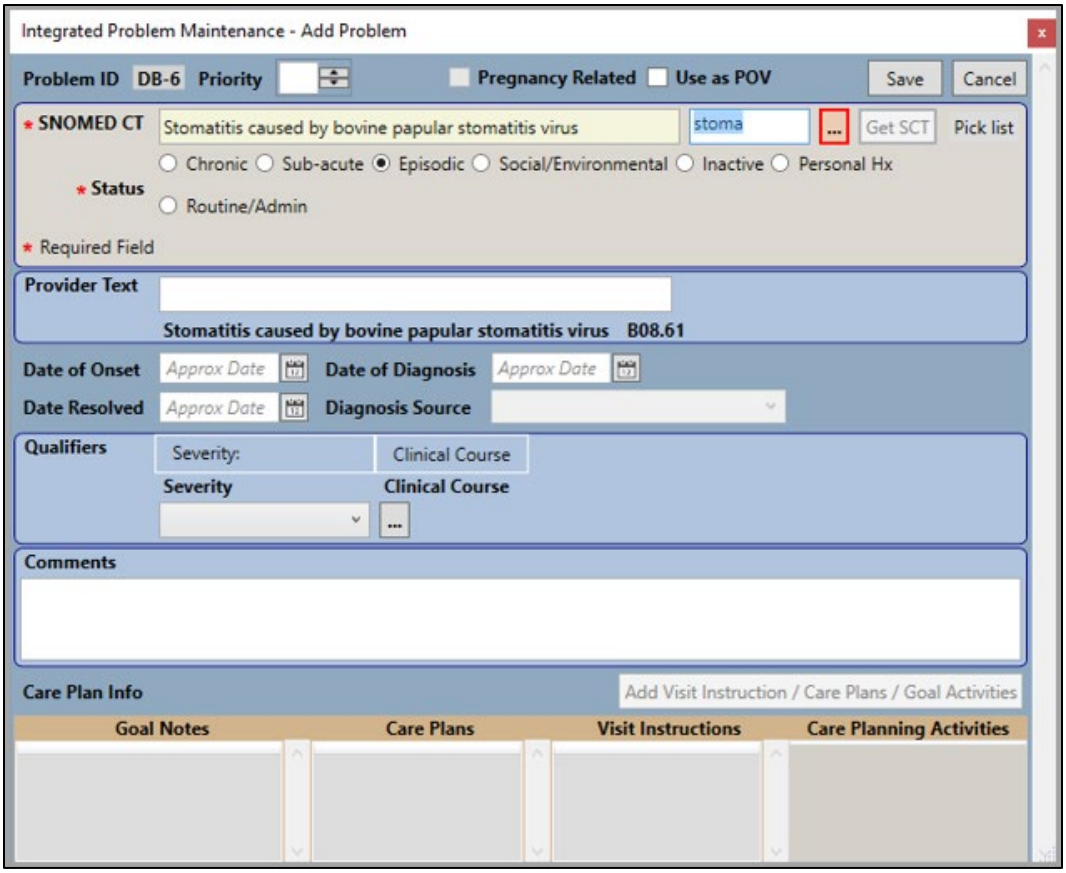


Figure 1-87: Expanded Add Problem dialog

In **Priority**, use the up and down arrows to select a priority level.

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

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

> **Note:** If **Use as POV** is selected, and if any fields have been changed or added, an information message displays 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 displays in the **POV** column of the **IPL** main window. Inactive problems may be **POV**.

4. In **Status**, click the **Applicable** option button:
   - **Chronic**
   - **Sub-acute**
   - **Episodic**
   - **Social/Environmental**
   - **Inactive**
   - **Personal Hx**

> **Note:** **Chart Review** is triggered if the user is editing a problem in IPL and the **Status** of a problem is changed and saved.

5. In **Provider Text**, type any **applicable text**. (Optional, 60-character limit.)

> **Note:** Briefly hover the mouse pointer over this field to view an information pop-up.

6. In the **Date of Onset** field (optional), enter the date in the text field or click the **Date** button ( ). A calendar (Figure 1-88) opens.

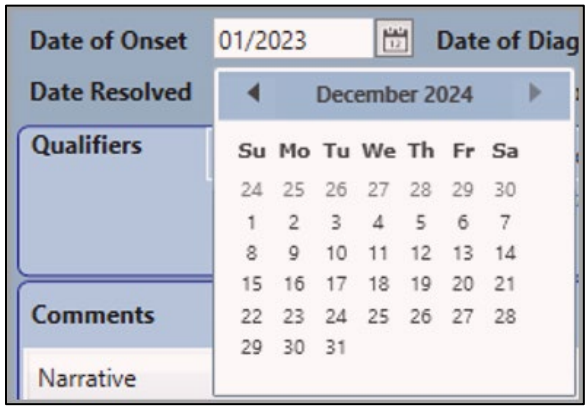


Figure 1-88: Select Date dialog calendar

- In the text field box, type a **date** in **xx/xx/xxxx** format.

  OR

- Select a **date** from the calendar. The date selected populates in the **Onset** Date field.

  OR

- In the text field box, type **T-X**, with **X** indicating number of days passed. The **Onset Date** populates with the current date minus the number of days indicated.

  OR

- In text field box, enter an imprecise date **YYYY**, **MMYYY**, or **MM/YYYY**.
  - The date entered cannot be in the future.
  - The date entered cannot be after the **Date of Diagnosis**.
  - The date entered cannot be prior to the patient's **date of birth**.

7. In the **Date of Diagnosis** field (optional) enter the date in the text field or click the **Date** button ( ). A calendar (Figure 1-89) opens.

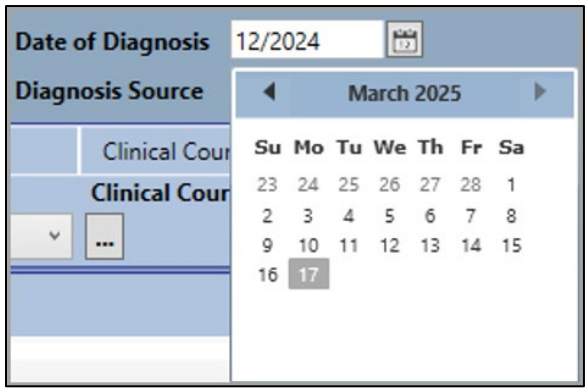


Figure 1-89: Date of Diagnosis field

- In the text field box, type a **date** in **xx/xx/xxxx** format.

  OR

- Select a date from the calendar. The date selected populates in the **Date of Diagnosis** field.

  OR

- In the text field box, type **T-X**, with **X** indicating number of days passed. The **Date of Diagnosis** populates with the current date minus the number of days indicated.

  OR

- In text field box, enter an imprecise date **YYYY**, **MMYYY**, or **MM/YYYY**.

- The date entered cannot be in the future.
- The date entered cannot be prior to the Onset Date.
- The date entered cannot be prior to the patient's date of birth.

8. In the **Date Resolved** field (optional) enter date in the text field or click the **Date** button (). A calendar (Figure 1-91) opens.

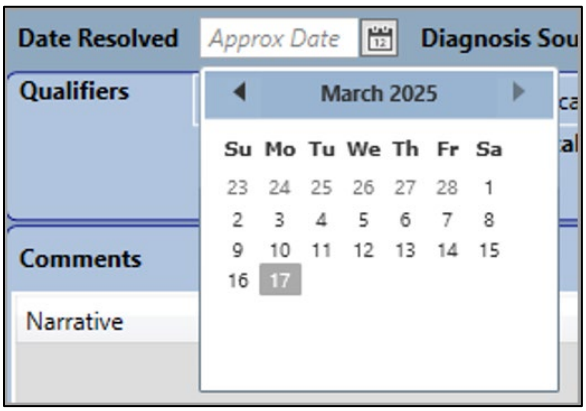


Figure 1-90: Date Resolved field Calendar

- In the text field box, type a **date** in **xx/xx/xxxx** format.

  OR

- Select a date from the calendar. The date selected populates in the **Date Resolved** field.

  OR

- In the text field box, type **T-X**, with **X** indicating number of days passed. The **Date Resolved** populates with the current date minus the number of days indicated.

  OR

- In text field box, enter an imprecise date **YYYY**, **MMYYY**, or **MM/YYYY**.

Note:	If the user enters a date, the system will update the problem status to inactive. If the user changes the status field to inactive, the system will update the Date Resolved to current system date.

  - The date entered cannot be in the future.
  - The date entered cannot be prior to the Onset Date or the Date of Diagnosis.
  - The date entered cannot be prior to the patient's date of birth.

9. In the **Diagnosis Source** field (optional) click the dropdown (Figure 1-90) to view values that can be selected.

    a. The **Diagnosis Source** field is not enabled unless a Date of Diagnosis is entered.

    b. A user can add additional content in the comment field to further clarify the source as needed.

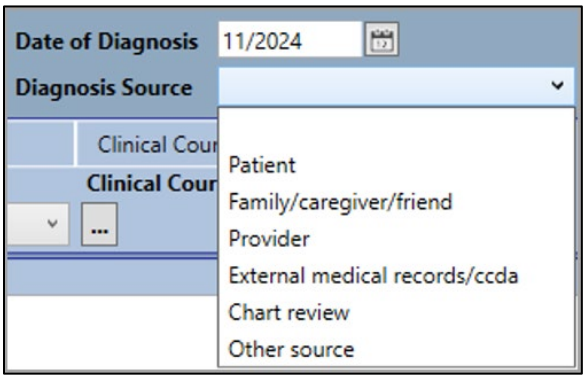


Figure 1-91: Source of Diagnosis field

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

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

11. Click the **Clinical Course Ellipsis** button (...) to populate the **Clinical Course** field. The **Select Clinical Courses** dialog (Figure 1-92) opens.

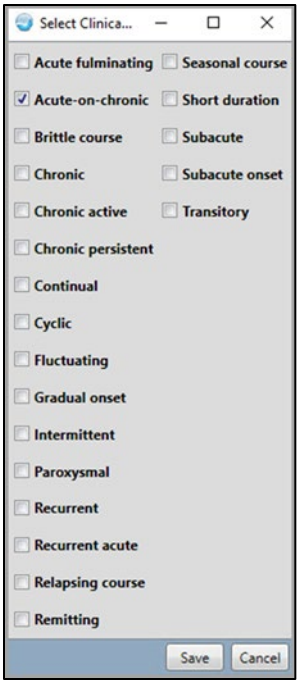


Figure 1-92: Select Clinical Courses dialog

a. Select one or more **courses**.

b. Click **Save**. The **Clinical Course** field updates with the selections.

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

12. In **Episodicities**, select one of the following from the drop-down menu:

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

13. Select the applicable **Asthma Classification** from the drop-down menu.

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

14. If applicable, select the **Is Injury** check box. The **Injury** section (Figure 1-93) 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.

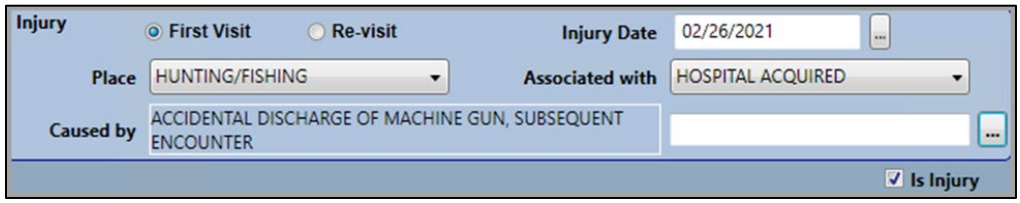


Figure 1-93: Injury section dialog

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**
- **Drug 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 (Figure 1-94) opens, showing only **E Coded** items.

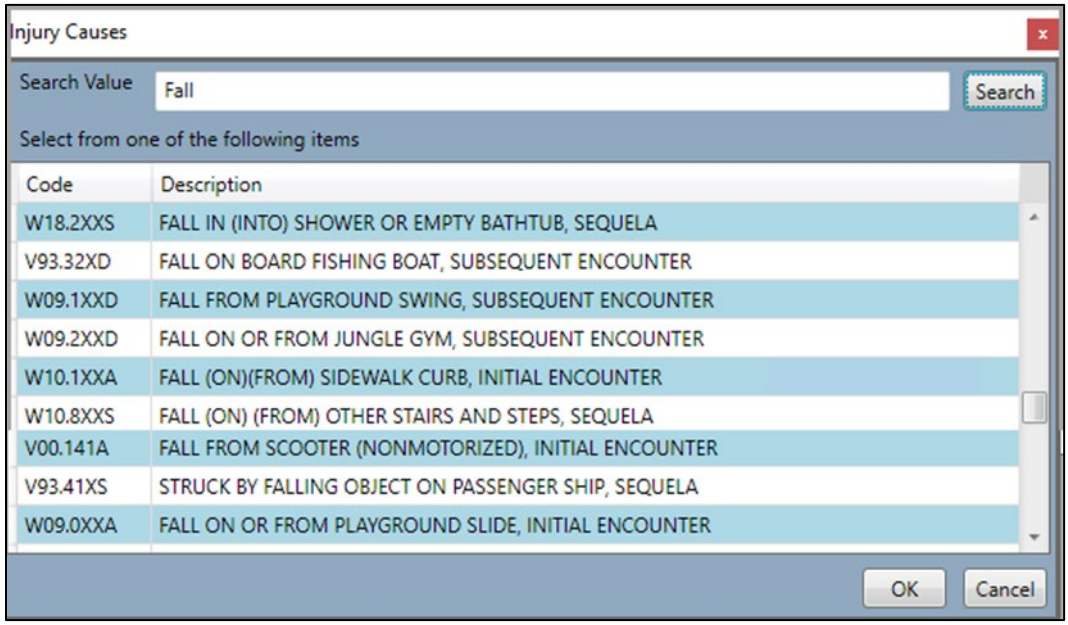


Figure 1-94: Injury Causes with E Codes dialog

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

g. In **Search** value, type a different search value if the 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.

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

15. Type a **comment** in the Comments section, if needed.

16. If the **Use as POV** check box was selected, the **Add Visit/Care Plan/Goal Activities** button is active. To add data, click the **Add Visit/Care Plan/Goal Activities** button. The **Add Visit Instructions/Care Plan Activities** dialog opens. Refer to the Adding Visit Instructions/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.

17. Click **Save** in the top-right of the **Add Problem** dialog. The 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.

1.8.2 Editing a Problem

To edit a problem, follow these steps:

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

> **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 (Figure 1-95) opens.

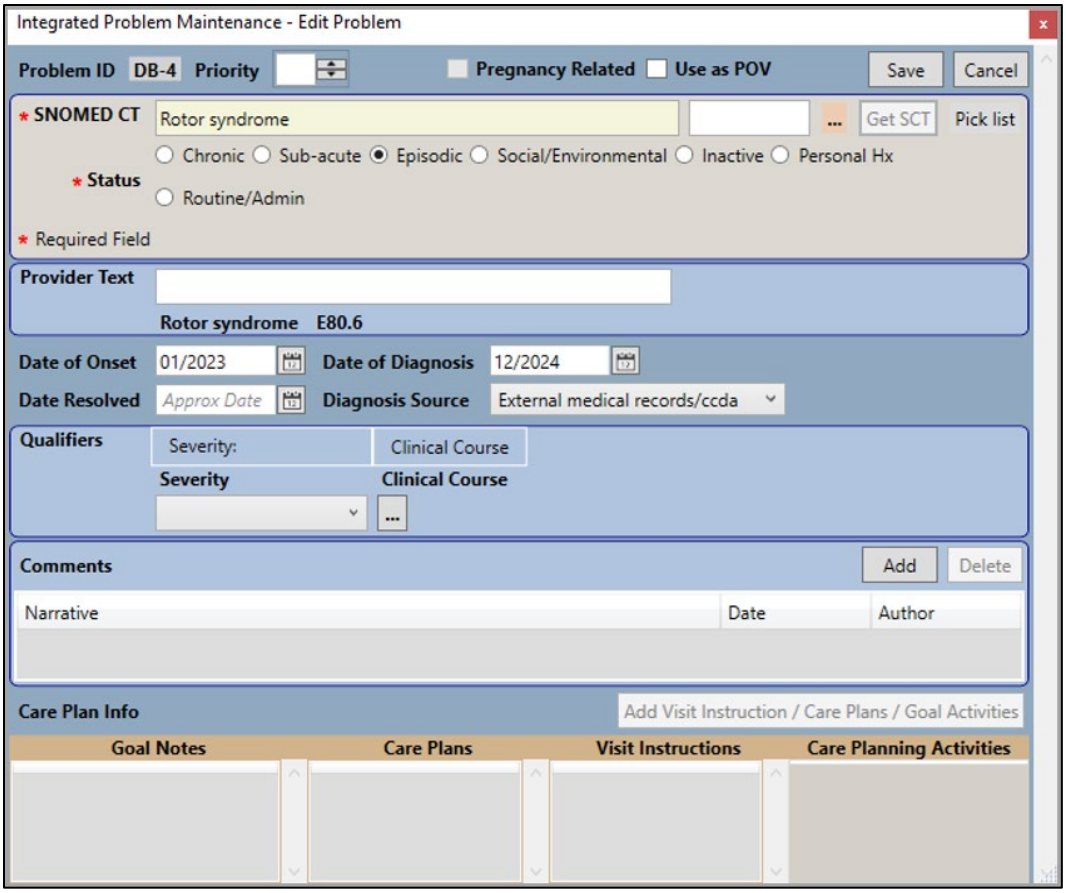


Figure 1-95: Integrated Problem List Maintenance – Edit Problem dialog

Note:	Users can enter an imprecise date for the **Injury Date** via **PCC Data Entry Staff** menu. The imprecise date displays as just the month and year. Once an imprecise date is entered, the user cannot change it.

Important:	If the problem currently exists in the patient's **Problem List**, the problem will open in the **Edit** dialog.

4. Edit fields as applicable. Refer to the Adding a Problem topic for instructions on completing the fields.

Note:	A **SNOMED CT** code must be selected to save the changes.

5. In the **Comments** section, **add** or **delete** comments.

1.8.2.1 Add Comments

1. Click the **Add** button. The **Add Comment** dialog (Figure 1-96) opens.

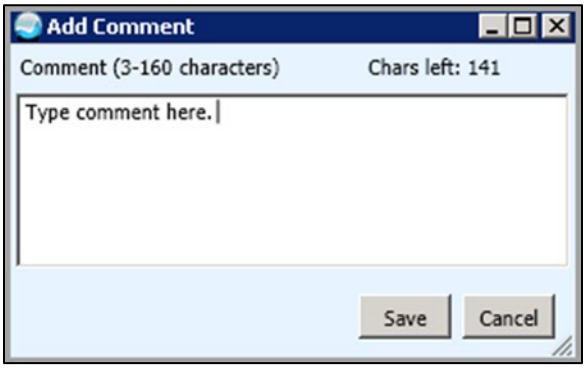


Figure 1-96: Add Comment dialog

2. In the **Comment** field, type a comment of **3-160 characters**.
3. Click **Save**. The comment appears in the **Comments** section (Figure 1-97), with a number automatically assigned and shown in the # column, the comment in the **Narrative** column, the date entered in the **Date** column, and the logged in user name in the **Author** column.

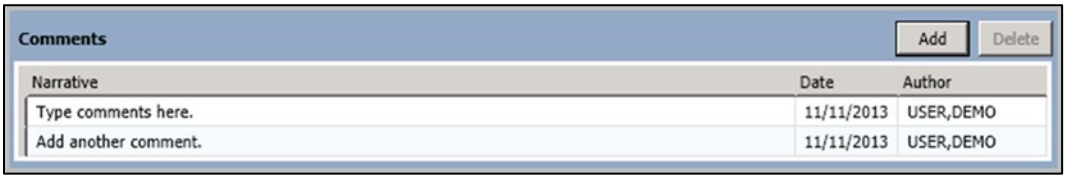


Figure 1-97: Comments List dialog

1.8.3 To Delete Comments

1. Select one or more comments the user wants to delete. The line items are highlighted and the **Delete** button becomes active.
2. Click the **Delete** button. The following message (Figure 1-98) displays:

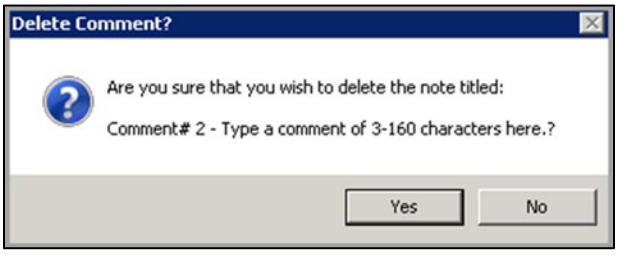


Figure 1-98: Delete Comment confirmation message

3. Click **Yes**. The comment no longer appears in the list.

4. 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.

1.8.3.1 Problem Status

The status stored for a new problem, or edited inactive problem, shall be inherited from default status for the selected SNOMED term set in Digital Terminal Status (DTS).

For an **Active** problem, a dialog (Figure 1-99) displays telling the user what the default status is. The user can click **Yes** to approve or **No** if the user does not approve. The system will store the SNOMED term without changing the problem status.

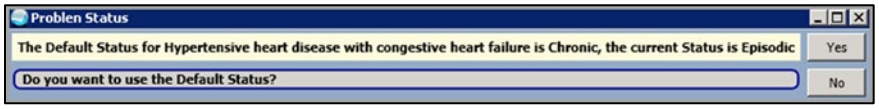


Figure 1-99: Problem Status dialog

1.8.4 Deleting a Problem

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 POV Dialog Columns 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 window.

The problem is cleared from the Integrated Problem List grid.

1.9 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 the **Care Plan** information is already expanded (Figure 1-100).

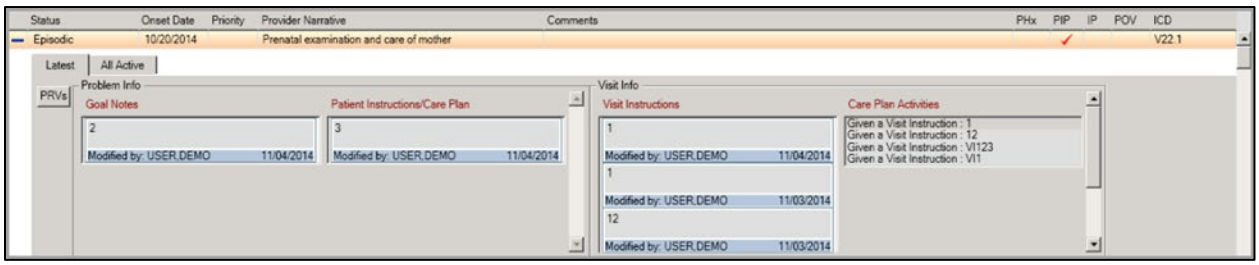


Figure 1-100: Expanded Care Plan dialog

- 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).

1.9.1 Latest Tab

On the **Latest** tab (Figure 1-101) of the **Care Plan** (displays when the **Plus** or **Expand All** is selected), 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.

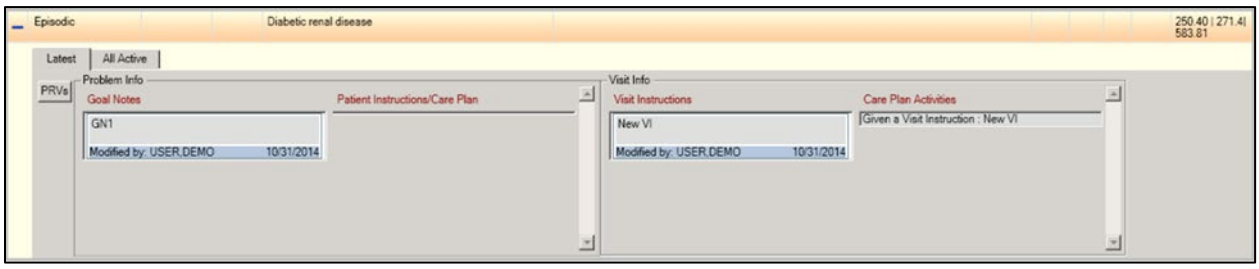


Figure 1-101: Latest Care Plan dialog

1.9.1.1 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 (Figure 1-102) opens.

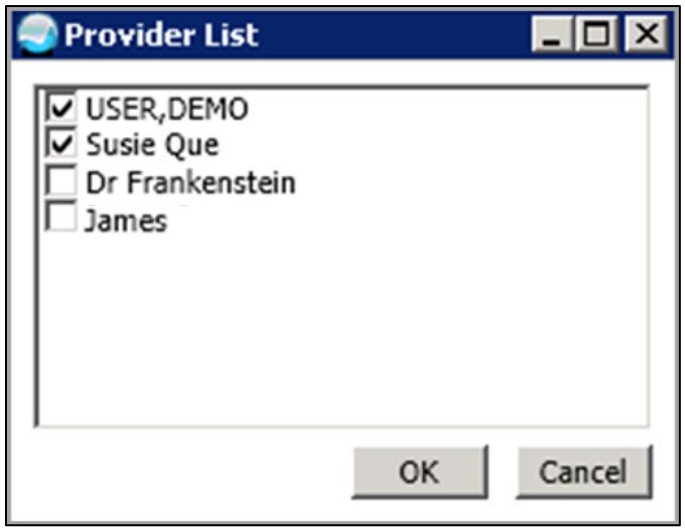


Figure 1-102: Provider List dialog

2. Select the check boxes to choose one or more **providers**, and then click **OK**. The **Provider List Results** dialog (Figure 1-103) displays.

   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**.

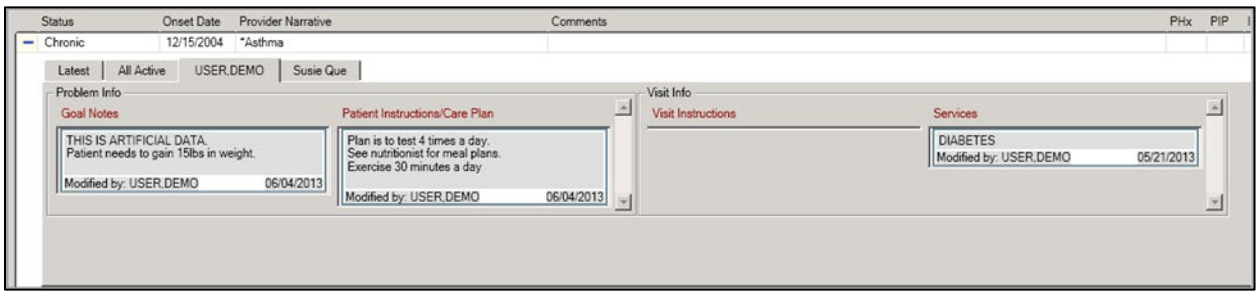


Figure 1-103: Provider list results dialog

1.9.2 All Active Tab

On the **All Active** tab (Figure 1-104), all active care planning activities are shown.

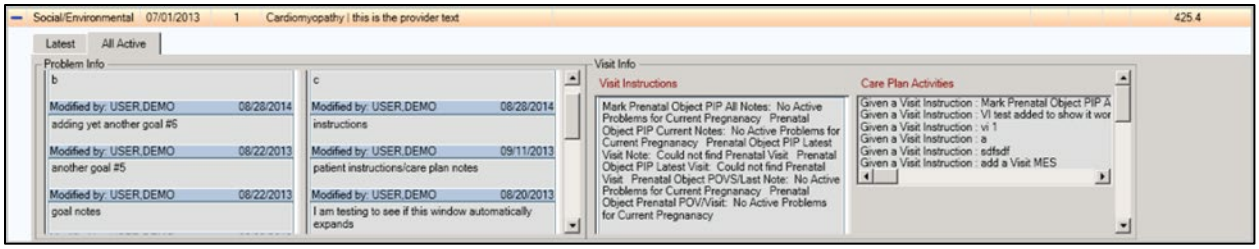


Figure 1-104: All active care plans

1.9.3 Adding, Replacing, Inactivating, and Deleting in Care Planning

This functionality is intended to inactivate the existing goal or care plan and initiate a new one. Use this 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.

For example, a patient with 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 hirsutism and metabolic effects of PCOS, and contraception. The user would then inactivate the plan and write a new one (the user may want to see the old care plan notes if the patient wants to try to conceive again).

Important:

Add, Replace/Edit, Inactivate, and Delete are actionable for Goal Notes and Care Plans.

Only Add and Delete are actionable for Visit Instructions.

User is not allowed to inactivate a visit instruction.

Only the Chief MIS and the owner of the note can delete.

The following columns have a right-click menu (Figure 1-105):

- **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.

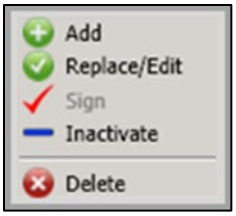


Figure 1-105: POV right-click menu

- **Add:** The **Add** dialog (Figure 1-106) opens. Type the **text** and click **OK**. The text shows in the column.

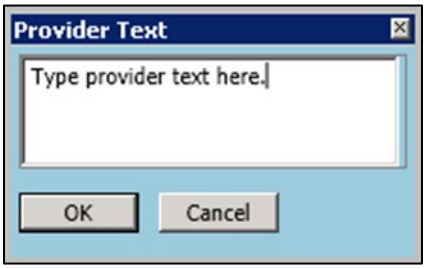


Figure 1-106: Add dialog

- **Replace:** The **Replace** function is used to edit existing text. A dialog (Figure 1-107) showing the original text opens. Type the edited text in the **Replacing Text** field and click **OK**. The edited text displays.

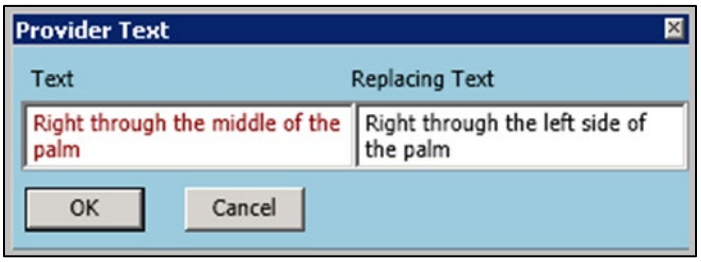


Figure 1-107: Replacing Text field

- **Sign:** The **Review/Sign** dialog (Figure 1-108) opens with a list of the items added by the user to sign. Type an **electronic signature**, and then click **OK**.

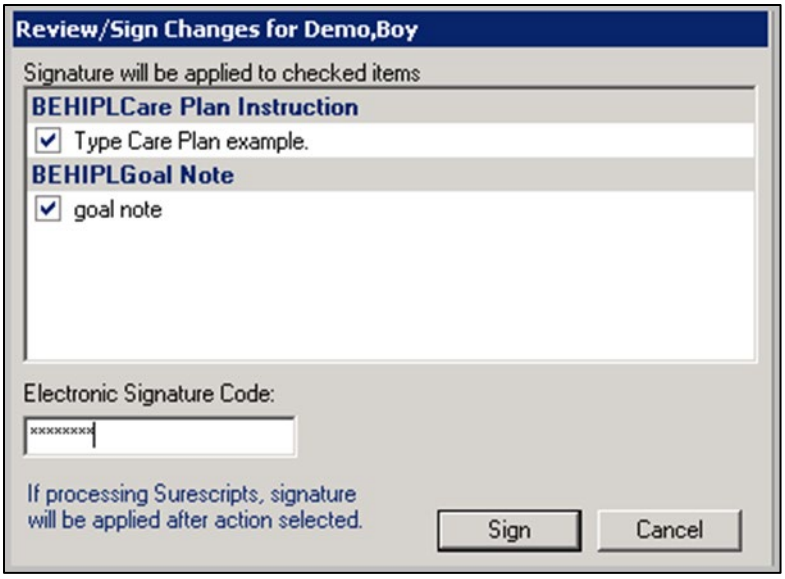


Figure 1-108: Review/Sign Changes for patient name for POV

- **Inactivate:** This functionality is intended to inactivate the existing goal or care plan and initiate a new one (Figure 1-109). Use this 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**.

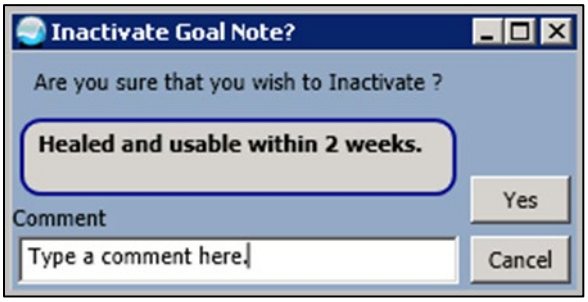


Figure 1-109: Inactivate Item dialog

- **Delete:** The **Delete** dialog (Figure 1-110) opens to confirm the deletion. Click **OK**.

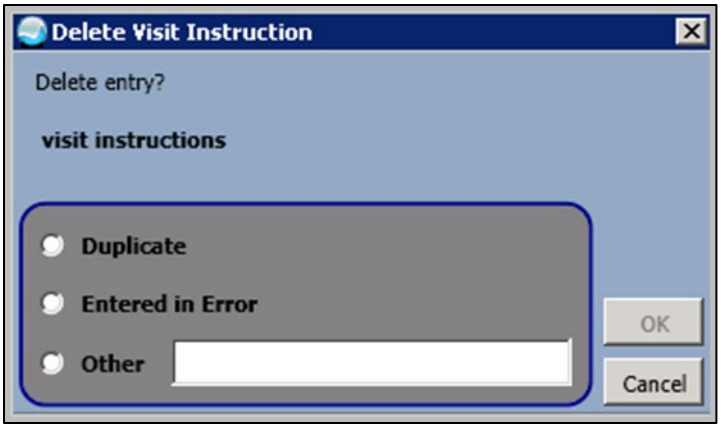


Figure 1-110: Delete confirm dialog (signed entry)

Note: This is a logical delete. The record is deleted, but the comment is retained in the file in FileMan for future reference.

This is a normal delete.

The **Delete** dialog below (Figure 1-111) displays when the instruction is unsigned. It removes the information entirely from the record, and the information is not retained in the file in FileMan.

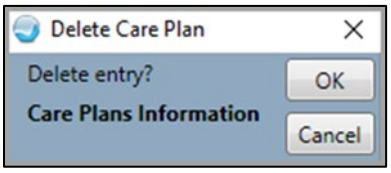


Figure 1-111: Care Plan Normal Delete dialog (unsigned)

1. Add any free-text information in the **Prov. (Provider) Text** field by selecting **Add** from the right-click menu. The **Provider Text** dialog (Figure 1-112) opens:

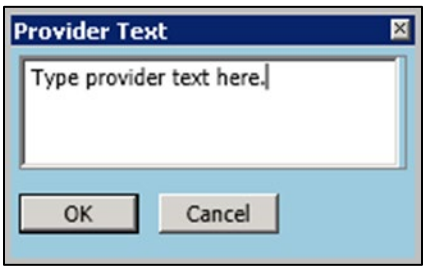


Figure 1-112: Provider Text dialog

   a. Type **provider text** to include more detail regarding the problem for TODAYS ENCOUNTER only. 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:

c. Type the new **provider text** in the **Replacing Text** field.

d. Click **OK**. The change shows in the **Prov. Text** column.

2. The **Goal Notes** column contains goals set for the patient to improve the problem, for example to reduce their cholesterol. The user can add a Goal Note by selecting **Add** from the right-click menu. The **Goal Note** dialog (Figure 1-113) opens.

- Click the **Template** button ( ) to select a template, if needed.

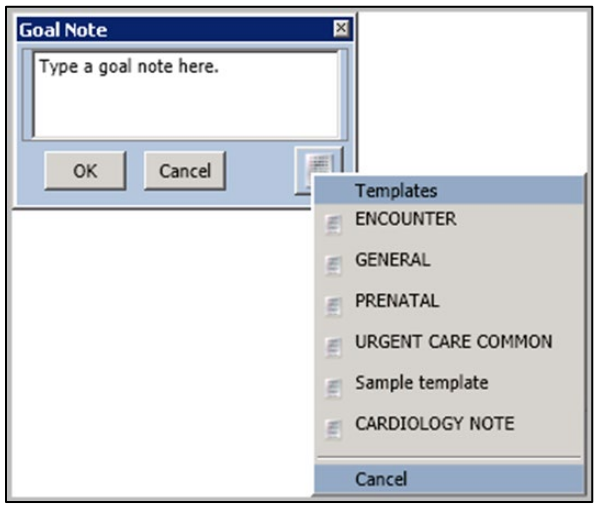


Figure 1-113 Goal Note dialog with Templates menu dialog

- The user can also type over an existing Goal Note by clicking in (or selecting) the text and making the changes.
- The **Care Plans** column contains instructions for the patient, for example, walk three times per week, and so on. The user 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.
- The user can also type over an existing Care Plan by clicking in (or selecting) the text and making the changes.

Important:

Add, Replace/Edit, Inactivate, and Delete are actionable for Goal Notes and Care Plans.

Only Add and Delete are actionable for Visit Instructions.

User is not allowed to inactivate a visit instruction.

Only the Chief MIS and the owner of the note can delete.

1.10 Adding Visit Instructions/Goal Notes/Care Plan Activities

When adding or editing a problem if the **Use as POV** check box is selected, the **Add Visit/Care Plans/Goal Activities** button (Figure 1-114) is enabled for adding, inactivating, or deleting visit instructions, goals, or Care Plan information. Refer to Using the POV Button for additional information.

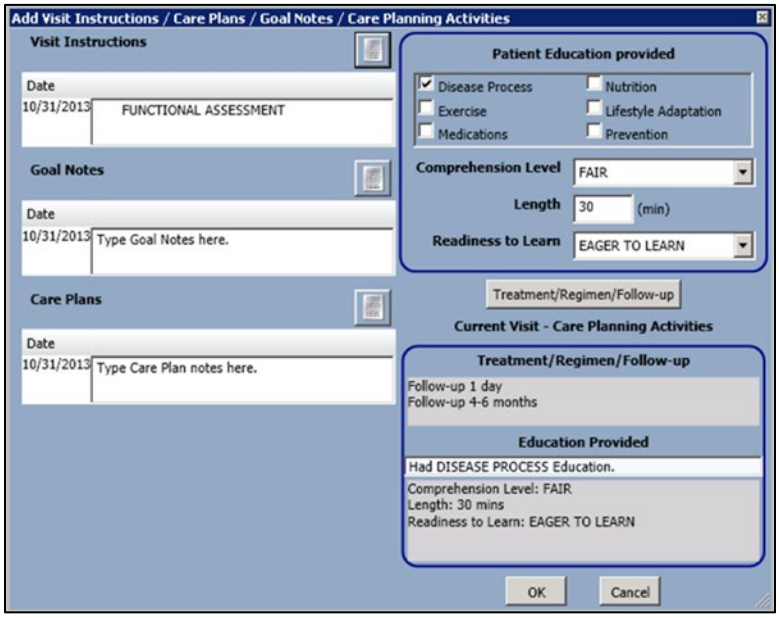


Figure 1-114: Add Visit Instructions/Care Plan/Goal Notes/Care Planning Activities dialog

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 (Figure 1-115) opens.

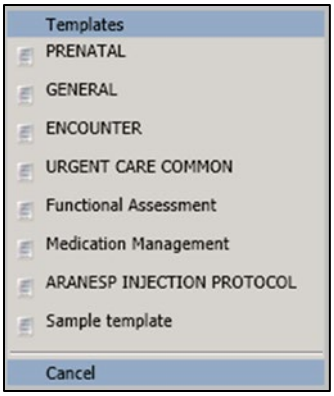


Figure 1-115: Templates list

b. Select a **template**. The template window opens.

- The selected template name displays in the **Visit Instructions**, **Goal Notes**, or **Care Plans** fields, as selected.

Note:	The user can also click the **Preview** button to view how the **Template** dialog displays. The Medication Management template in the Visit Instructions is shown as an example, below (Figure 1-116).

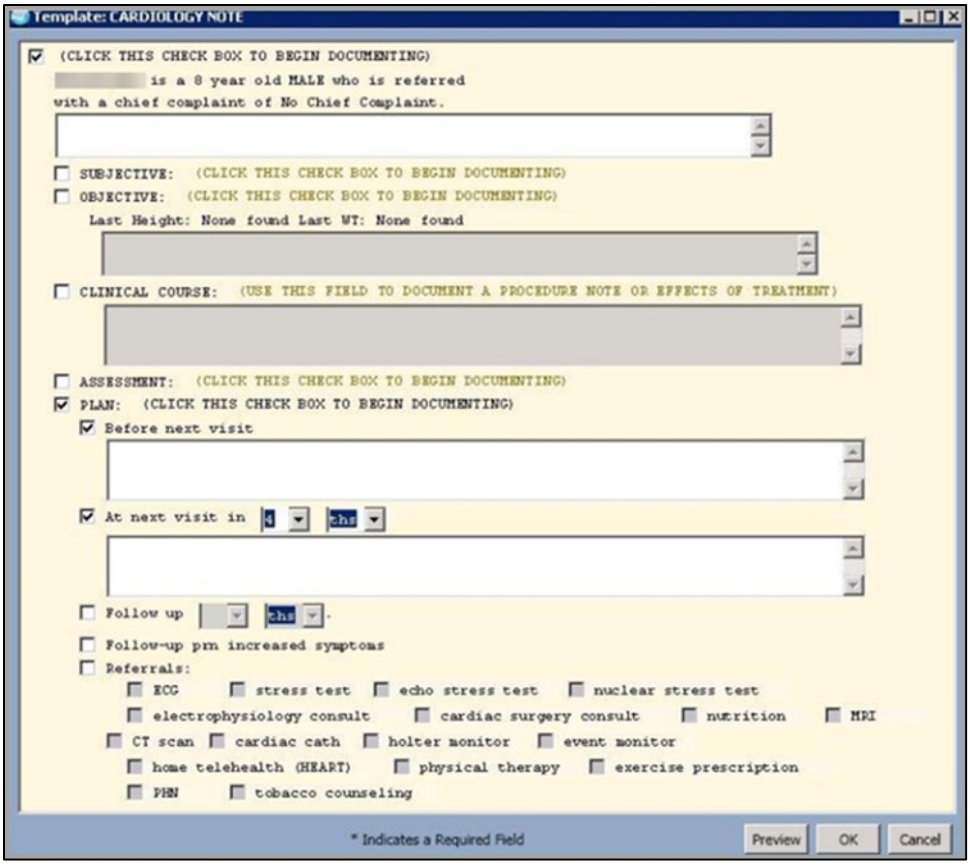


Figure 1-116: Medication Management Template dialog

c. Make any necessary changes and click **OK**.

- Repeat the steps above 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**

The 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 (Figure 1-117) opens.

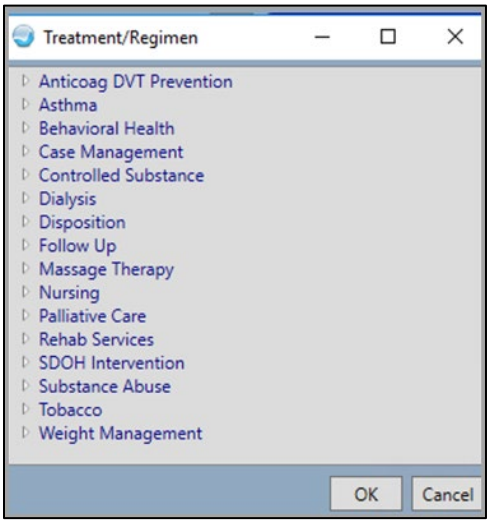


Figure 1-117: Treatment/Regimen dialog

a. Click the small arrow next to an item in the list to expand the list.

Note: The **Treatment/Regimen** dialog contains multiple TREG pick lists, organized alphabetically.

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

c. Click **OK**. The selections show in the **Treatment/Regimen/Follow-up** section.

4. Click **OK**. The **Review/Sign Changes for Patient Name** dialog (Figure 1-118) opens, showing a list of the items added or changed. Sign by adding the **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 the changes.

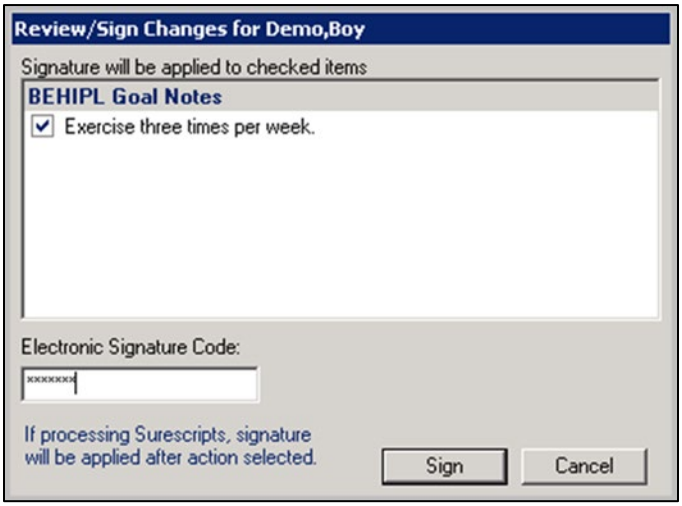


Figure 1-118: Review/Sign Changes for Patient Name dialog

Refer to the Care Planning Feature for adding, editing, and replacing instructions. The **Add/Edit** window for **IPL** contains the same functionality.

Important:

Add, Replace/Edit, Inactivate, and Delete are actionable for Goal Notes and Care Plans.

Only Add and Delete are actionable for Visit Instructions.

User is not allowed to inactivate a visit instruction.

Only the Chief MIS and the owner of the note can delete.

2.0 Medication Management

The Medication Management component (Figure 2-1) lists the outpatient and inpatient medications that have been ordered for the currently selected patient, as well as any documented outside medications. If a visit context was created, it allows users to create new medication orders and interact with existing medication orders. If the site participates in ePrescribing and allows for change and renew requests, users must process those requests in the **Surescripts Mailbox** (also called **SS Mailbox** or **Mailbox**) component.

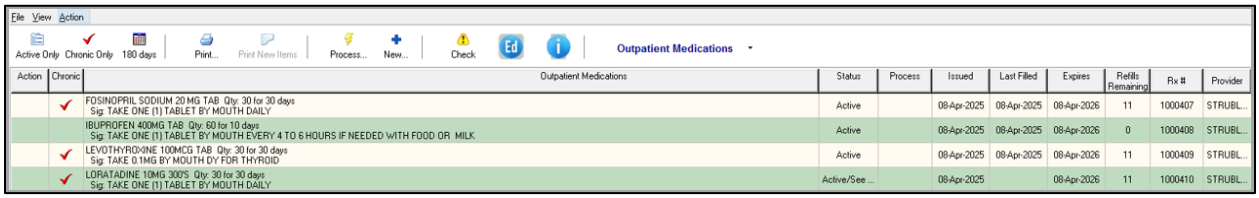


Figure 2-1: Medication management component

2.1 Medication Management Component Display

The Medication Management component display features:

- A menu bar with **File**, **View**, and **Action** options.
- A tool bar with buttons to adjust the **view**, **perform actions**, **obtain information**, and a drop-down for **activating a group**.
- Three display groups representing **Outpatient (top)**, **Outside (middle)**, and **Inpatient (bottom)** medications. The middle display group label is site configurable, so may read differently at each site.
  - **Outpatient Medications** are prescribed by in-house providers, most often those ordered for the patient to use at home or may be an item administered in the clinic when the patient is not admitted.
  - **Outside Medications** are those items that are neither prescribed by in-house providers nor dispensed at the local site, and may include over the counter (OTC), dietary supplement, and herbal preparations.
  - **Inpatient Medications** are most often those that are ordered by in-house providers and administered while the patient is admitted to the local facility or may be an item administered in the clinic when the patient is not admitted.
- The **File** menu contains the **Print** function.
- The **View** menu contains the **Details**, **Administration History** (for Outpatient and Inpatient display groups only), and **Refresh** options.
- The **Action** menu changes based on the currently selected display group.

The tool bar contains several buttons that affect only the medication display within the group users are working.

For example, if working with the **Outpatient Medications** display group, the action selected applies only to the **Outpatient Medications** display group and does not affect the **Inpatient Medications** or **Outside Medications** display groups. The buttons include the options below:

- **Active Only**. Restricts the view to items with status of **Active** (Figure 2-2). May be used in conjunction with the **Chronic Only** button.



Figure 2-2: Active Only button

- **Chronic Only**. Restricts the view to items marked **Chronic** (Figure 2-3). May be used in conjunction with the **Active Only** button.



Figure 2-3: Chronic Only button

- **Restrict Medication Activity**. Restricts the view to items active within the number of days set here (Figure 2-4). The button displays the current number of days set.



Figure 2-4: Restrict Medication Activity button

- Click the **button** to open the **Restrict Medication Activity** dialog (Figure 2-5) to change the number of days.

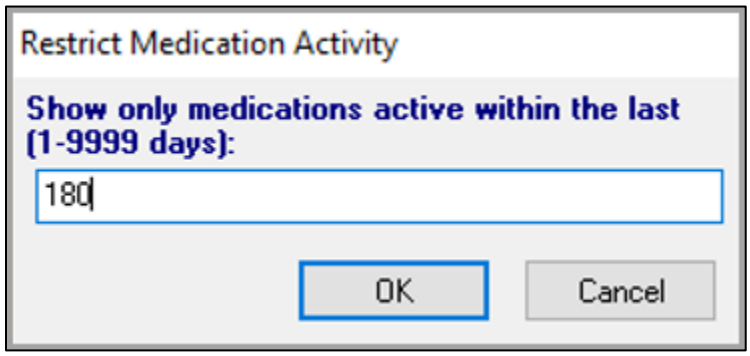


Figure 2-5: Restrict Medication Activity dialog

- **Print**. Prints the currently selected item or items (Figure 2-6). This is the same as the **File** menu **Print** option. Refer to Print for additional information.



Figure 2-6: Print button

- **Print New Items**. Is only active when there are items to print (Figure 2-7). When active, the button shows the number of items awaiting printing. Refer to Print for additional information.



Figure 2-7: Print New Items active button

- **Process**. Allows varying actions to be taken on a group of selected items (Figure 2-8). For Outpatient Medications only. Refer to Outpatient Medication Process for additional information.



Figure 2-8: Process button

- **New**. Create a new order or entry for the currently selected display group (Figure 2-9). Refer to Outpatient Medication New Medication for additional information.



Figure 2-9: New button

- **Check**. Run order checking on the currently selected patient's active and pending medications (Figure 2-10) in both the Outpatient and Outside Medications display groups.



Figure 2-10: Check button

- **Education Information (Ed)**. Searches for patient education information (Figure 2-11) for the currently selected medication or medications and then prompts users to document patient education. The button currently searches MedlinePlus Connect.



Figure 2-11: Education Information button

The **Add Patient Education Event** dialog (Figure 2-12) displays.

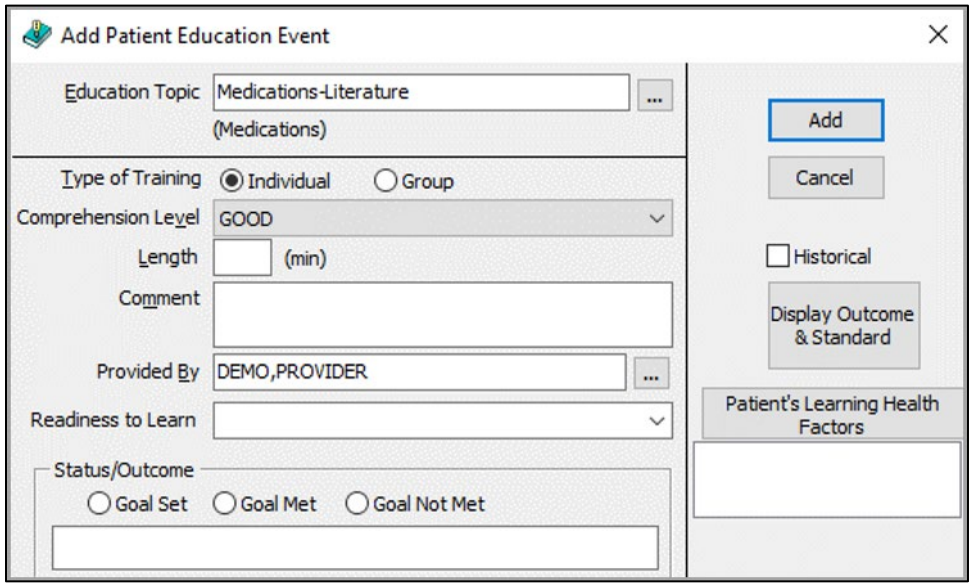


Figure 2-12: Add Patient Education Event dialog

- **Clinical Decision Support (i)**. Searches for clinical information for the currently selected medication or medications (Figure 2-13). Users may select from several sources to search that are set up locally.



Figure 2-13: Clinical Decision Support button

- **Group Selection drop-down**. Displays the currently active group (Figure 2-14). Users may select a group by clicking within the group or by using the drop-down list to select the group.



Figure 2-14: Group Selection drop-down list

2.2 Outpatient Medications Group

The **Outpatient Medications** group displays the outpatient medications that have been ordered for the currently selected patient with visibility based on the **Active Only**, **Chronic Only**, and **Restrict Medication Activity** settings.

2.3 Columns

The **Outpatient Medications** group has the following columns:

- **Action**. Shows the action taken on an existing entry. Required column.
- **Chronic**. Shows a check mark if the item is marked as a chronic medication. Required column.
- **Outpatient Medications**. Shows the order information. Required column.
- **Status**. Shows the status of the item, including but not limited to Pending, Active, Active/See Details, Expired, Discontinued. Required column.
- **Process**. Displays an icon as noted below indicating the process used to order the medication. Required column.
  - A **medical building** for internal pharmacy (Figure 2-15).



Figure 2-15: Internal Pharmacy icon

  - A **printer** for printed external pharmacy (Figure 2-16). The icon may include a check mark if the item was printed.



Figure 2-16: Print icons–Unprinted, Printed

– **A Lightning Bolt for Electronic External Pharmacy** (Figure 2-17). The icon contains a dashed circle when transmitting, a green check on successful transmission, and a red circle when transmission was not successful.



Figure 2-17: Electronic icons–Transmitting, Successful, Failed

- **Issued**. Displays the date the order or prescription was created. Optional column.
- **Last Filled**. If available, display the date the item was last filled. Optional column.
- **Expires**. Displays the date the order or prescription will expire. Optional column.
- **Refills Remaining**. If available and applicable, displays the number of refills that have not yet been used. Optional column.
- **Rx #**. If applicable, displays the prescription number stored in the local system. Optional column.
- **Provider**. Displays the name of the prescriber who ordered the Medication. Optional column.

2.3.1 Column Notes

- Any of the column headers noted as **optional** can be hidden from view if desired by right-clicking a column header (Figure 2-18).
- Checked items display, while cleared items are hidden.
- Use the **Show All** or **Hide All** options to quickly show or hide all the optional columns.
- Use **Restore Defaults** to return to the saved default view and **Save Settings** to create a new default view.

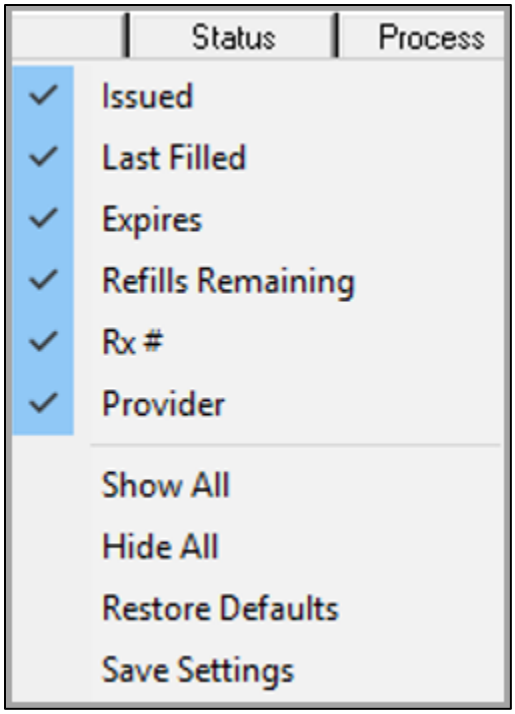


Figure 2-18: Outpatient medications columns right-click menu

2.3.2 Sort Order

The default sort order is set locally. Users may sort the group contents for any of the columns by left-clicking the column label. The first click sorts **A to Z** or **low to high** (Figure 2-19), while additional clicks reverse the current sort order (Figure 2-20). A small, dark-gray triangle shows in the column header to indicate the column used to sort and the sort order.

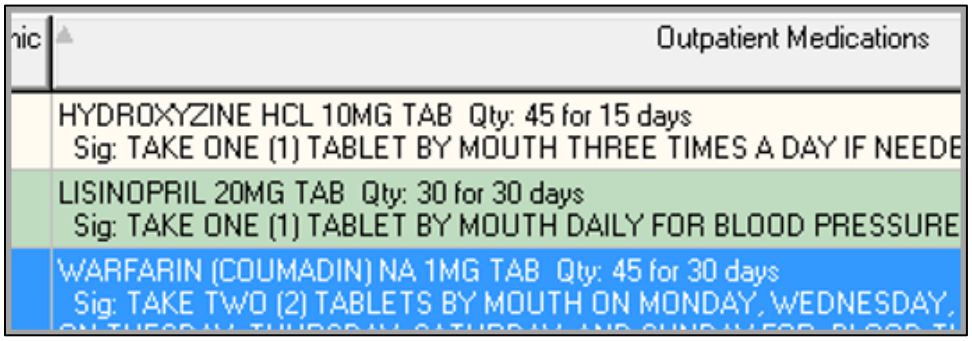


Figure 2-19: Sort Indicator in Outpatient Medications column A to Z

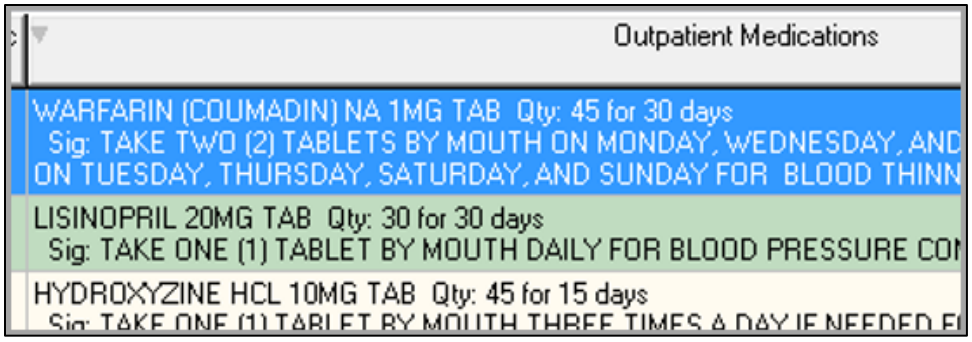


Figure 2-20: Sort Indicator in Outpatient Medications column Z to A

2.4 Outpatient Medication Print

The Print function can be used to print reports, labels, orders, receipts, or prescriptions, depending on each site's configuration. Users may access the print functionality from the **File** menu, the **Print** button, or for certain cases, from the **Print New Items** button.

2.4.1 Print New Items Button

The **Print New Items** button brings up the same print dialogs as for Print but for an automatic queue of items that must be printed from the current session. With the release of EHR patches supporting ePrescribing through Surescripts and Electronic Prescribing of Controlled Substances (EPCS), the need to print orders and prescriptions should be minimal. However, there are safeguards in place to prevent diversion and fraudulent orders, including logging of orders and print events and non-removable text denoting that a printed copy is not fillable when printing an item that was successfully transmitted.

2.5 Outpatient Medications Reports

Reports may be printed as **Brief** or **Detailed** (Figure 2-21).

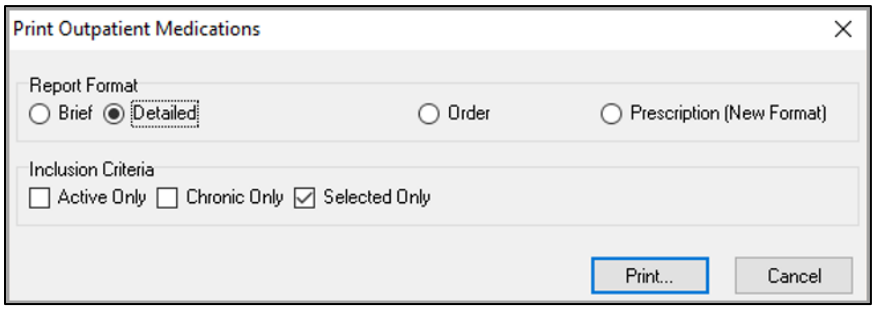
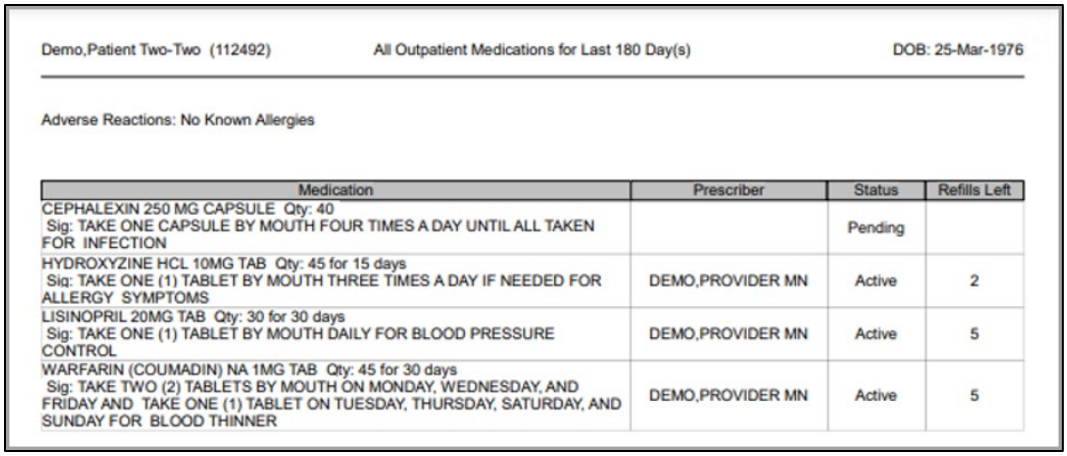


Figure 2-21: Print Outpatient Medications with Report Format Detailed selected

Brief reports (Figure 2-22) contain the information in the **Medication**, **Prescriber**, **Status**, and **Refills Left** columns and are printed in portrait orientation.



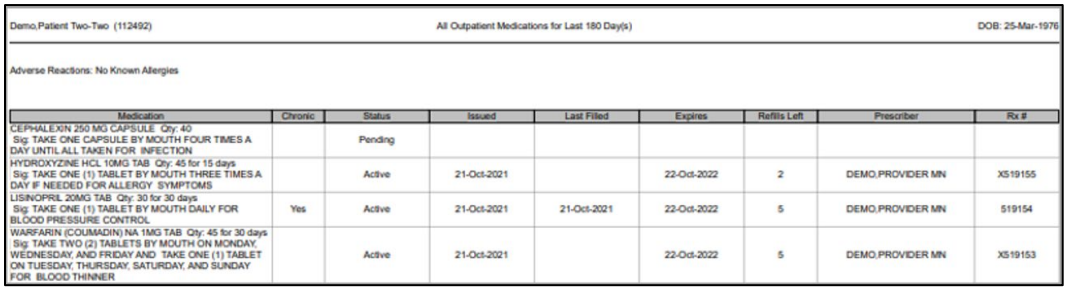
Demo,Patient Two-Two (112492) All Outpatient Medications for Last 180 Day(s) DOB: 25-Mar-1976

Adverse Reactions: No Known Allergies

Medication	Prescriber	Status	Refills Left
CEPHALEXIN 250 MG CAPSULE Qty: 40 Sig: TAKE ONE CAPSULE BY MOUTH FOUR TIMES A DAY UNTIL ALL TAKEN FOR INFECTION		Pending	
HYDROXYZINE HCL 10MG TAB Qty: 45 for 15 days Sig: TAKE ONE (1) TABLET BY MOUTH THREE TIMES A DAY IF NEEDED FOR ALLERGY SYMPTOMS	DEMO,PROVIDER MN	Active	2
LISINOPRIL 20MG TAB Qty: 30 for 30 days Sig: TAKE ONE (1) TABLET BY MOUTH DAILY FOR BLOOD PRESSURE CONTROL	DEMO,PROVIDER MN	Active	5
WARFARIN (COUMADIN) NA 1MG TAB Qty: 45 for 30 days Sig: TAKE TWO (2) TABLETS BY MOUTH ON MONDAY, WEDNESDAY, AND FRIDAY AND TAKE ONE (1) TABLET ON TUESDAY, THURSDAY, SATURDAY, AND SUNDAY FOR BLOOD THINNER	DEMO,PROVIDER MN	Active	5

Figure 2-22: Outpatient Medications brief report

Detailed reports (Figure 2-23) contain the information from all the available columns and are printed in landscape orientation. The information is printed regardless of the visibility of the columns in the current view.



Demo,Patient Two-Two (112492) All Outpatient Medications for Last 180 Day(s) DOB: 25-Mar-1976

Adverse Reactions: No Known Allergies

Medication	Chronic	Status	Issued	Last Filled	Expires	Refills Left	Prescriber	Rx #
CEPHALEXIN 250 MG CAPSULE Qty: 40 Sig: TAKE ONE CAPSULE BY MOUTH FOUR TIMES A DAY UNTIL ALL TAKEN FOR INFECTION		Pending						
HYDROXYZINE HCL 10MG TAB Qty: 45 for 15 days Sig: TAKE ONE (1) TABLET BY MOUTH THREE TIMES A DAY IF NEEDED FOR ALLERGY SYMPTOMS		Active	21-Oct-2021		22-Oct-2022	2	DEMO,PROVIDER MN	X519155
LISINOPRIL 20MG TAB Qty: 30 for 30 days Sig: TAKE ONE (1) TABLET BY MOUTH DAILY FOR BLOOD PRESSURE CONTROL	Yes	Active	21-Oct-2021	21-Oct-2021	22-Oct-2022	5	DEMO,PROVIDER MN	519154
WARFARIN (COUMADIN) NA 1MG TAB Qty: 45 for 30 days Sig: TAKE TWO (2) TABLETS BY MOUTH ON MONDAY, WEDNESDAY, AND FRIDAY AND TAKE ONE (1) TABLET ON TUESDAY, THURSDAY, SATURDAY, AND SUNDAY FOR BLOOD THINNER		Active	21-Oct-2021		22-Oct-2022	5	DEMO,PROVIDER MN	X519153

Figure 2-23: Outpatient Medications Detailed report

Reports may be further refined using the Inclusion Criteria to restrict to the **Selected Only** item or items, **Active Only** items, **Chronic Only** items, or any combination of the available options.

Note: Be careful when selecting criteria, as it is possible to set the Inclusion Criteria so that nothing prints.

1. Click **Print** when the criteria selection has been made. The **Print Setup** dialog (Figure 2-24) displays.

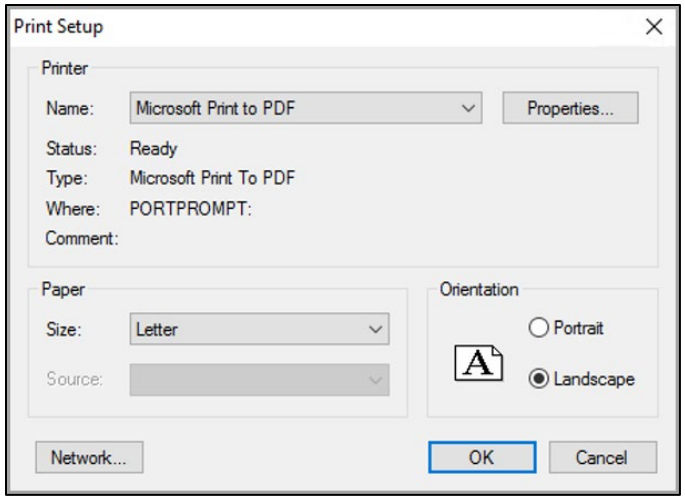


Figure 2-24: Print Setup dialog

2. Click **OK** to print the report once the printer and other options have been selected.

   The information included on the report reflects the columns and information documented.

No Print Warning Message

If the selected item or items are not eligible to be printed or if the inclusion criteria were set such that no items can be printed, a no print **Warning** message (Figure 2-25) displays.

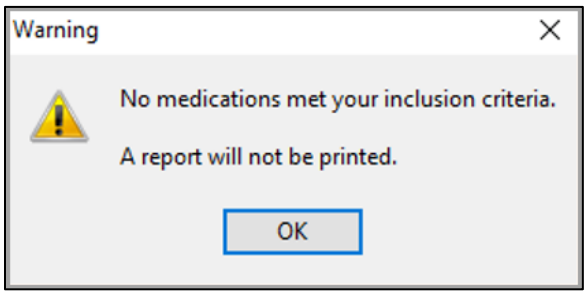


Figure 2-25: No Items Meeting Inclusion Criteria warning message

Click **OK** to dismiss the warning.

2.6 Outpatient Medications Label

Labels may be printed if allowed by the site. Labels may be generated for any item with an active status regardless of order process (**internal**, **electronic**, **printed**), but can only be printed on the day the order was created.

Note: Special printers may be required.

If labels are allowed, the **Label** option (Figure 2-26) displays on the **Print Outpatient Medications** dialog.



Figure 2-26: Print Outpatient Medications dialog with Label option

If not allowed, the **Label** option (Figure 2-27) is hidden from the dialog.

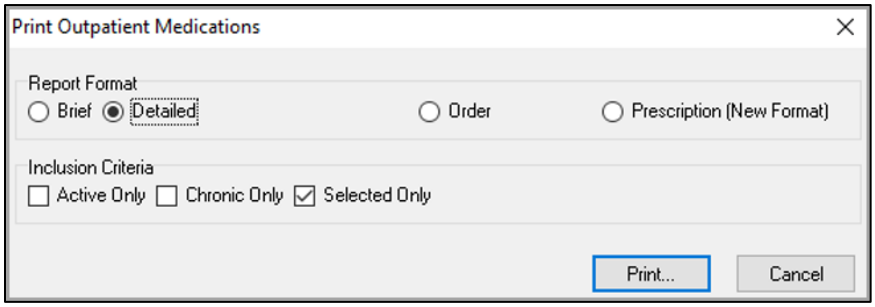


Figure 2-27: Print Outpatient Medications dialog without Label option

To print a label:

1. Select the **Label** option.
2. Set the **Inclusion Criteria**.
3. Click **Print**. The **Print Setup** dialog (Figure 2-28) displays.

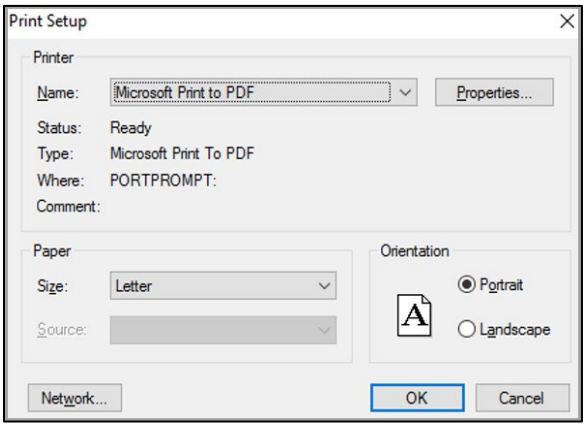


Figure 2-28: Print Setup dialog

4. Click **OK** to print the report (Figure 2-29) once the printer and other options are selected.

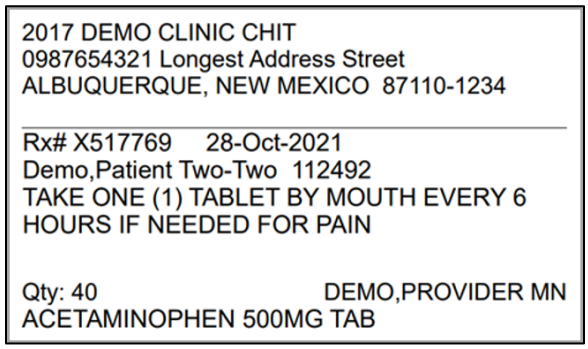


Figure 2-29: Outpatient medication label print format

No Print Warning Message

If the selected item or items are not eligible to be printed or if the inclusion criteria were set such that no items can be printed, a no print warning message (see Figure 2-25) displays.

Click **OK** to dismiss the warning.

2.7 Outpatient Medications Order

Users may print an order for wet signature when the item is in a signed and pending state. For most facilities, this is only required for providers who are not credentialed for EPCS. Check the site's policies to determine if a printed order requires an ink signature.

Users may only print an order for an item going to the internal pharmacy that is signed and that has not yet been processed by the pharmacy. The **Order** format requires an active item, so the **Inclusion Criteria for Active Only** is selected and not changeable. However, the **Chronic Only** and **Selected Only** options (Figure 2-30) are available to adjust if needed.



Figure 2-30: Print Outpatient Medications dialog

1. Click **Print** when all criteria are set. The **Print** dialog (Figure 2-31) opens allowing users to select a template and a printer, and to allow or not allow for multiple orders per page.

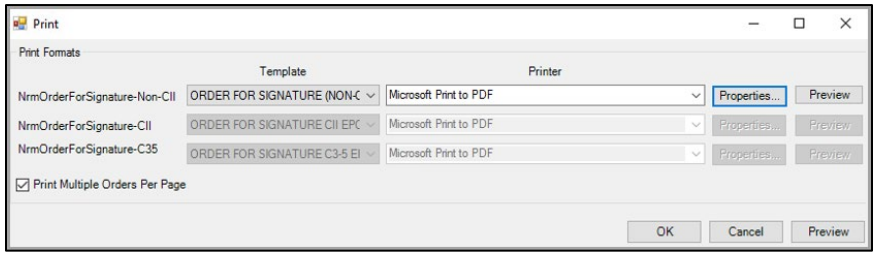


Figure 2-31: Print dialog

The **order templates** and **printer defaults** are set up at each local facility.

2. Click **Properties** to access the **page setup** (Figure 2-32) if needed.

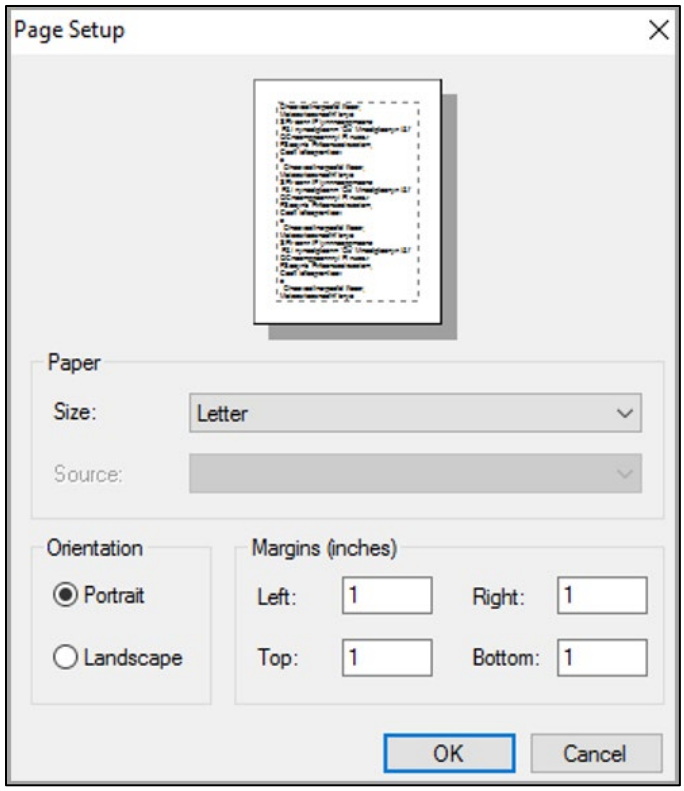


Figure 2-32: Page Setup dialog

3. Click **Preview** to see a copy (Figure 2-33) of what will print.

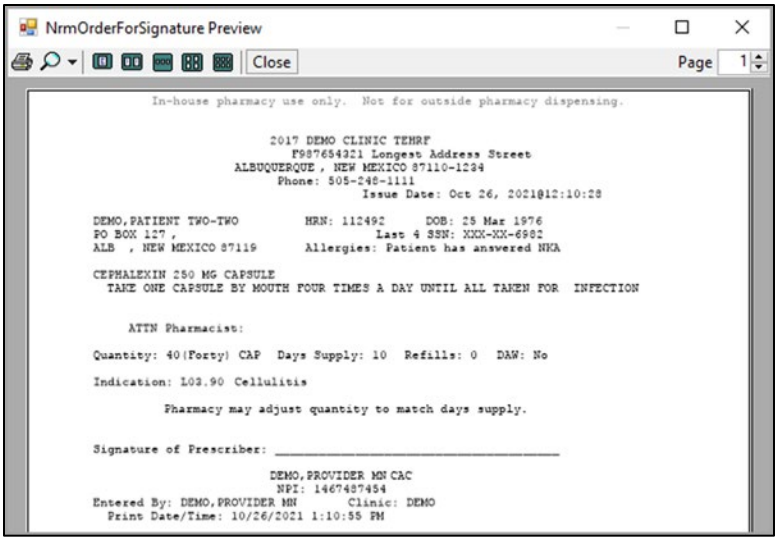


Figure 2-33: Preview of Order print format window

4. Check or clear the **Print Multiple Orders Per Page** option (Figure 2-34).

   Using this option depends on how the templates are set up locally, as some templates may take the entire page already.



Figure 2-34: Print Multiple Orders Per Page option

5. Click **OK** to print the order for signature.

   If the selected item or items are not eligible to be printed, or if the inclusion criteria were set such that no items can be printed, a Warning displays (Figure 2-35). Click **OK** to dismiss the warning.

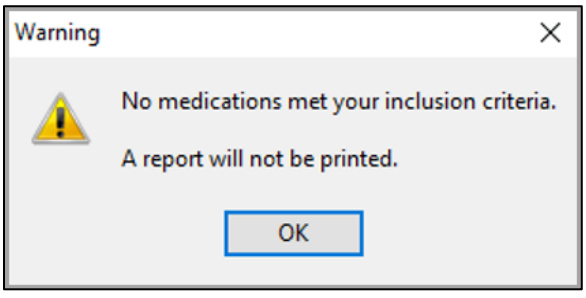


Figure 2-35: No items meeting inclusion criteria Warning message

2.8 Outpatient Medications Receipt

A Receipt is available for items that are sent electronically to an external pharmacy. Users must select **Receipt** on the **Print Outpatient Medications** dialog (Figure 2-36). It provides the patient with something tangible to take with them as a reminder of a medication to be picked up and can help an external pharmacy know what is expected for the patient if something goes wrong in the transmission. With electronic transmission becoming more common, these are used less often.

Receipt is not an available option if the items were transmitted on a different day, or if a receipt was already printed and the patient context is changed.

The Receipt format requires an active item, so the **Inclusion Criteria for Active Only** is selected and not changeable. However, the **Chronic Only** and **Selected Only** options are available to adjust if needed.



Figure 2-36: Print Outpatient Medications dialog Receipt option

1. Click **Print** when the criteria are set. The **Print** dialog (Figure 2-37) opens to allow users to select a template and a printer, and to allow or not allow for multiple orders per page.

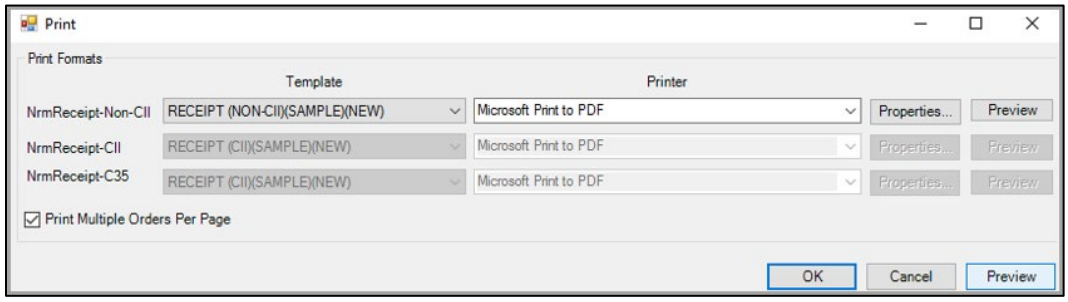


Figure 2-37: Print dialog with Template and Printer defaults

The receipt templates and printer defaults are set up at the local facility.

2. Click **Properties** to access the **Page Setup** dialog (Figure 2-38) if needed.

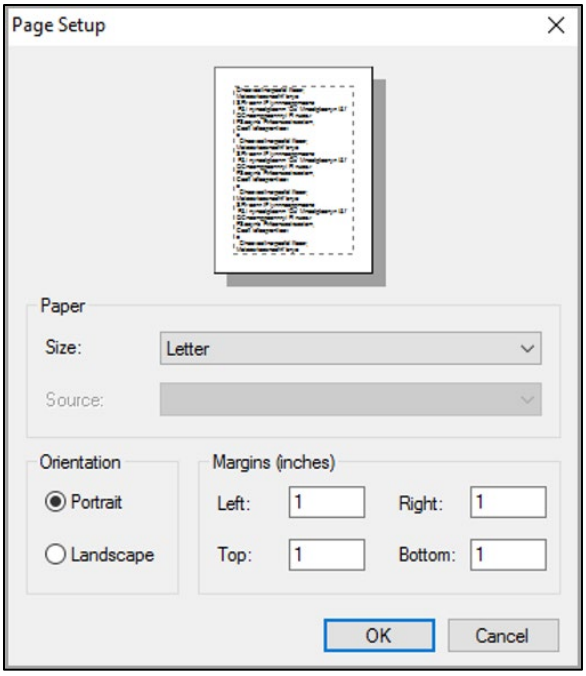


Figure 2-38: Page Setup dialog

3. Click **Preview** (Figure 2-37) to view the **NrmReceipt Preview** window (Figure 2-39) displays with a preview of what will print.

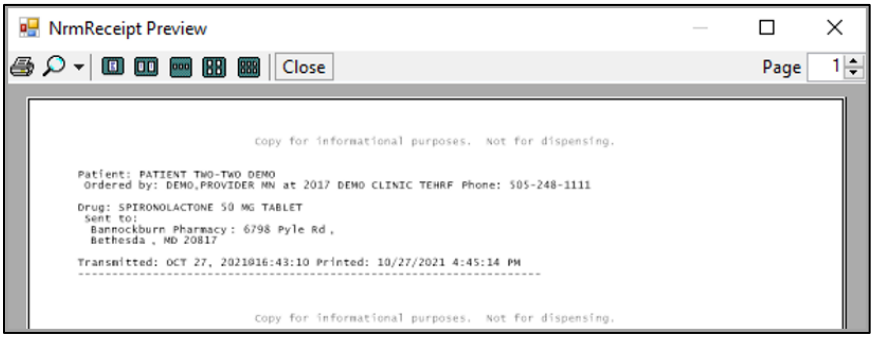


Figure 2-39: NrmReceipt Preview window

4. Select or clear the **Print Multiple Orders Per Page** option (Figure 2-40). Using this option depends on how the templates are set up locally, as some templates may take the entire page already.



Figure 2-40: Print Multiple Orders Per Page check box

5. Click **OK** to print the receipt.

2.9 Outpatient Medications Prescription (New Format)

Users may print a prescription for wet signature (Figure 2-41) when the item is in a signed and active state. These are mostly be used for items going to external pharmacies when electronic prescribing is either not set up for the site or is not currently functioning.

The prescription format requires an active item, so the **Inclusion Criteria** for **Active Only** is selected and not changeable. However, the **Chronic Only** and **Selected Only** options are available to adjust if needed.

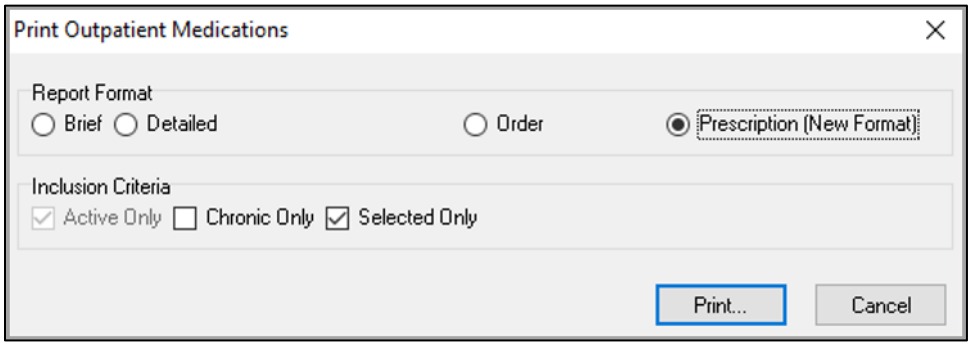


Figure 2-41: Print Outpatient Medications Prescription (New Format) option

1. Click **Print** when the criteria are set. The **Print** dialog (Figure 2-42) opens to allow users to select a template and a printer, and to allow or not allow for multiple orders per page.

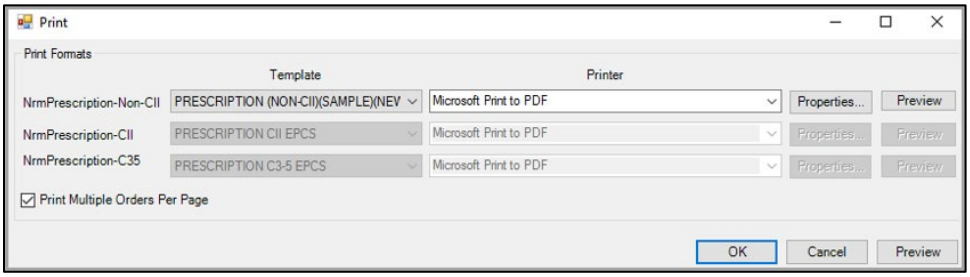


Figure 2-42: Print dialog with Template and Printer defaults

Note: The prescription templates and printer defaults are set up at the local facility. Click **Properties** to access the page setup (Figure 2-43) if needed.

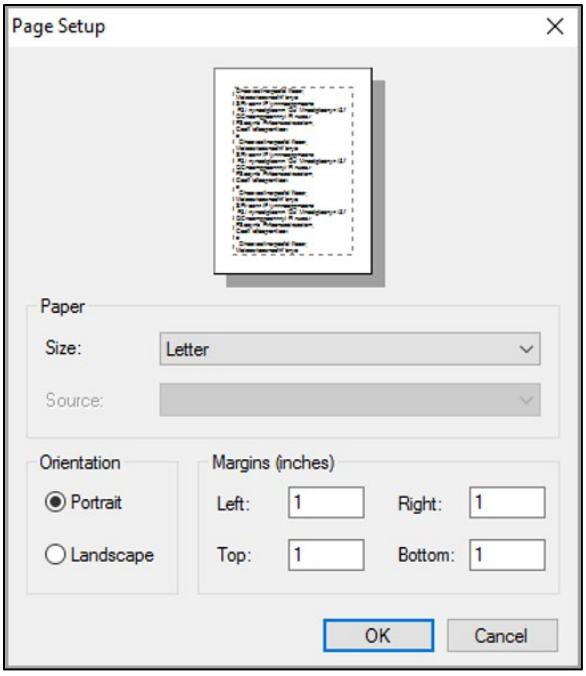


Figure 2-43: Page Setup dialog

2. Click **Preview** to see a preview (Figure 2-44) of what will print.

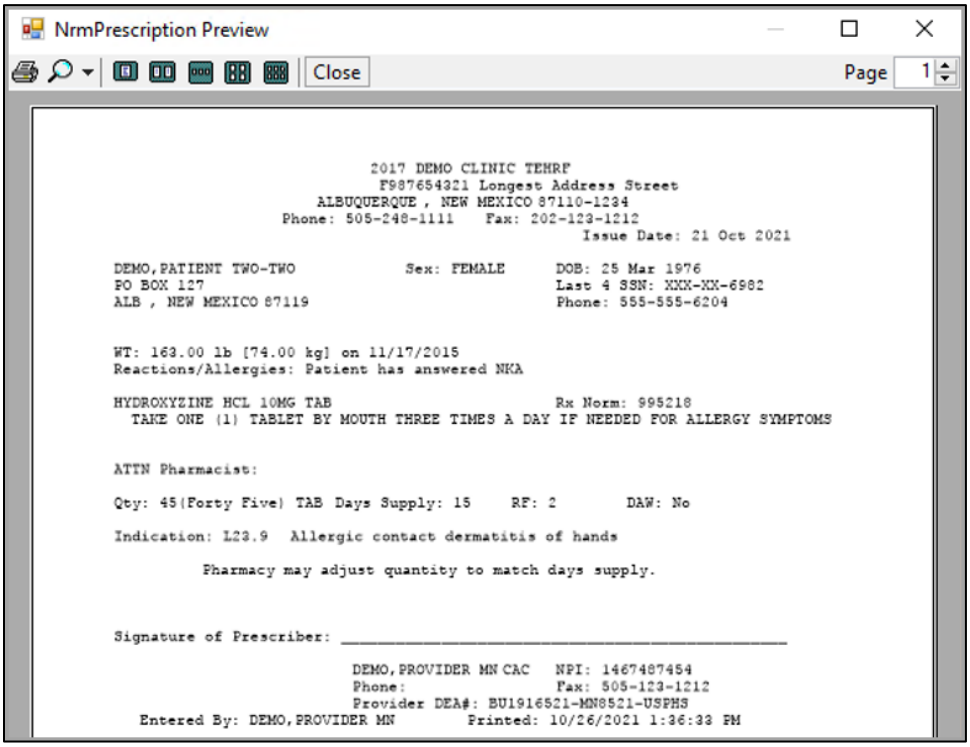


Figure 2-44: New Prescription Preview window

3. Select or clear the **Print Multiple Orders Per Page** option (Figure 2-45). Using this option depends on how the templates are set up locally, as some templates may take the entire page already.



Figure 2-45: Print Multiple Orders Per Page check box

4. Click **OK** to print the prescription.

   If the selected item or items are not eligible to be printed, or if the inclusion criteria were set such that no items can be printed, a Warning (Figure 2-46) displays. Click **OK** to dismiss the warning.

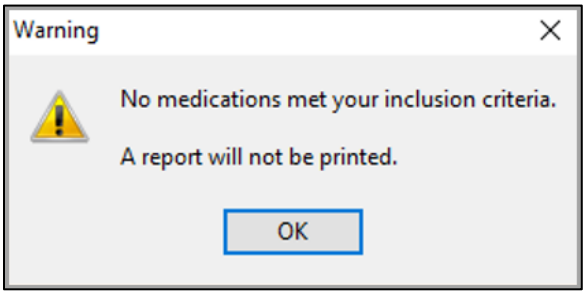


Figure 2-46: No medications meeting inclusion criteria Warning message

Note: Prescription print events are tracked to prevent fraud and diversion. Once an item has been successfully printed, additional print attempts require a reason (Figure 2-47) to be selected.

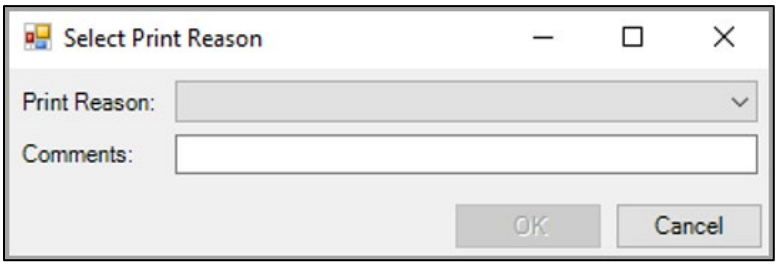


Figure 2-47: Select Print Reason dialog

5. Click the **Print Reason** drop-down arrow to select a reason or select **Other** and add a comment (Figure 2-48) to explain the reason for the reprint.

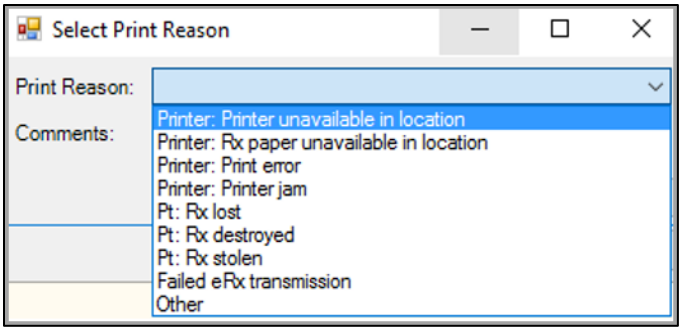


Figure 2-48: Select Print Reason dialog with reasons displaying

Each of the prescription print events (and if documented, the print reason) is recorded in the **Activity Log** for the item and can be viewed in the Details. Print events may also be recorded in the **BUSA log** that records many different events related to potential diversion.

To prevent diversion, printing a Controlled Substance order that was digitally signed and transmitted to the internal pharmacy is not permitted. Reprinting a prescription that was already completed by the internal pharmacy causes the following statement to appear on the printed copy:

COPY ONLY–Not valid for dispensing, only for informational purposes

A similar statement, including information on when the order was transmitted and to where, is included if users try to reprint a prescription from an order that was successfully transmitted to an external pharmacy electronically.

2.10 Outpatient Medication View

The **View** menu (Figure 2-49) for **Outpatient Medications** includes **Details**, **Administration History**, and **Refresh** options.

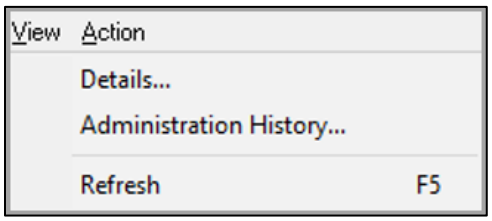


Figure 2-49: Outpatient Medications View menu

2.10.1 Outpatient Medication Details

The **Details** option opens the **Outpatient Medications Details** window (Figure 2-50) for the currently selected item. Double-clicking a line item also opens the **Details** window. If more than one item is selected, the **Details** window opens for each in turn. The information contained in the details varies based on the specific item selected.

This information may be printed. The font size of the display may be adjusted using the Font Size control, though this does not affect the printed font size. The contents of the entire window may be printed using the **Print** button. The **Outpatient Medications Details** window may also be opened by double-clicking the line item, or by selecting **Details** from the right-click menu.

The top portion of the **Details** window displays the actual order content, time stamps, order number, and other data related to the order and the actions taken on the order.

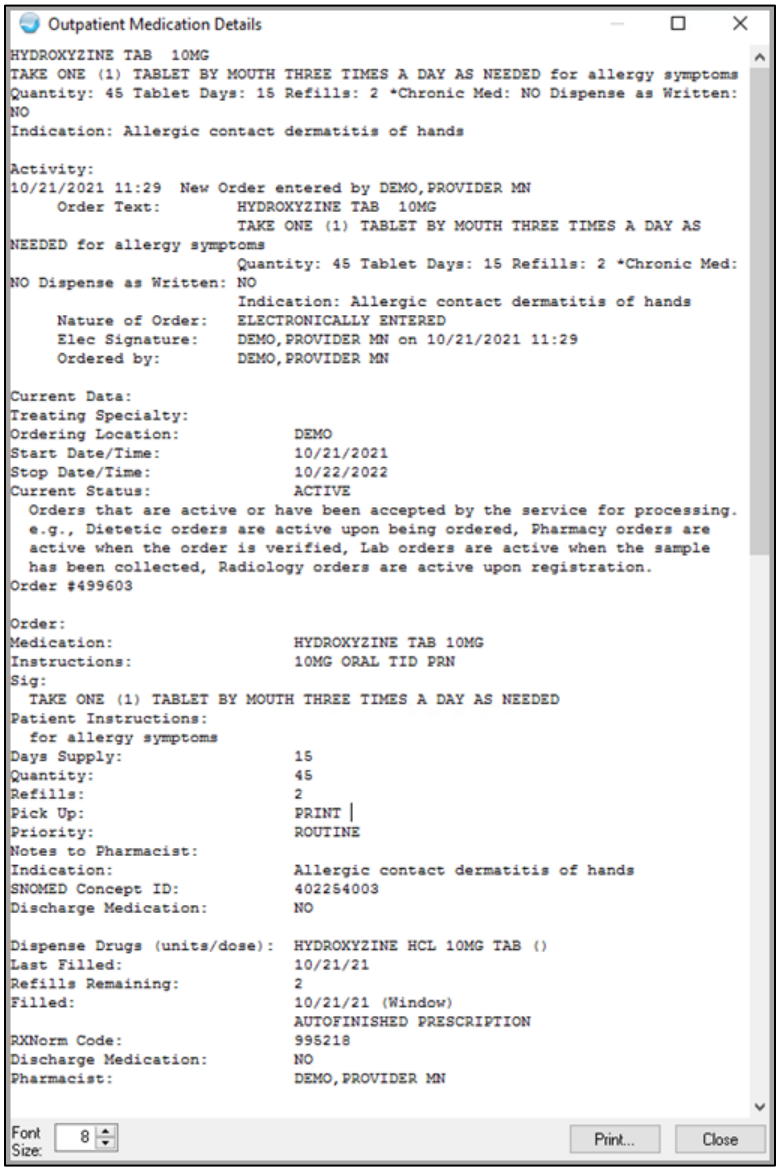


Figure 2-50: Outpatient Medication Details window top

The middle portion contains the **Activity Log and Order Check** information. This portion will be most useful to users when prescribing items using the **eRx** options.

The **Activity Log** section (Figure 2-51) includes entries for processing events, print events, electronic transmission events, and electronic fill messages (if configured), among other items. The **Order Check** section shows the order checks that were shown to the prescriber when the item was ordered, and the response.

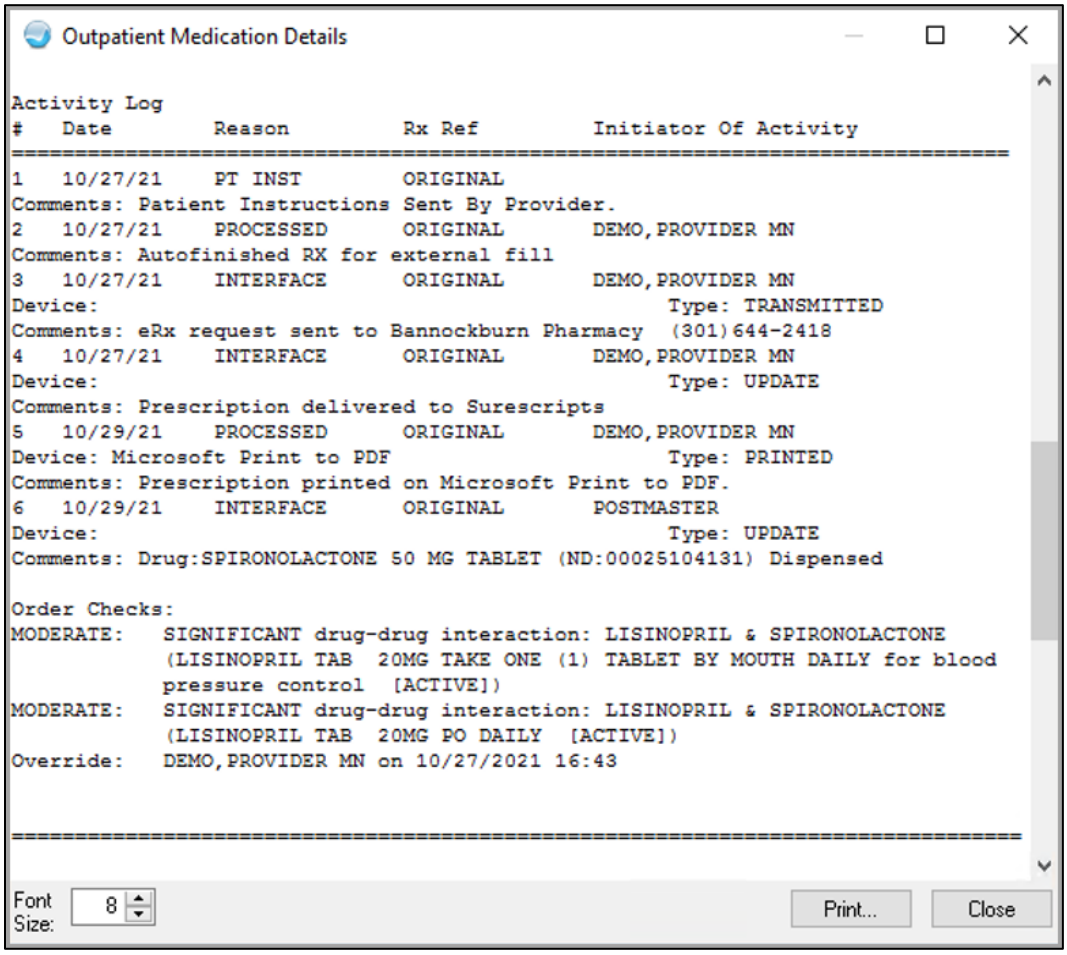


Figure 2-51: Outpatient Medication Details window middle

The Pickup Log section (Figure 2-52) includes all fills that were picked up by the patient or their proxy. It displays the date, type, refill#, and staff that entered the date. It includes all the information captured within the **Document RX Pickup** dialog for the patient and the medication.

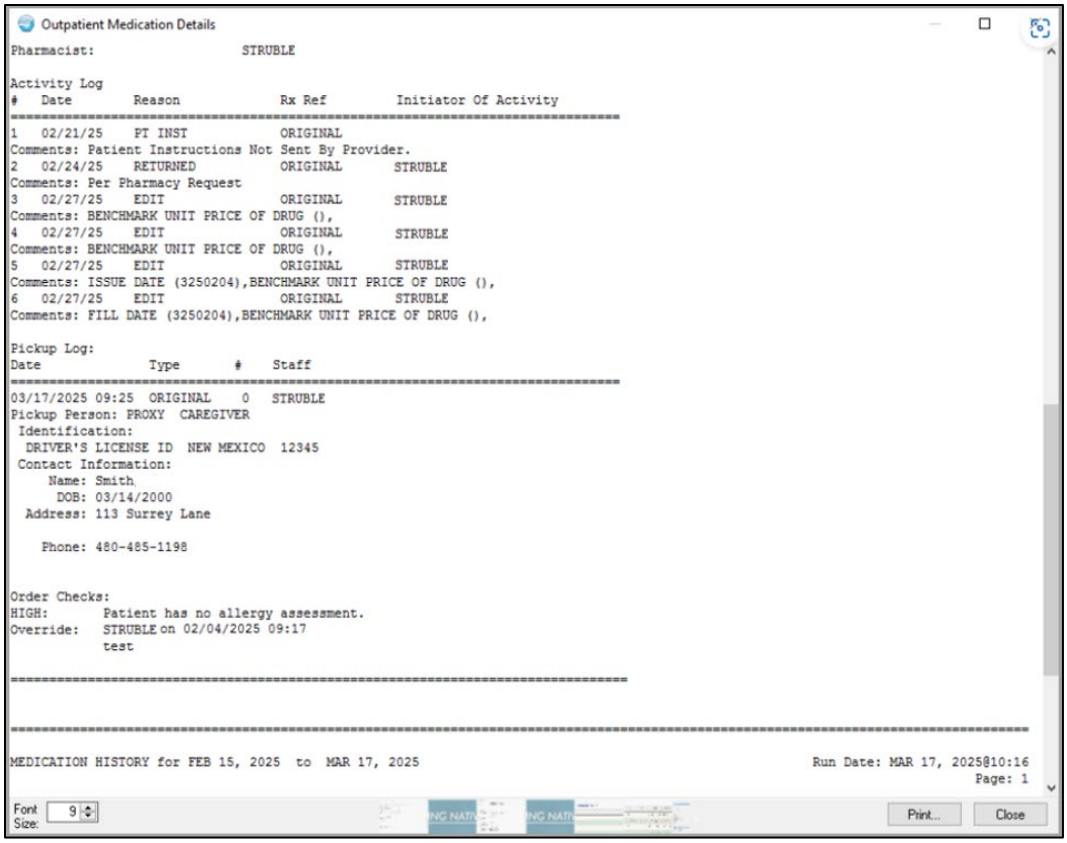


Figure 2-52: Outpatient Medication Details window Pickup Log

The bottom portion contains the Medication History (Figure 2-53), including the Administration history, though this area may not have much information, if any, for outpatient medications. The information comes from the **Bar Code Medication Administration** package documentation.

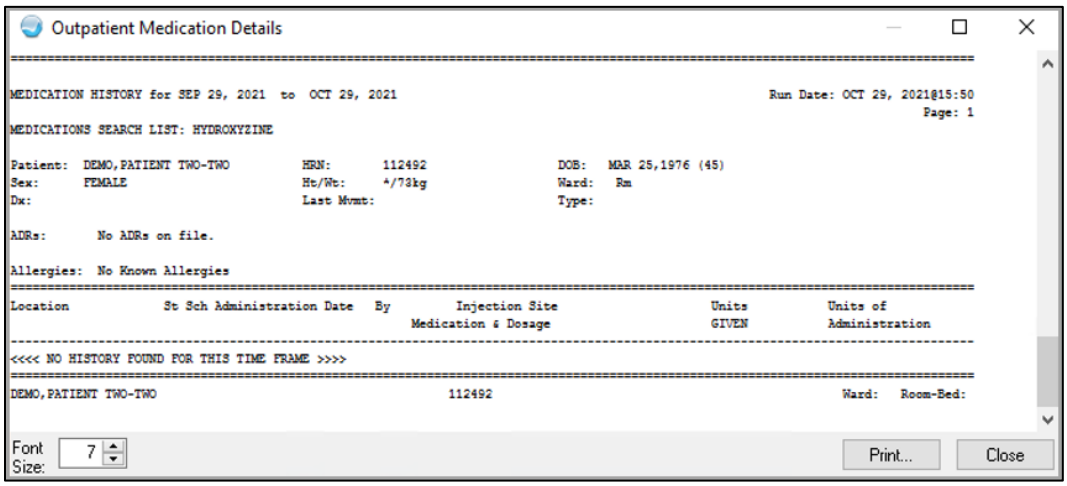


Figure 2-53: Outpatient Medication Details window bottom

2.10.2 Outpatient Medication Administration History

The **Administration History** option opens the **Outpatient Medication Administration History** window (Figure 2-54) for the currently selected item. If more than one item is selected, the window opens for each in turn. This is the same as the bottom part of the Details, containing the Medication History. There is normally very limited information for an outpatient medication. The information comes from the **Bar Code Medication Administration** package documentation.

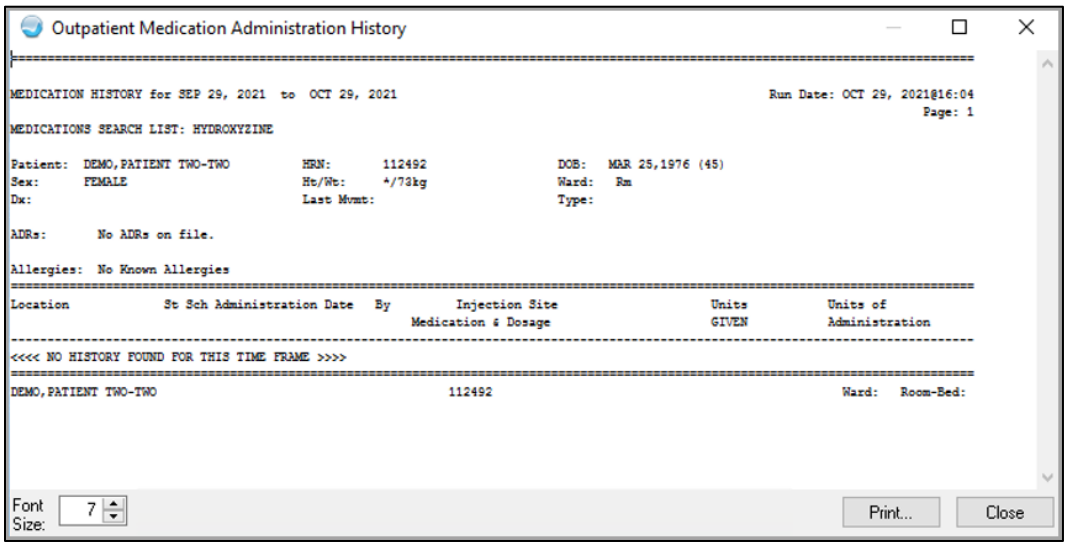


Figure 2-54: Outpatient Medication Administration History window

2.10.3 Outpatient Medication Refresh

The **Refresh** option refreshes the contents of the **Medication Management** component.

2.11 Outpatient Medication Action Menu

The **Outpatient Medications Action** menu (Figure 2-55) includes:

- New Medication
- Change
- Copy to New Order
- Discontinue/Cancel
- Process
- Refill
- Renew
- Document Rx Pickup

- Transfer to Inpatient
- Chronic Medication

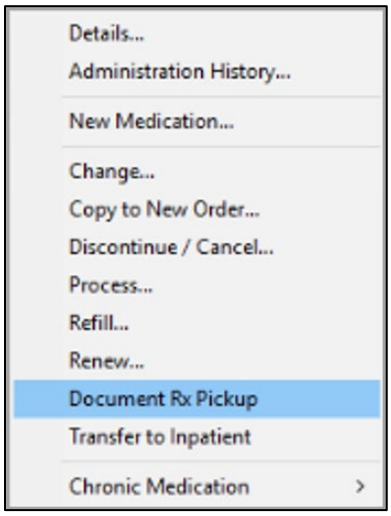


Figure 2-55: Outpatient medications action menu

2.11.1 Outpatient Medication New Medication

Users may create a new medication entry by selecting one of the following:

- New Medication option on the Action menu
- New button on the tool bar
- Outpatient Medications section and selecting New Medication

When users choose to create a new medication entry, the results depend on each site's settings. Most sites are setup to open a **Quick Order Menu** (Figure 2-56). This menu consists of other **Quick Order Menus**, **Quick Orders**, **Order Dialogs**, or combinations of these. Quick Orders are medication orders with most or all the information defaulted to help providers make new orders quickly and easily. Different menus may be displayed depending on the status of the currently selected patient (outpatient or inpatient). For the purposes of this example, it is assumed that the **New Medication** option opens a standard outpatient **Quick Order Menu**.

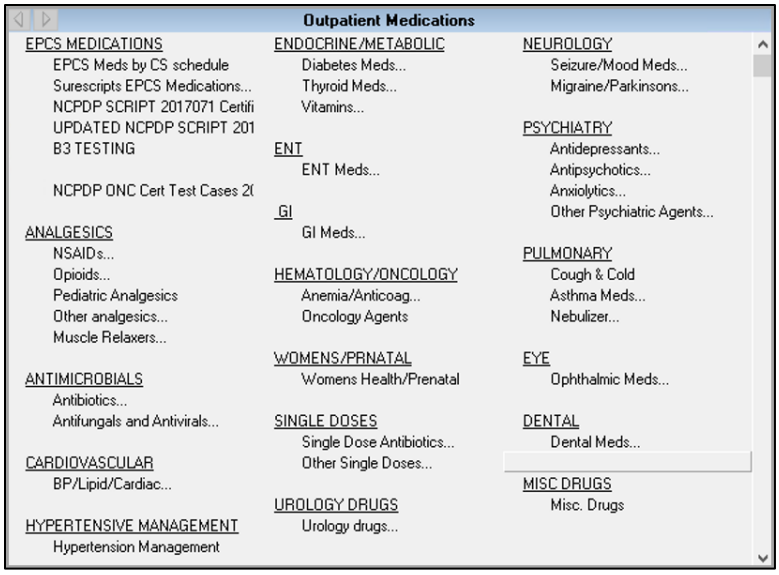


Figure 2-56: Outpatient Medication quick order menu example

The example menu shown above is a typical menu of menus, and each item listed, when clicked, opens another order menu. Those secondary menus may consist of more menus or of actual **Quick Orders** (Figure 2-57).

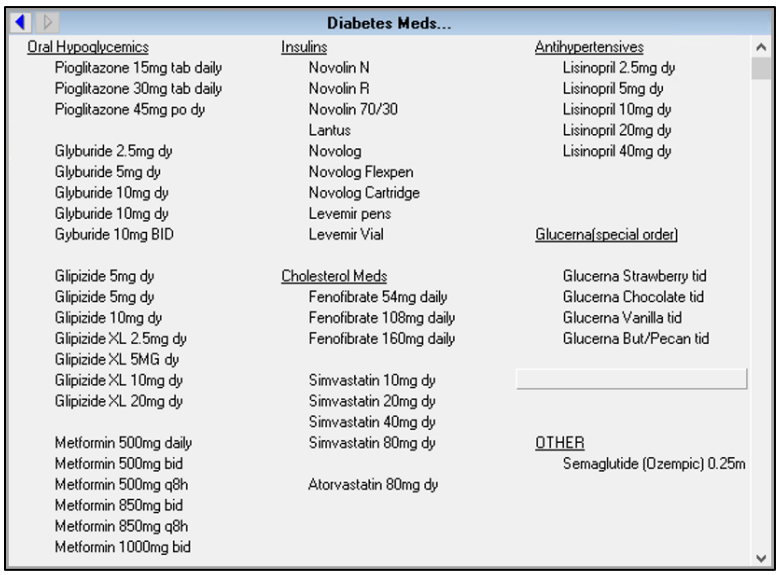


Figure 2-57: Diabetes Meds quick order menu example

To select more than one item, press and hold the **Control** key while clicking the needed menu, quick order, or other link. The selected items are then presented in turn. If one or more items selected is a **Quick Order Menu**, repeat pressing and holding the **Control** key and click to select the items from that menu when it is presented. When multiple items are selected, a **Selected Orders** dialog (Figure 2-58) displays showing the items selected, with a **Stop Order Set** button to cancel the remaining items.



Figure 2-58: Selected Orders dialog

Clicking a **Quick Order** opens the **Medication Order** dialog (Figure 2-59). Fields in the **Medication Order** dialog may be edited as needed.

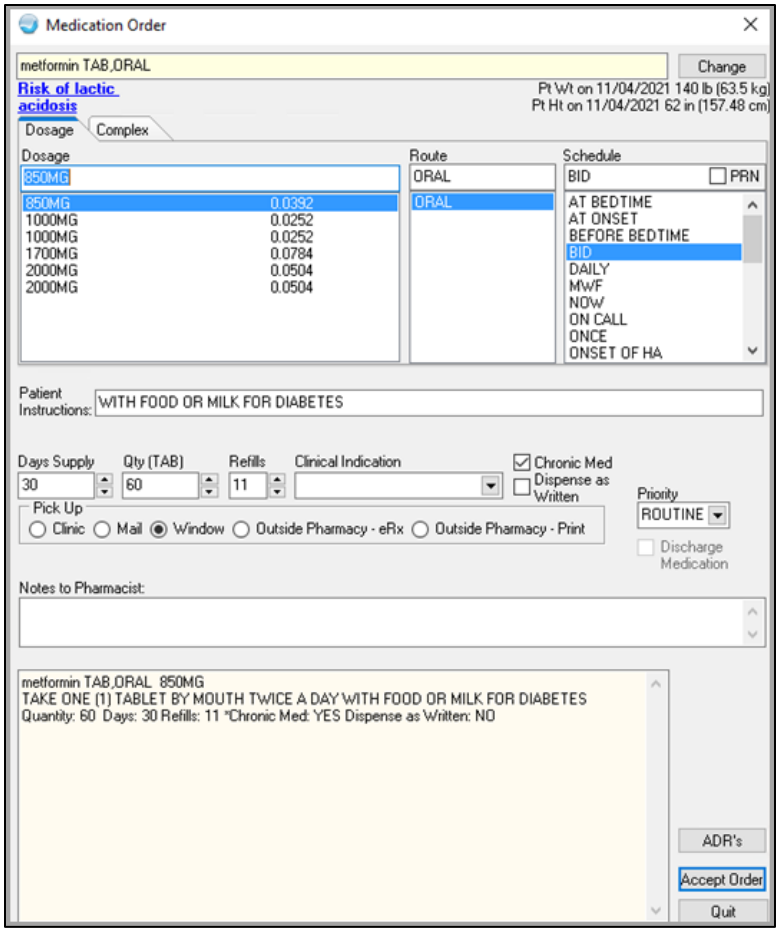


Figure 2-59: Medication Order dialog from a Quick Order

The **Medication Order** dialog contains the following fields and text:

- **Orderable Item:** Shows the drug and dosage form selected. This item is not labeled and displays at the top of the dialog.
- **Change button:** Allows users to change the orderable item selected. Click **Change**, then search (Figure 2-60) for the desired item.

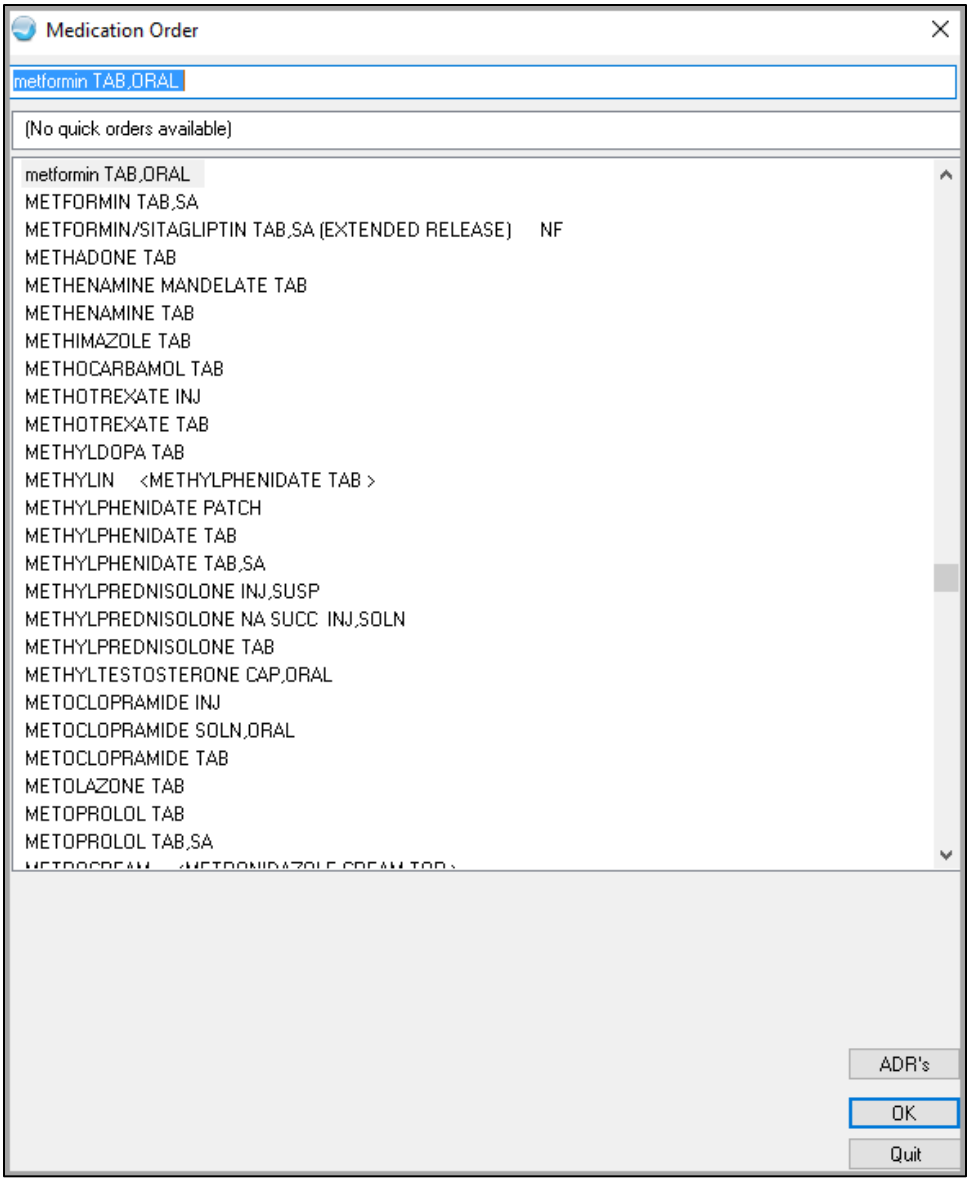


Figure 2-60: Change button search dialog

- **Drug Text:** If applicable, displays either the Drug Text, partial Drug Text (Figure 2-61), or the text Display Restrictions/Guidelines (Figure 2-62), depending on the overall length of the text. A **Drug Text** is used to alert users to restrictions, guidelines, warnings, dosing charts, or other information. **Drug Texts** are set up at the user's local facility (Figure 2-63). Click the **Drug Text** link to see the **Restrictions/Guidelines** message (Figure 2-64) with the full text.

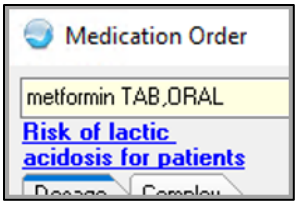


Figure 2-61: Partial drug text display

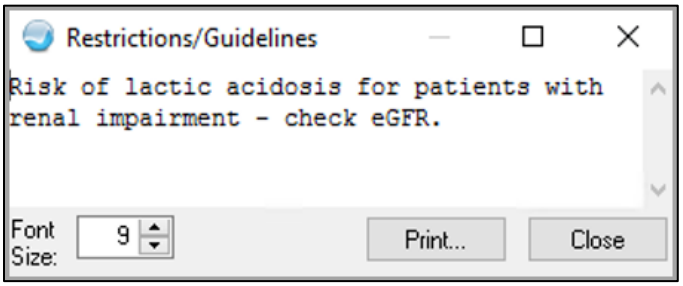


Figure 2-62 Restrictions/Guidelines message

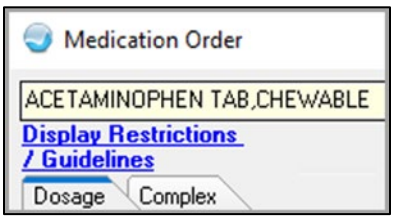


Figure 2-63: Display Restrictions/Guidelines dialog

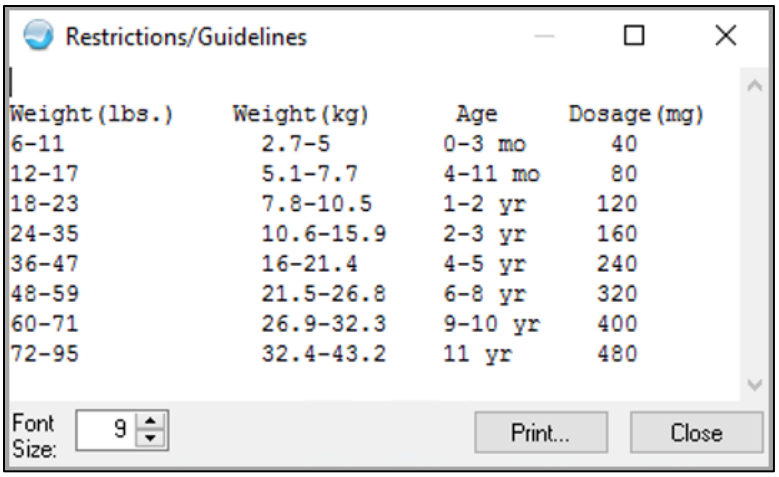


Figure 2-64: Restrictions/Guidelines dialog

- **Pt Wt:** If applicable, displays the last weight for the patient and the date it was recorded. Text only.
- **Pt Ht:** If applicable, displays the last height for the patient and the date it was recorded. Text only.

- **Dosage and Complex Tabs:**
  - **Dosage Tab:** Allows for simple instructions with a single Dosage, Route, and Schedule (Figure 2-65). There is a **PRN** check box to indicate if the item should be taken only if needed.

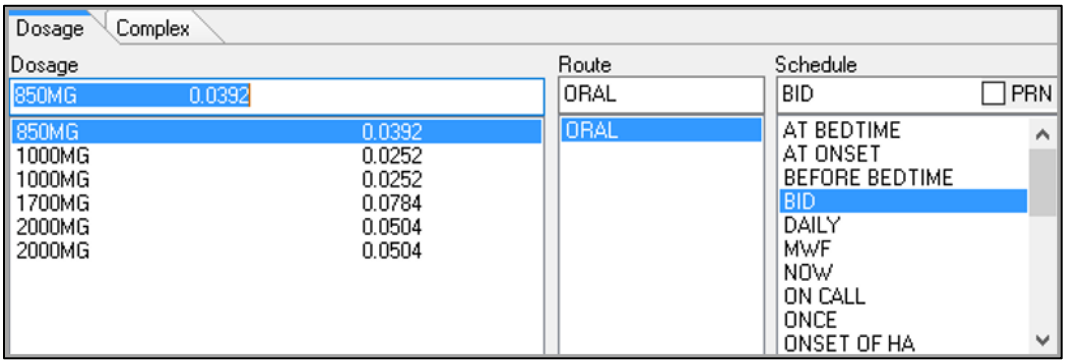


Figure 2-65: Dosage tab with Dosage, Route, and Schedule

  - **Complex Tab:** Allows for more complex instructions with multiple Dosages, Routes, Schedules, and Durations combined with Conjunctions of and, then, or except (Figure 2-66 and Figure 2-67). Additional rows are added as more information is added, and users may add or delete rows with the + **Row** and – **Row** buttons.
    - **Duration** (Figure 2-66) is optional.

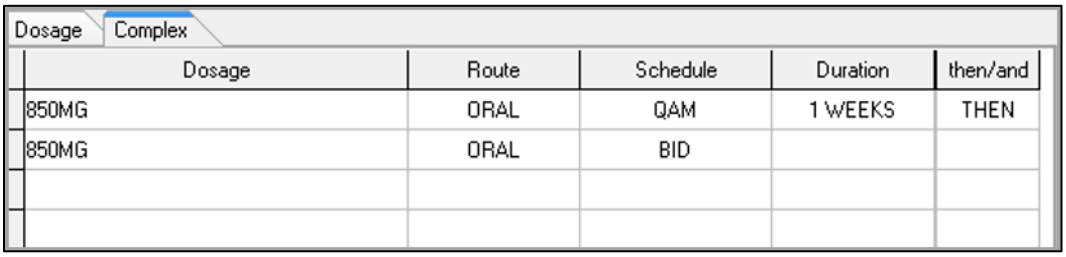


Figure 2-66: Complex tab showing Dosage, Route, Schedule, Duration, and Conjunction

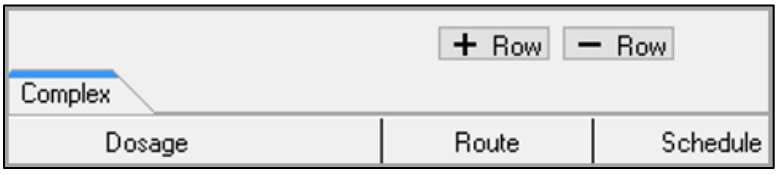


Figure 2-67: Complex tab showing + Row and–Row buttons

  - **Dosage (Both Tabs):** A list of options to select from, though users may also enter free-text. Entering free-text dosages requires users to select the dispense drug when the order is accepted.
  - **Route (Both Tabs):** A list of options to select from. Free-texting is strongly discouraged here.

  - **Schedule (Both Tabs):** A list of options to select from. Free-texting is strongly discouraged here.
  - **Duration (Complex Tab Only):** A number with a secondary selection of time units. Available units are months, weeks, days, hours, and minutes.

- **Patient Instructions:** Allows users to add additional information for the patient to assist them in properly taking the ordered medication. Patient instructions should not contain Dosage, Route, or Schedule information or contradict the contents of the **Dosage**, **Route**, or **Schedule** fields.
- **Days Supply:** Allows users to note the number of days the ordered medication should last. This may be automatically calculated based on the selected Dosage and Schedule.
- **Quantity:** Allows users to indicate the desired quantity of medication to be dispensed.
- **Refills:** Allows users to indicate the desired number of refills. The **Refills** field does not allow a number that is higher than legally allowed based on a day's supply and the medication's legal schedule as determined by the local drug file entry.
- **Clinical Indication:** Allows users to indicate the clinical indication for the medication using **SNOMED CT** terms (Figure 2-68). This field may or may not be present based on local settings but is strongly encouraged for most sites and is required for EPCS and ePrescribing. Clicking the drop-down arrow in the **Clinical Indication** field displays the current Purpose of Visit (if applicable) and the problems from the Integrated Problem List (if any) as well as Other… .

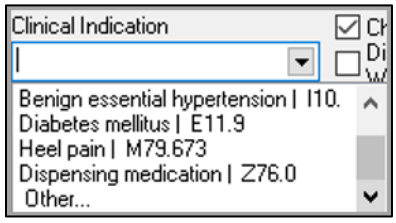


Figure 2-68: Clinical Indication field with drop-down activated

Select an **entry** to use it for the Clinical Indication or select **Other…** to search for a new clinical indication. Selecting **Other…** opens the **SNOMED CT Lookup** dialog (Figure 2-69).

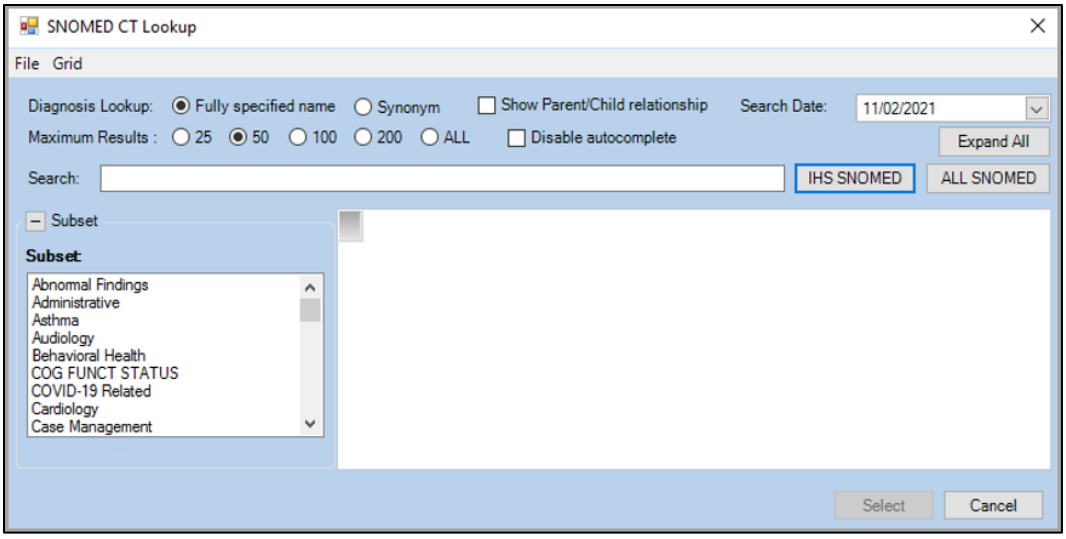


Figure 2-69: SNOMED CT Lookup dialog with default settings

Users may set the parameters for **Diagnosis Lookup** and **Maximum Results**, choose **Show Parent/Child relationships**, choose **Disable autocomplete**, or leave the defaults. Enter a search term and choose to search the IHS SNOMED set or ALL SNOMED (Figure 2-70). Users may also choose one or more subsets to search. Click a **subset** to select it and click it a second time to clear it. Once the desired Clinical Indication is found, **highlight it** and click the **Select** button.

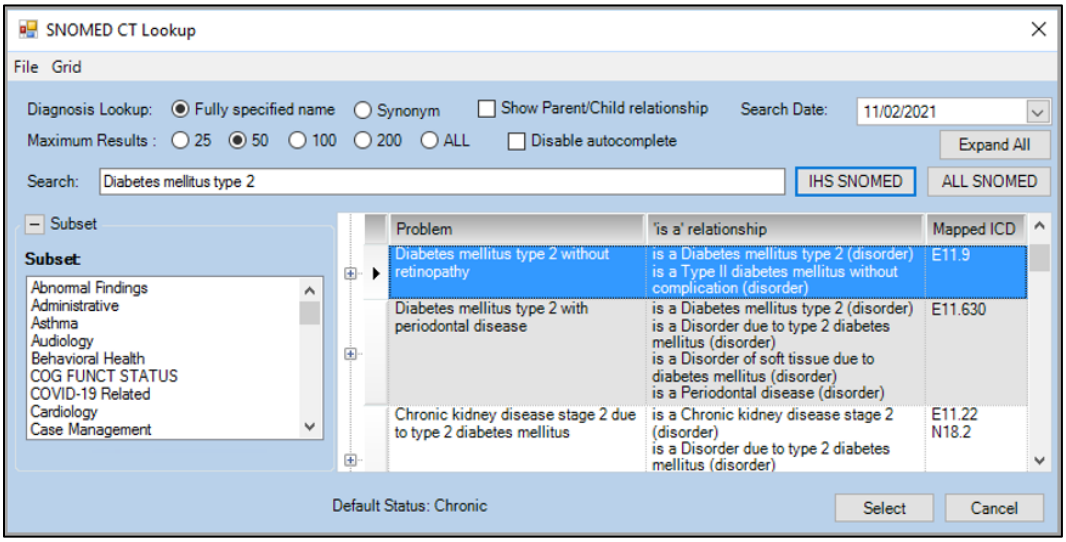


Figure 2-70: SNOMED CT Lookup with results

- **Chronic Med:** Allows users to indicate if the medication is taken chronically.
- **Dispense as Written:** Allows users to indicate Brand Medically Necessary. Should only be used when the local drug file has been set up with a brand item.

- **Earliest Fill Date:** For Controlled Substances in Schedule 2, if enabled. Allows users to set the earliest date that a prescription may be filled (Figure 2-71).

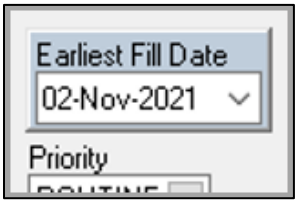


Figure 2-71: Earliest Fill Date field

When using the Earliest Fill Date, users may add up to three orders for the same medication with successive earliest fill dates, provided they are entered on the same day. Each order may be for no more than a 30-day supply, and all three together may not exceed a 90-day supply. The Earliest Fill Date for each order may not overlap based on the date chosen and the day's supply indicated.

- **Pick Up:** Allows users to set how the medication is filled. The pickup locations that are active and selectable vary based on site settings, provider set up, medication set up, and other factors. Pickup locations may include:
  - **Clinic:** Generally, for items administered in clinic and not sent home with the patient, or for prepackaged items designed to be dispensed by the provider outside of normal pharmacy hours. If the item is a controlled substance, no two-factor authentication is required, and print is not triggered. Duplicate orders for C-II medications with a different pick-up method is allowed so that an additional order to be filled at an internal or external pharmacy may be created without having to discontinue the clinic order.
  - **Mail:** For items that are mailed to the patient, either through the VA's **Consolidated Mail Order Pharmacy (CMOP)** program or a local mail order system.
  - **Window:** For items to be filled at the onsite pharmacy using RPMS Pharmacy package.
  - **Outside Pharmacy–eRx:** For items to be sent to an external pharmacy using the **ePrescribing** system. Only licensed prescribers may use this option. Additional information on using the **eRx** option is listed below.
  - **Outside Pharmacy–Print:** For items to be sent to an external pharmacy by printing and signing an order to be hand carried or faxed to the pharmacy.
- **Priority:** Allows users to set the priority for the ordered medication. This affects internal pharmacy prescriptions only. Options include:
  - **ASAP:** Give as soon as possible.
  - **Done:** Bypass order checks and review by pharmacy. Based on IHS policies, this should not be used.

  - **Routine:** Default selection, and strongly recommended for most outpatient orders.
  - **Stat:** Give immediately.
- **Discharge Medication:** Allows users to note that a medication is a discharge medication. It should only be used at inpatient facilities when ordering medications for a currently admitted patient to take home once they are discharged.
- **Pharmacy:** Displays only when **Outside Pharmacy – eRx** option (Figure 2-72) is selected. Allows users to specify the external pharmacy to receive the prescription.

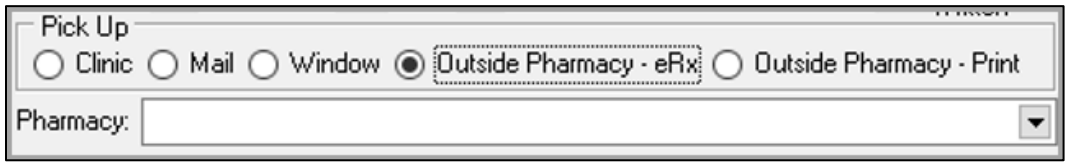


Figure 2-72: Pick Up of Outside Pharmacy–eRx opens the Pharmacy field

If the patient has had prescriptions sent by **eRx** before, the last three pharmacies display in the list (Figure 2-73), along with Other.

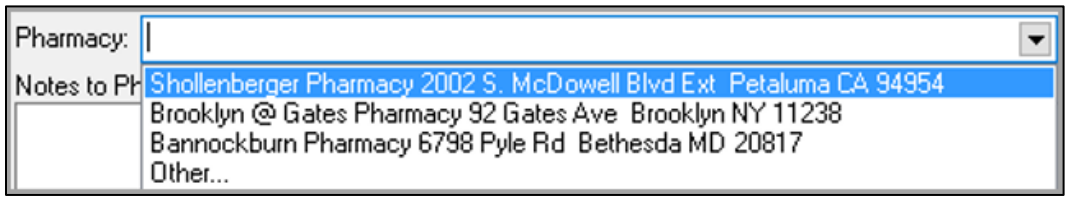


Figure 2-73: Pharmacy drop-down with previous entries

If the patient has no entries or if the user wants a different pharmacy, select **Other** to open the **Select a Pharmacy** dialog (Figure 2-74).

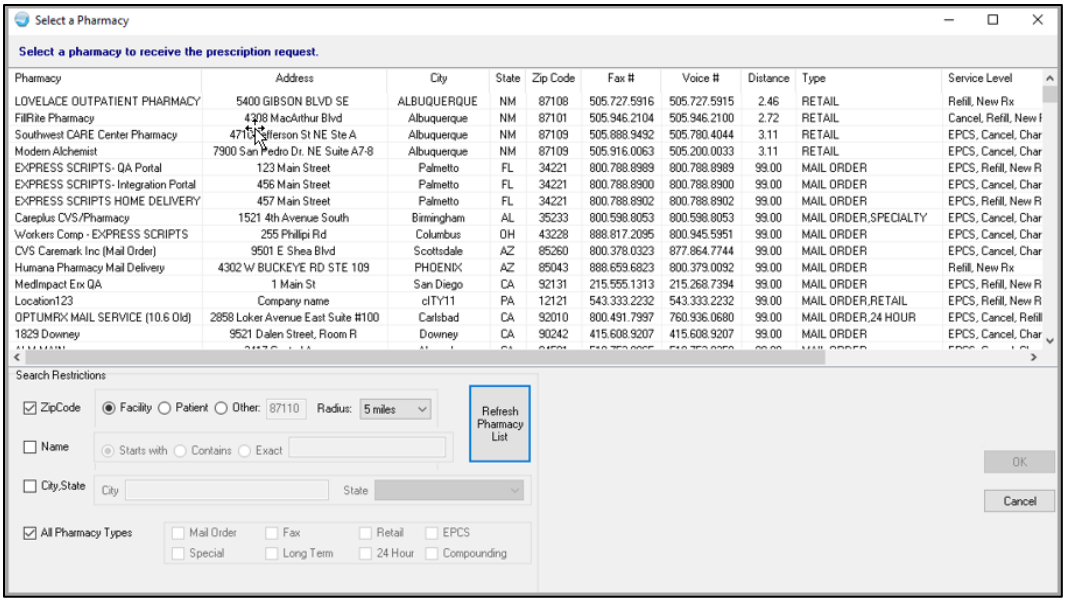


Figure 2-74: Select a Pharmacy dialog

The default search is by ZIP code proximity to the facility, with the radius default distance set at the local site. Here, the radius is set at five miles. The search may be adjusted by several criteria, including:

- Using the ZIP code radius by patient or a specified ZIP code
- By the name of the pharmacy with search criteria of Starts with, Contains, or Exact
- By the city and state of the pharmacy address
- By pharmacy type

Search criteria may be combined but using too many criteria can cause no pharmacies to be returned.

Once the criteria are set, click **Refresh Pharmacy List** to update the search results. The search results include:

- Pharmacy name
- Address
- City
- State
- ZIP code
- Fax number
- Voice number
- Distance from search criteria ZIP code
- Type
- Service level

Users may want to search for a specific type of pharmacy or review the service level to be sure the prescription is accepted, such as EPCS. Once the correct pharmacy is found, highlight it and click **OK**, or double-click the **line item**.

- **Notes to Pharmacist:** Allows users to give directions to the pharmacist. These are not intended for the patient.
- **Summary:** Displays the order information for review (Figure 2-75 and Figure 2-76). Additional information is displayed if the item is to be ePrescribed. For eRx items, users must scroll through the information before the order can be accepted. Text only.

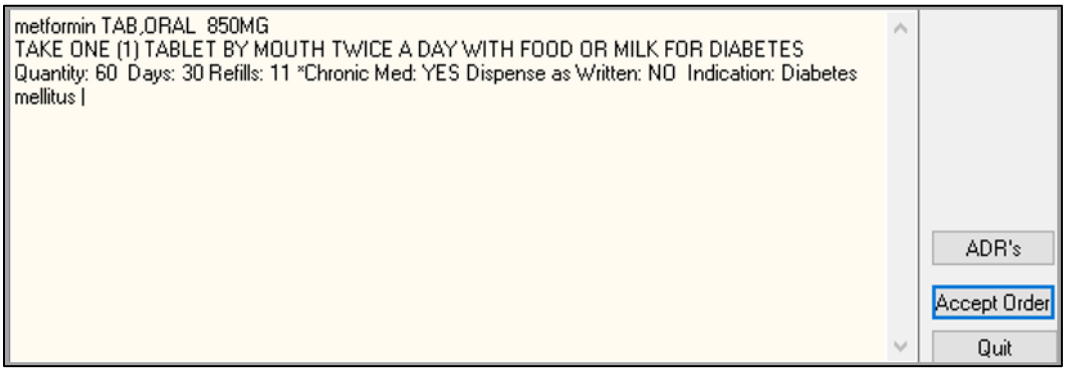


Figure 2-75: Outpatient medication summary field for Non-eRx Pharmacy Order

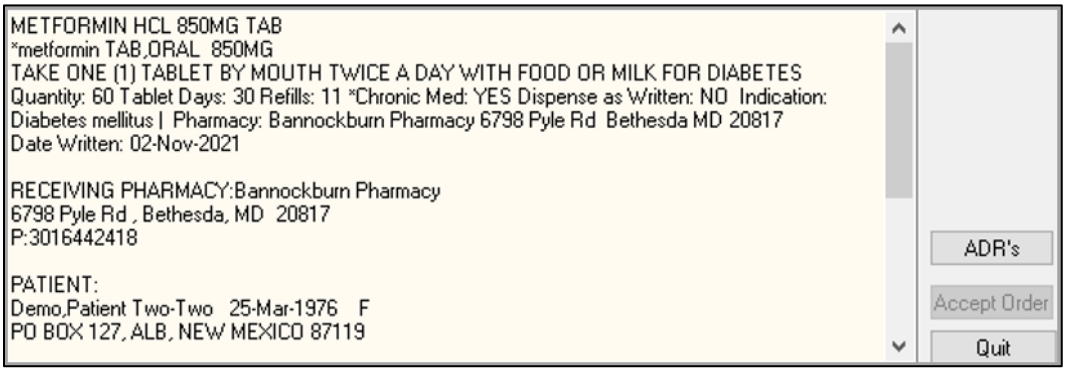


Figure 2-76: Outpatient medication summary field for eRx Pharmacy Order

- **ADR's button:** Opens the **Patient Postings** dialog (Figure 2-77) with Allergies information, as well as the Crisis Notes, Warning Notes, Directives information, if any exists.

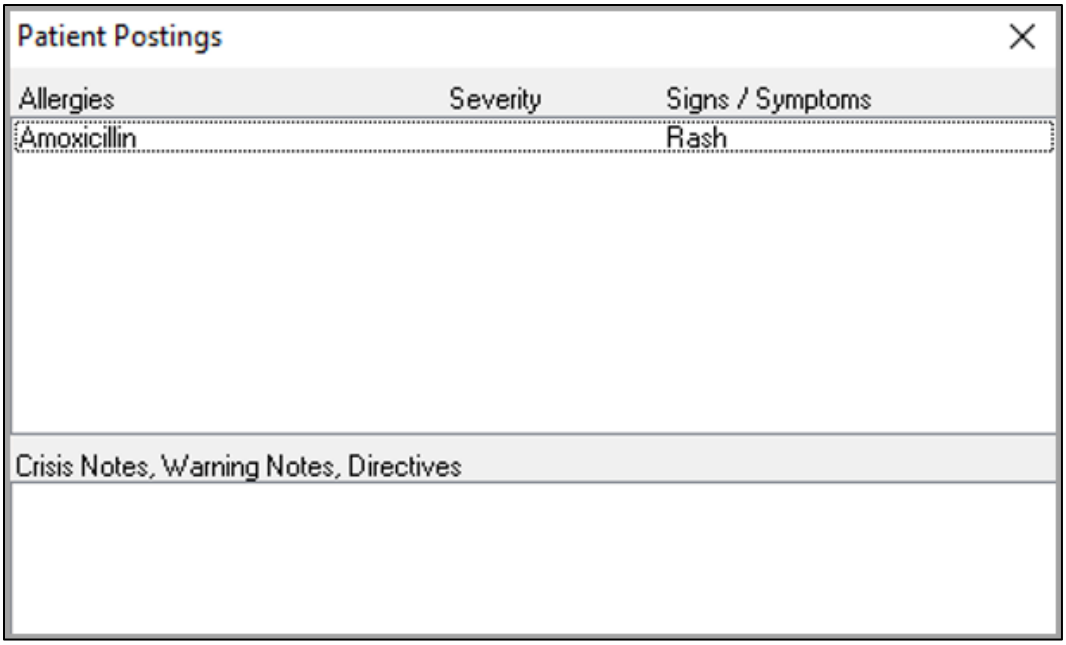


Figure 2-77: Patient Postings dialog

Clicking the **adverse reaction** entry (in this case Amoxicillin) shows the detailed information (Figure 2-78) for the entry.

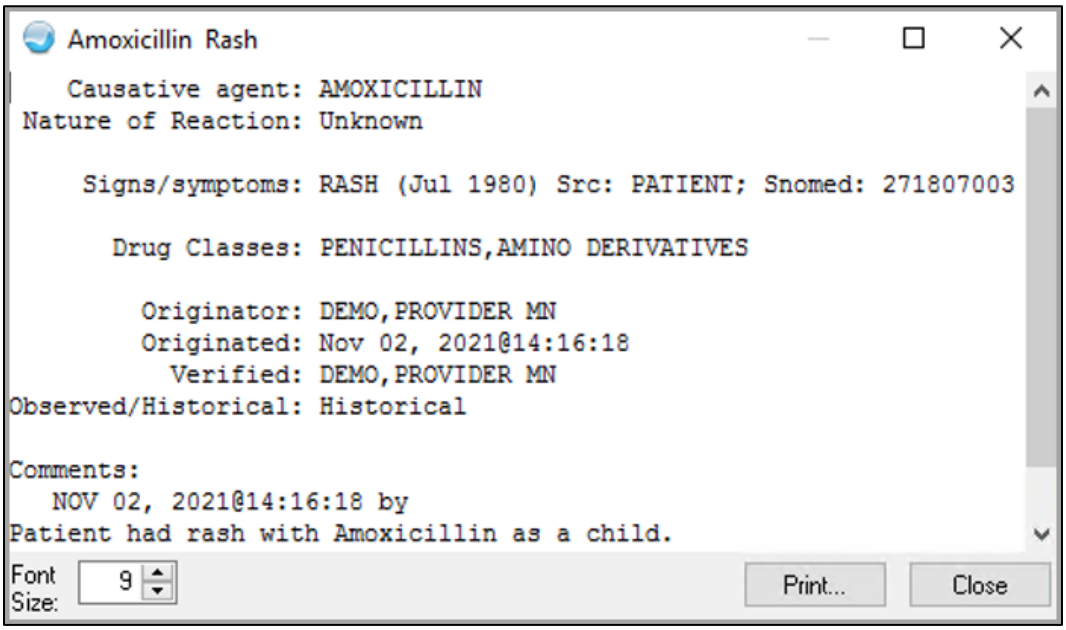


Figure 2-78: Adverse reaction detail window

- **Accept Order button:** Allows users to accept the order with the information entered. It may be inactive (Figure 2-79) if using **eRx** and have not scrolled to the bottom of the summary (Figure 2-80).



Figure 2-79: Accept Order button Inactive



Figure 2-80: Accept Order button Active

- **Quit button:** Allows users to stop the ordering process for the displayed item.

Once all fields are set as desired, click **Accept Order** to save it. If applicable, the **Order Checking** dialog displays with items related to the order that was entered. The source for the information is listed in the title bar.

Click **Accept Order** (Figure 2-81) to continue or **Cancel Order** to cancel the order.

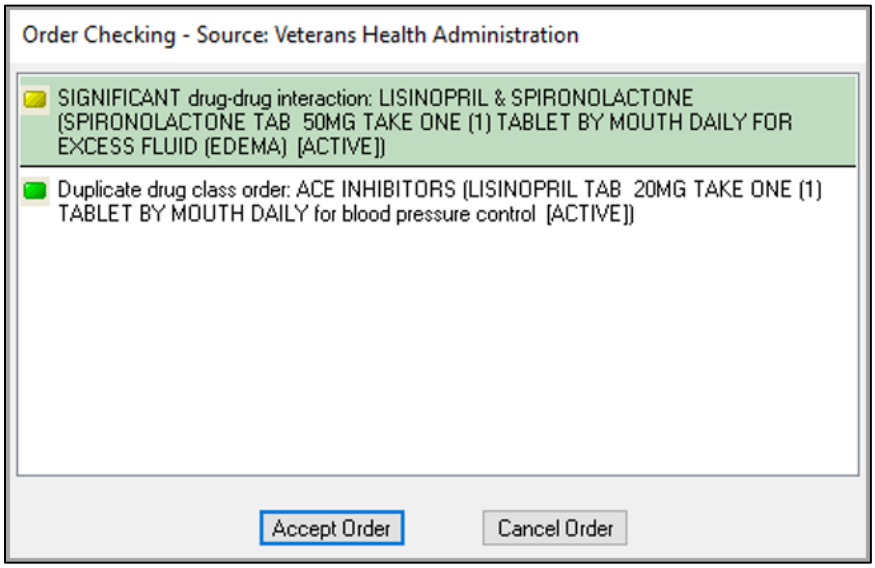


Figure 2-81: Order Checking dialog during Order Creation

The order displays in the grid (Figure 2-82) with bold, blue text as unsigned with the **Action** column showing **New**.

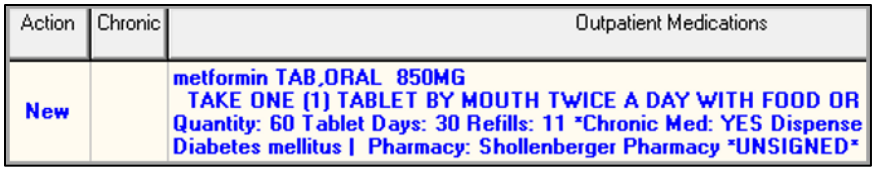


Figure 2-82: Outpatient medication dialog item with New for Action column

When ready, sign the **orders**. Refer to Signing Orders for additional information.

2.11.2 Outpatient Medication Change

Change is used to edit an existing order or prescription. Highlight the order or orders then access the option by selecting the **Change** option on the **Action** menu, clicking the **Process** button on the tool bar then selecting **Change**, or right-clicking in the **Outpatient Medications** section and selecting **Change**.

Discontinued items or Active/See Details items may not be changed. When a user is working with a controlled substance medication, the actual medication order cannot be changed.

When more than one item is highlighted before selecting **Change**, the **Medication Order** dialog opens for each one in turn. This dialog is like the one used for **New Medication**. Make the desired changes, then accept the order.

When users Change an item, a new order is created, and the existing order is discontinued and shows a status of **Discontinued (Edit)**. The unsigned order (Figure 2-83) displays in the grid with bold, blue text, and an **Action** column status of **Change**. Before the order to change an item is signed, it can be reverted to the original status by selecting the item with the **Action** column status of **Change** and using the **Discontinue/Cancel** option.

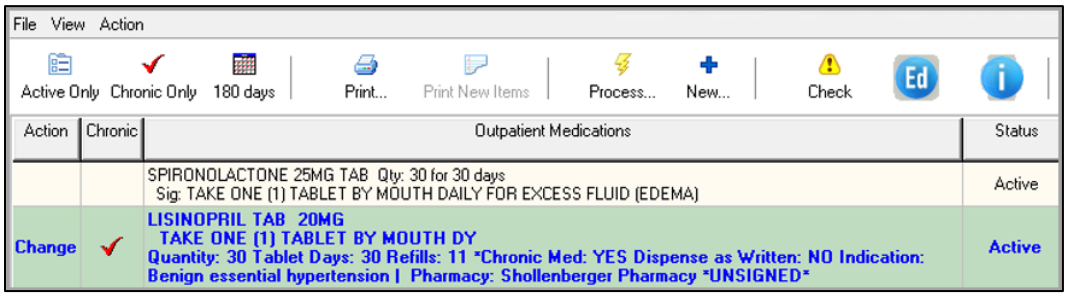


Figure 2-83: Unsigned item from Change process with an Action column status of Change

When ready, sign the orders. Refer to Signing Orders for additional information.

2.11.3 Outpatient Medication Copy to New Order

Copy to New Order is used to create a new order from an existing one. Highlight the **order or orders** then access the option by selecting the **Copy to New Order** option on the **Action** menu or right-clicking in the **Outpatient Medications** section and selecting **Copy to New Order**. **Copy to New Order** may be used on existing entries with any status.

Selecting **Copy to New Order** opens the **Copy Medication Order** dialog (Figure 2-84). This is presented only once, even if multiple orders are selected to copy, and applies to all the items selected.

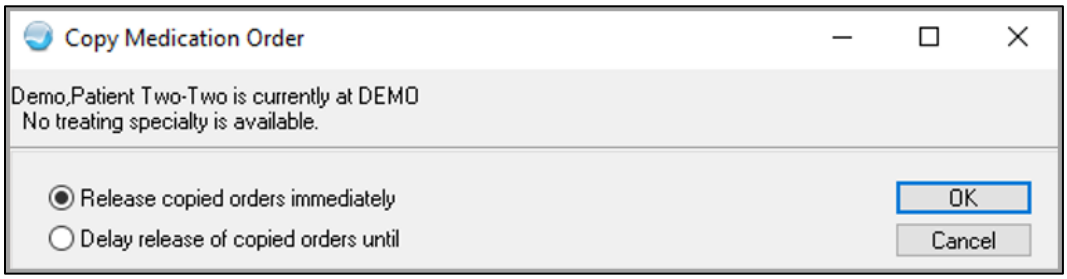


Figure 2-84: Copy Medication Order default dialog

Users may choose to release the copied orders immediately (default when dialog opens) or delay them (Figure 2-85) for an event such as an admission, a transfer from one inpatient unit to another, a discharge, or when manually released. If the patient is not currently admitted, the transfer and discharge events will not be present. Specific events are set up locally and may vary at each site. When orders are delayed, they cannot be processed or carried out until they are released, either automatically because the release event occurred, or manually.

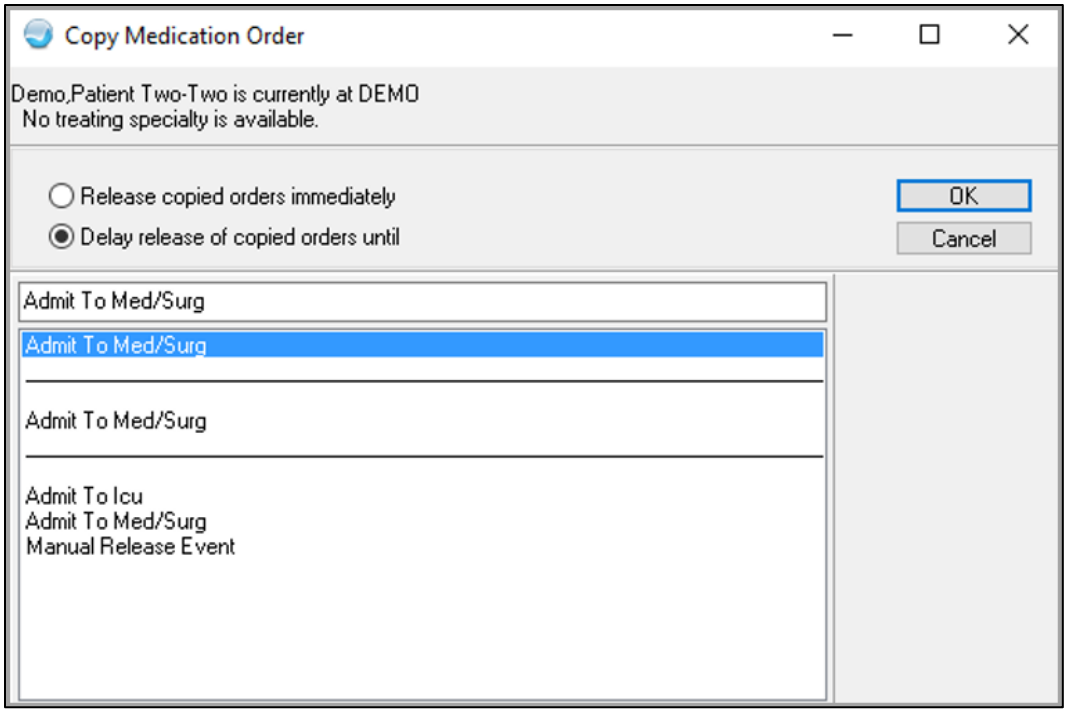


Figure 2-85: Copy Medication Order dialog with Delay selected

When more than one item is highlighted before selecting **Copy to New Order**, each item is presented in turn after the **Copy Medication Order** dialog. The **New Order** dialog (Figure 2-86) displays with the order details.

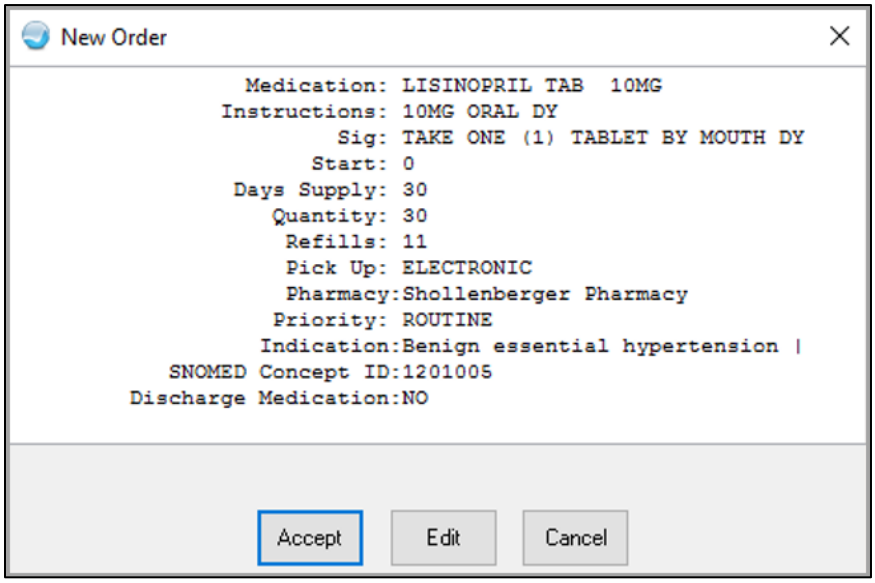


Figure 2-86: New Order dialog

Click **Edit** to make any changes. The **Medication Order** dialog (Figure 2-88) opens. It is the same as used for New Medication. Users may edit any field. When ready, click **Accept Order** to create the new order.

If users have selected an order that was created from an eRx request, the **Order** dialog is modified and the **Dosage**, **Route**, **Schedule**, and **Patient Instructions** fields are reset to avoid a prescription that reads ***See sig as written***. The original order text is displayed above the **Dosage** and **Complex** tabs. Complete the order and click **Accept Order**.

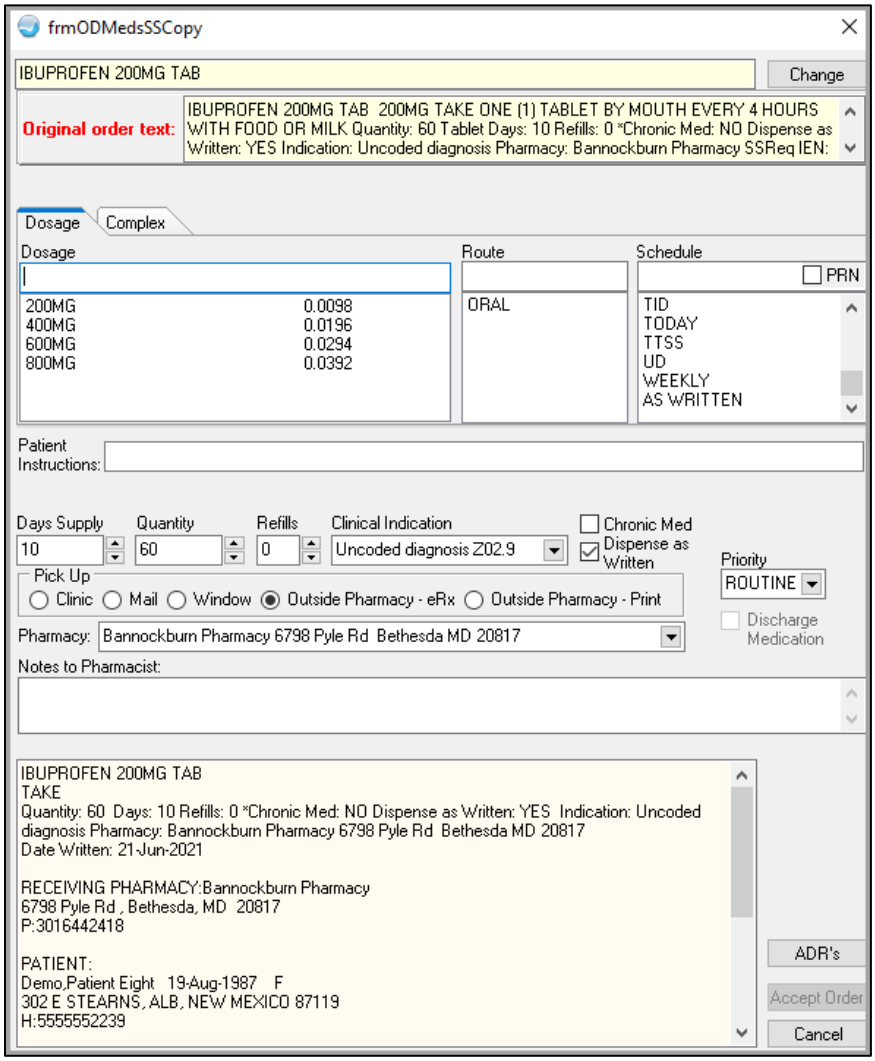


Figure 2-87: frmODMedsSSCopy dialog with Original order text field

Once the order has been accepted, it displays in the grid with bold, blue text as unsigned in the **Action** column as **New** (Figure 2-88). Before the order to copy an item is signed, it can be reverted to the original status by selecting the item with the **Action** of **New** and using the **Discontinue/Cancel** option.

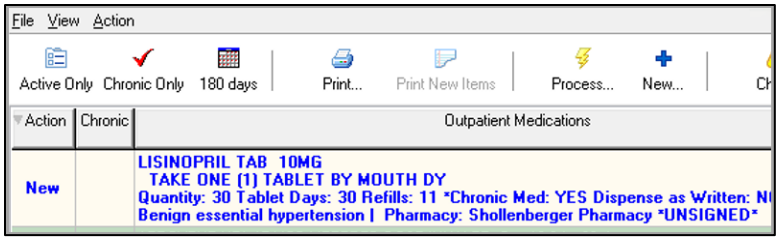


Figure 2-88: Unsigned item from copy to New Order process – Action of New

When ready, sign the orders. Refer to Signing Orders for additional information.

2.11.4 Outpatient Medication Discontinue/Cancel

Discontinue/Cancel is used to discontinue an existing order or prescription. Highlight the item or items then access the option by selecting the **Discontinue/Cancel** option on the **Action** menu, clicking the **Process** button on the tool bar, then selecting **DC**, or right-clicking in the **Outpatient Medications** section and selecting **Discontinue/Cancel**.

Selecting Discontinue/Cancel opens the **Discontinue/Cancel Order** dialog (Figure 2-89). Except when using Process, when more than one item is highlighted before selecting **Discontinue/Cancel**, selected items are displayed together. The reasons are set locally and may be different at each site.

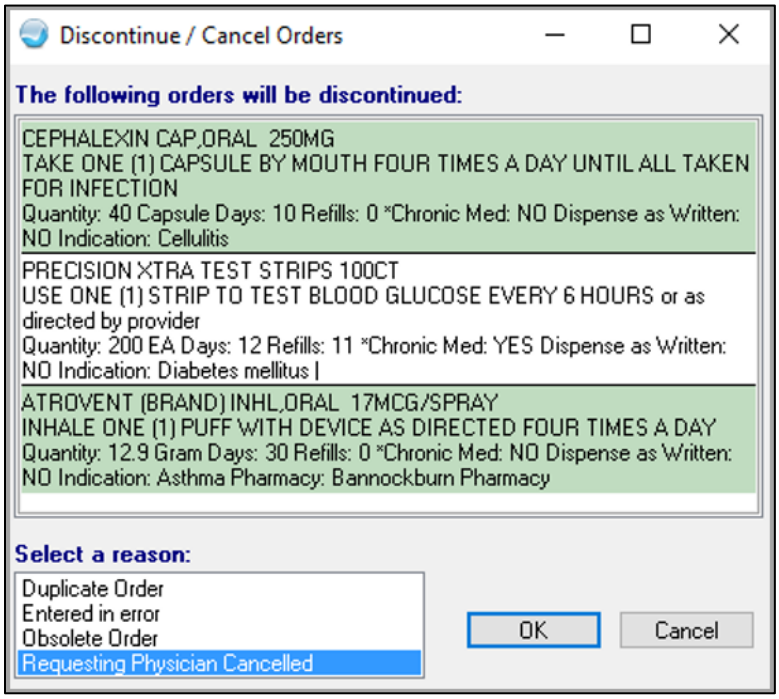


Figure 2-89: Discontinue / Cancel Orders example

Select a **reason** and click **OK** to discontinue the medication or medications or click **Cancel** to cancel the process. The order displays in the grid (Figure 2-90) with bold, blue text and an **Action** of **DC**. Use the **Integrated Signature Tool** to sign the order or orders. Any ePrescribed item transmits the discontinue message to the external pharmacy upon signature, but for a printed prescription users must personally contact the external pharmacy.

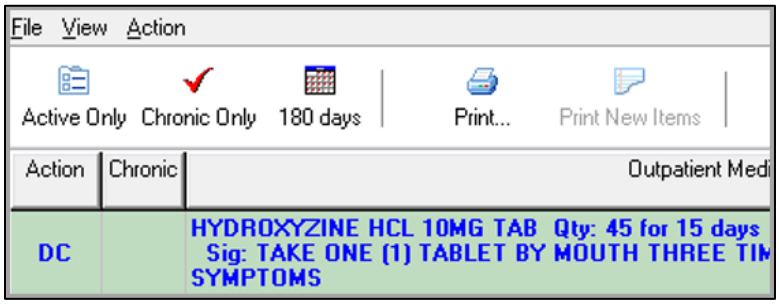


Figure 2-90: Unsigned Item from Discontinue/Cancel process – Action of DC

Before the order to discontinue an item is signed, it can be reverted to the original status by selecting the item with the **Actio**n of **DC** and using the **Discontinue/Cancel** option again.

If the item was unsigned when discontinued, it is removed from the system and is no longer visible. If the item was signed when discontinued, the item still displays on the **Meds** tab with a status of **Discontinued**. If an item was sent through the Surescripts network, a cancel message is sent to the receiving pharmacy upon signature of the order to discontinue.

2.11.5 Outpatient Medication Process

Process is used when users want to perform different actions on a group of existing orders. Highlight the **order** or **orders** then access the option by clicking the **Process** button on the tool bar, selecting the **Process** option on the **Action** menu, or right-clicking in the **Outpatient Medications** section of the **Medication Management** component and selecting **Process**.

A modified **Medication Order** dialog (Figure 2-91) opens for the first item selected. The modified version contains an additional pane with an **Action** section at the top with options **None**, **Change**, **Renew**, **Refill**, **or Release** (if available), and **D/C**. (Figure 2-92). At the bottom of the pane are buttons for **Details**, **Skip**, and **Quit**. The **Skip** button changes with the Action selected. Each action selected in the **Process** option behaves the same as if the action was selected in the **Action** menu or right-click menu.

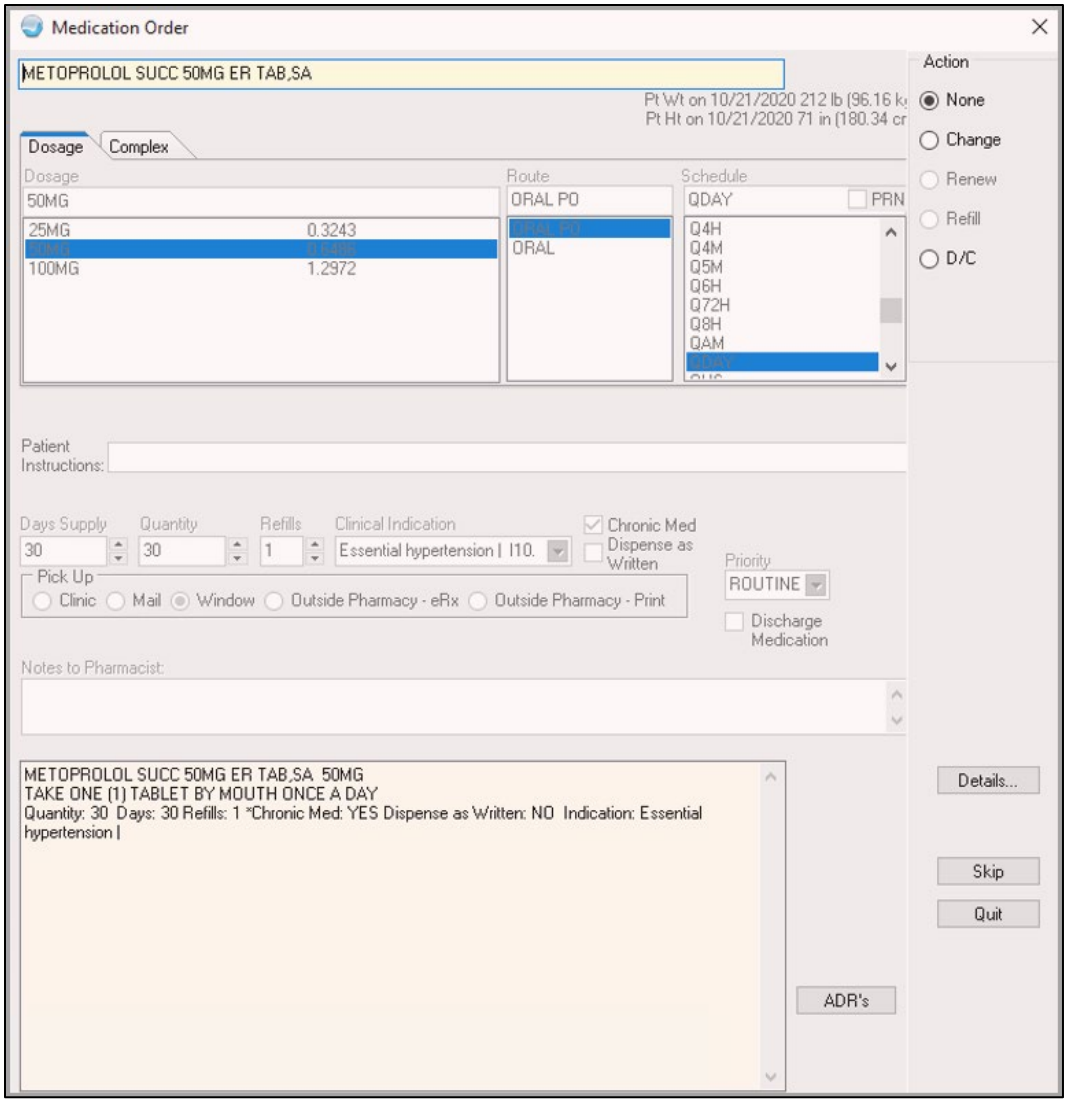


Figure 2-91: Medication Order dialog for Process

- Select **None** and **Skip** to go to the next item without taking any action on the current item.
- Select **Change** to edit the order.
- Select **Renew** to renew the order.
- Select **Refill** to send a refill request to the internal pharmacy.
- Select **D/C** to discontinue the item.

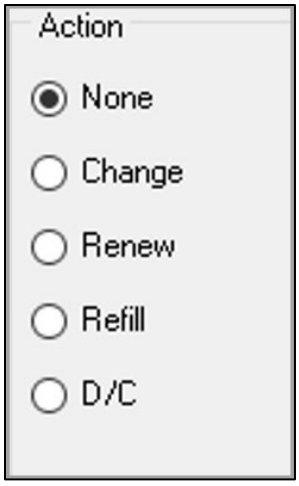


Figure 2-92: Action Selected – button text changes

If an action cannot be taken on the selected item, it is not active. Hovering the mouse over the action that is not available (Figure 2-93) displays text indicating why the action is not available.

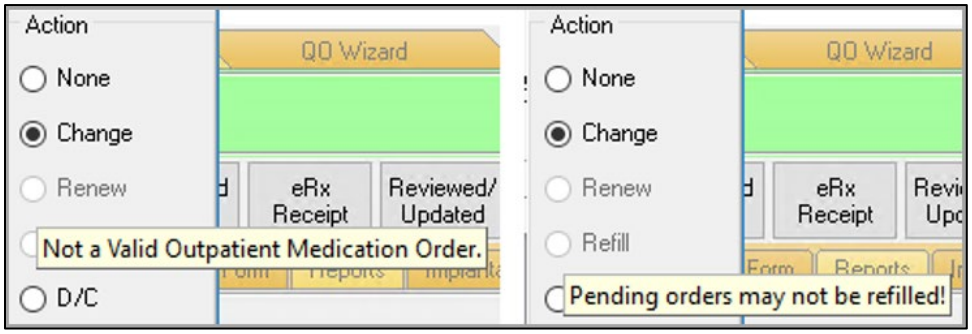


Figure 2-93: Hover text indicating why action is not available

Each item, user highlighted originally comes up, in turn, as the user works through the items.

The unsigned items show in the grid in bold, blue text with and **Action** corresponding to the action the user took.

2.11.6 Document Rx Pickup

Document Rx Pickup (Figure 2-94 and Figure 2-95) is used to update the existing orders medication prescription activity for medications dispensed at the facility. Highlight the order or orders then access the option by clicking the **Action** menu, or right-clicking in the **Outpatient Medications** section of the **Medication Management** component and selecting **Document Rx Pickup**.

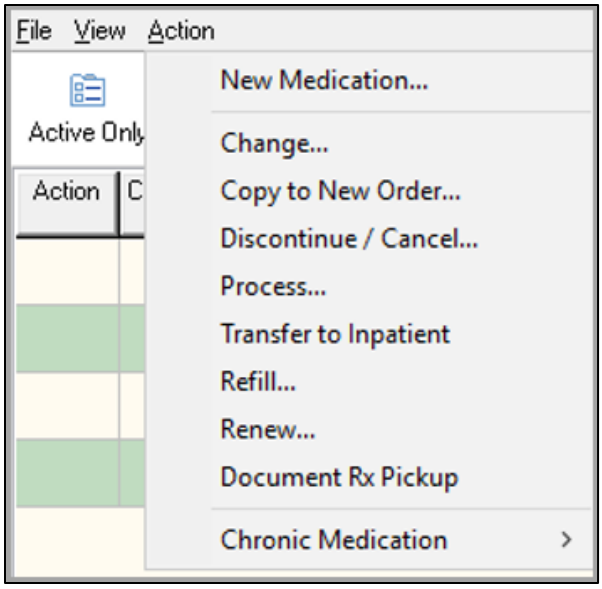


Figure 2-94: Accessing Document Rx Pickup through Action menu

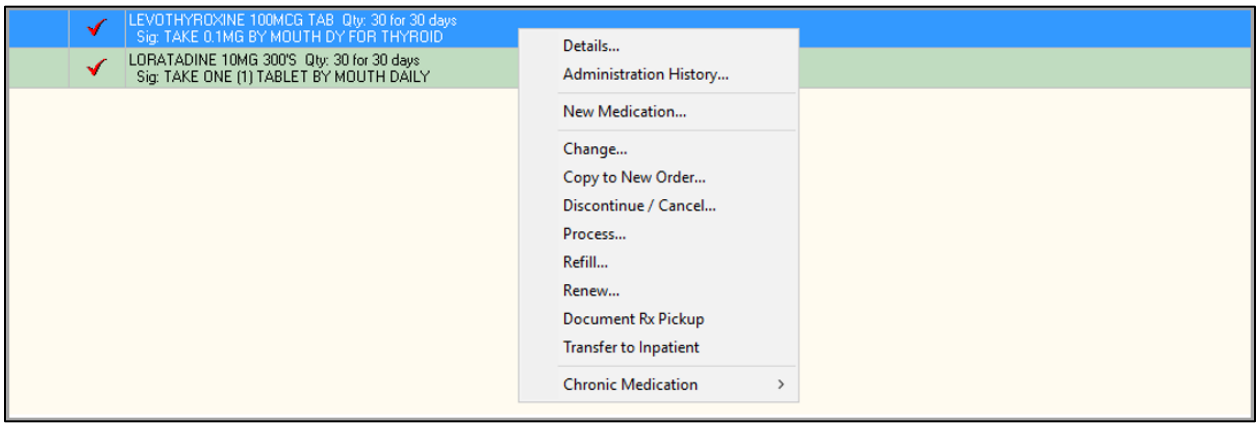


Figure 2-95: Accessing Document Rx Pickup through right-click menu

Users holding security keys for **Pharmacists** or **Pharmacy Tech** will have access to Document Rx Pickup. Without these security keys if a user selects the menu option they will be presented with the message:

The account lacks sufficient permissions to use the Document RX Pickup option.

2.11.6.1 Single Medication Pickup Activity Log Entry

1. Select a **patient** with active medications with refills or expired medications with refills (Figure 2-96).

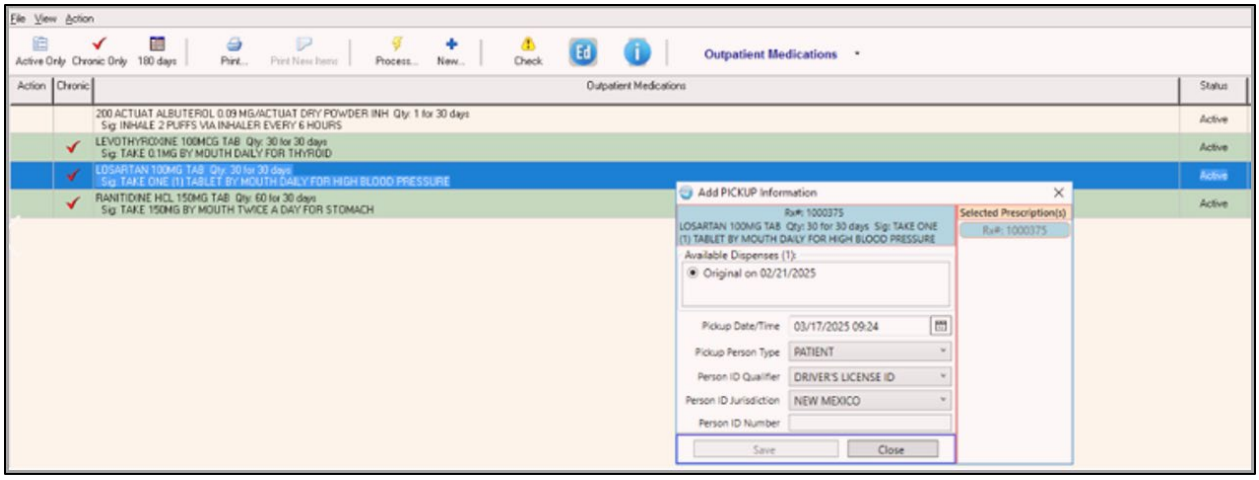


Figure 2-96: Single medication activity log documentation with single available dispenses

2. Navigate to the **Medication Management** component.
3. Select one **medication row**.
4. Select the **Action** menu option **Document Rx Pickup** or right-click the row selected and select menu option **Document RX Pickup**.
5. Select an available **dispense** option button. If there is only one available the system will default the option button.
6. Click the **Pickup Person Type** list (Figure 2-97).

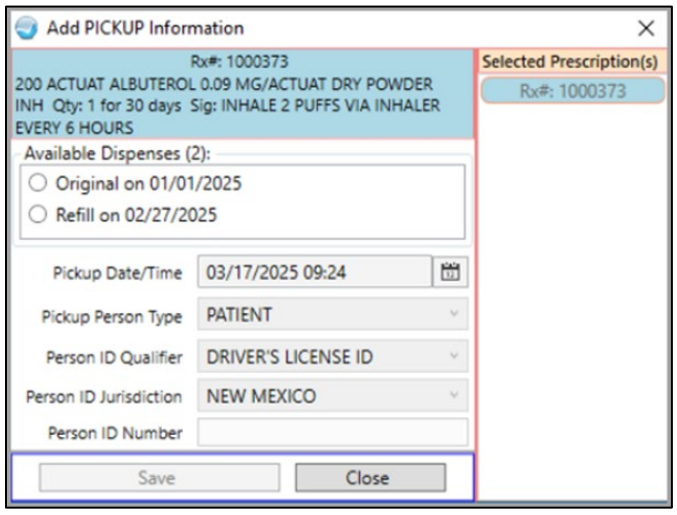


Figure 2-97: Single medication activity log documentation with multiple available dispenses

7. Select **Proxy** or **Patient**. Patient is the default value in the list. If the user chooses Proxy, additional data entry fields will present.

8. Complete the **Pickup Activity** utilizing defaults or user selected changes.

> **Note:** All fields are required, if they are not completed the **Save** button will not enable.

9. Click the **Save** button.

2.11.6.2 Multiple Medication Pickup Activity Log Entry

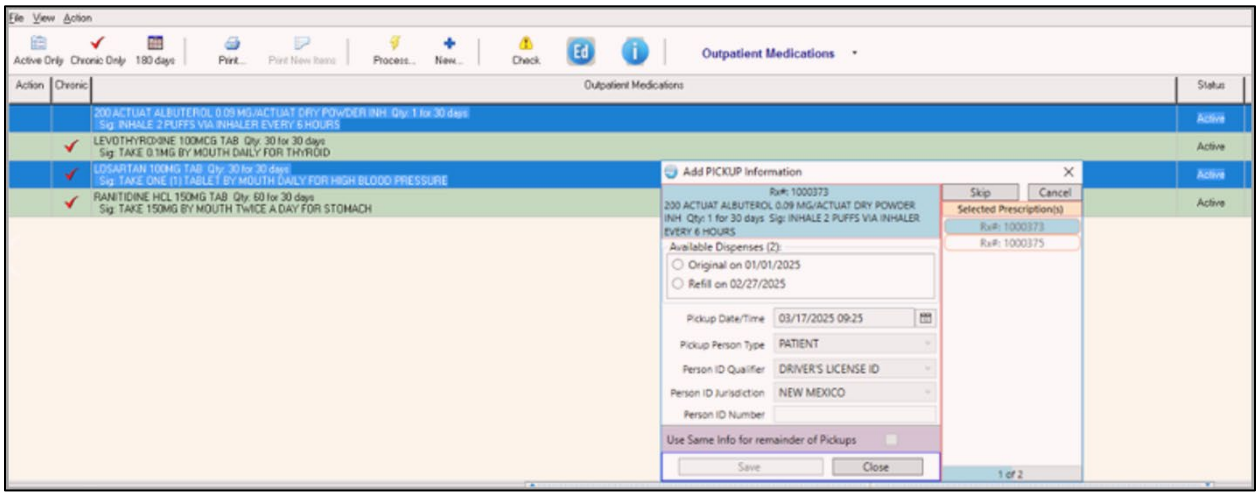


Figure 2-98: Multiple medication activity log documentation

1. Select a **patient** with multiple, active medications with refills or expired medications with refills (Figure 2-97).
2. Navigate to the **Medication Management** Component.
3. Select two (2) or more **medication rows**.
4. Select the **Action** menu option **Document Rx Pickup** or right-click the row selected and choose menu option **Document RX Pickup**.
5. Choose an available **dispense** option button. If there is only one available, the system will default the option button.
6. Complete the **Pickup Activity** utilizing defaults or user selected changes. If the user selected proxy, additional data-entry fields will display (Figure 2-99) and are required to be completed.

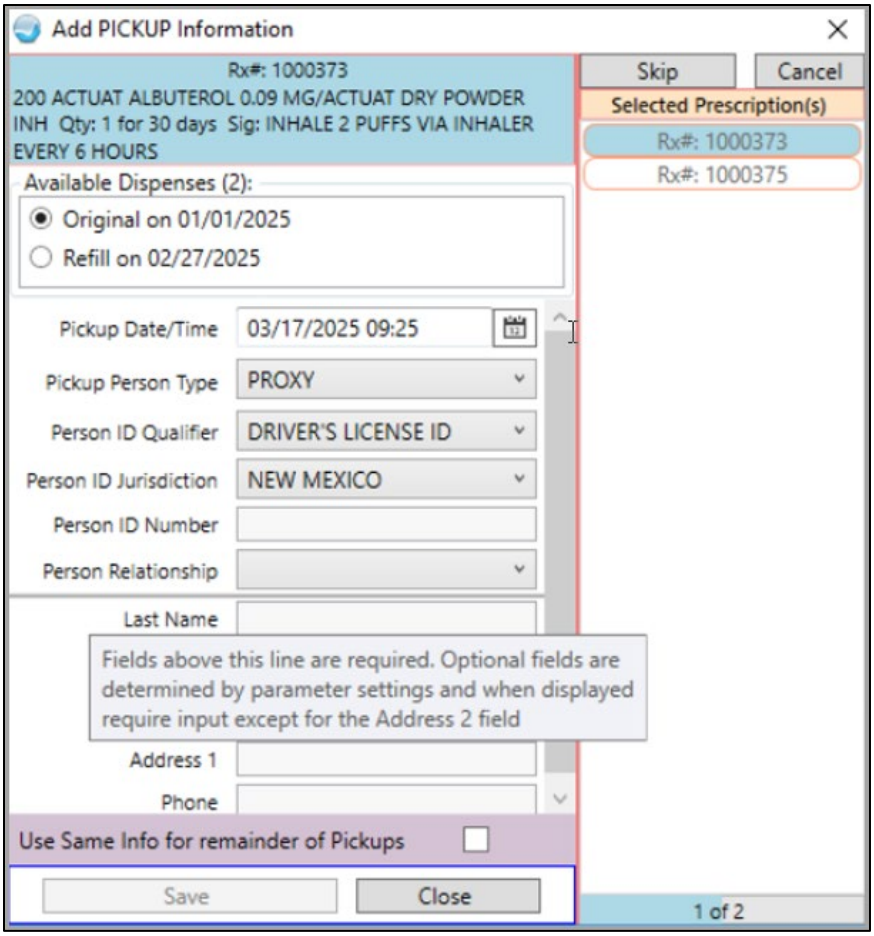


Figure 2-99: Pickup person type proxy additional required field data entry

7. Select the **Use Same Info for Remainder of Pickups** checkbox to use the required information previously entered for all other medication pickup activity documentation.

8. Click **Save**.

   Users can click the **Skip** button (Figure 2-100) if one of the medications selected to document was selected in error or they do not want to document any longer. The next medication selected will display. There is a progress bar in the lower-right corner of the dialog displaying how many pickup activities have been completed or skip and what remains to be completed.

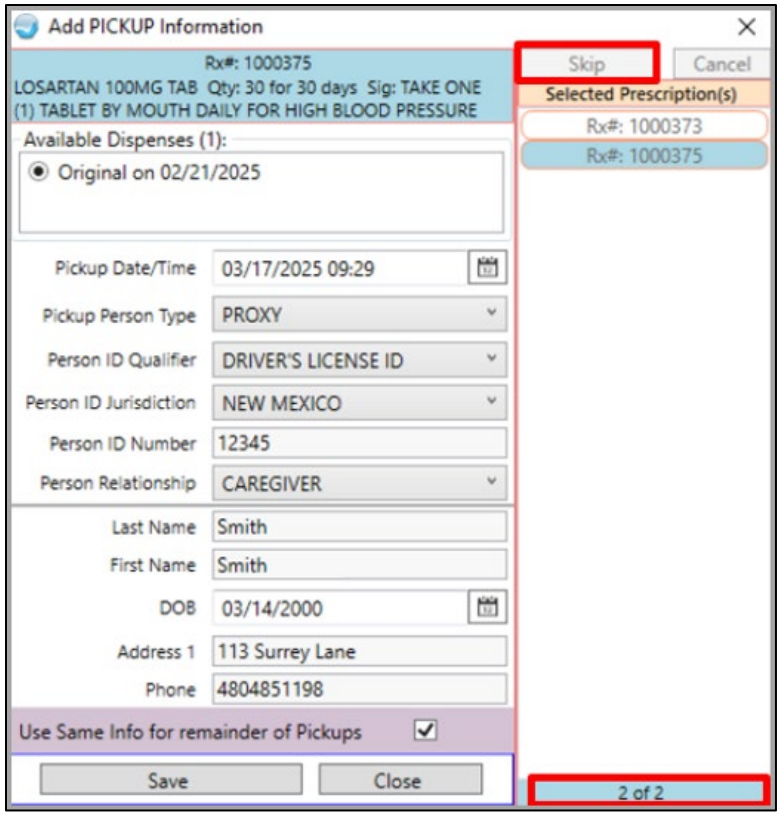


Figure 2-100: Multiple pickup activity log additional functionality

A user can hover the mouse over the **Selected Prescription(s)** pane **RX#** to view the medication's order detail information (Figure 2-101).

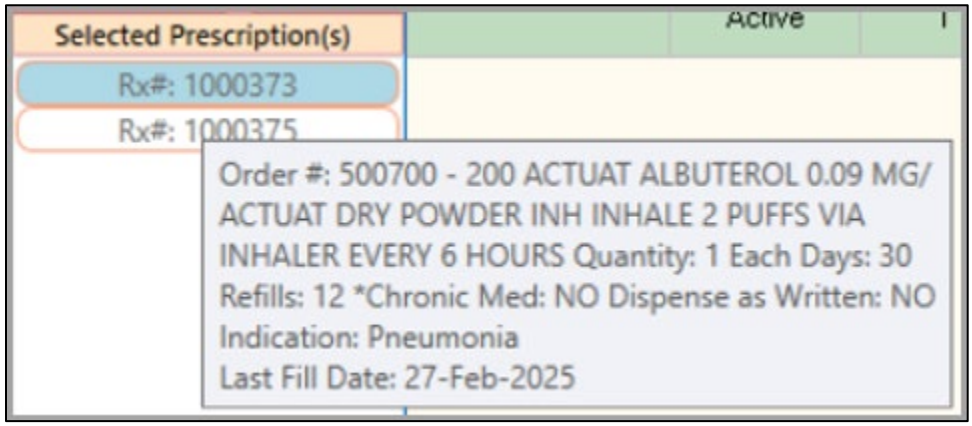


Figure 2-101: Medication order detail information window

9. Complete remaining selected medications.

   - If the user clicks the **Save** button on the last selected medication, the dialog will close.

- If the user clicks the **Cancel** button, the dialog closes and those medications not saved will not be updated.

2.11.7 Outpatient Medication Transfer to Inpatient

Transfer to Inpatient is used to copy the existing outpatient orders to inpatient orders when admitting a patient. Medication orders may be transferred to inpatient if they are for a medication that is allowed for inpatient use, and if they are not an order created from a Surescripts request. Highlight the order or orders then access the option by selecting the **Transfer to Inpatient** option on the **Action** menu or right-clicking in the **Outpatient Medications** section of the **Medication Management** component and selecting **Transfer to Inpatient**.

If the patient is not already admitted, the **Transfer Medication Order** dialog opens. Otherwise, go straight to the **Medication Order** dialog (Figure 2-102). If the site has quick order menus set up for admission orders, it may be best to complete the admission orders, then use **Transfer to Inpatient** for the needed items.

Users may only use the delay option for admission orders. Select the **event** from the options presented, which are locally created.

1. Click **OK**.

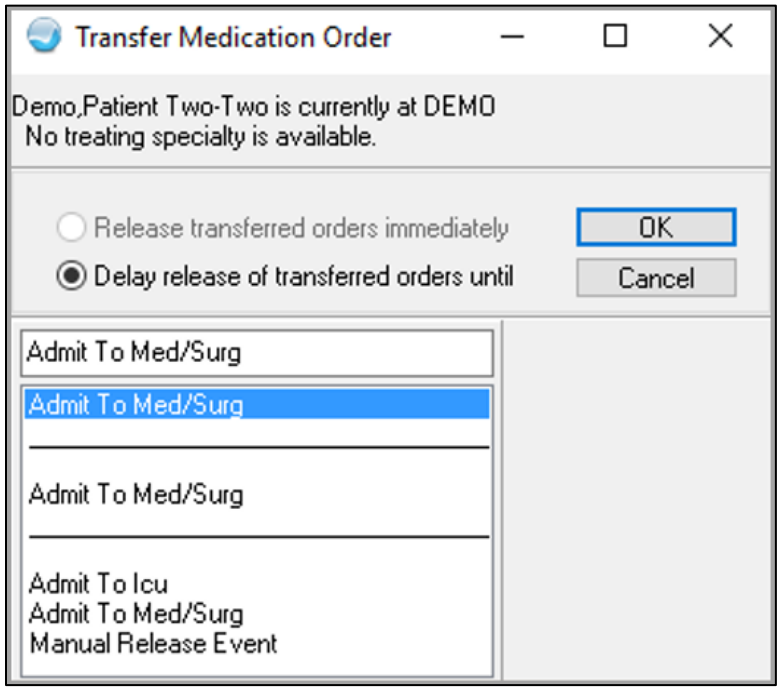


Figure 2-102: Transfer Medication Order dialog

If **Manual Release Event** is selected, the **Move Patient** dialog (Figure 2-103) opens. Complete the fields.

2. Click **Accept Order**.

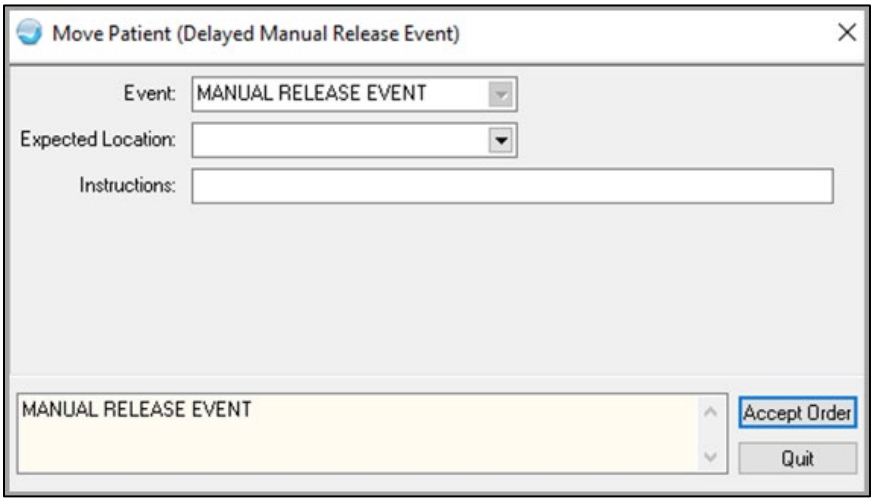


Figure 2-103: Move Patient (Delayed Manual Release Event) dialog

If users select an admission event and there is no existing admission order, the **Admit Patient** dialog (Figure 2-104) opens.

3. Complete the fields and select **Accept Order**. The fields may vary depending on the local site set up.

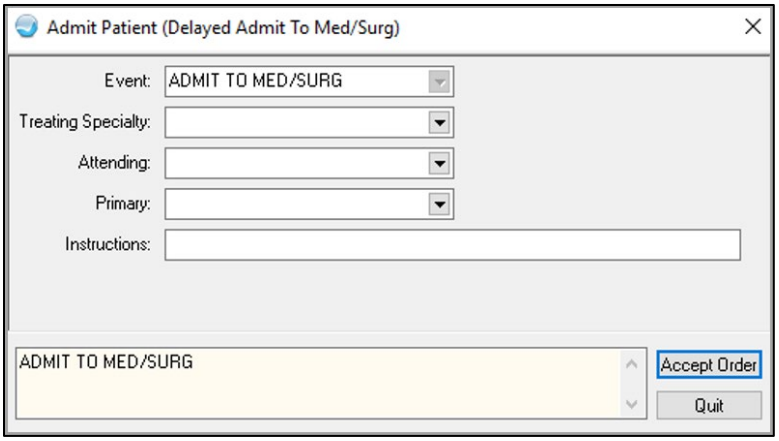


Figure 2-104: Admit Patient (Delayed Admit to Med/Surg) dialog

4. The inpatient version of the **Medication Order** dialog (Figure 2-105) opens. Adjust the **Dosage**, **Route**, and **Schedule** or use the **Complex** tab. Add **Comments** if needed.

5. Click **Accept Order**.

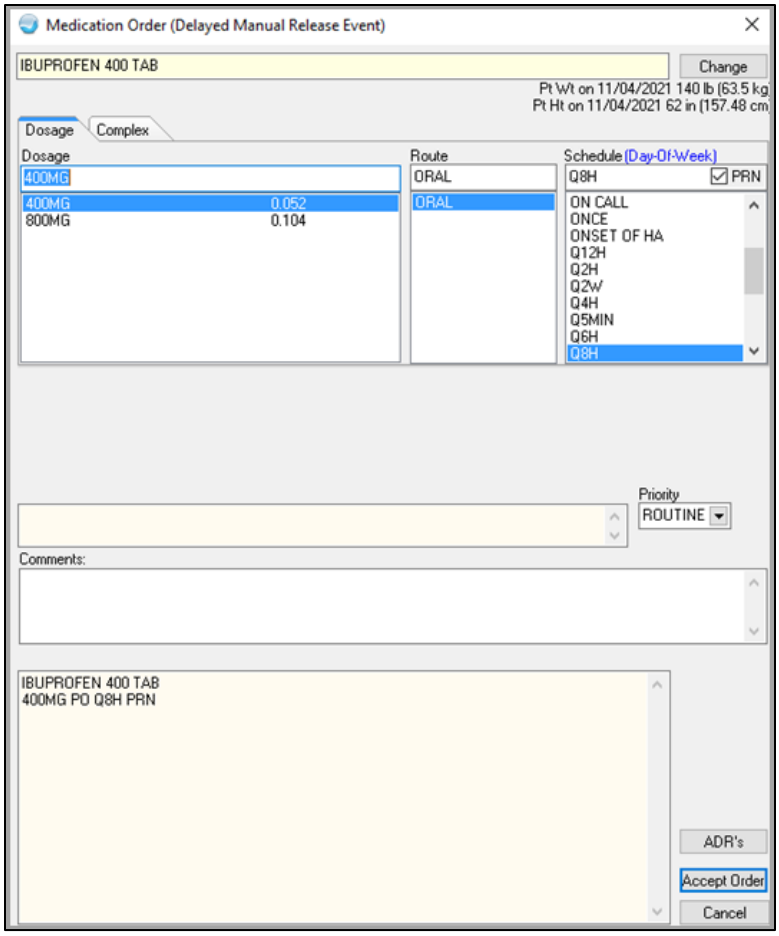


Figure 2-105: Medication Order (Delayed Manual Release Event) dialog

The newly created order appears in the **Inpatient Medications** display group in bold, blue text with an **Action** of **New**.

6. When ready, sign the **orders**. Refer to Signing Orders for additional information.

   If delayed orders were created, they may not show on the **Medications** tab after signing until the release event has occurred.

2.11.8 Outpatient Medication Refill

Refill is used to ask the internal pharmacy to process an existing refill on an existing prescription and does not create a new order or prescription. As such, it cannot be used for prescriptions sent to an external pharmacy.

1. Highlight the **prescription** or **prescriptions**.

   a. Access the **Refill** option by one of three methods:

      - Selecting the **Refill** option on the **Action** menu

OR

- Click the **Process** button on the **tool bar**.

OR

- Select **Refill** or right-click in the **Outpatient Medications** section and select **Refill**.

The **Refill Order** dialog (Figure 2-106) opens. Users may adjust the **Pick Up** options between **Clinic**, **Mail**, and **Window** only. Users may not edit the prescription in any way.

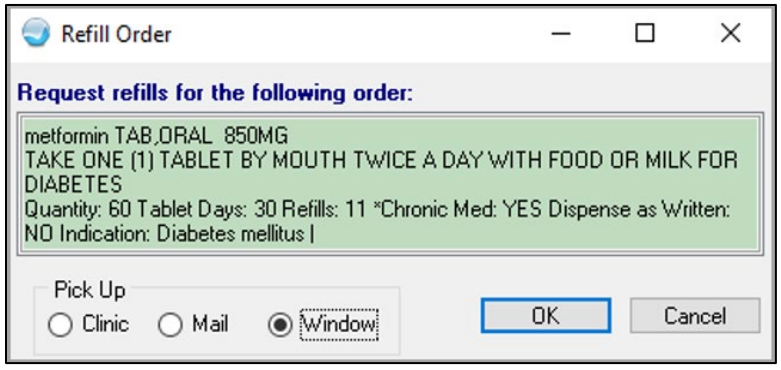


Figure 2-106: Refill Order dialog

2. Click **OK** to send the refill request to the internal pharmacy.

   The item displays (Figure 2-107) in the grid in bold, blue text with an **Action** of **Refill**. Users do not need to sign for a **Refill** action.

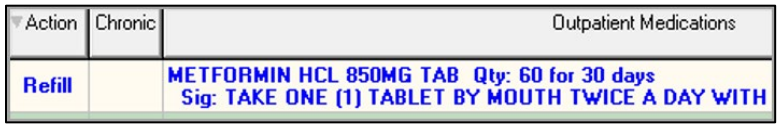


Figure 2-107: Item from Refill Process dialog – Action of Refill

Important: Users may not cancel a pending refill action through the EHR. If a user does not want the medication to be refilled, they must contact the pharmacy directly.

2.11.9 Outpatient Medication Renew

Renew is used to create a new order from an existing one. It differs from Copy to New Order in that Renew is intended to create an exact copy with little to no editing.

1. Highlight the **prescription** or **prescriptions**.
2. Access the **Renew** option by one of three methods:

- Selecting the Renew option on the Action menu.

OR

- Click the **Process** button on the tool bar and select **Renew**.

OR

- Right-click in the **Outpatient Medications** section and selecting **Renew**.

Note:	Renew may not be used on pending orders, orders created from a Surescripts request, orders in active/see details status, or orders with a discontinued (edit) status. Additionally, the local set up may restrict certain drugs from being renewed.

The Order Check information displays if applicable.

Click **Cancel** to cancel the process, or **OK** to dismiss the order checks.

Unless using the **Process** function, the **Renew Order** dialog (Figure 2-108) opens. The order information is shown, with buttons for **Change**, **OK**, and **Cancel**. If more than one item is selected to renew, all the selected items show in the same dialog. The **Change** button is inactive.

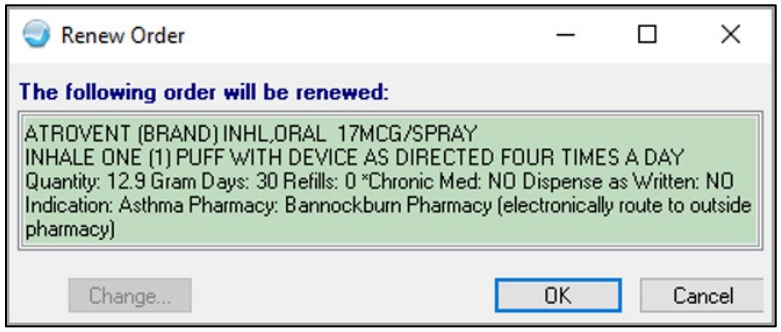


Figure 2-108: Renew Order dialog

Renew allows editing only of Refills, limited editing of Pick Up, Chronic Marking, and if applicable, Pharmacy.

- If these fields do not need to be edited, click **OK** to accept the order. Otherwise, click the **order information** and the **Change** button becomes active.
- Click **Change** (Figure 2-109 and Figure 2-110).

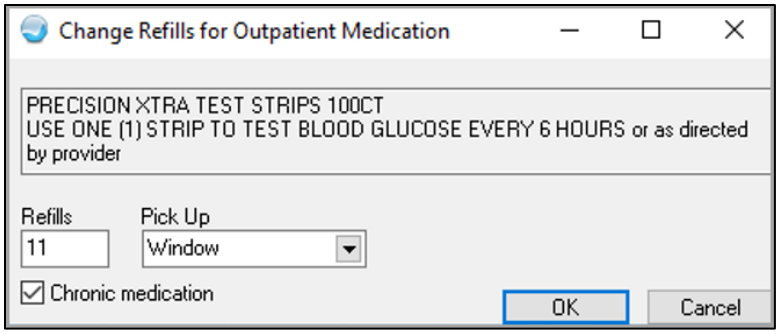


Figure 2-109: Change Refills for Outpatient Medication dialog Internal Pharmacy

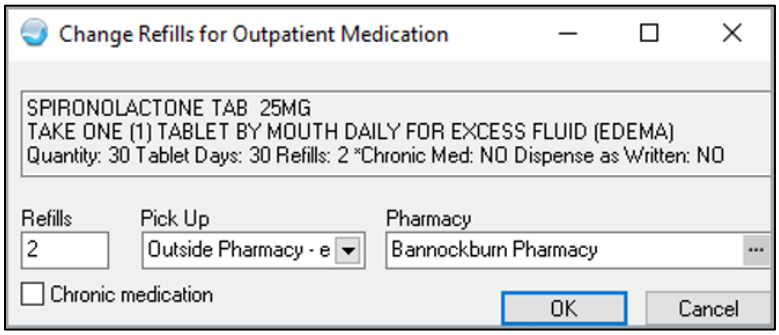


Figure 2-110: Change Refills for Outpatient Medication dialog External Pharmacy

Users may change the pick-up location in limited fashion. If originally sent to the internal pharmacy, the pickup locations available will be Window, Mail, and Clinic. If originally sent to an external pharmacy, the pickup locations available will be Clinic, Outside Pharmacy–eRx, and Outside Pharmacy–Print.

1. Once the information is correct, click **OK**.
2. Then click **OK** on the **Renew Order** dialog (Figure 2-111). The new order displays in bold, blue text with the **Action** column displaying **Renew**.

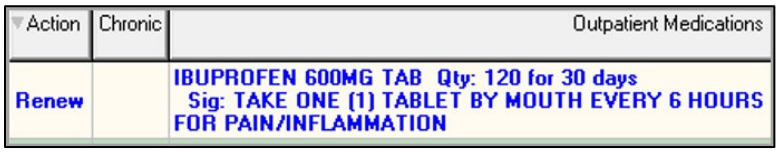


Figure 2-111: Unsigned item from Renew Process dialog – Action of Renew

3. When ready, sign the **orders**. Refer to Signing Orders for additional information.

2.11.10 Outpatient Medication Chronic Medication

Chronic Medication is used to mark or unmark items as chronic or to select all the items currently marked as chronic. The **Chronic Medication** options (Figure 2-112) are found in the **Action** menu, as well as on the right-click menu.

To mark an item as chronic:

1. Select the **item**.
2. Select the **Chronic Medication** option (Figure 2-112) from either the **Action** menu or by right-clicking the **highlighted item**.
3. Click **Yes**.

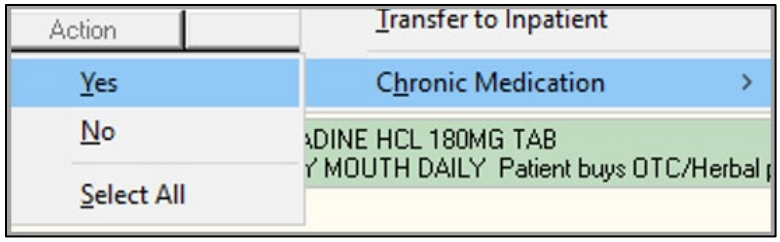


Figure 2-112: Chronic medication dialog with option Yes

A red check-mark (Figure 2-113) displays in the **Chronic** column.

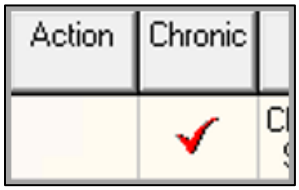


Figure 2-113: Chronic column with check mark

To **clear** an item as **chronic**:

1. Select the **item**.
2. Select the **Chronic Medication** option from either the **Action** menu or by right-clicking the **highlighted item**.
3. Click **No**.

The **Chronic** column is now blank.

To select all items currently marked as **chronic**:

1. Select the **Chronic Medication** option from either the **Action** menu or by right-clicking the any **medication item**.
2. Click **Select All**.

All items currently marked as chronic (Figure 2-114) are highlighted.

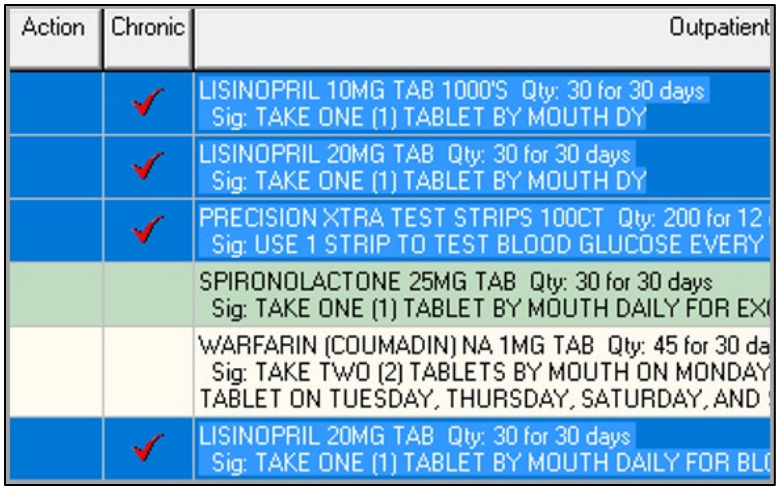


Figure 2-114: All Chronic column medications selected

2.12 Outside Medications Group

The **Outside Medications** group displays the items that the patient may be taking that are neither prescribed nor dispensed at the local facility and may include Over the Counter (OTC) medications, herbal preparations, or dietary supplements as well as prescription medications.

These are not orders, but simply documentation of the information, though they do participate in order checking for interactions and allergies.

2.12.1 Outside Medications Columns

The **Outside Medications** group has the following columns:

- **Action:** Shows the action taken on an existing entry
- **Outside Medications:** Shows the entry information
- **Status:** Shows the status of the item, including but not limited to Active and Discontinued
- **Start Date:** If available, displays the date the item was started by the patient

Users may adjust the column widths and save the setting if desired.

1. Set the **column widths** as preferred.
2. Right-click any **column header** (Figure 2-115) and select **Save Settings**.
3. Choose **Restore Defaults** to return to the default column widths.

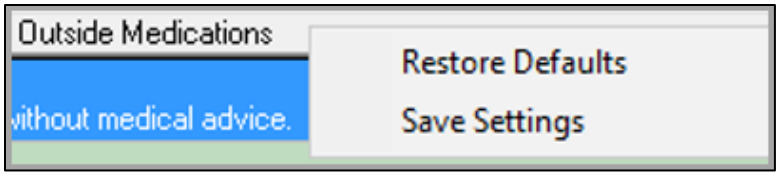


Figure 2-115: Outside Medications columns right-click menu

Users may sort the group contents on any of the columns by left-clicking the column label. The first click sorts **A to Z** (Figure 2-116) or **low to high**, while additional clicks reverse the current sort order (Figure 2-117). A small, dark-gray triangle displays in the column header to indicate the column used to sort and the sort order.

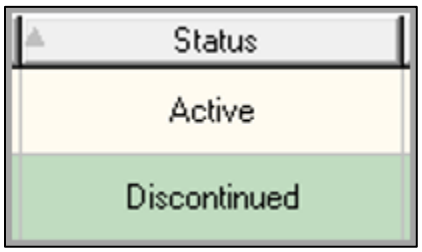


Figure 2-116: Sort indicator in Status column A to Z

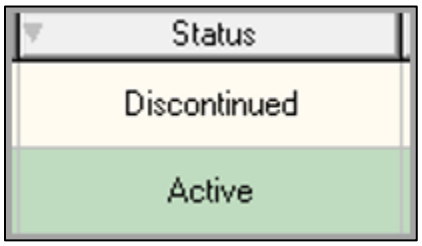


Figure 2-117: Sort indicator in Status column Z to A

2.12.2 Outside Medications Print

The Print function can be used to print reports from the Outside Medications display group. Users may access the Print functionality from the **File** menu or the **Print** button.

Reports may be printed as **Brief** or **Detailed** (Figure 2-118). Both reports contain the information from the **Outside Medication**, **Status**, and **Started** columns. Brief reports are printed in portrait orientation. Detailed reports are printed in landscape orientation.

Reports may be further refined by using the Inclusion Criteria to restrict to only the selected item or items or only active items, or any combination. Be careful, as it is possible to set the inclusion criteria so that nothing prints.

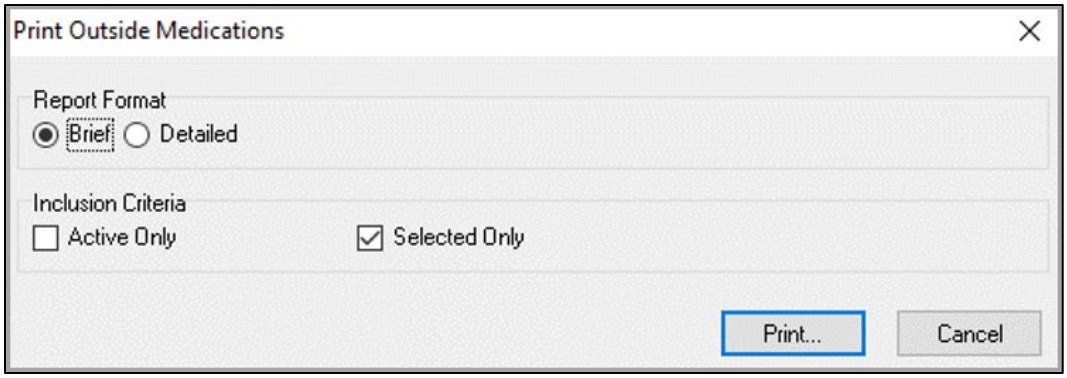


Figure 2-118: Print Outside Medications dialog

When the criteria are set, click **Print**. The **Print Setup** dialog (Figure 2-119) displays.

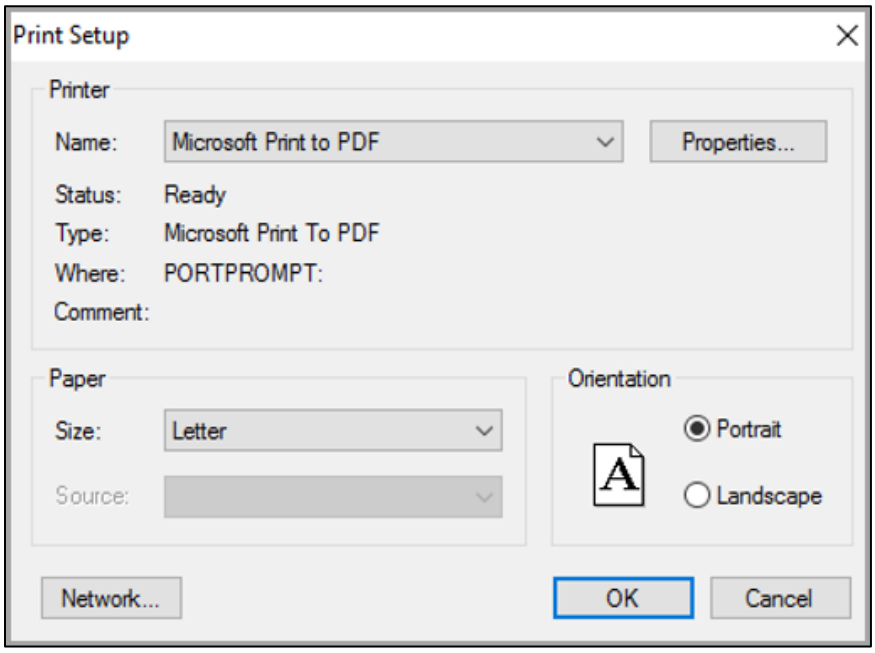
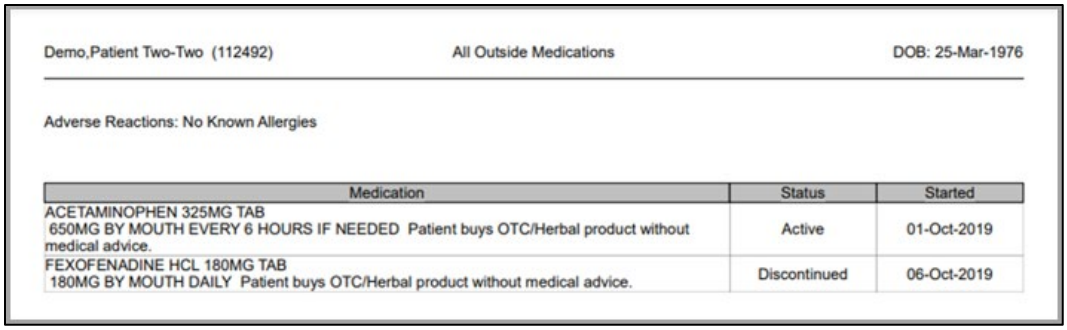


Figure 2-119: Print Setup dialog

Once the printer and other options have been selected, click **OK** to print the report (Figure 2-120 and Figure 2-121). The information included on the report reflects the information documented.

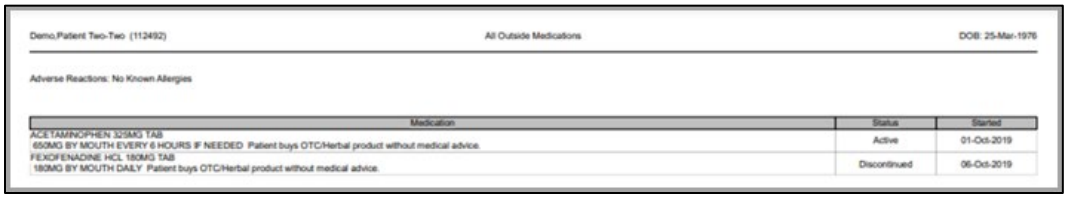


Demo,Patient Two-Two (112492) All Outside Medications DOB: 25-Mar-1976

Adverse Reactions: No Known Allergies

Medication	Status	Started
ACETAMINOPHEN 325MG TAB 650MG BY MOUTH EVERY 6 HOURS IF NEEDED Patient buys OTC/Herbal product without medical advice.	Active	01-Oct-2019
FEXOFENADINE HCL 180MG TAB 180MG BY MOUTH DAILY Patient buys OTC/Herbal product without medical advice.	Discontinued	06-Oct-2019

Figure 2-120: All Outside Medications Brief report



Demo,Patient Two-Two (112492) All Outside Medications DOB: 25-Mar-1976

Adverse Reactions: No Known Allergies

Medication	Status	Started
ACETAMINOPHEN 325MG TAB 650MG BY MOUTH EVERY 6 HOURS IF NEEDED Patient buys OTC/Herbal product without medical advice.	Active	01-Oct-2019
FEXOFENADINE HCL 180MG TAB 180MG BY MOUTH DAILY Patient buys OTC/Herbal product without medical advice.	Discontinued	06-Oct-2019

Figure 2-121: All Outside Medications Detailed report

2.12.3 View menu

The **View** menu for Outside Medications (Figure 2-122) includes **Details** and **Refresh** options.

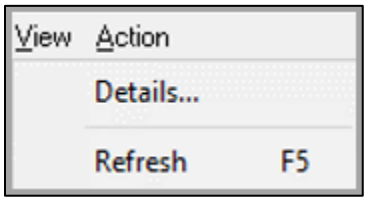


Figure 2-122: Outside medications View menu

2.12.4 Outside Medications Details

The **Details** option opens the **Outside Medication Details** dialog for the currently selected item. The information contained in the details varies based on the specific item selected. This information may be printed. The font size of the display may be adjusted using the **Font Size** control, though this does not affect the printed font size. The Details may also be opened by double-clicking the line item, or by selecting Details from the right-click menu.

The **Outside Medication Details** dialog (Figure 2-123) contains the information documented for the item selected, the actions taken on the item, and the order check information.

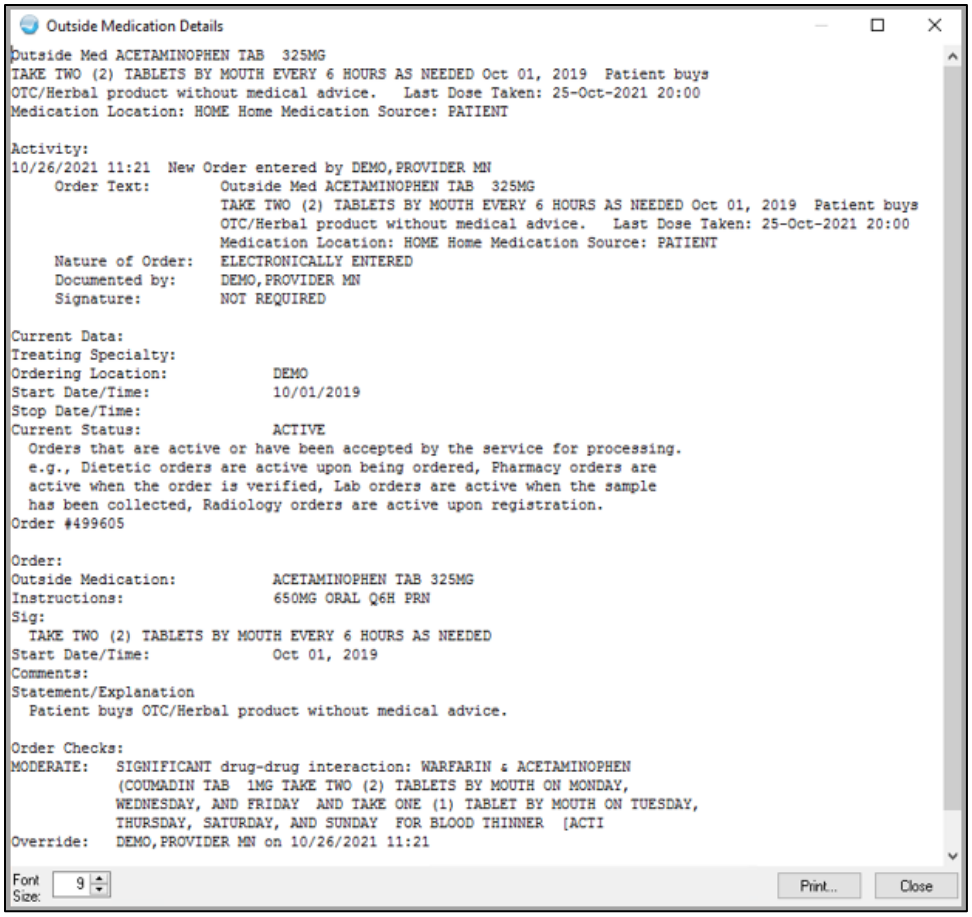


Figure 2-123: Outside Medication Details dialog

2.12.5 Outside Medication Refresh

The **Refresh** option refreshes the contents of the **Medication Management** component.

2.12.6 Outside Medication Action Menu

The **Action** menu for Outside Medications (Figure 2-124) includes:

- **Outside Medication Group New Medication**
- **Outside Medication Group Change**
- **Outside Medication Group Discontinue/Cancel**
- **Outside Medication Group Transfer to Inpatient**
- **Outside Medication Group Transfer to Outpatient**

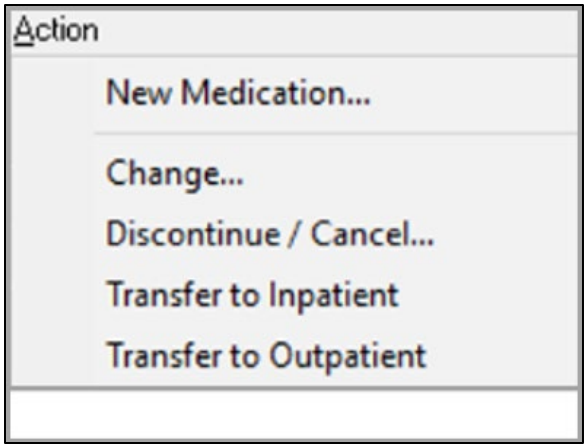


Figure 2-124: Outside Medications Action menu

2.12.7 Outside Medication New Medication

Users may create a new medication entry by doing one of the following:

- Select the **New Medication** option on the **Action** menu.
- Click the **New** button on the tool bar.
- Right-click in the **Outside Medications** section and selecting **New Medication**.

While some sites may have **Quick Order** menus for Outside Medications, for most sites, users see the **Document Herbal/OTC/Home Medications** search dialog (Figure 2-125). All medications that have been allowed for Outside Medication use display.

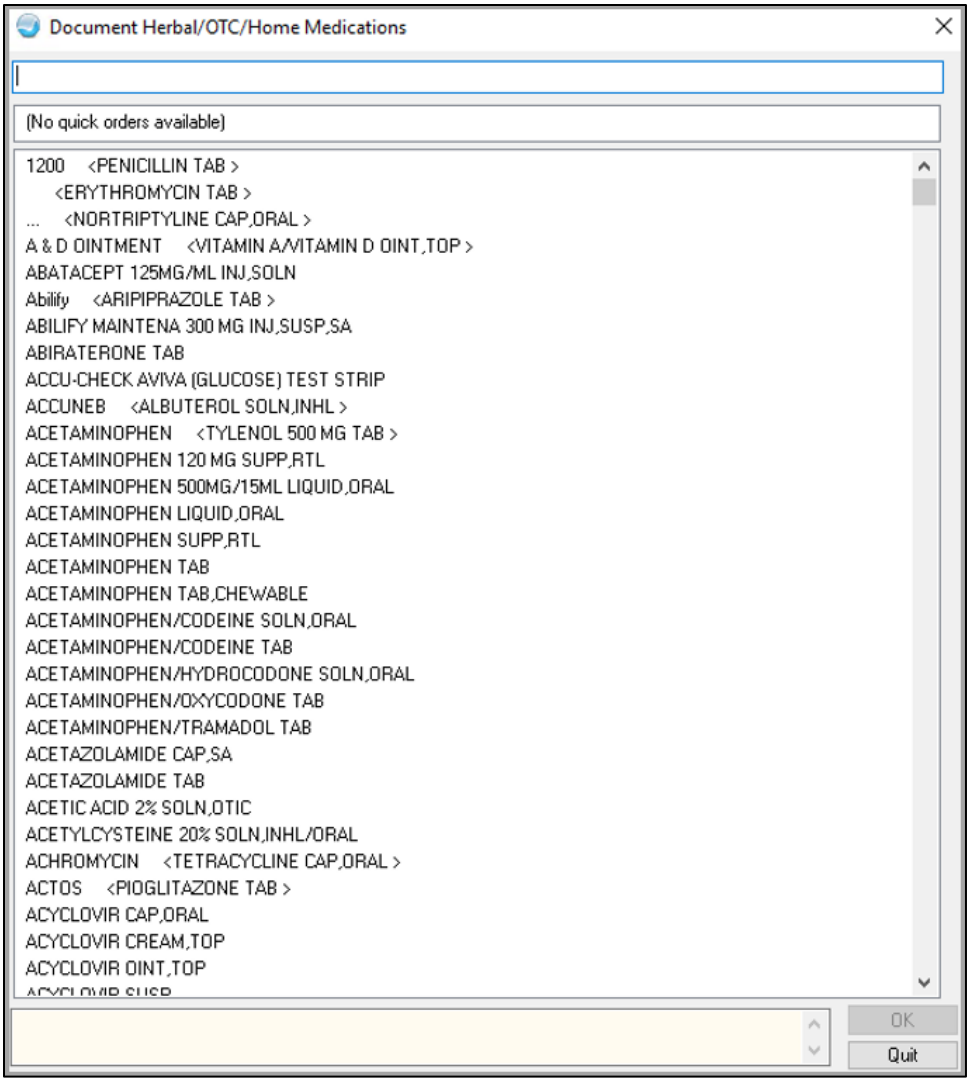


Figure 2-125: Document Herbal/OTC/Home Medications search dialog

4. Scroll through the list or type in the first few letters of the medication to search for the correct item.

5. Ensure the correct medication displays, then click the item name. The **Document Herbal/OTC/Home Medications** dialog (Figure 2-126) opens.

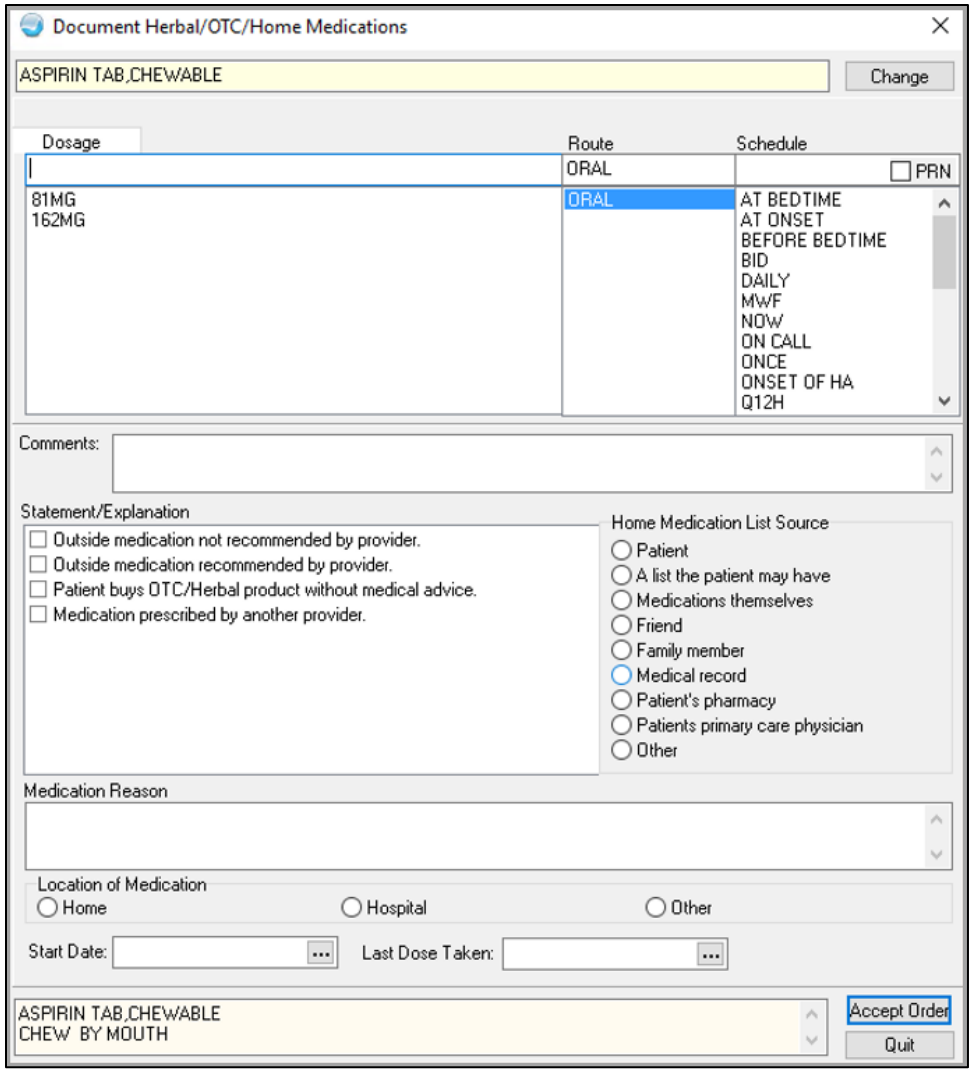


Figure 2-126: Document Herbal/OTC/Home Medications dialog

This dialog contains the following fields:

- **Orderable Item:** Shows the drug and dosage form selected. This item is not labeled and displays at the top of the dialog
- **Change button:** Allows the user to change the orderable item selected. Click Change then search for the desired item.
- **Dosage:** Select from the list if available or type in a dosage.
- **Route:** Select from the list if present or type in a route.
- **Schedule:** Select from the list or type in the schedule.
- **PRN:** Select the **PRN** check box if the patient uses the item on an as needed basis.

- **Comments:** Add comments if needed.
- **Statement/Explanation:** Select the best explanation for the medication being in the Outside Medications section. The list can be adjusted locally.
- **Home Medication List Source:** Select the source from which the information was obtained.
- **Medication Reason:** Type the reason the patient is taking the medication.
- **Location of Medication:** Select where the medication is located.
- **Start Date:** Select or type in the start date of the medication, if known. Use the calendar control to select a specific date, or type in a year, month and year, or month day and year into the field.
- **Last Dose Taken:** Select or type in the date and time of the last known dose, if known.
- **Summary:** Displays the information entered so the user can review it before accepting the entry.
- **Accept Order button:** Accepts the entry, though the button text is misleading. Users are not creating an order but simply documenting the information.
- **Quit button:** Exit the process without saving the entry.

This section is about documentation and not creating an order, so no fields other than the medication are required. However, users should document as much information as available.

> **Note:** If a user cannot determine the name of a medication, or if the medication needed is not available, the documentation can still be started.
>
> Each site must set up a medication code for an unknown medication. Many sites name this code **UNKNOWN MED MISCELLANEOUS**, but confirm with the pharmacy informaticist which medication should be used for this purpose. In this documentation, **UNKNOWN MED MISCELLANEOUS** is used as an example.

1. Select the unknown medication and enter any descriptive information in the **Dosage** or **Comments** field (Figure 2-127).

   This may be something like Little Round Pink pill, Oblong White pill, or even the specific name of a medication if it is known but not available in the search list. Enter as much additional information as possible.

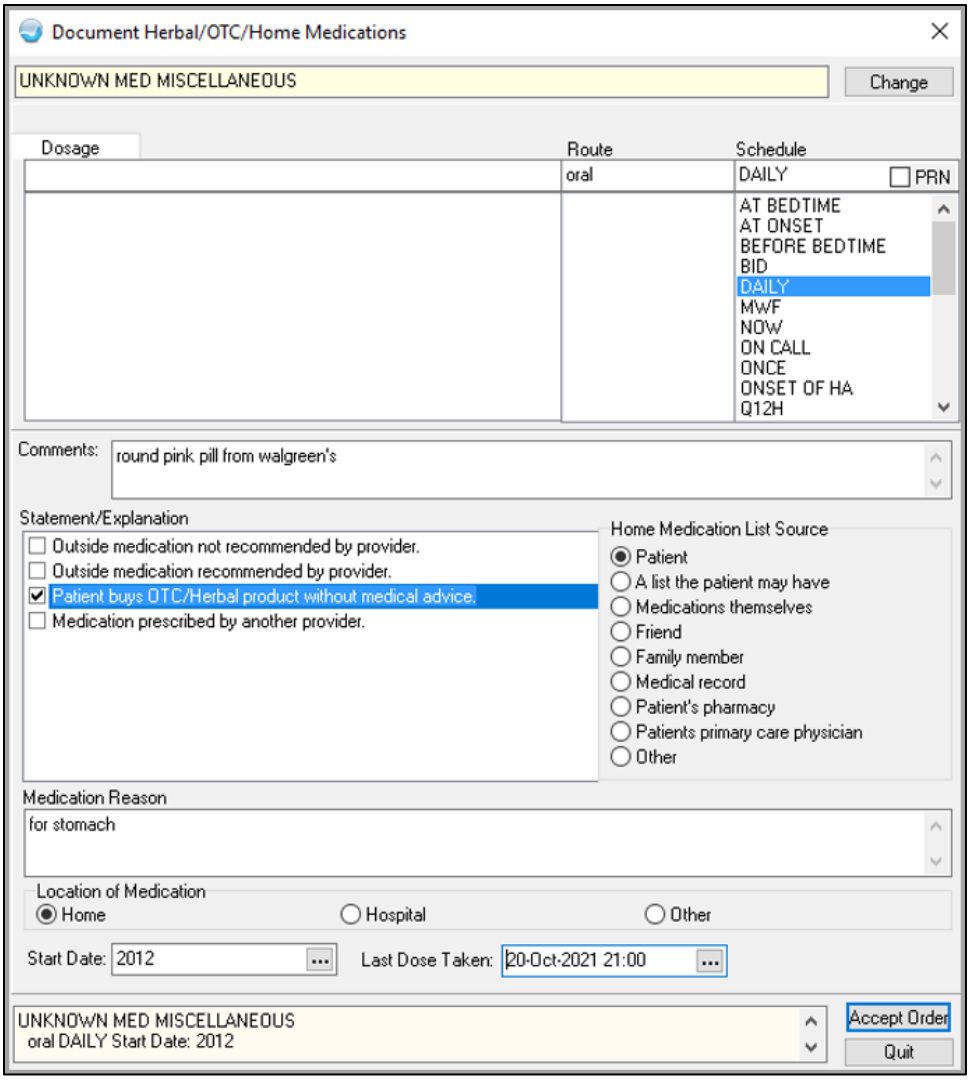


Figure 2-127: Document Herbal/OTC/Home Medications dialog with unknown medication

2. Once the information is documented in the dialog, click **Accept Order** to save the entry.

   If applicable, the **Order Checking** dialog (Figure 2-128) displays. Remember, anything documented as an unknown medication cannot properly order check.

3. Click **Accept Order** to continue.

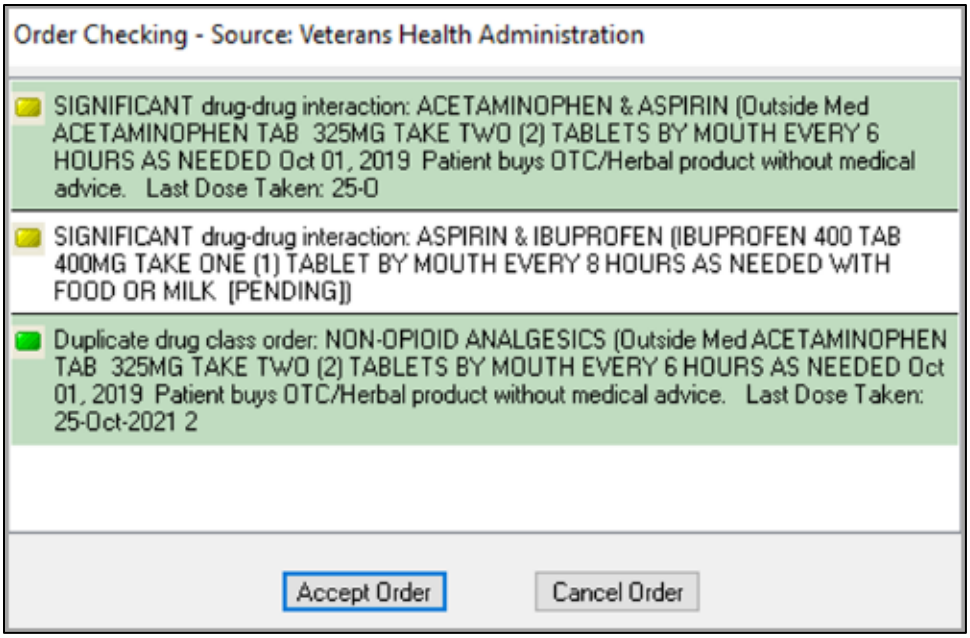


Figure 2-128: Order Checking dialog

The **Document Herbal/OTC/Home Medications** search dialog displays again so additional entries can be added.

4. If there are no other items to add, click the **Quit** button.

   The documented item or items appear in the **Outside Medications** dialog (Figure 2-129) display group in bold, blue text with an **Action** of **New**.

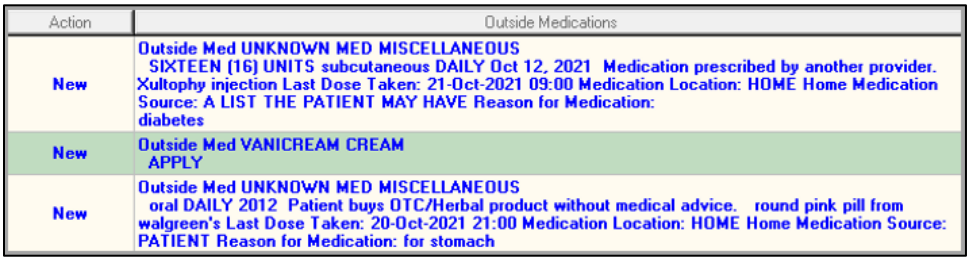
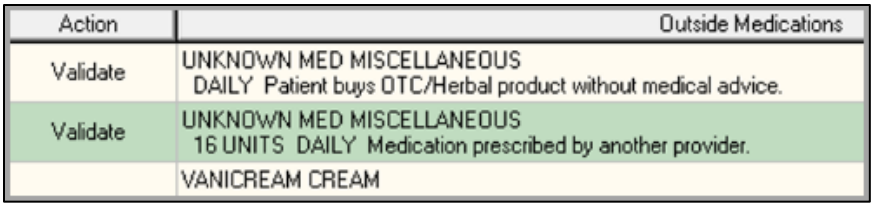


Figure 2-129: Outside Medications dialog with Action of New

5. When ready, sign the **items**.

   Refer to Signing Orders for additional information. Because these are not orders, no actual signature is required.

   For any entries using the unknown medication, once signed they display with the **Action** of **Validate** (Figure 2-130).



Action	Outside Medications
Validate	UNKNOWN MED MISCELLANEOUS DAILY Patient buys OTC/Herbal product without medical advice.
Validate	UNKNOWN MED MISCELLANEOUS 16 UNITS DAILY Medication prescribed by another provider.
	VANICREAM CREAM

Figure 2-130: Outside medication unknown med miscellaneous with Validate in the Action column

Once the medication is determined (if unknown) or entered (if unavailable), users can edit the entry using the **Change** process to select the correct item and finish the documentation.

2.12.8 Outside Medication Change

Change is used to edit an existing entry.

1. Highlight the item or items then access the option by selecting **Change** on the **Action** menu or right-clicking in the **Outside Medications** display group and selecting **Change**.

   Users may not change items with a status of **Discontinued**. When more than one item is selected, they are presented to the user in turn. The **Document Herbal/OTC/Home Medications** dialog (Figure 2-131) opens. It is the same as what was used to create the new entry.

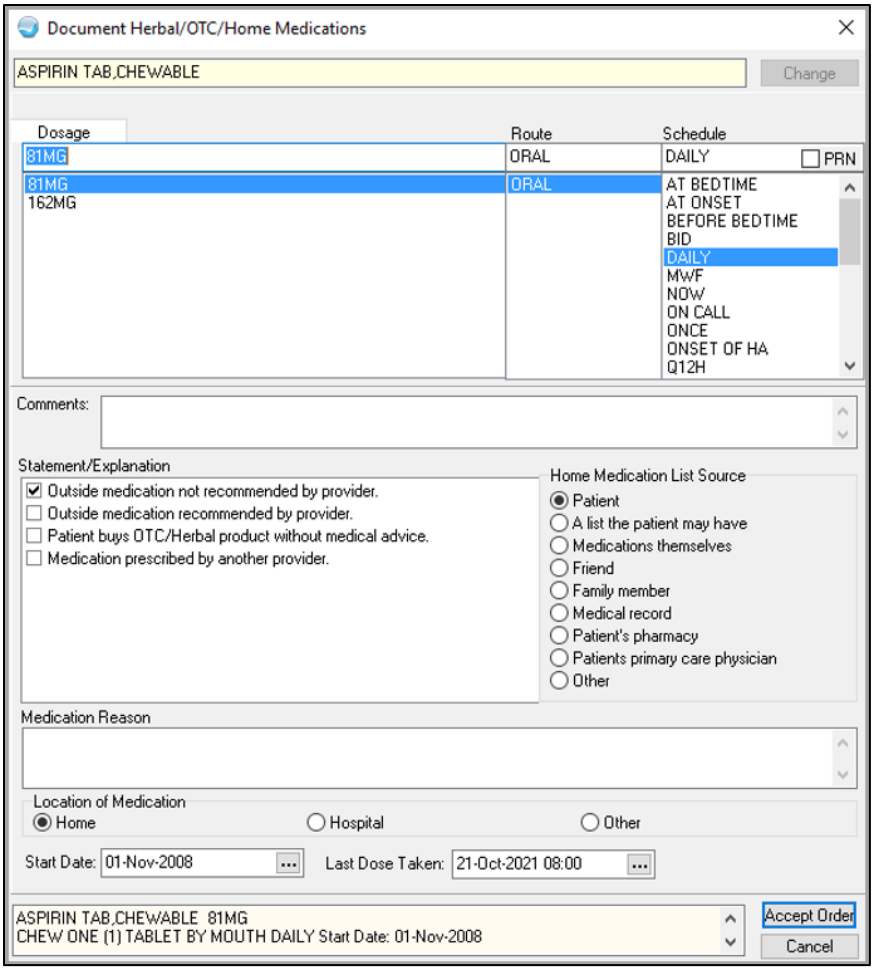


Figure 2-131: Document Herbal/OTC/Home Medications dialog

Users may edit any field except the medication, unless the unknown medication was initially used, and the item has a status of **Validate**. For these items, click the **Change** button at the top to search for, and select, the correct medication. Fill in the remaining information.

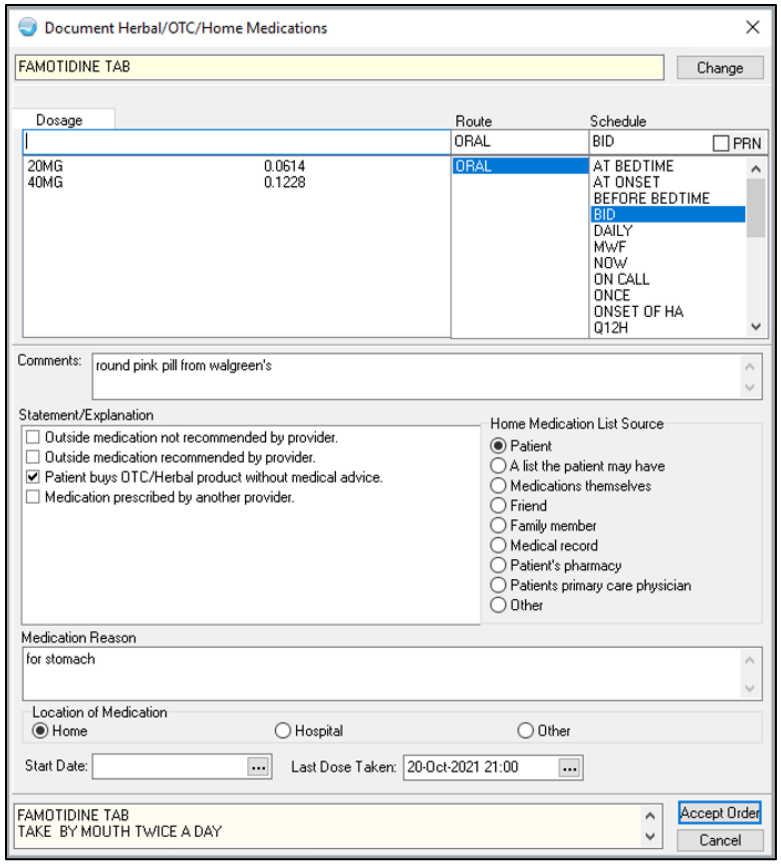


Figure 2-132: Document Herbal/OTC/Home Medication dialog–changing unknown med to Famotidine

2. Once all the information is changed, click **Accept Order** to save the entry.

   Items that were not in a **Validate** status display in bold, blue text with an **Action** of **Change**. Items that had a status of **Validate** display in bold, blue text with an **Action** of **Validate**.

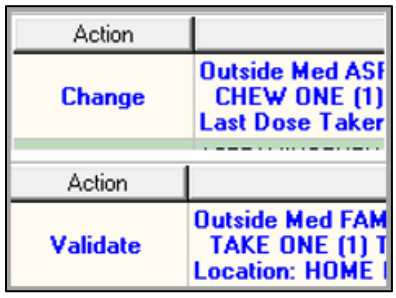


Figure 2-133: Outside medications with Change and Validate in the Action column

3. When ready, sign the **items**.

   Refer to Signing Orders for additional information. As with New items for Outside Medications, no actual signature code is required.

When using Change with a Validate item, when signed the original item is discontinued, and a new item is created with the correct medication.

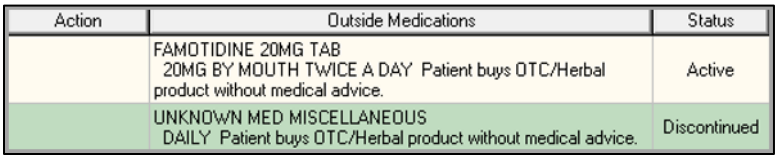


Figure 2-134: Outside medication with an Active changed order and a Discontinued unknown medication in the Status column

2.12.9 Discontinue/Cancel

Discontinue/Cancel is used to discontinue an existing item.

1. Highlight the item or items then access the option by selecting the **Discontinue/Cancel** option on the **Action** menu or right-clicking in the **Outside Medications** section and selecting **Discontinue/Cancel**.

   Selecting **Discontinue/Cancel** opens the **Discontinue/Cancel Order** dialog (Figure 2-135). When more than one item is highlighted before selecting Discontinue/Cancel, selected items are displayed together. The reasons are set locally and may be different at each site.

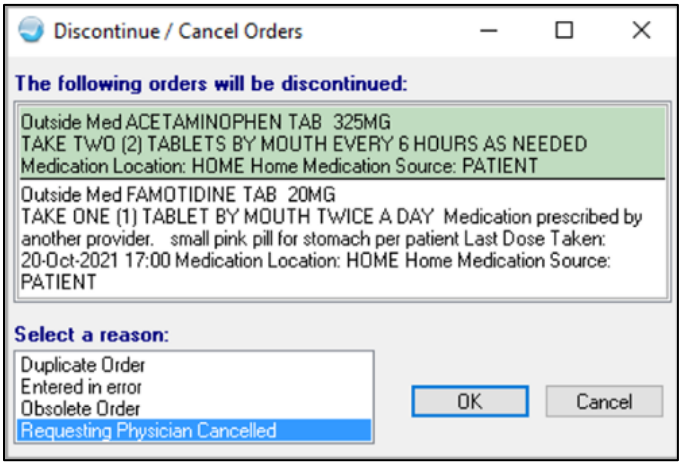


Figure 2-135: Discontinue/Cancel Order dialog

2. Select a **reason** and click **OK** to discontinue the item or items or click **Cancel** to cancel the process. The item displays in the grid with bold, blue text and an **Action** of **DC** (Figure 2-136).

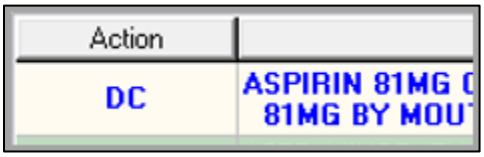


Figure 2-136: Outside medication with DC in the Action column

3. When ready, sign the **items**.

   Refer to Signing Orders for information. As with New items for Outside Medications, no actual signature code is required.

2.12.10 Outside Medication Transfer to Inpatient

Transfer to Inpatient is used to copy existing outside medication entries to inpatient orders when admitting a patient. Items may be transferred to inpatient if they are in an active status and are for a medication that is allowed for inpatient use.

1. Highlight the **item** or **items** then access the option by selecting the **Transfer to Inpatient** option on the **Action** menu or right-clicking in the **Outside Medications** section of the **Medication Management** component and selecting **Transfer to Inpatient**.

   If the patient is not already admitted, the **Transfer Medication Order** dialog opens. Otherwise, users go straight to the **Medication Order** dialog. If the site has quick order menus set up for admission orders, it may be best to complete the admission orders, then use **Transfer to Inpatient** for the needed items.

   Users may only use the **Delay** option (Figure 2-137) for admission orders.

2. Select the **event** from the options presented, which are locally created.

3. Click **OK**.

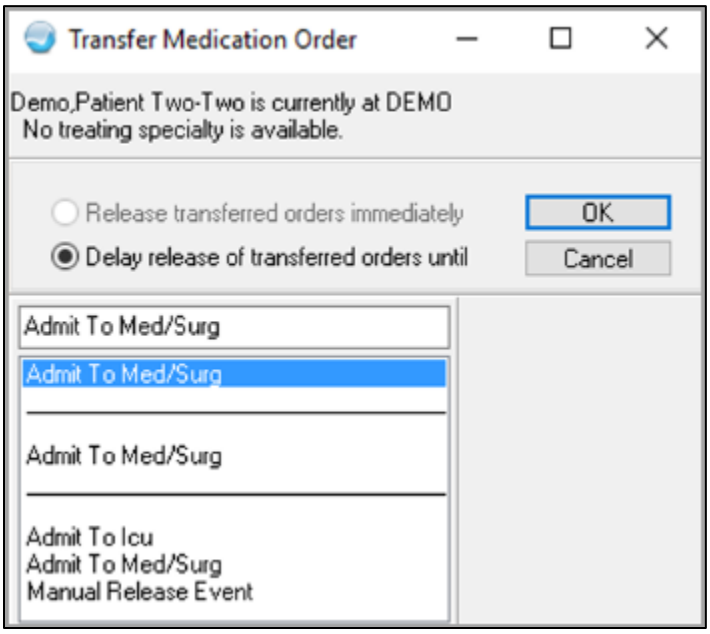


Figure 2-137: Transfer Medication Order dialog

If the **Manual Release Event** is selected, the **Move Patient** dialog opens.

4. Complete the **fields** and click **Accept Order**.

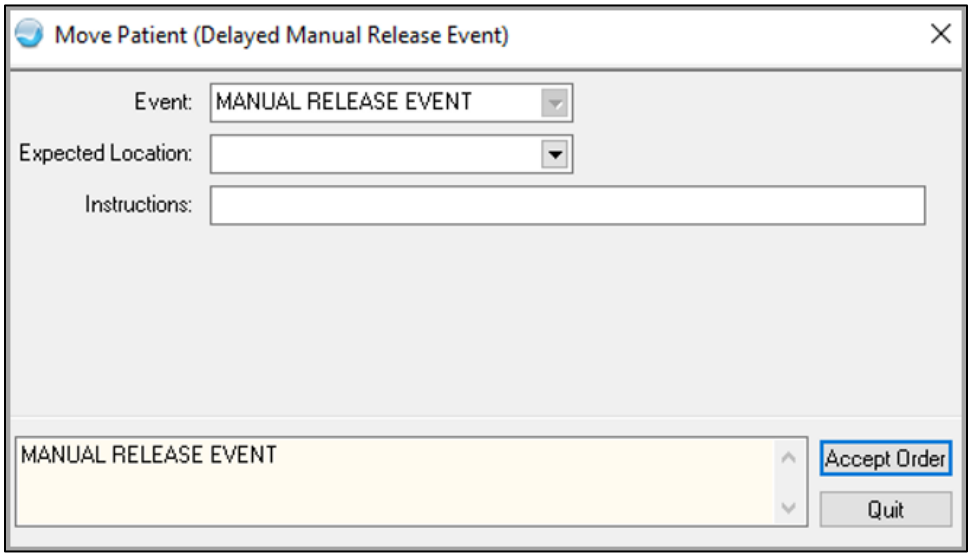


Figure 2-138: Move Patient (Delayed Manual Release Event) dialog

If an admission event is selected and there is no existing admission order, the **Admit Patient** dialog (Figure 2-139) opens. Otherwise, go to the **Medication Order** dialog. Complete the fields and select **Accept Order**. The fields may vary depending on the local site set up.

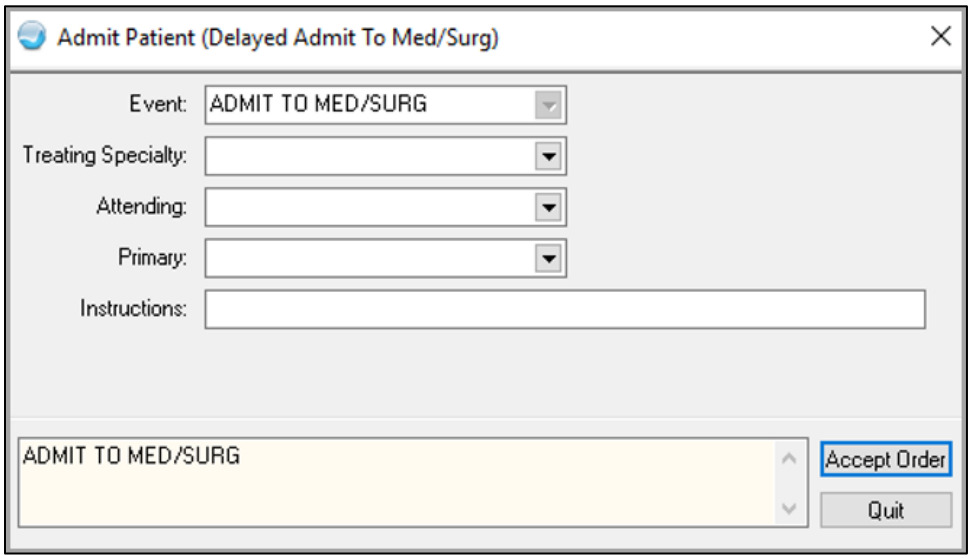


Figure 2-139: Admit Patient (Delayed Admit To Med/Surg) dialog

The inpatient version of the **Medication Order** dialog (Figure 2-140) opens. Adjust the **Dosage**, **Route**, and **Schedule** or **Complex** tab, add **Comments** if needed, and click **Accept Order**.

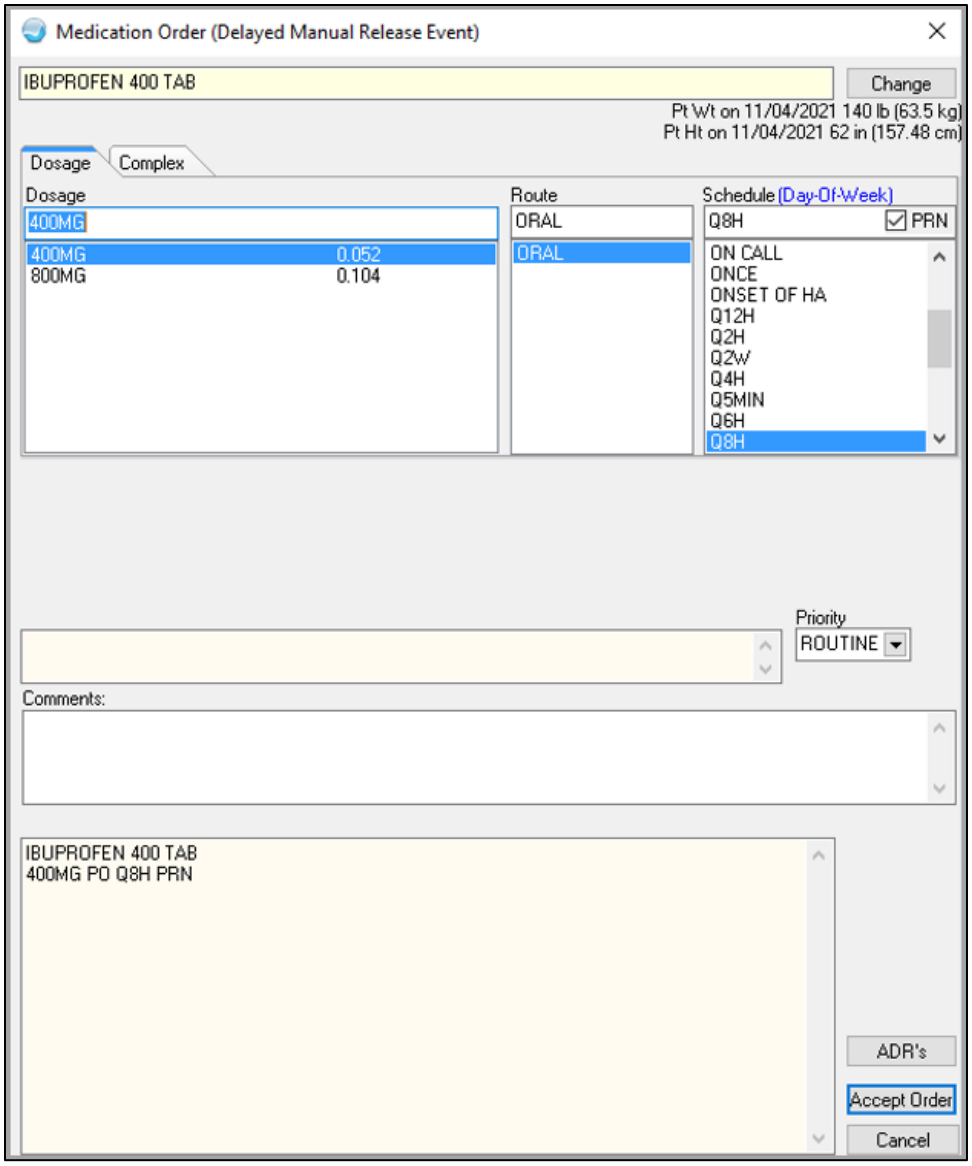


Figure 2-140: Medication Order dialog

The newly created order appears in the **Inpatient Medications** display group in bold, blue text with an **Action** of **New**.

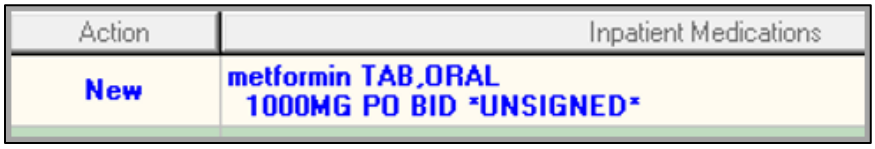


Figure 2-141: Inpatient Medications unit dose item with Action of New

When ready, sign the orders. Refer to Signing Orders for additional information. If delayed orders were created, they may not show on the **Medications** tab after signing until the release event has occurred.

2.12.11 Outside Medication Transfer to Outpatient

Transfer to Outpatient is used to copy existing outside medication entries to outpatient orders. Items may be transferred to outpatient if they are in an active status and are for a medication that is allowed for outpatient use. If an item is a controlled substance, then the **EPCS** rules will also apply.

1. Highlight the **item** or **items**.
2. Access the option by selecting the **Transfer to Outpatient** option on the **Action** menu or right-clicking in the **Outside Medications** section of the **Medication Management** component and selecting **Transfer to Outpatient**.

   The outpatient version of the **Medication Order** dialog (Figure 2-147) opens.
3. Complete the **fields** as described in the Outpatient Medication New Medication section and click **Accept Order**.

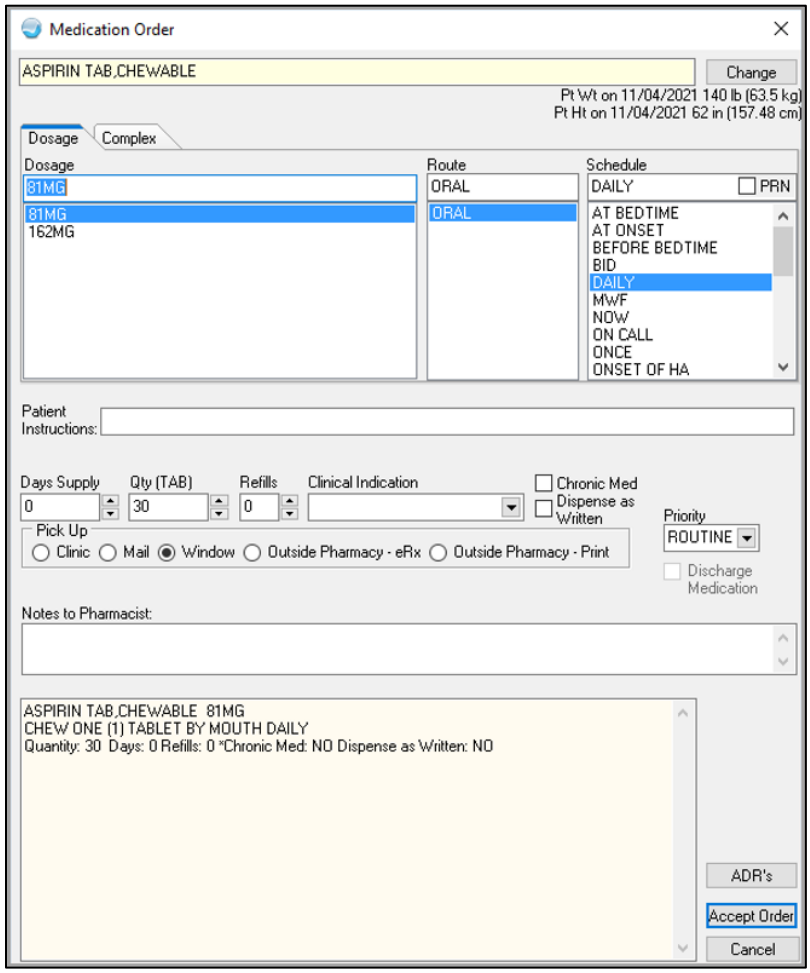


Figure 2-142: Medication Order dialog

The newly created order appears in the **Outpatient Medications** display group (Figure 2-143) in bold, blue text with an **Action** of **New**.

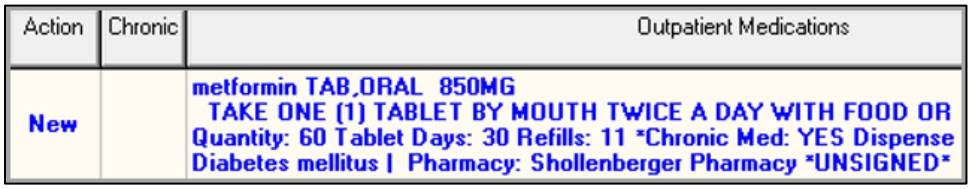


Figure 2-143: Outpatient Medication item with New for Action

When ready, sign the orders. Refer to Signing Orders for additional information.

2.13 Inpatient Medications Group

The **Inpatient Medications** group displays those medications that are or were being administered to the patient during an admission. This section may also include items that were administered at the facility while the patient was not admitted, depending on how the site is set up. Medications here may include both unit dose type items such as oral, subcutaneous, intramuscular, or topical dosage forms, as well as infusion type items such as intravenous dosage forms, piggyback infusions, or large volume infusions.

2.14 Inpatient Medications Columns

The **Inpatient Medications** group (Figure 2-144) has the following columns:

- **Action:** Shows the action taken on an existing entry.
- **Inpatient Medications:** Shows the order information.
- **Status:** Shows the status of the item, including but not limited to Pending, Active, Expired, and Discontinued.
- **Stop Date:** If available, displays the date the item was, or will be, stopped based on local settings.

Users may adjust the column widths and save the setting if desired.

1. Set the **column widths** as desired, right-click any **column header**, and select **Save Settings**.
2. Choose **Restore Defaults** to return to the default column widths.

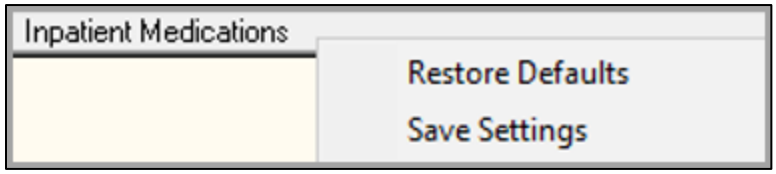


Figure 2-144: Inpatient Medications columns right-click menu

Users may sort the group contents of any of the columns (Figure 2-145) by right-clicking the **column label**. The first click sorts A to Z or low to high, while additional clicks reverse the current sort order. A small, dark-gray triangle shows in the column header to indicate the column used to sort and the sort order.

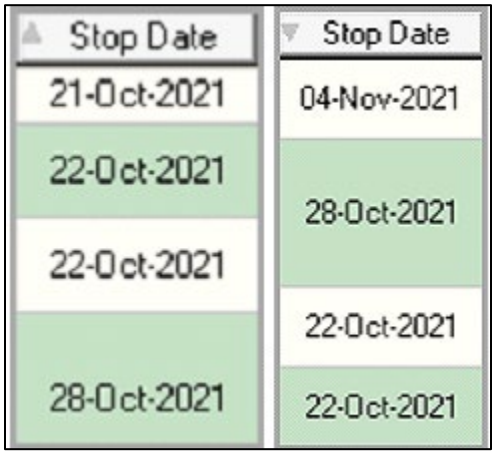


Figure 2-145: Sort indicator in Stop Date column low-to-high and high-to-low

2.14.1 Inpatient Medications Print

The **Print** function (Figure 2-146) can be used to print reports from the **Inpatient Medications** display group. Users may access the **Print** functionality from the **File** menu or the **Print** button.

Reports may be printed as **Brief** or **Detailed**. Both reports contain the information from the **Inpatient Medication**, **Status**, and **Stop Date** columns. **Brief** reports are printed in portrait orientation. **Detailed** reports are printed in landscape orientation.

Reports may be further refined by using the **Inclusion Criteria** to restrict to only the selected item or items or only active items, or any combination. Be careful, as it is possible to set the inclusion criteria so that nothing will print.



Figure 2-146: Print Inpatient Medications dialog

When the criteria are selected, click **Print**. The **Print Setup** dialog (Figure 2-147) displays.

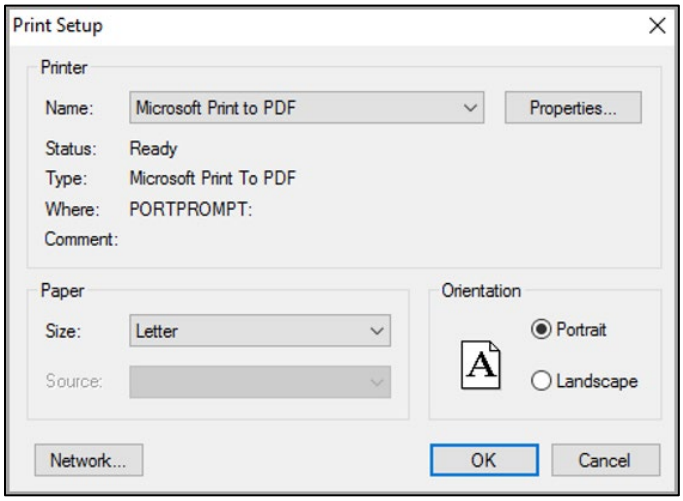


Figure 2-147: Print Setup dialog

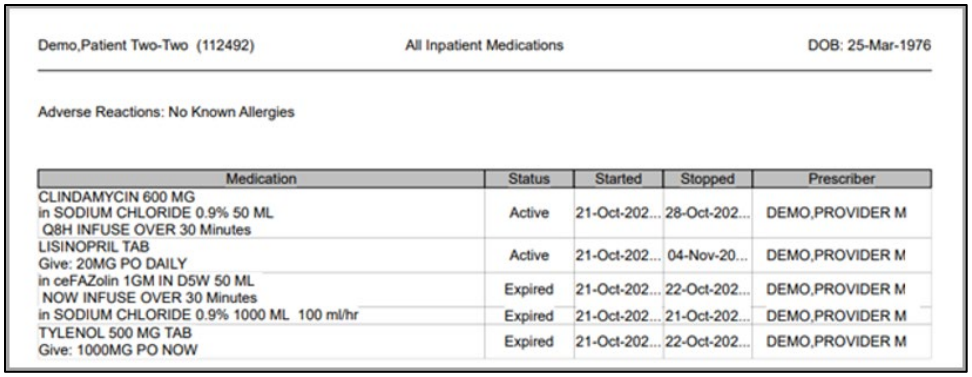
Once the printer and other options are selected, click **OK** to print the report. Information included on the report (Figure 2-148 and Figure 2-149) reflects the medications documented.

Demo,Patient Two-Two (112492) All Inpatient Medications DOB: 25-Mar-1976

Adverse Reactions: No Known Allergies

Medication	Status	Started	Stopped	Prescriber
CLINDAMYCIN 600 MG in SODIUM CHLORIDE 0.9% 50 ML Q8H INFUSE OVER 30 Minutes	Active	21-Oct-...	28-Oct-...	DEMO,PROVIDE...
LISINOPRIL TAB Give: 20MG PO DAILY	Active	21-Oct-...	04-Nov-...	DEMO,PROVIDE...
in ceFAZolin 1GM IN D5W 50 ML NOW INFUSE OVER 30 Minutes	Expired	21-Oct-...	22-Oct-...	DEMO,PROVIDE...
in SODIUM CHLORIDE 0.9% 1000 ML 100 ml/hr	Expired	21-Oct-...	21-Oct-...	DEMO,PROVIDE...
TYLENOL 500 MG TAB Give: 1000MG PO NOW	Expired	21-Oct-...	22-Oct-...	DEMO,PROVIDE...

Figure 2-148: All Inpatient Medications brief report



Demo,Patient Two-Two (112492) All Inpatient Medications DOB: 25-Mar-1976

Adverse Reactions: No Known Allergies

Medication	Status	Started	Stopped	Prescriber
CLINDAMYCIN 600 MG in SODIUM CHLORIDE 0.9% 50 ML Q8H INFUSE OVER 30 Minutes	Active	21-Oct-202...	28-Oct-202...	DEMO,PROVIDER M
LISINOPRIL TAB Give: 20MG PO DAILY	Active	21-Oct-202...	04-Nov-20...	DEMO,PROVIDER M
in ceFAZolin 1GM IN D5W 50 ML NOW INFUSE OVER 30 Minutes	Expired	21-Oct-202...	22-Oct-202...	DEMO,PROVIDER M
in SODIUM CHLORIDE 0.9% 1000 ML 100 ml/hr	Expired	21-Oct-202...	21-Oct-202...	DEMO,PROVIDER M
TYLENOL 500 MG TAB Give: 1000MG PO NOW	Expired	21-Oct-202...	22-Oct-202...	DEMO,PROVIDER M

Figure 2-149: All Inpatient Medications detailed report

2.14.2 Inpatient Medications View Menu

The **View** menu (Figure 2-150) for Inpatient Medications includes **Details**, **Administration History**, and **Refresh** options.

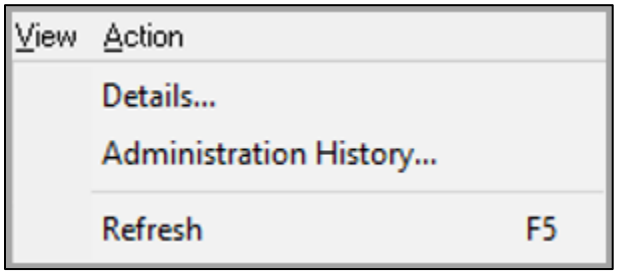


Figure 2-150: Inpatient medications view menu

2.14.3 Details

The **Details** option opens the **Inpatient Medications Details** dialog for the currently selected item. If more than one item is selected, the **Details** dialog opens for each in turn. The information contained in the details varies based on the specific item selected. The font size of the display may be adjusted using the Font Size control, though this does not affect the printed font size. The contents of the entire dialog may be printed using the **Print** button. The **Inpatient Medications Details** dialog may also be opened by double-clicking the line item, or by selecting **Details** from the right-click menu.

The top portion (Figure 2-151) of the **Details** dialog displays the actual order content, time stamps, order number, and other data related to the order and the actions taken on the order.

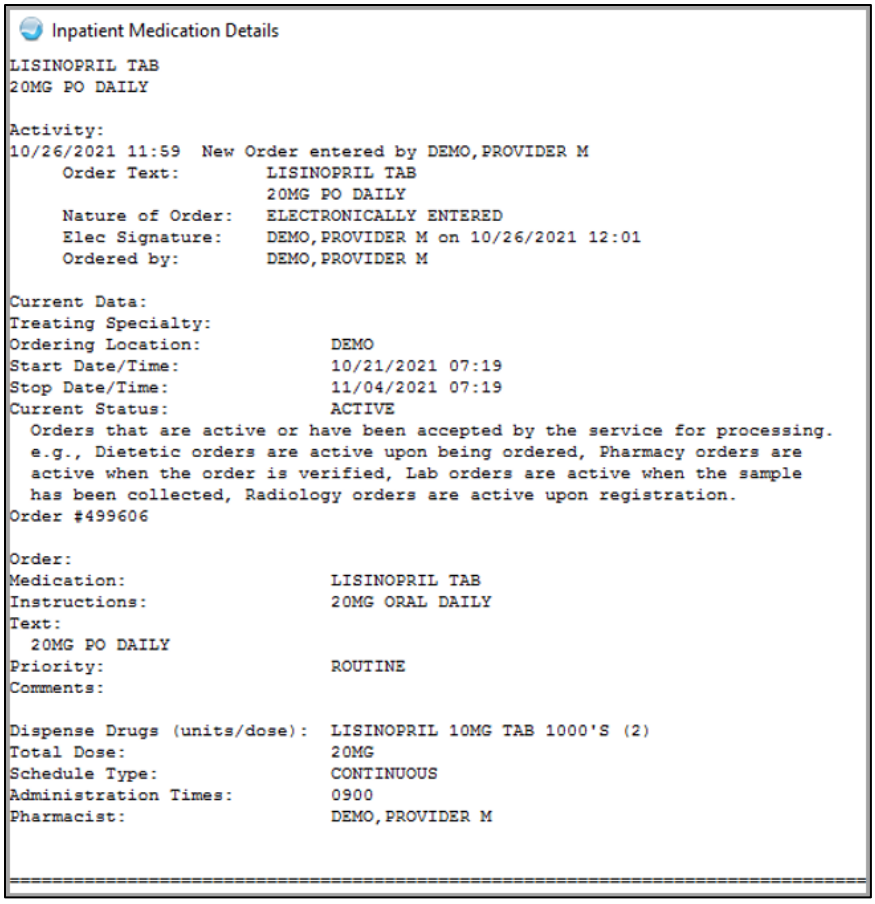


Figure 2-151: Inpatient Medication Details dialog, top portion

The bottom portion (Figure 2-152) contains the **Medication History** including the administration history. The information comes from the **Bar Code Medication Administration (BCMA)** package documentation, so only displays if the site is using **BCMA**.

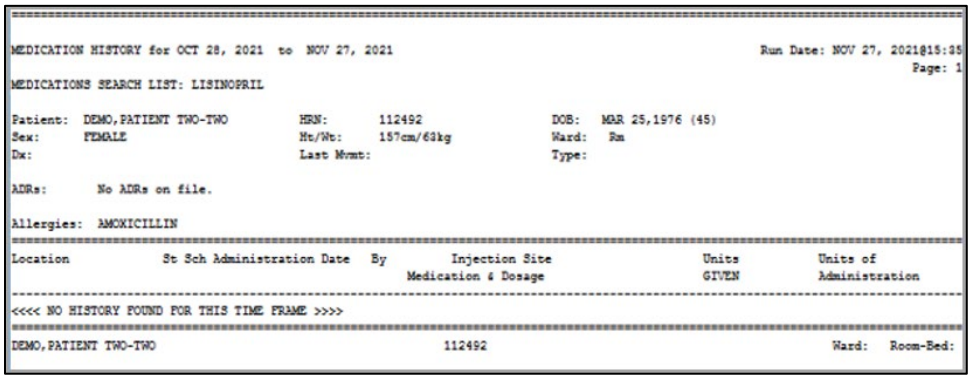


Figure 2-152: Inpatient medication details dialog, bottom portion

2.14.4 Administration History

The **Administration History** option (Figure 2-153) opens the **Inpatient Medication Administration History** dialog for the currently selected item. If users select more than one item, the dialog opens for each in turn. This is the same as the bottom part of the **Details** dialog, containing the Medication History. The information comes from the **Bar Code Medication Administration (BCMA)** package documentation, so only displays data if the site is using BCMA.

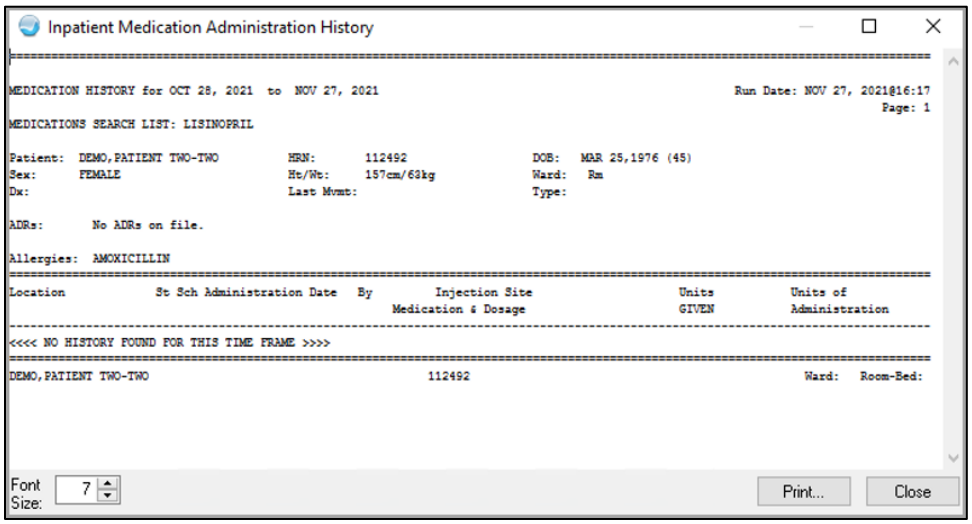


Figure 2-153: Inpatient Medication Administration History

2.14.5 Refresh

The **Refresh** option refreshes the contents of the **Medication Management** component.

2.14.6 Action Menu

The **Action** menu (Figure 2-154) for **Inpatient Medications** includes:

- New Medication
- Change
- Copy to New Order
- Discontinue/Cancel
- Transfer to Outpatient
- Renew

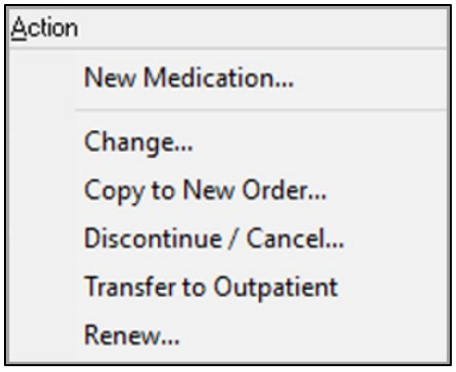


Figure 2-154: Inpatient Medications Action menu

2.14.7 Inpatient Medications New Medication

Users may create a new medication entry by selecting the **New Medication** option on the **Action** menu, clicking the **New** button on the tool bar, or right-clicking in the **Inpatient Medications** section and selecting **New Medication**.

What happens when a user chooses to create a new medication entry depends on the site's settings, but most sites have the system set to open a **Quick Order Menu** (Figure 2-155).

A **Quick Order Menu** consists of other **Quick Order Menus**, **Quick Orders**, **Order Dialogs**, or combinations of these. Quick Orders are medication orders with most or all the information defaulted to help providers make new orders quickly and easily. Different menus may be displayed depending on the status of the currently selected patient of outpatient or inpatient. For the purposes of this document, the **New Medication** option opening a standard inpatient **Quick Order Menu** is assumed.

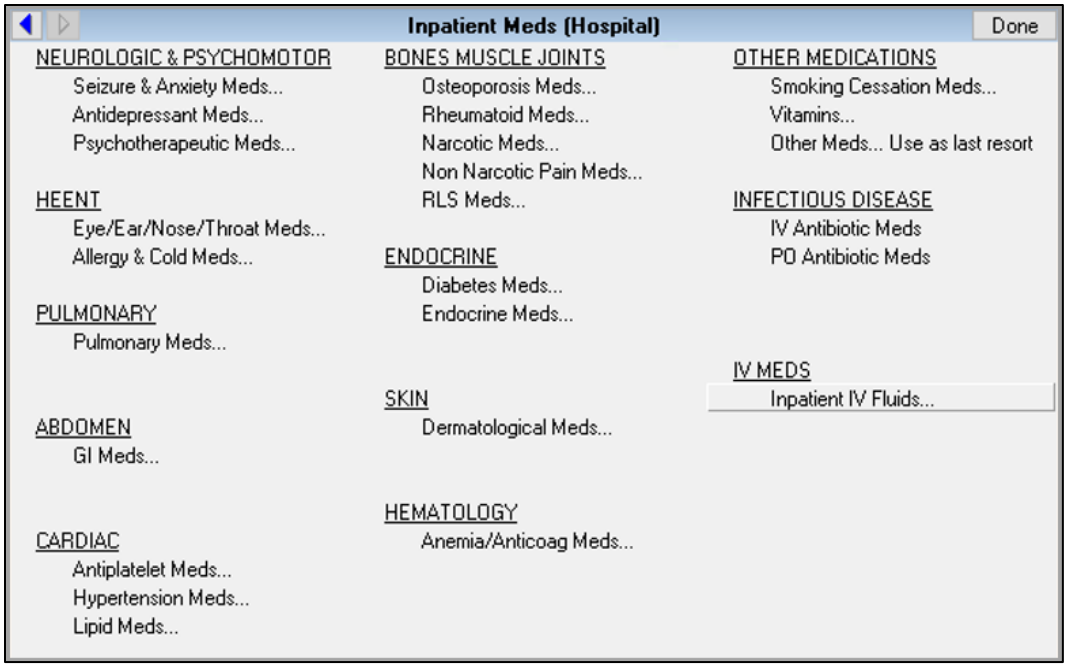


Figure 2-155: Inpatient medication quick order menu example

The example menu shown above is a typical menu of menus, and each item listed, when clicked, opens another order menu (Figure 2-156). Those secondary menus may consist of more menus or of actual **Quick Orders**.

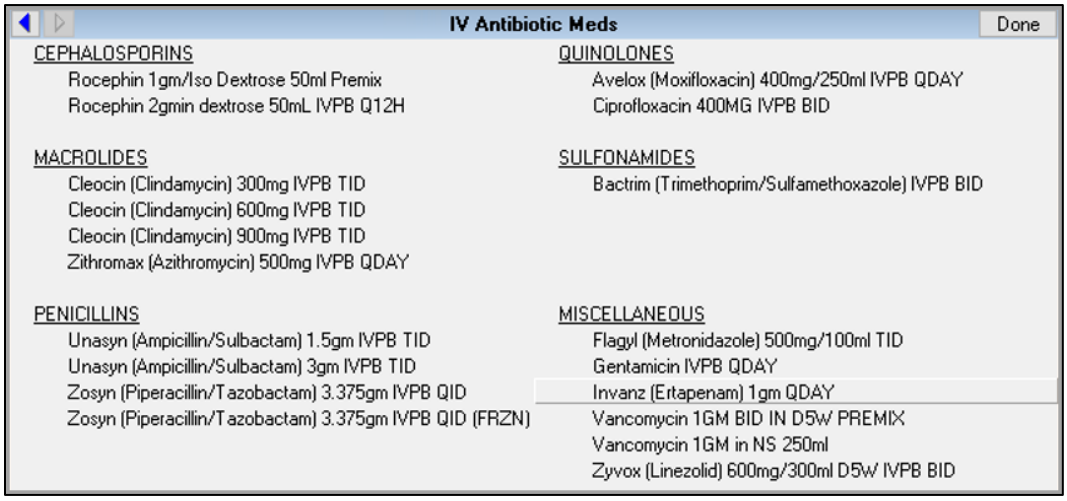


Figure 2-156: IV Antibiotic Meds quick order menu example

To select more than one item, press and hold the **Control** key while clicking the needed menu, quick order, or other link. Each item is then presented in turn. If one or more items selected is a **Quick Order** menu, users can repeat the **Control** key and click to select the items from that menu when it is presented. When multiple items are selected, a **Selected Orders** dialog (Figure 2-157) displays showing the items selected, with a **Stop Order Set** button to cancel the remaining items.



Figure 2-157: Selected Orders dialog

Clicking a **Quick Order** opens the **Medication Order** dialog or the **Infusion Order** dialog, depending on the type of medication selected. These order dialogs are described in the following sections.

If the site has implemented **Electronic Prescribing of Controlled Substances (EPCS)**, there will be an additional check to see if the user is authorized to prescribe the schedule of medication selected. An error message (Figure 2-158) displays if the user is not allowed.

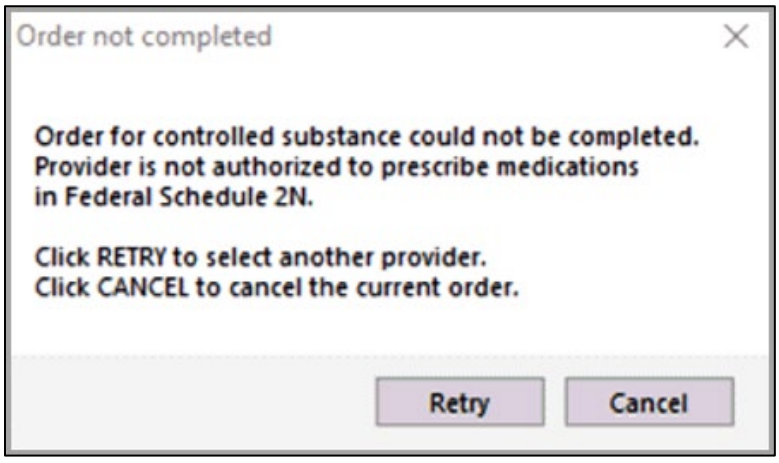


Figure 2-158: Order not completed dialog

When ready, sign the **orders**. See Signing Orders for details.

2.14.8 Inpatient Medications Medication Order–Unit Dose Medications

Unit Dose medications include tablets and capsules, topicals, non-infusion injectables, inhalants, etc. These medications are ordered using a modified **Medication Order** dialog (Figure 2-159) like the one used for outpatient medications.

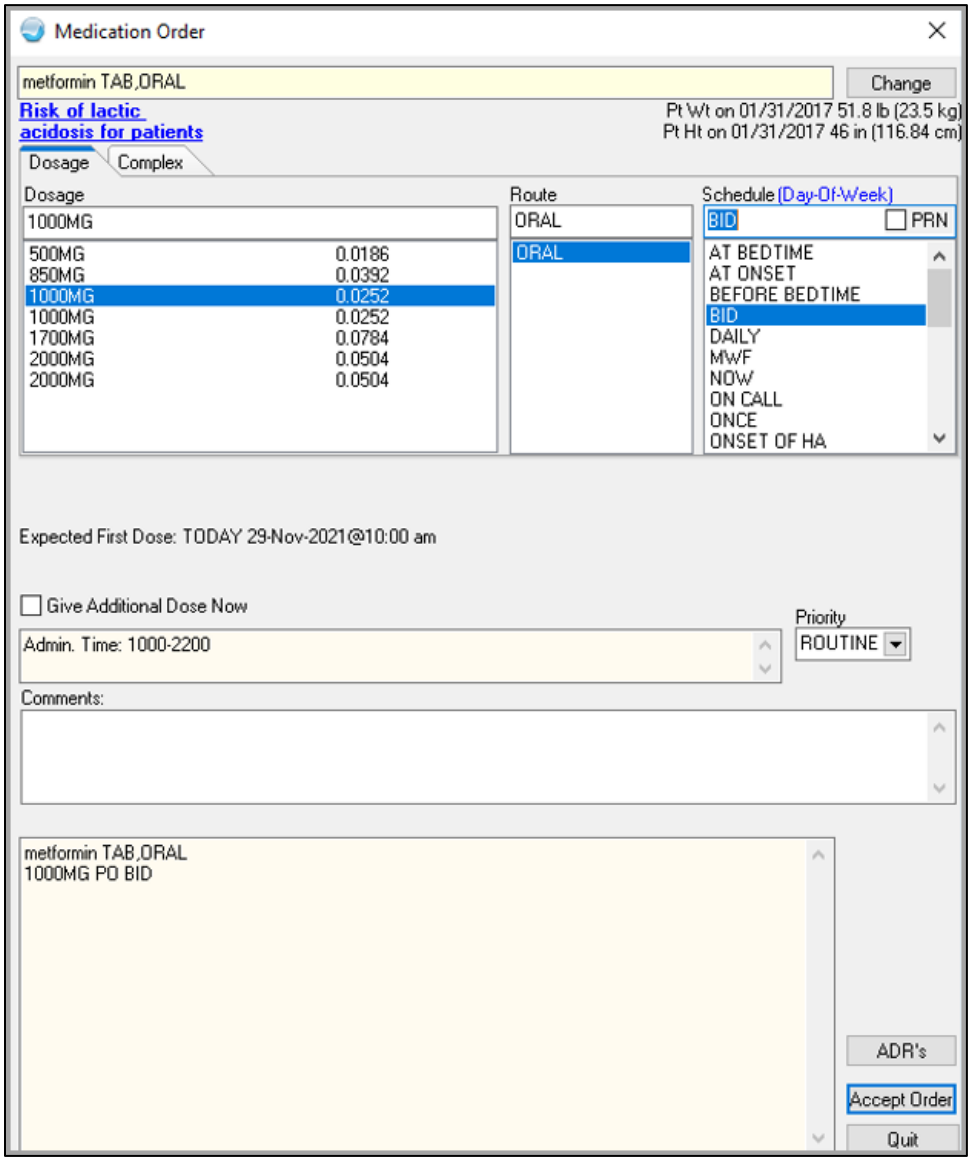


Figure 2-159: Medication Order dialog for inpatient medications

The **Medication Order** dialog contains the following fields and text:

- **Orderable Item:** Shows the drug and dosage form selected. This item is not labeled and displays at the top of the dialog.

- **Change button:** Allows users to change the orderable item selected. Click **Change** (Figure 2-160) then search for the desired item.

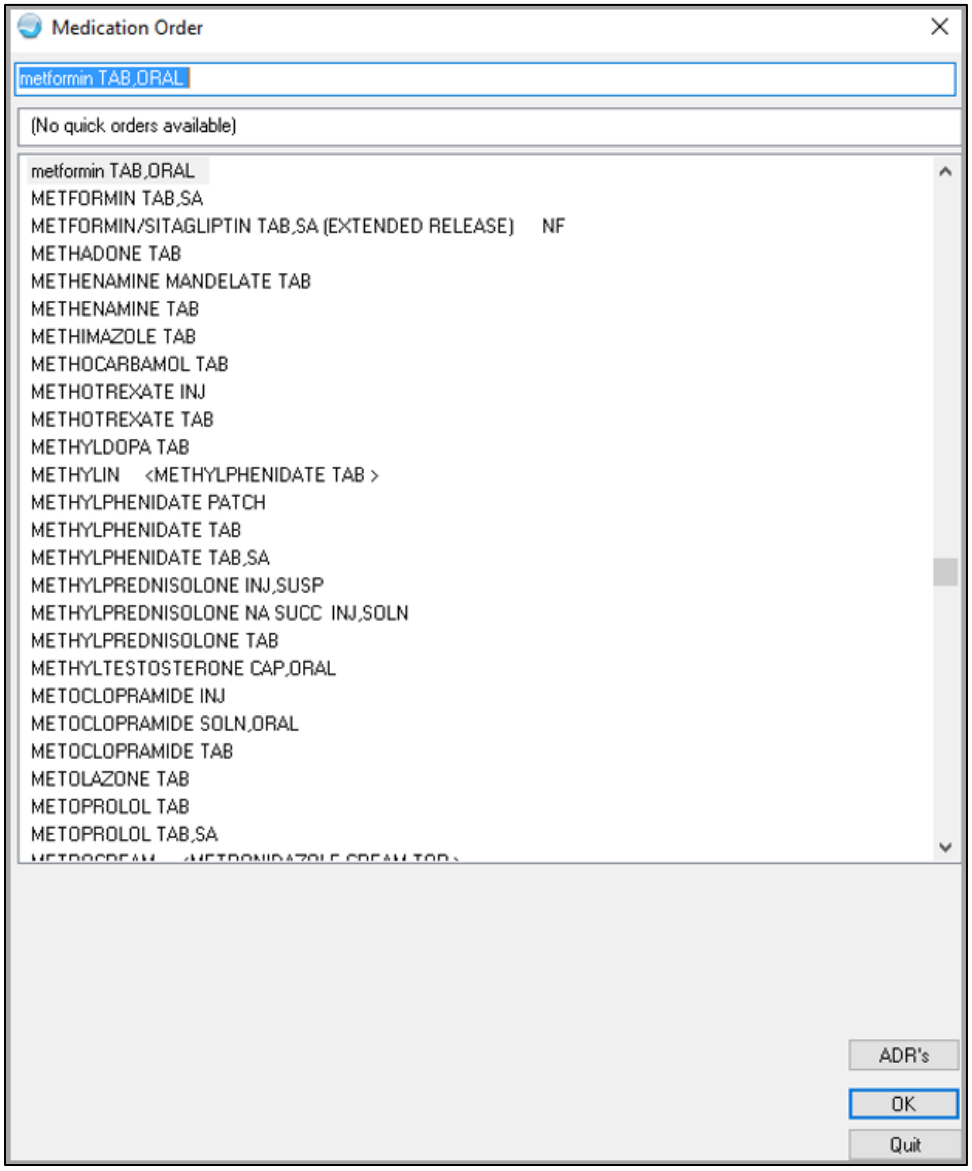


Figure 2-160: Change button search dialog

- **Drug Text:** If applicable, displays either the Drug Text, Partial Drug Text, or the text Display Restrictions/Guidelines as link, depending on the overall length of the text. Drug Text is used to alert users to restrictions, guidelines, warnings, dosing charts, or other information. Drug Texts are set up at each local facility. Click the Drug Text link in the dialog to see the **Restrictions/Guidelines** dialog with the full text.
- **Pt Wt:** If applicable, displays the last weight for the patient and the date it was recorded. Text only.

- **Pt Ht:** If applicable, displays the last height for the patient and the date it was recorded. Text only.
- **Dosage and Complex** tabs.
  - **Dosage tab:** Allows for simple instructions with a single Dosage, Route, and Schedule (Figure 2-161). Schedule allows for a Day-Of-Week schedule. There is a **PRN** check box to indicate if the item should be taken only if needed.

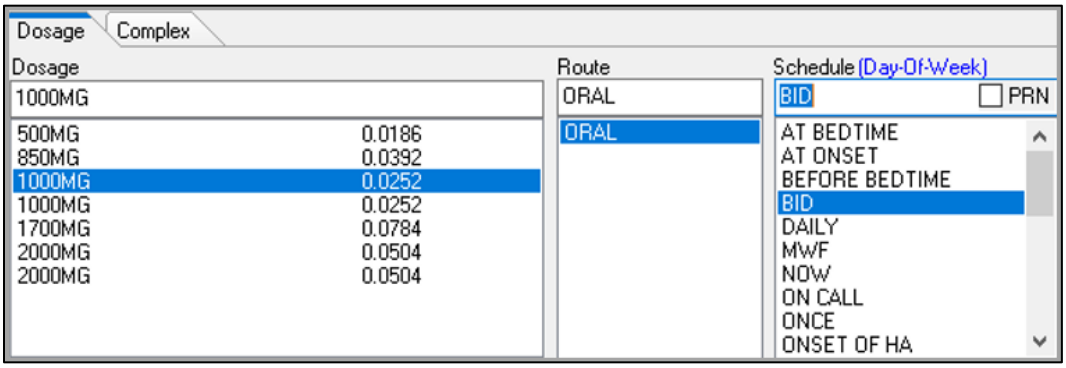


Figure 2-161: Dosage tab with Dosage, Route, and Schedule

  - **Complex tab:** Allows for more complex instructions with multiple Dosages, Routes, Schedules, and Durations (Figure 2-162) combined with conjunctions of, or, and then. Duration is optional. Additional rows are added as information is added, and users may add or delete rows with the + **Row** and – **Row** buttons.

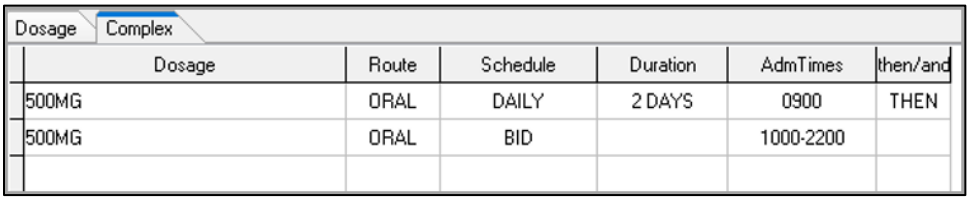


Figure 2-162: Complex tab with Dosage, Route, Schedule, Duration, and Conjunction



Figure 2-163: Complex tab + Row and – Row buttons

  - **Dosage (Both Tabs):** Should have a list of options to select from, though users may also enter in free text. Entering free-text dosages requires users to select the dispense drug when the order is accepted.
  - **Route (Both Tabs):** Should have a list of options to select from. Free texting is strongly discouraged here.

– **Schedule (Both Tabs):** Should have a list of options to select from. Free texting is strongly discouraged here. Day-Of-Week allows users to build a specific schedule for specific days of the week. The Day-Of-Week schedule options may be accessed by clicking the **Day-Of-Week** link or selecting **Other** in the schedule field. The **Order with schedule 'OTHER'** dialog (Figure 2-164) opens.

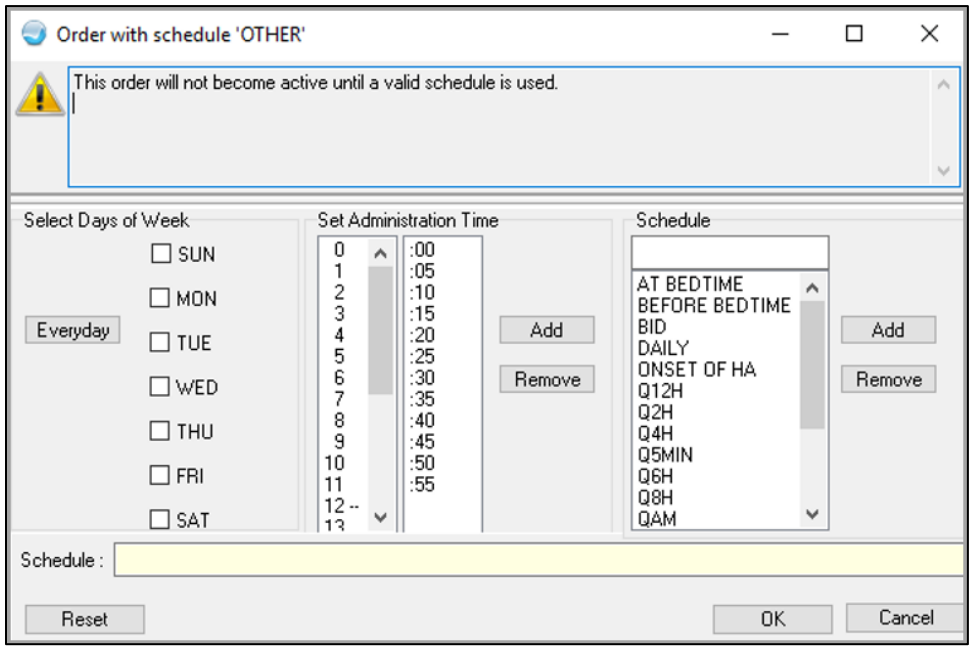


Figure 2-164: Order with schedule 'OTHER' dialog in default state

Select the **day** or **days** in the first pane or click the **Everyday** button to select all days. Then select an **Administration Time** or a **Schedule**. Users may not select both an Administration Time and a Schedule (Figure 2-165). To use more than one Administration Time, choose the earliest time and click **Add**, then select the next time and click **Add**.

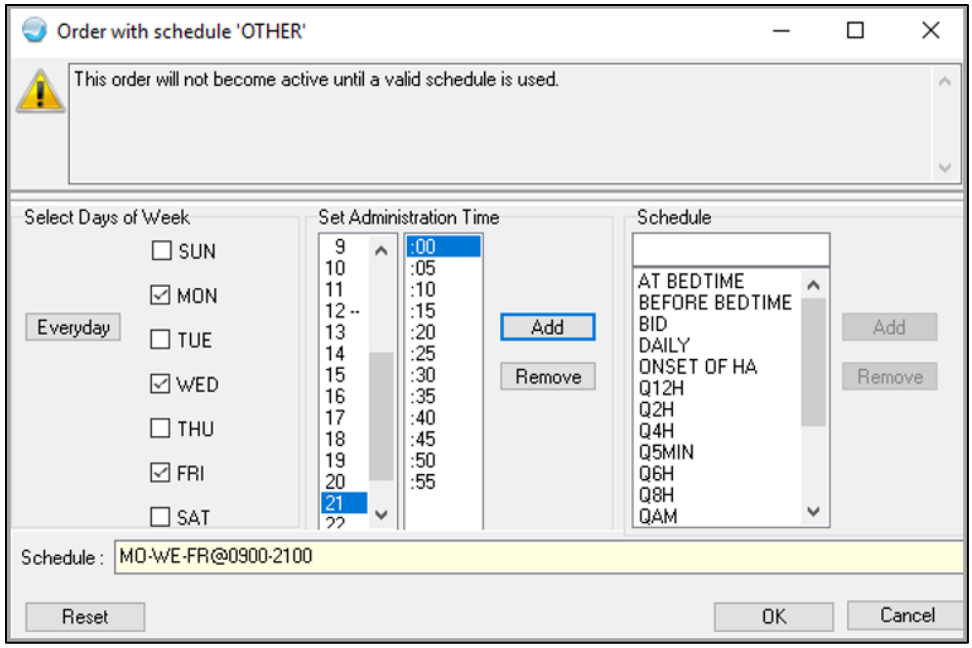


Figure 2-165: Order with schedule 'OTHER' dialog with schedule built

Continue until all the needed times have been added. Use the **Remove** buttons to clear the Administration Time or Schedule. Use the **Reset** button to start over.

  - **Duration (Complex tab only):** A number with a secondary selection of time units. Available units are months, weeks, days, hours, and minutes.

- **Expected First Dose:** Displays the date and time of the expected first dose. Text only, not editable.
- **Give Additional Dose Now:** Allows users to create a second order with a schedule of Now in case the expected first dose is too far away. When the check box is selected, a warning displays noting that two orders will be created.
- **Priority:** Allows users to set the priority for the ordered medication. Options include:
  - **ASAP:** Give as soon as possible.
  - **Routine:** Default selection and recommended for most inpatient orders.
  - **Stat:** Give immediately.
- **Comments:** Allows users to add additional information to the order. Particularly helpful to provide direction for PRN dosing, to indicate under what conditions a medication should be given.
- **Summary:** Displays the order information (Figure 2-166) for review based on the options selected. Text only.

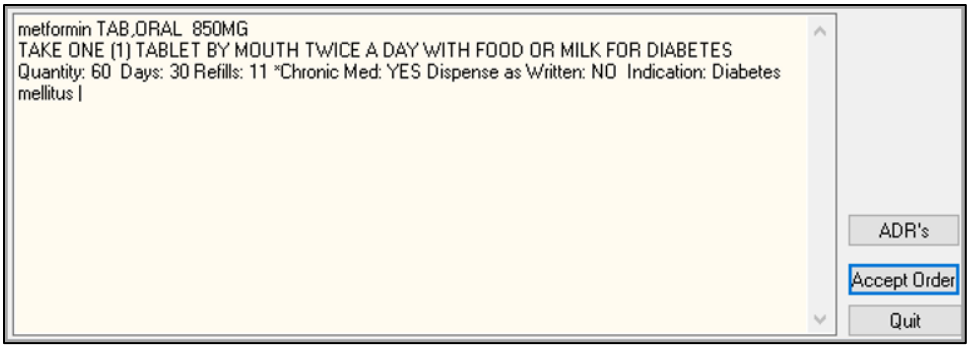


Figure 2-166: Inpatient Medication Summary field

- **ADR's button:** Opens the **Patient Postings** dialog (Figure 2-167) with Allergies information, as well as Crisis Notes, Warning Notes, and Directives information, if any exists.

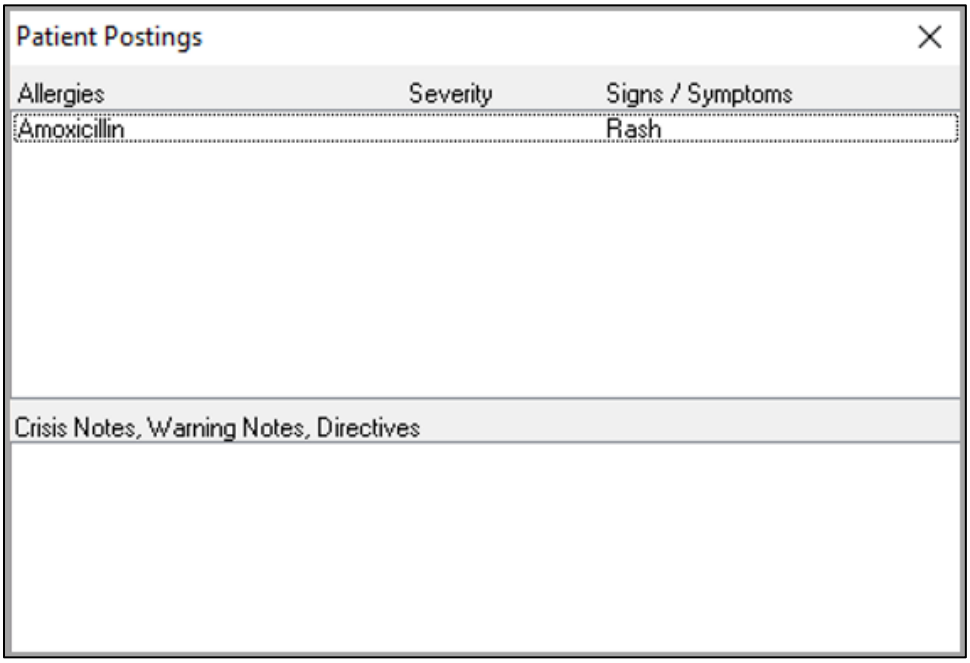


Figure 2-167: Patient Postings dialog

Clicking the **Adverse Reaction** entry (Figure 2-168) shows the detailed information for the entry.

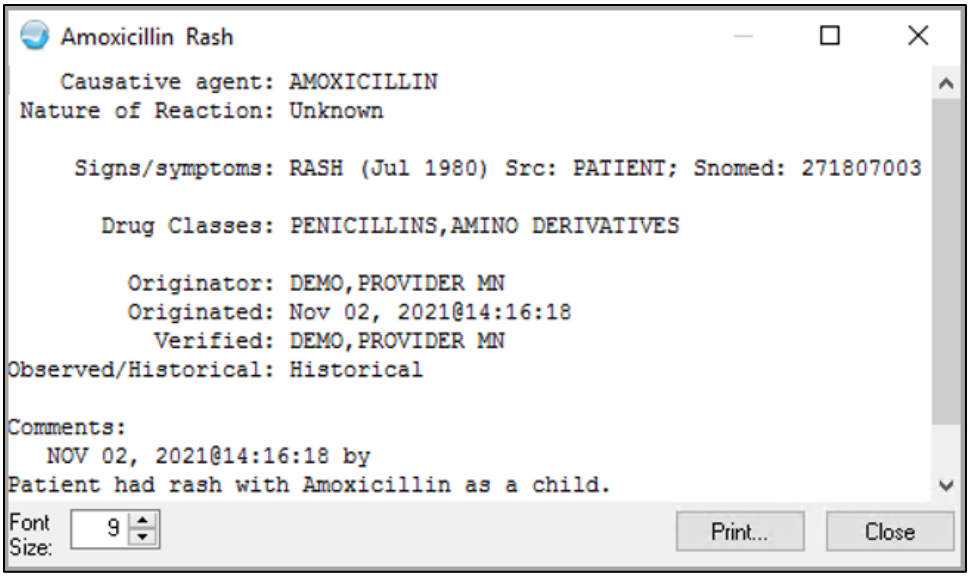


Figure 2-168: Adverse Reaction Detail dialog

- **Accept Order button:** Allows users to accept the order with the information entered.
- **Quit button:** Allows users to stop the ordering process for the displayed item.

Once the fields are set as desired, click **Accept Order** to save the order. If applicable, the **Order Checking** dialog (Figure 2-169) displays with items related to the order users are entering. The source for the information is listed in the title bar. Click **Accept Order** to continue or **Cancel Order** to cancel the order.

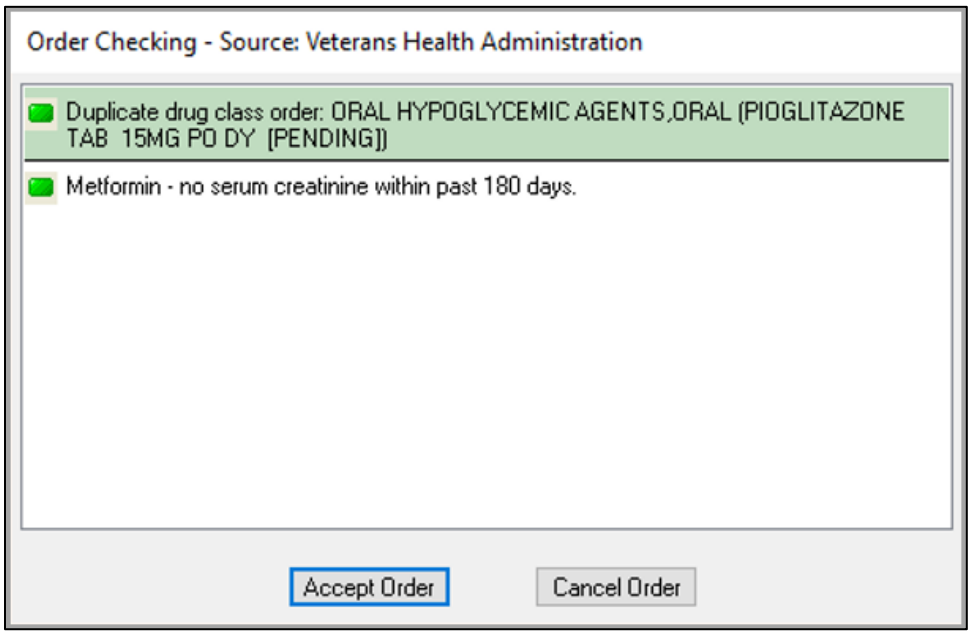


Figure 2-169: Order Checking dialog during Order Creation

The order displays in the grid (Figure 2-170) with bold, blue text as unsigned with an **Action** of **New**.

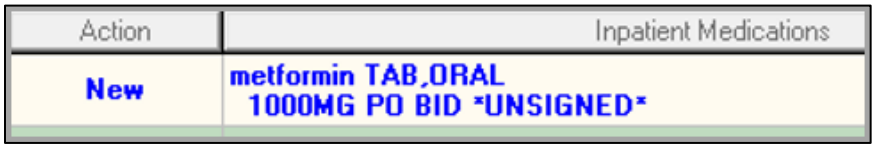


Figure 2-170: Inpatient Medications unit dose item with Action of New

2.14.8.1 Inpatient Medications Infusion Order – Intravenous Infusion Medications

Intravenous (IV) Infusion medications include large volume IV infusions and piggyback type small volume infusions, as well as certain syringes for IV injection. These medications are ordered using a special **Infusion Order** dialog (Figure 2-171).

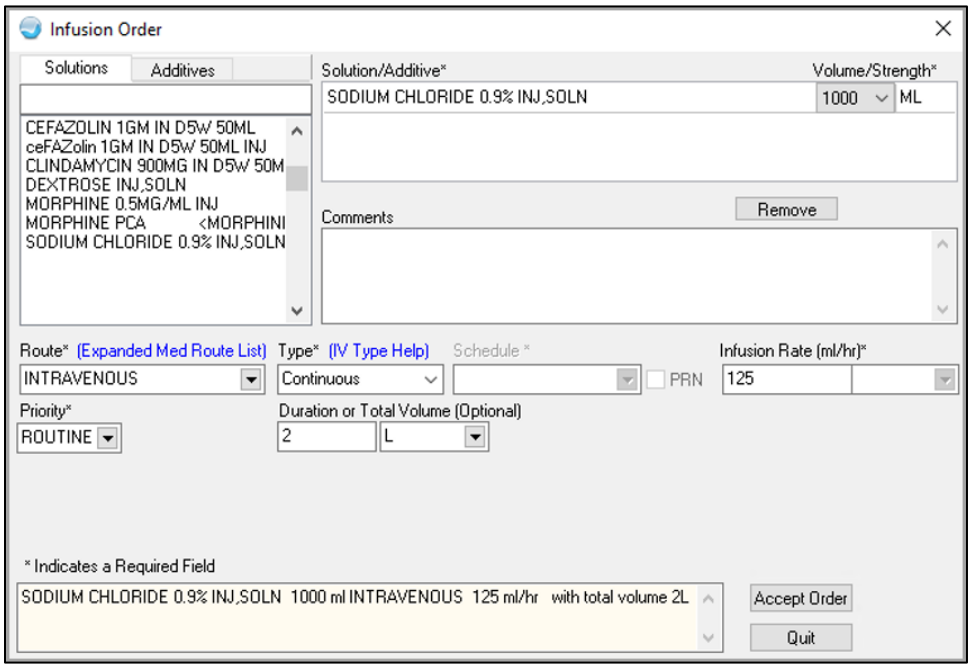


Figure 2-171: Infusion Order dialog

The **Infusion Order** dialog contains the following fields and text:

- **Solutions tab:** Contains a list of available solutions as set up at each site. This may include premixed antibiotic piggybacks or other premixed items. Once a solution is selected, it shows in the **Solution/Additive** field described below, and the **Additives** tab becomes active.
- **Additives tab:** Contains a list of available additives, as set up at each site. Users may select none, one, or more than one additive for each order. Once an additive has been selected, it displays in the **Solution/Additive** field described below.

- **Solution/Additive:** Displays the items selected. The **Volume/Strength** field described below fills in based on the defaults set at each site.
- **Volume/Strength:** Displays the selected volume or strength of the solution or additive selected (Figure 2-172 and Figure 2-173). This is split into the numeric volume or strength and the volume or strength unit. The volume or strength unit is set locally. The numeric volume of a solution may be edited if there is more than one volume set up at each local site. The numeric strength of the additive may be typed in. Each solution and additive must have a volume or strength.

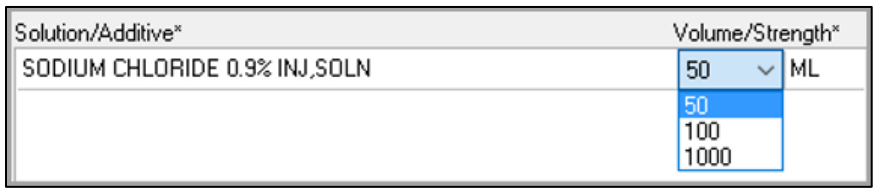


Figure 2-172: Multiple Solution Volume drop-down list

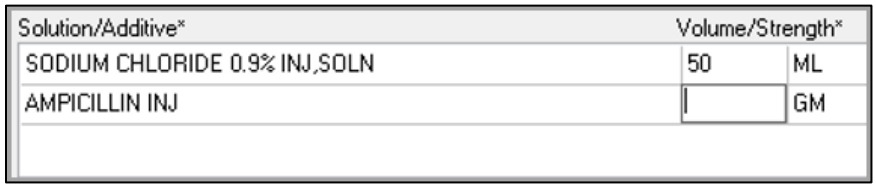


Figure 2-173: Additive Strength typed in

- **Remove button:** Allows users to remove a solution or additive. Highlight the **item** and click the **Remove** button.
- **Comments:** Allows users to add additional information to the order. Particularly helpful to provide direction for PRN dosing, to indicate under what conditions a medication should be given.
- **Route:** Displays a limited list of routes that are relevant to an infusion.
- **Expanded Med Route List link:** Also accessed by selecting **OTHER** in the **Route list**, displays an expanded list of routes that have been flagged for IV use at each site. It is possible that there are no other entries in the expanded list.
- **Type:** Allows users to select **Continuous** or **Intermittent**.
  - **Continuous:** Is for items that run all the time at a specified rate, such as a large volume infusion or drip.
  - **Intermittent:** Is for items that are given at specified intervals or as a one-time dose such as an IV push or piggyback.
- **IV Type Help link:** Displays definitions of the IV types.
- **Schedule:** Displays the list of schedules available at each site. Active for Intermittent type infusions only.

- **Day-Of-Week link:** Allows users to build a specific schedule for specific days of the week on intermittent type infusions only. The Day-Of-Week schedule options may be accessed by clicking the **Day-Of-Week** link or selecting **Other** in the schedule field. The **Order with schedule 'OTHER'** dialog (Figure 2-174) opens.

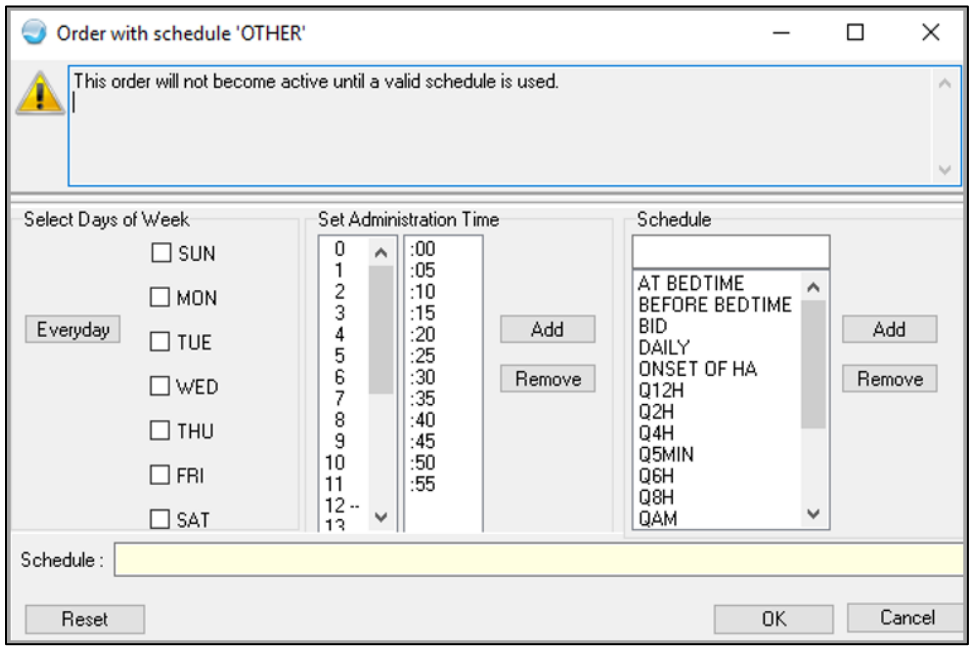


Figure 2-174: Order with Schedule OTHER dialog in Default State

- Select the **day** or **days** in the first pane or click the **Everyday** button to select all days.
- Then select an **Administration Time** or a **Schedule**. Users may not select both an **Administration Time** and a **Schedule**.
- To use more than one Administration Time, choose the **earliest time** and click **Add**, then select the next **time** and click **Add**.

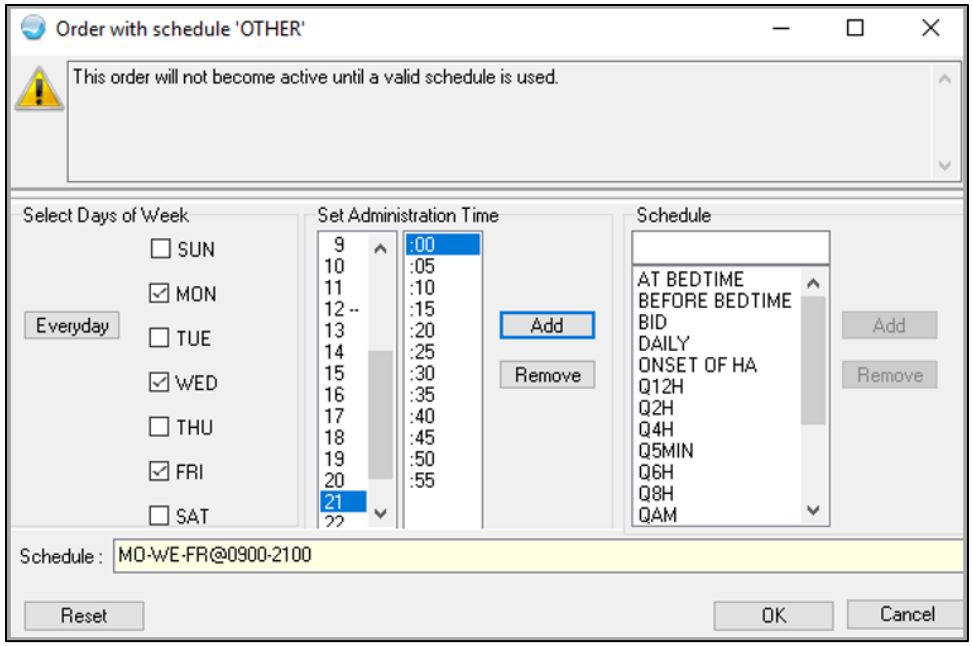


Figure 2-175: Order with Schedule OTHER dialog with Schedule Built

Continue until all the needed times have been added. Use the **Remove** buttons to clear the Administration Time or Schedule. Use the **Reset** button to start over.

- **PRN check box:** Allows users to indicate if the item should be given only if needed. Active for Intermittent type only.
- **Infusion Rate (ml/hr):** Allows users to set the desired rate of infusion in mL/hr. Active for Continuous type only.
- **Infuse Over Time (Optional):** Allows users to set the amount of time over which the infusion should be run, in either minutes or hours. Active for Intermittent type only.
- **Priority:** Allows users to set the priority for the ordered medication. This affects Internal Pharmacy Prescriptions only. Options include:
  - **ASAP:** Give as soon as possible.
  - **Routine:** Default selection, and strongly recommended for most inpatient orders.
  - **Stat:** Give immediately.
- **Duration or Total Volume (Optional):** Allows users to set a duration or total volume limit. Split into a numeric field and a unit field. Available units are **L**, **mL**, **days**, **hours**, and **doses**.
- **Give Additional Dose Now check box:** Allows users to create a second order with a schedule of Now in case the expected first dose is too far away. When the check box is selected, a warning displays noting that two orders will be created. Active for Intermittent type only.

- **Admin. Time:** Displays the specific administration times associated with the selected schedules, as set up at each site. Text only, not editable. Displayed for Intermittent type only.
- **Expected First Dose:** Displays the date and time of the expected first dose. Text only, not editable. Displayed for Intermittent type only.
- **Summary field:** Displays the order information for review based on the options selected. Text only, not editable.
- **Accept Order button:** Allows users to accept the order with the information entered.
- **Quit button:** Allows users to stop the ordering process for the displayed item.

Once the fields are set as desired, click **Accept Order** to save the order. If applicable, the **Order Checking** dialog displays with items related to the order being entered. The source for the information is listed in the title bar. Click **Accept Order** to continue or **Cancel Order** to cancel the order.

The order displays in the grid with bold, blue text as unsigned with an **Action** of **New**.

2.14.9 Inpatient Medications Change

Change is used to edit an existing order. Highlight the order or orders then access the option by selecting the **Change** option on the **Action** menu or right-clicking in the **Inpatient Medications** section and selecting **Change**. When more than one item is highlighted, before selecting **Change**, the **Medication Order** or **Infusion Order** dialog opens for each one in turn.

Make the desired changes, then accept the order and use the **Integrated Signature Tool** to sign the order. Discontinued or Expired items or items may not be changed.

The unsigned order (Figure 2-176) displays in the grid with bold, blue text and an **Action** of **Change**. Once the new order is signed, the existing order is discontinued.

Action	Inpatient Medications
Change	AMPICILLIN INJ 2 GM in SODIUM CHLORIDE 0.9% INJ,SOLN 100 ml IV INFUSE OVER 60 Minutes Q8H *UNSIGNED*

Figure 2-176: Unsigned item from Change process with Action of Change

Before the order to change an item is signed, it can be reverted to the original status by selecting the item with the **Action** of **Change** and using the **Discontinue/Cancel** process.

When ready, sign the **orders**. Refer to Signing Orders for additional information.

2.14.10 Inpatient Medications Copy to New Order

Copy to New Order is used to create a new order from an existing one. Highlight the order or orders then access the option by selecting the **Copy to New Order** option on the **Action** menu or right-clicking in the **Inpatient Medications** section and selecting **Copy to New Order**. Copy to New Order may be used on existing entries with any status.

Selecting **Copy to New Order** opens the **Copy Medication Order** dialog (Figure 2-177 and Figure 2-178). This is presented only once even if a user selected multiple orders to copy and applies to all the items selected. Users may choose to release the copied orders immediately or delay them for an event such as an admission, a transfer from one inpatient unit to another, a discharge, or when manually released. If the patient is not currently admitted, the transfer and discharge events will not be present. Specific events are set up locally and may vary at each site. When orders are delayed, they cannot be processed or carried out until they are released, either automatically because the release event occurred, or manually.

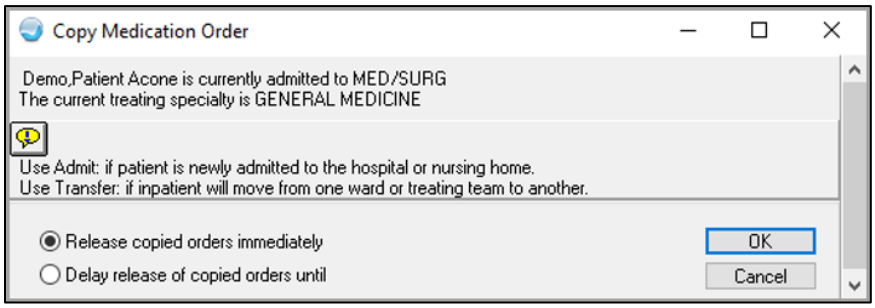


Figure 2-177: Copy Medication Order default

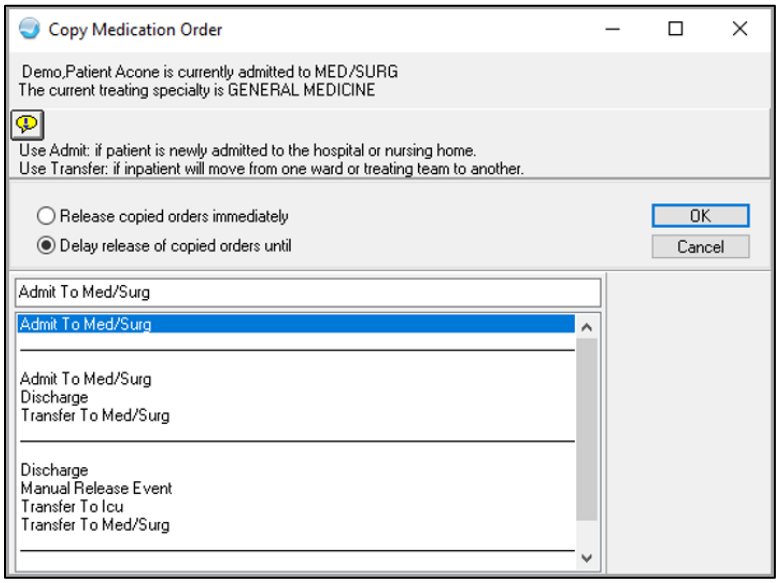


Figure 2-178: Copy Medication Order with Delay selected

When more than one item is highlighted before selecting Copy to New Order, each item is be presented in turn after the **Copy Medication Order** dialog. The **New Order** dialog (Figure 2-179) displays with the order details. If no changes are made, click Accept to create the new order.

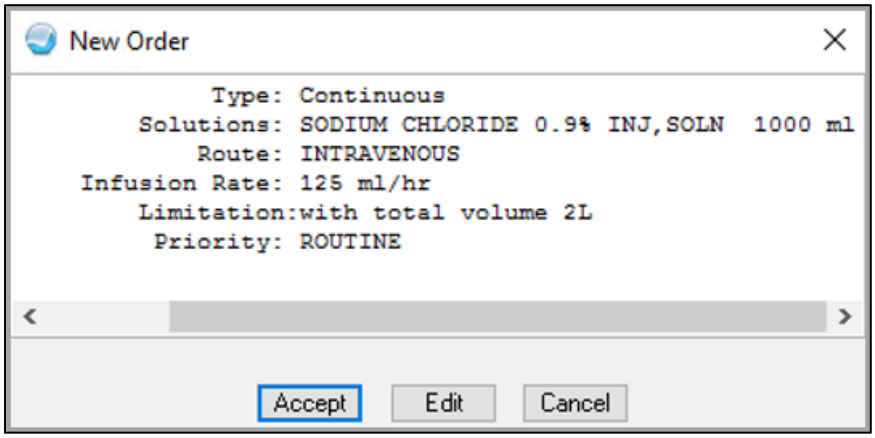


Figure 2-179: New Order dialog

Click **Edit** if changes are needed. The **Medication Order** or **Infusion Order** dialog (Figure 2-180) opens depending on the type of medication involved. Users may edit any field. When ready, click **Accept Order** to create the new order.

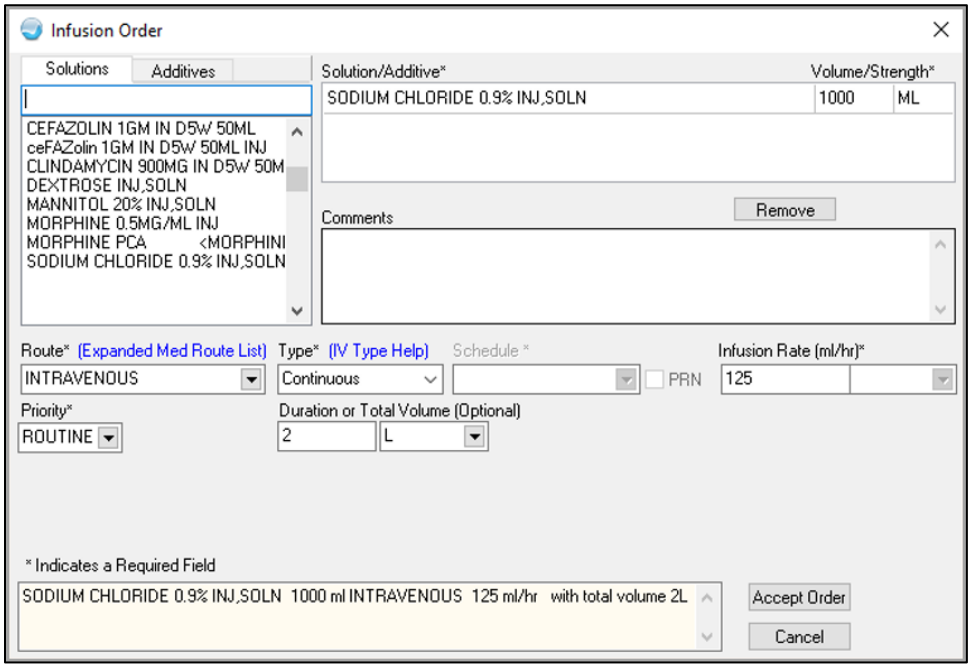


Figure 2-180: Infusion Order dialog

Once the user has accepted the order, it displays in the grid with bold, blue text as unsigned with an **Action** of **New**. Use the **Integrated Signature Tool** to sign the order.

Before the order to copy an item is signed, it can be reverted to the original status by selecting the item with the **Action** of **New** and using the **Discontinue/Cancel** option.

When ready, **sign the orders**. Refer to Signing Orders for additional information.

2.14.11 Inpatient Medications Discontinue/Cancel

Discontinue/Cancel is used to discontinue an existing order. Highlight the item or items then access the option by selecting the **Discontinue/Cancel** option on the **Action** menu or right-clicking in the **Inpatient Medications** section and selecting **Discontinue/Cancel**.

Selecting Discontinue/Cancel opens the **Discontinue/Cancel Order** dialog (Figure 2-181). When more than one item is highlighted before selecting Discontinue/Cancel, selected items are displayed together (Figure 2-182). The reasons are set locally and may be different at each site.

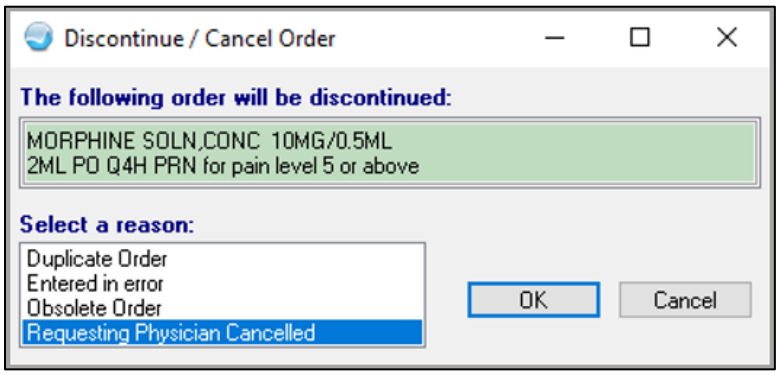


Figure 2-181: Discontinue/Cancel Order for one medication

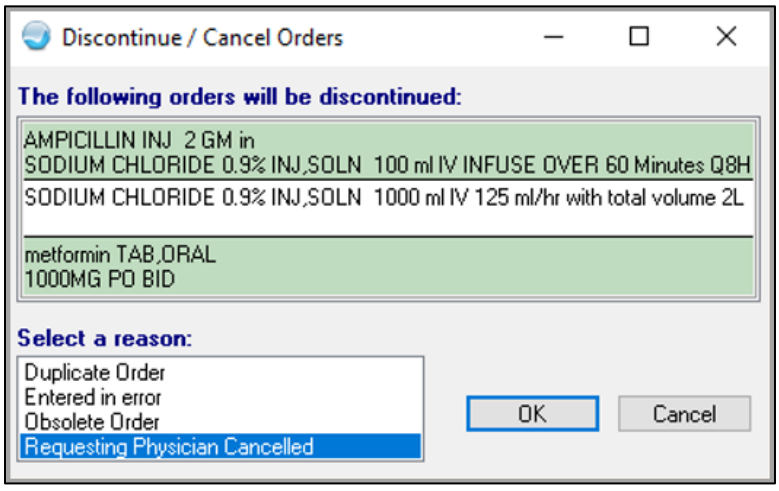


Figure 2-182: Discontinue/Cancel Order for More than One Medication

Select a **reason** and click **OK** to discontinue the medication or medications or click **Cancel** to cancel the process. The order displays in the grid with bold, blue text and an **Action** of **DC**.

Before the order to discontinue an item is signed, it can be reverted to the original status by selecting the item with the **Action** of **DC** and using the **Discontinue/Cancel** option again.

If the item was unsigned when discontinued, it is removed from the system and will no longer be visible. If the item was signed when discontinued, the item still displays on the **Meds** tab with a status of **Discontinued**.

When ready, sign the orders. Refer to Signing Orders for additional information.

2.14.12 Inpatient Medications Transfer to Outpatient

Transfer to Outpatient is used to copy existing **Inpatient Medications** entries to **Outpatient** orders. Items may be transferred to outpatient if they are in an active status and are for a medication that is allowed for outpatient use. If an item is a controlled substance, then the **EPCS** rules also apply.

Highlight the **item** or **items** then access the option by selecting the **Transfer to Outpatient** option on the **Action** menu or right-clicking in the **Inpatient Medications** section of the **Medication Management** component and selecting **Transfer to Outpatient**.

The outpatient version of the **Medication Order** dialog (Figure 2-183) opens. Complete the fields as described in the Outpatient Medication New Medication section and click **Accept Order**.

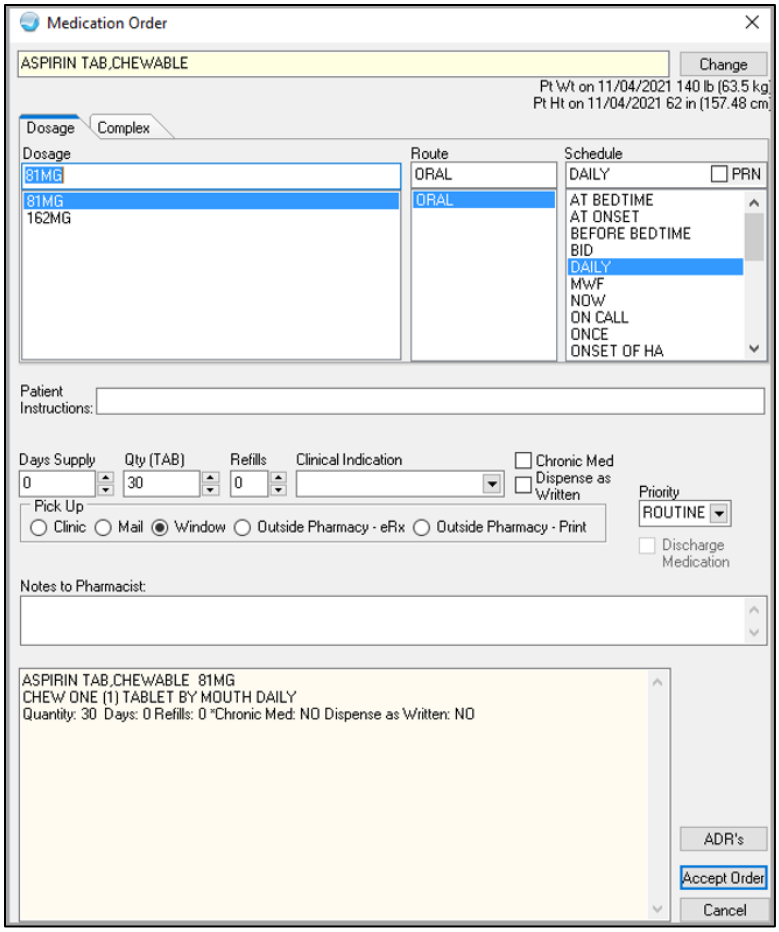


Figure 2-183: Medication Order dialog

The newly created order appears in the **Outpatient Medications** display (Figure 2-184) group in bold, blue text with an **Action** of **New**.

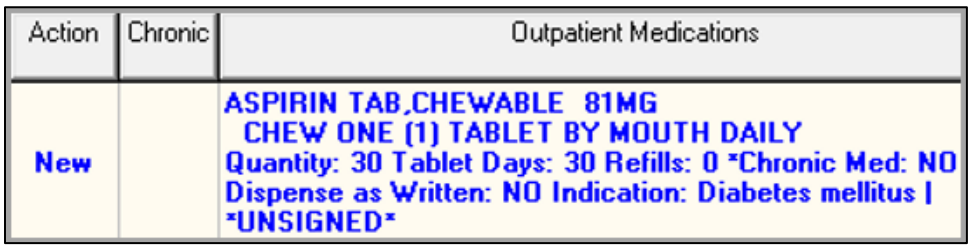


Figure 2-184: Outpatient Medication item with New for Action

When ready, sign the orders. Refer to Signing Orders for additional information.

2.14.13 Inpatient Medications Renew

Renew is used to create a new order from an existing one. It differs from Copy to New Order in that Renew is intended to create an exact copy with no editing. Highlight the **item** or **items** then access the option by selecting the **Renew** option on the **Action** menu or right-clicking in the **Inpatient Medications** section and selecting **Renew**. Renew may not be used on **Pending** orders or orders with a Discontinued status. Additionally, the local set up may restrict certain drugs from being renewed.

The order check information displays if applicable (Figure 2-185). Click **Cancel Order** to cancel the process or **Accept Order** to dismiss the order checks.

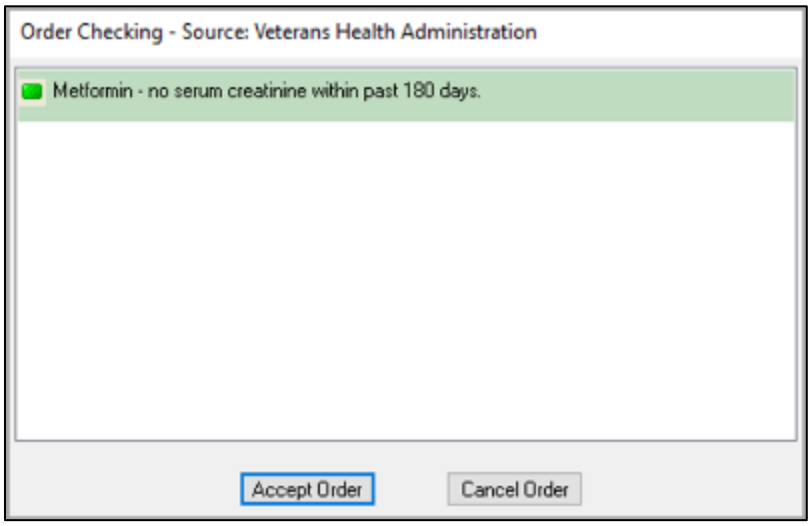


Figure 2-185: Order Checking dialog

The **Renew Order** dialog (Figure 2-186) opens. The order information is shown, with buttons for **Change**, **OK**, and **Cancel**. If more than one item is selected to renew, all items show in the same window. The **Change** button is inactive.

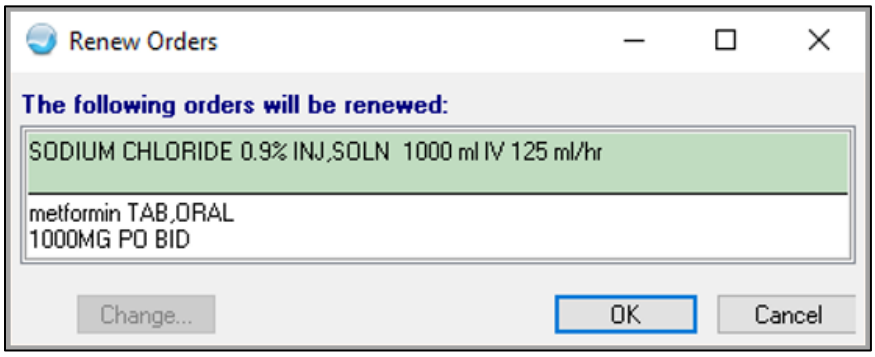


Figure 2-186: Renew Orders dialog

Unlike the Renew process for Outpatient Medications, there is no editing allowed for inpatient orders. Click **OK** to accept the order. The new order displays in bold, blue text with an **Action** of **Renew**.

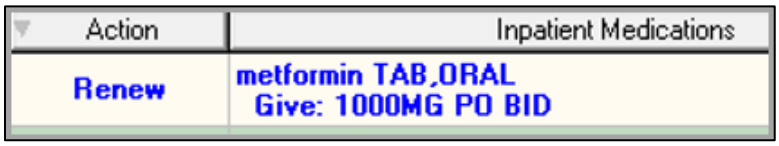


Figure 2-187: Unsigned item from Renew process with Action of Renew

When ready, sign the orders. Refer to Signing Orders for additional information.

2.15 Signing Orders

When all orders have been entered and the user is ready to sign the orders and other items requiring a signature, click the **Integrated Signature Tool** button (Figure 2-188).



Figure 2-188: Integrated Signature Tool button

The **Review/Sign Changes** dialog (Figure 2-189) opens. All items that the user needs to sign display, not just the medications. Users can clear any items that are not yet ready to sign, except for outside medication. No electronic signature is required for the Outside Medication entries.

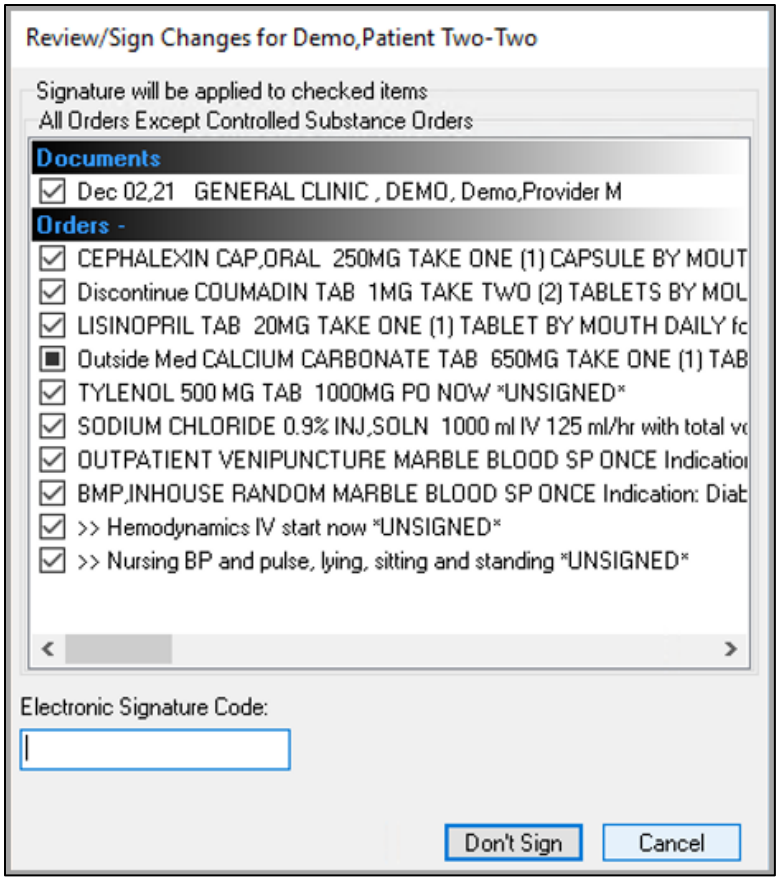


Figure 2-189: Review/Sign Changes dialog

Before entering an electronic signature code, the buttons read **Don't Sign** and **Cancel**. While these seem similar, they cause different results in EHR. Clicking **Don't Sign** indicates the user is not going to sign the item now and the Integrated Signature Tool turns inactive. Clicking **Cancel** indicates the user is pausing the process and the Integrated Signature Tool remains active. Keeping the Integrated Signature Tool active helps with easily signing the items later.

Enter an **electronic signature code** (Figure 2-190) and the buttons change to **Sign** and **Cancel**. Click **Sign** to sign the orders.

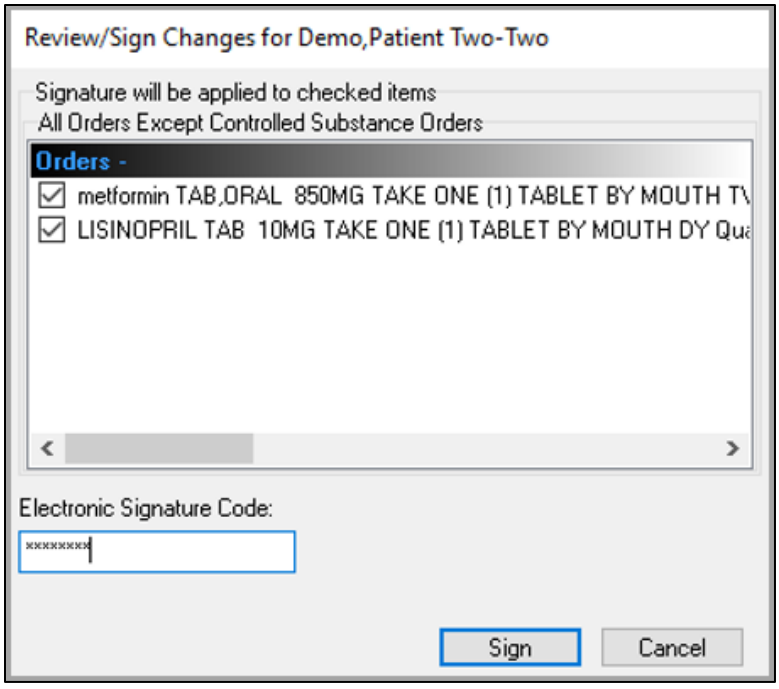


Figure 2-190: Review/Sign Changes with Electronic Signature Code entered

The **Order Checking** dialog (Figure 2-191) displays, if applicable. This dialog contains order checks for all items ordered in the session. Select the check box and click **Cancel Selected Order(s)** to cancel an order or **Continue** to continue.

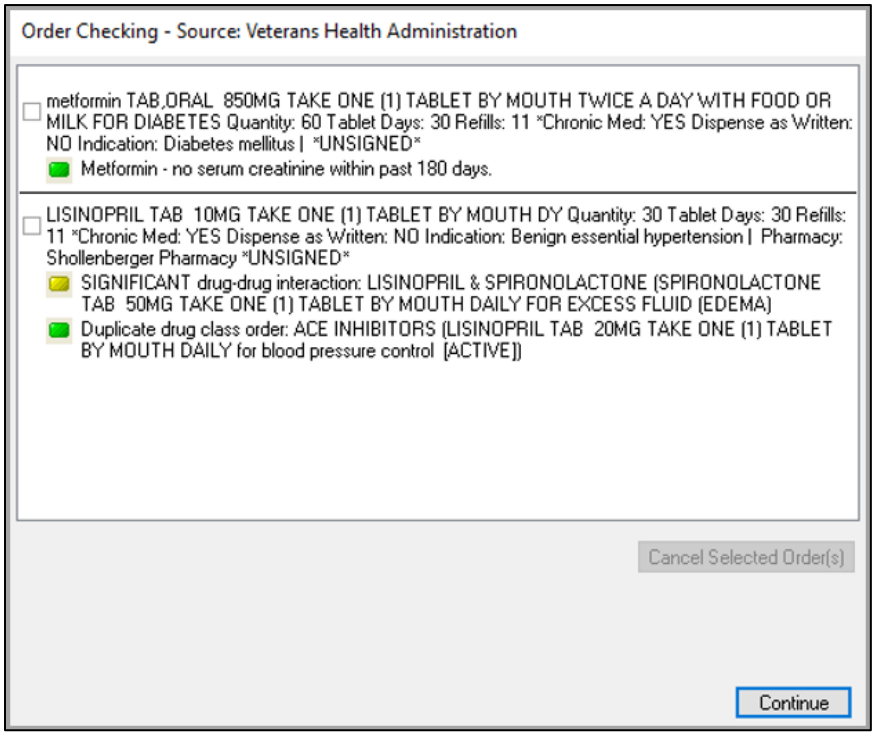


Figure 2-191: Order Checking dialog at signing for all orders this session

If any **Order Check (**Figure 2-192) is considered critical, users must enter an override reason.

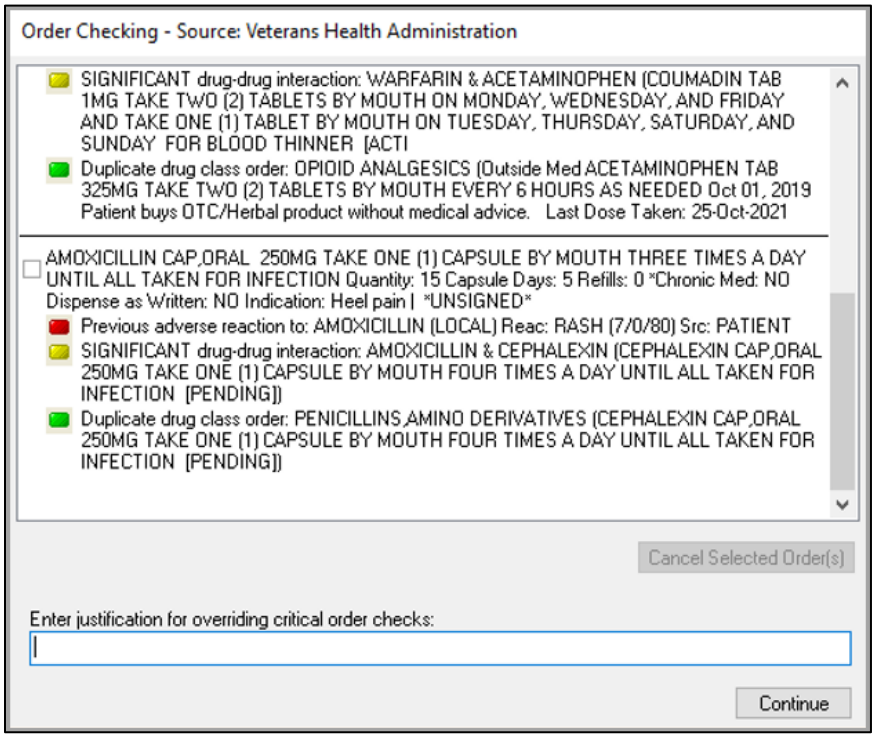


Figure 2-192: Order Checking dialog with critical item and override field

If any outpatient **Controlled Substances (CS)** are ordered and the site is using **Electronic Prescribing for Controlled Substances (EPCS)**, the CS medications are displayed in a separate section (Figure 2-193) and are not checked by default. **Inpatient CS** orders are not subject to the **EPCS** rules.

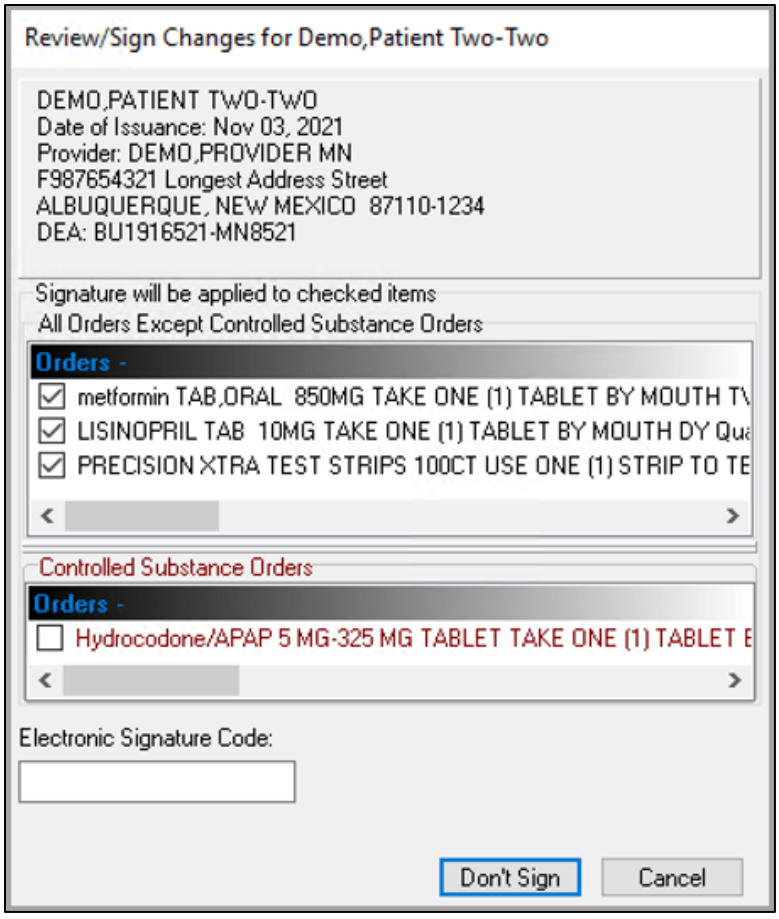


Figure 2-193: Review/Sign Changes with Controlled Substance Orders

Select the check box to indicate the order is ready for signature. The required **two-factor authentication (2FA)** statement (Figure 2-194) displays.

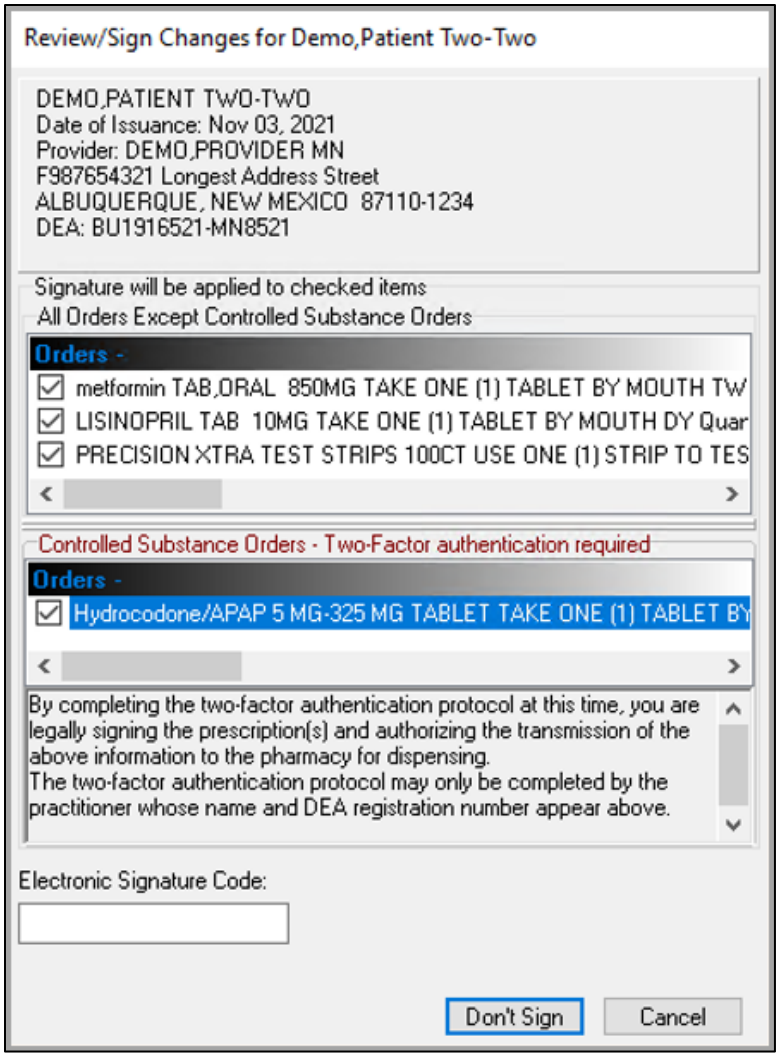


Figure 2-194: Review/Sign Changes with two factor statement

Enter an electronic signature code and click **Sign** to sign the orders. The **Order Checking** dialog displays if applicable. Once the Order Checks are completed, or if there were no Order Checks, the **Identity Verification** dialog (Figure 2-195) displays. The user's PIV card or token certificate displays with a field to enter the **PIN**.

Enter a **PIN** and the **Sign** button becomes active. Click **Sign**.

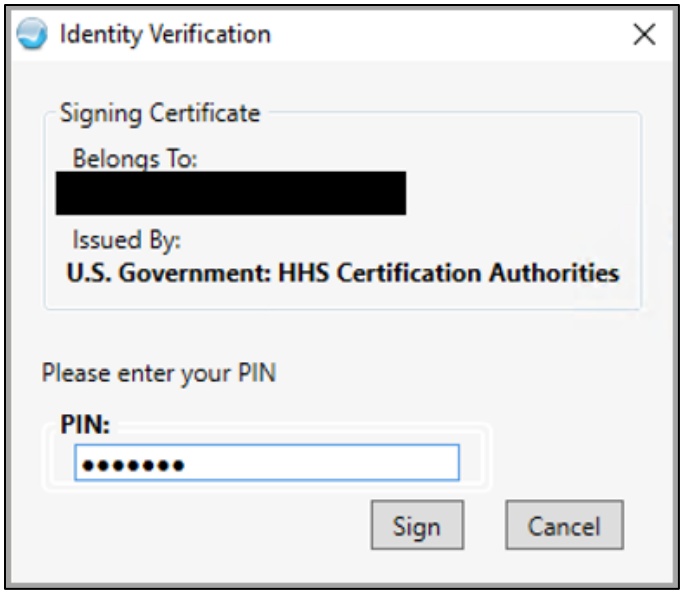


Figure 2-195: Identity Verification dialog with PIN entered

The system performs the verification, and the dialog displays **Checking PIN…** (Figure 2-196). This step may take some time. The **Review/Sign Changes** dialog with blanked out signature may display again. Do not re-enter the signature code but wait for the process to complete.

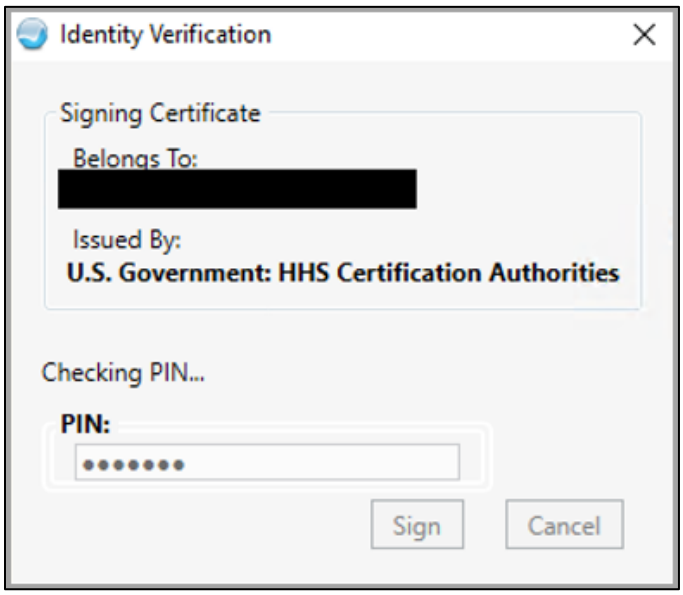


Figure 2-196: Identity Verification dialog Checking PIN…

Once the verification is complete, the **Identity Verification** dialog and the **Review/Sign Changes** dialog closes. The new items display in the appropriate section of the **Medication Management** component.

Before the item is signed, it can be removed from the record by performing the **Discontinue/Cancel** option. Once signed, using **Discontinue/Cancel** cancels the order, but leaves a record of the order with a status of **Discontinued**.

For any items being transmitted to an external pharmacy, transmission happens upon successful signature, including **2FA**, if applicable. If the transmission is successful, no further action is required. If the transmission fails, a notification is sent to the user. Processing the notification results in a dialog (Figure 2-197) noting the specific order and the error reason, and allowing the user to retransmit, print, or quit (do nothing).

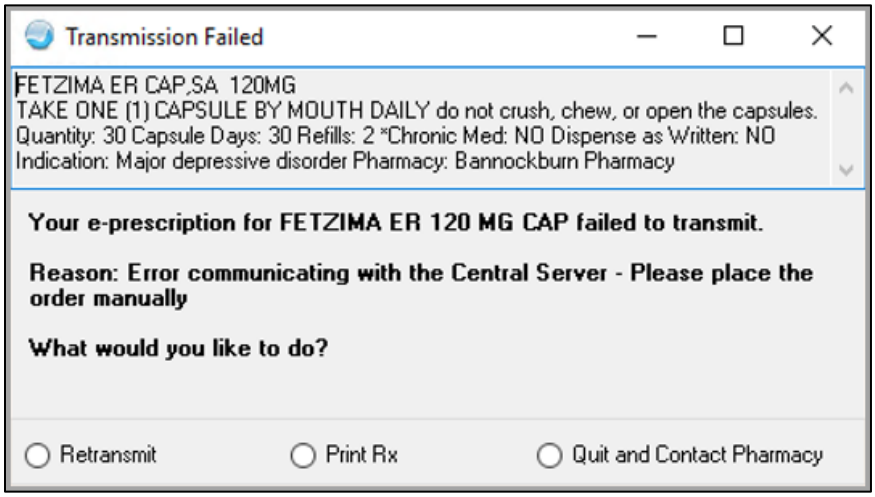


Figure 2-197: Transmission Failed dialog

Choosing to print the item creates a log of the print event. Users must review the printed copy, manually sign it, and send it to the pharmacy by other than electronic means. If the item is a controlled substance, a text is sent indicating the failed transmission, the intended pharmacy, and the date and time the transmission was attempted.

3.0 Reproductive Factors

The Reproductive Factors application is available for female patients only. After selecting a female patient, the application (Figure 3-1) displays the most recent reproductive factors information, if available.

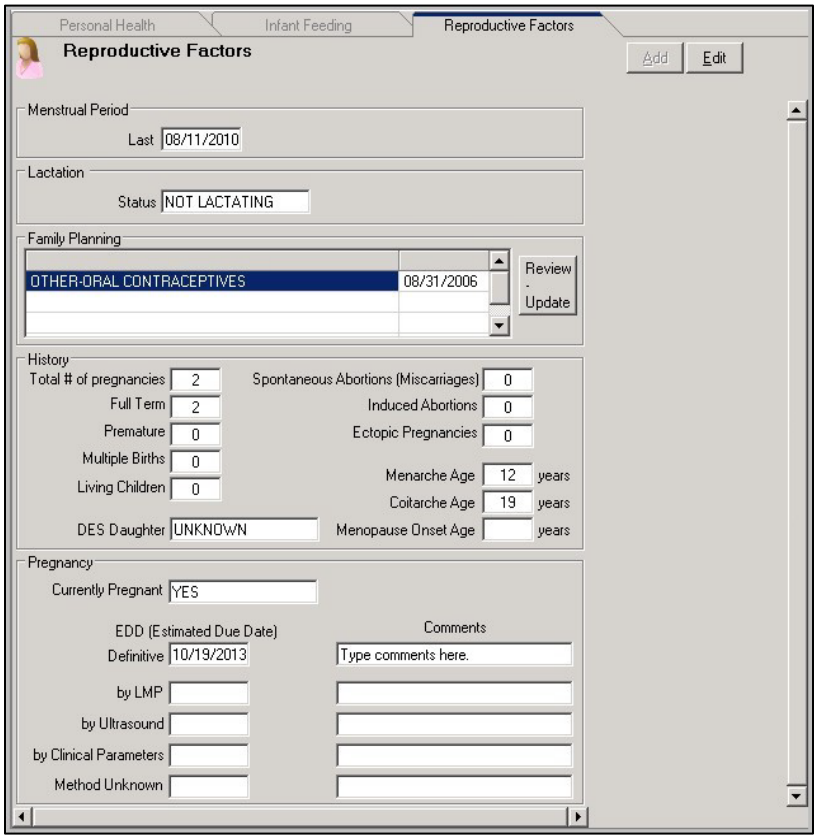


Figure 3-1: Reproductive Factors data for female patient

A visit does not need to be selected. The **Reproductive Factors** application is used for populating PCC data in RPMS.

3.1 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 (Figure 3-2) 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.

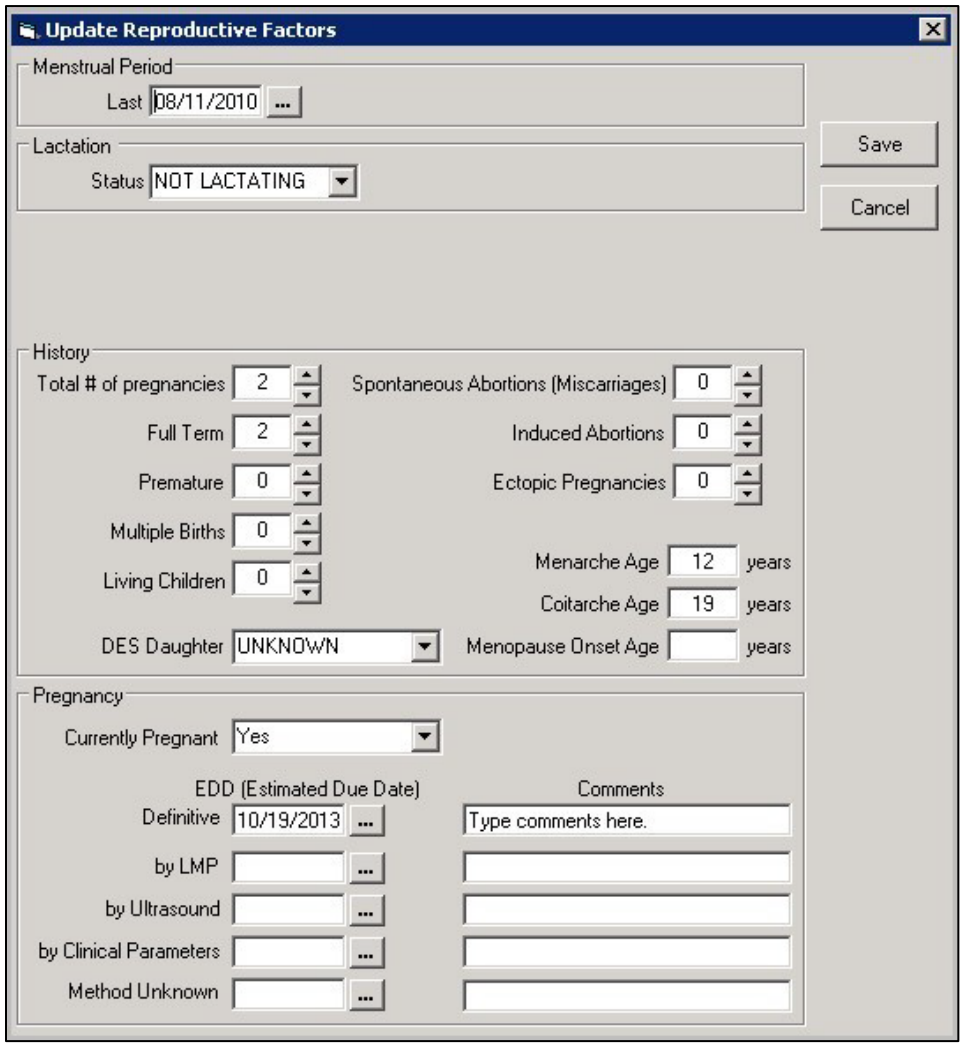


Figure 3-2: Add/Edit Update Reproductive Factors dialog

2. Provide the **date** of the patient's last menstrual period. This cannot be a future date. If the user enters 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 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 (Figure 3-3), complete the fields as applicable:

Note: Zero is an acceptable entry for the numeric fields.

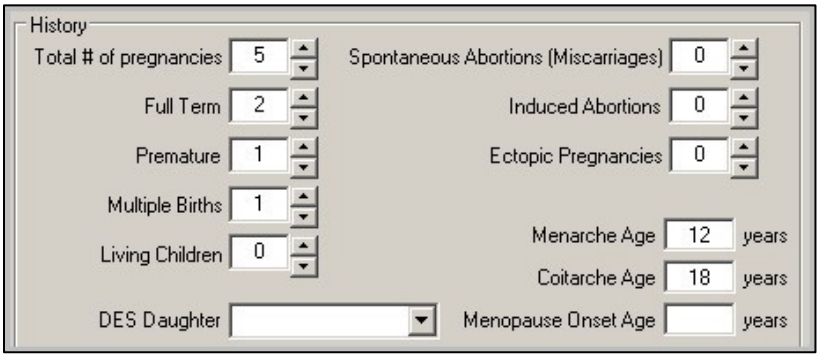


Figure 3-3: Reproductive History fields

   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:

      - **Yes**
      - **No**
      - **Unknown**
      - **Refused to Answer**

5. In the **Pregnancy** section (Figure 3-4), complete the pregnancy information:
6. In **Currently Pregnant**, select one of the following:

   - **Yes**
   - **No**
   - **Unknown**
   - **Possibly Pregnant**

- **Refused to Answer**

Note: The fields in this section only become active if **Yes**, **Unknown**, or **Possibly Pregnant** is selected.

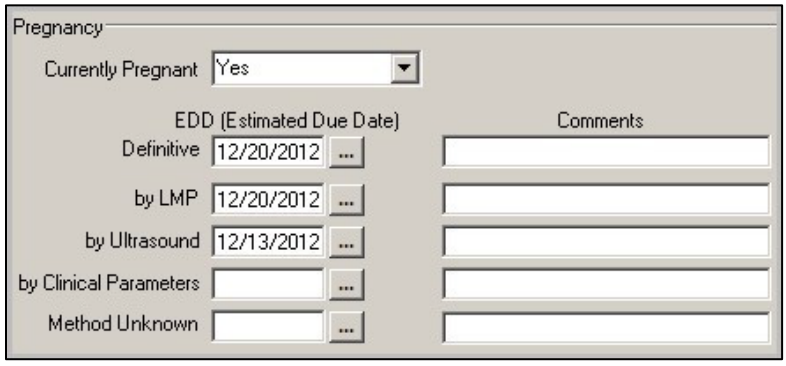


Figure 3-4: Pregnancy data dialog

Note: If dates and comments are entered, and the **Currently Pregnant** drop-down menu is changed to **No**, the fields are cleared.

a. 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.

b. In the **Comments** fields, type any **notes**, as needed.

7. Click **Save** at the top of the **Update Reproductive Factors** dialog.

To edit Reproductive Factors:

a. Click **Edit** on the **Reproductive Factors** dialog. The **Update Reproductive Factors** dialog opens. Make any changes or updates, as necessary.

b. Click **Save** at the top of the **Update Reproductive Factors** dialog to save the changes.

3.2 Add/Edit Family Planning

Active family planning entries appear in the **Reproductive Factors** dialog (Figure 3-5). The **Review/Update** button on this dialog is used to review and update family planning.

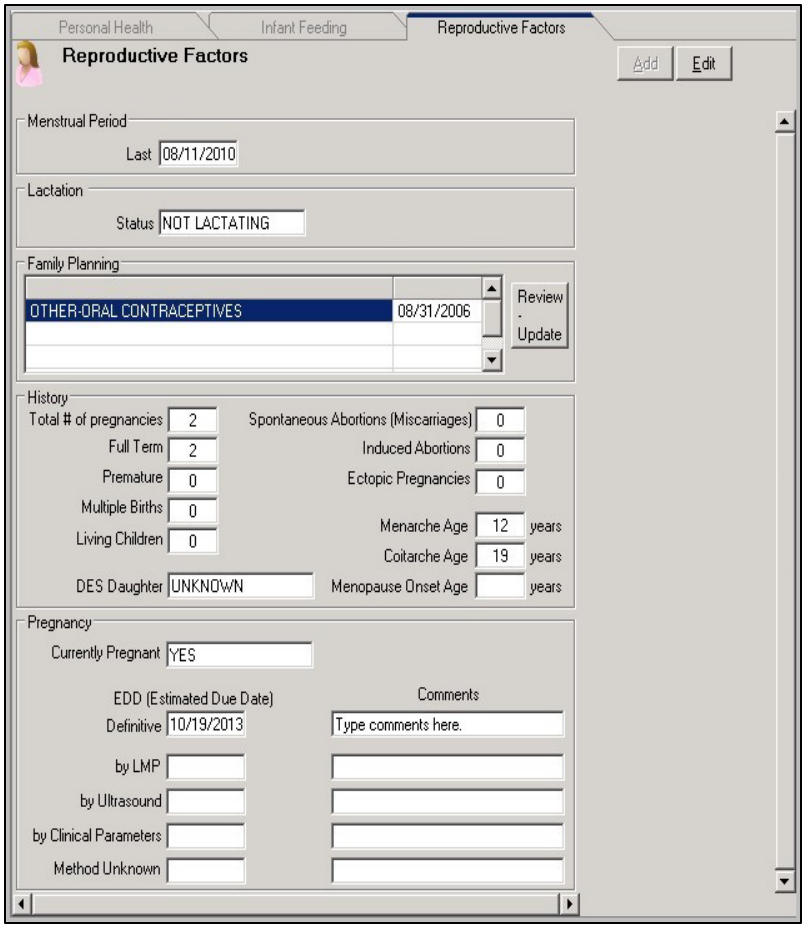


Figure 3-5: Reproductive Factors history review dialog

Click the **Review/Update** button. The **Review/Update of Family Planning Methods** dialog opens.

3.3 To Add a New Family Planning Method

1. Click **New** to add a new family planning method (Figure 3-6). Entry fields appear in the **Edit Method Information** section at the bottom of the dialog.

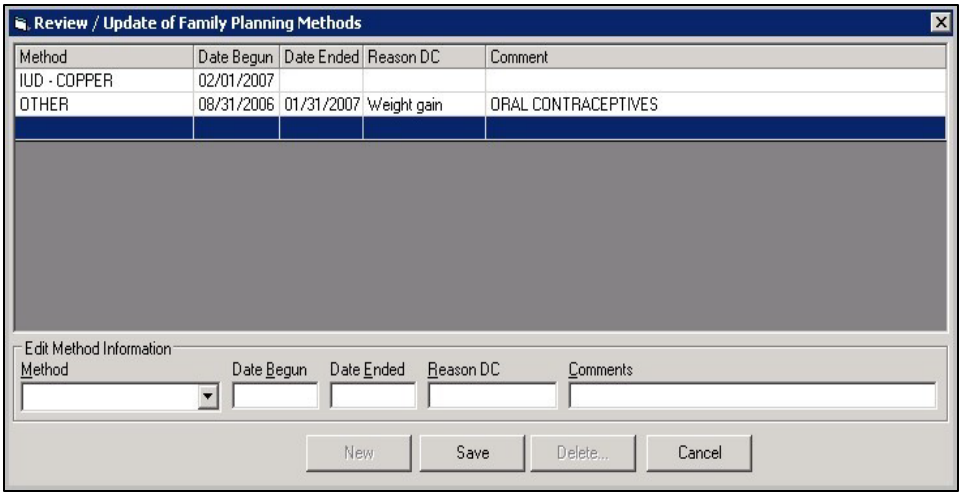


Figure 3-6: New Birth Control Method dialog

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**. The entry displays in the list.

3.4 To Edit an Existing Family Planning Method

1. Select an **existing method** to edit (Figure 3-7). The **Edit Method Information** section fields appear with the current information populated.

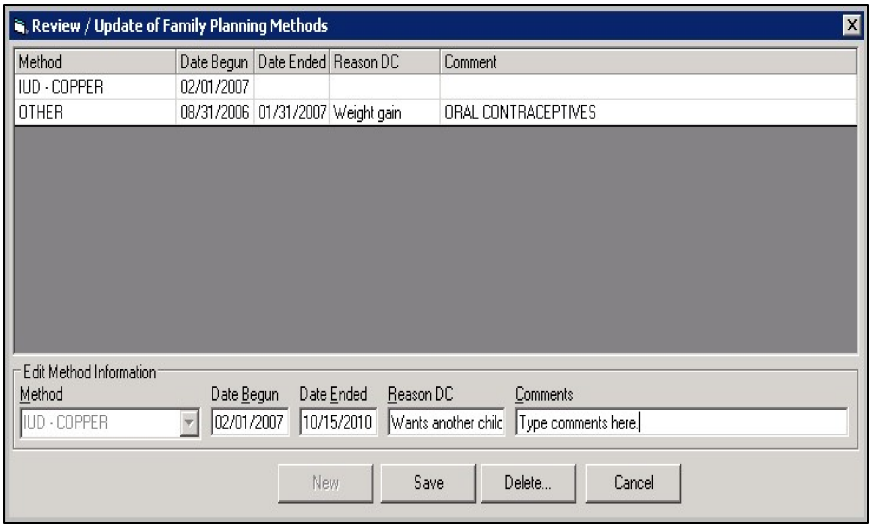


Figure 3-7: Edit existing birth control method dialog

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.

3.5 To Delete an Existing Family Planning Method

1. Select an **existing method** to edit.
2. Click the **Delete** button. The **Reason for Deletion** dialog (Figure 3-8) opens.

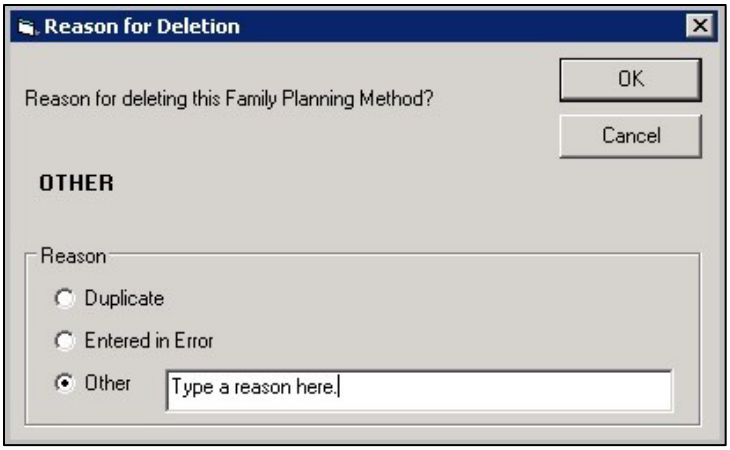


Figure 3-8: Reason for Deletion dialog

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 (Figure 3-9) displays.
     - Click OK to dismiss the message and provide a reason.



Figure 3-9: Other delete information message

4. Click **OK**. The entry is deleted.

4.0 Clinical Information Reconciliation Tool

The **Clinical Information Reconciliation (CIR) Tool** (Figure 4-1) in the RPMS EHR has been redeveloped to comply with the 21st Century Cures Act. It is intended to allow providers and other clinical staff to reconcile information from other facilities or from the patient or caregiver to ensure all relevant information is available for the care of the patient.

Information used by the **CIR Tool** may be obtained from sources such as documents sent to the user's facility in the **Consolidated Clinical Document Architecture (CCDA)** format, or from a patient or caregiver interview, a medication list the patient or caregiver has, actual medication bottles, or any other source that can provide information regarding problems, adverse reactions, or medications.

In most cases, CCDAs received from external partners should be imported into the patient's IHS medical record. Follow the processes, procedures, and policies for document import. This section assumes the site has set up and configured the Veterans Health Information System and Technology Architecture (VistA) Imaging Capture tool (known as VIC) and knows how to use the tool. If the VIC setup and configuration is unknown, check with the site Information System Security Officer (ISSO), Health Information Management (HIM) personnel, local Informaticist, or Clinical Application Coordinator (CAC) for more information. All images shown within this section are for illustration purposes and contain demo data only.

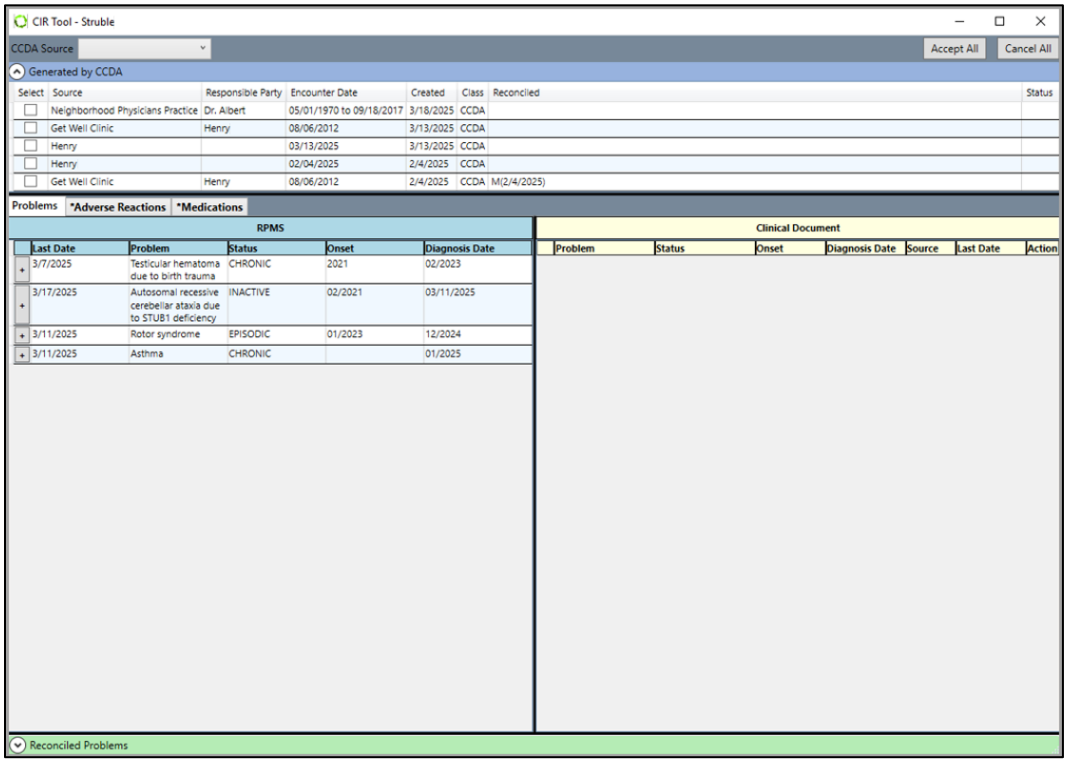


Figure 4-1 CIR Tool dialog

The main functionality of the **CIR Tool** includes:

- Display data from two or more sources in a manner that enables the user to view the data and its attributes, including the source and last modification date of the information.
- Allow the user to add or remove data to the Resource and Patient Management System (RPMS) from the outside source.
- Allow the user to review and validate the accuracy of a final set of data elements, and on confirmation update the patient's problem, adverse reaction, and medication lists.

4.1 CIR Tool Icon

The CIR component is a button style component suitable for adding to the header pane portion of the Electronic Health Record (EHR) graphical user interface (GUI) template that exists at most sites. There are no specific properties for the **CIR Tool** component.

4.1.1 Icon Display

The **CIR Tool** icon (Figure 4-2) is a circle of four arrows with the text CIR or a number. When a patient has not been selected, the icon will be green with the letters CIR in the center:



Figure 4-2: CIR Icon display – No patient selection

Once a patient has been selected, the icon will be green if the patient has no CCDA documents to reconcile or if no documents were received for the patient (Figure 4-3). The number on the icon will represent the number of CCDA documents received.



Figure 4-3: CIR Icon display – Patient selected with no CCDA documents

If the patient has CCDA documents that must be reconciled, the icon will be red (Figure 4-4) and display the number of CCDA documents not reconciled.



Figure 4-4: CIR Icon display with three CCDA documents to reconcile

Hovering the mouse pointer over the **CIR Tool** icon (Figure 4-5) displays the number of CCDA documents that have already been reconciled, as well as the total number of documents.

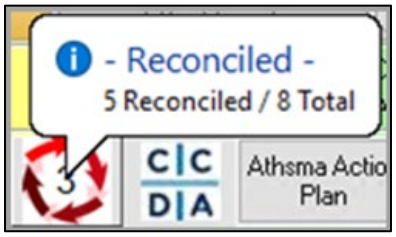


Figure 4-5: Hover text for CIR icon – Shows number of reconciled and total number of CCDA documents

4.2 CIR Tool Orientation

Launch the **CIR Tool** by clicking the icon. It opens in a pop-up window over the main EHR window.

- CIR opens initially with the **RPMS** pane displaying all problem, allergy, and medication information for the patient entered in EHR from previous visits.
- The **Reconciled** pane is collapsed.
- The **Generated by CCDA** pane will be empty if the patient does not have any imported CCDA documents.
- The tabs default to **Problems**.
- The **Adverse Reactions** and **Medications** tabs will have asterisks until they are selected to review.
- The overall window and the various panes may be resized by dragging the edges or splitter bars to the desired size.
- Column widths may also be resized and clicking a column header will sort by that column. Clicking again reverses the sort order.

- The various panes may be resized by dragging the splitter bar separating the panes. The window is broken out into three sections:
  - Top pane
  - Middle pane
  - Bottom pane

4.2.1 Top Pane

4.2.1.1 Visit Button

A visit context is required when a user reconciles the clinical information. The visit context may be set prior to opening the **CIR Tool** component, or users may use the **Visit** button to set the visit context. The **Visit** button will only display if the visit context is not yet set. Clicking the Visit button opens the **Encounter Settings for Current Activities** dialog (Figure 4-6). Once a visit context is selected the **Visit** button will no longer show in the window.

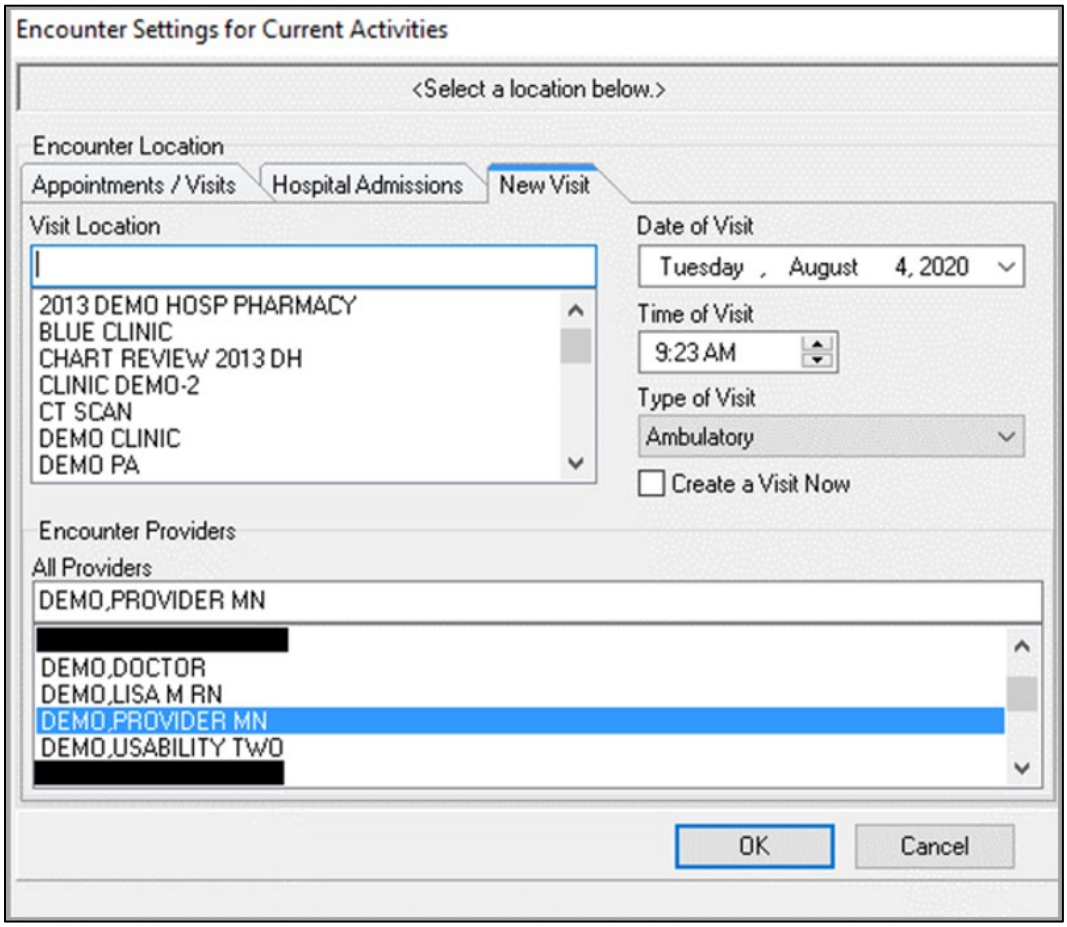


Figure 4-6: Encounter settings for Current Activities dialog

4.2.1.2 CCDA Source Drop-Down List

The **CCDA Source** field is a drop-down list that displays the items configured by the site (Figure 4-7). While these are site specific, most sites will have entries such as:

- Patient History
- Caregiver
- Patient Medication List

This list is only used if there are no CCDA documents needing to be reconciled, but additional information is gathered via the source selected from the list.

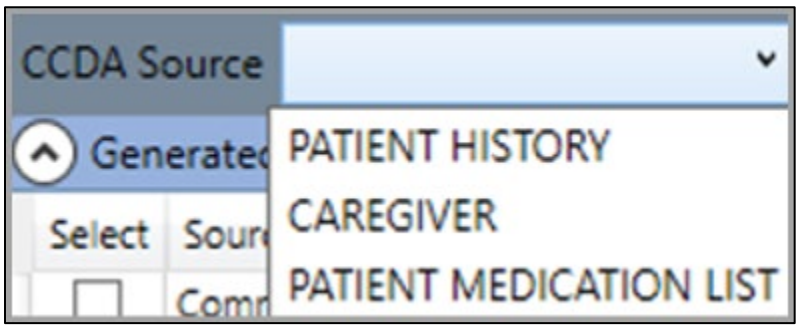


Figure 4-7: CCDA source field with drop-down choices

If the user chooses a CCDA source, the entry will display as a row in the **Generated by CCDA** section.

4.2.1.3 Generated by CCDA Section

The **Generated by CCDA** section (Figure 4-8) displays all CCDA documents received for the patient and added by the **HIM** department by utilizing **VistA Imaging Capture**. These documents were sent to the site electronically and uploaded to allow for reconciliation of information being sent by another facility or provider. This section also displays CCDA source information gather during patient provider interaction.

The section contains a table with the following fields:

- **Select:** A checkbox field allowing the user to choose which entry to reconcile.
- **Source:** The named source of the information.
- **Responsible Party:** Who sent or entered the information to be reconciled.
- **Encounter Date:** The visit date(s) that the information was gathered on.
- **Created:** When the entry was added to the table.
- **Class:** If the data was received from an outside facility or provider and captured in VistA Imaging this value will be CCDA. Other CCDA sources will display this field blank.

- **Reconciled:** If reconciliation was completed and accepted the following displays:
  - **M**–For Medication and a date when reconciled.
  - **A**–For Allergies and a date when reconciled.
  - **P**–For Problems and a date when reconciled.

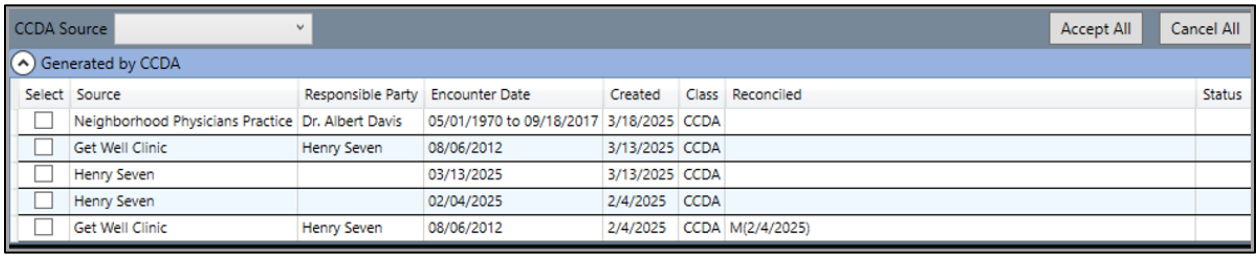


Figure 4-8: Generated by CCDA section

If the entry in the table is a CCDA class, a user may view the CCDA in full, or one of its sections, by right-clicking the row and selecting the appropriate option from the drop-down list (Figure 4-9). The list of sections will vary based on the document selected, as not all documents will contain all sections.

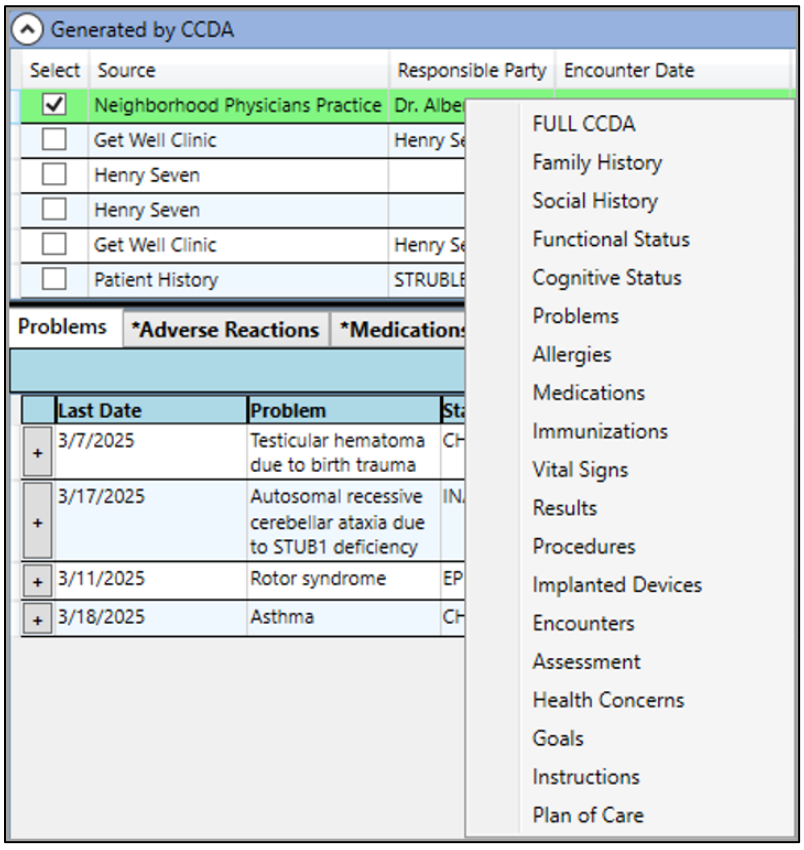


Figure 4-9: Right-click option for CCDA Class rows

If the user chooses to see the full CCDA, the **CCDA** window (Figure 4-10) opens with a title reflecting the information in the source column. This window shows the sections with check boxes on the left, and the CCDA document content on the right. There are **Preferences** and **Show All Sections** menu options.

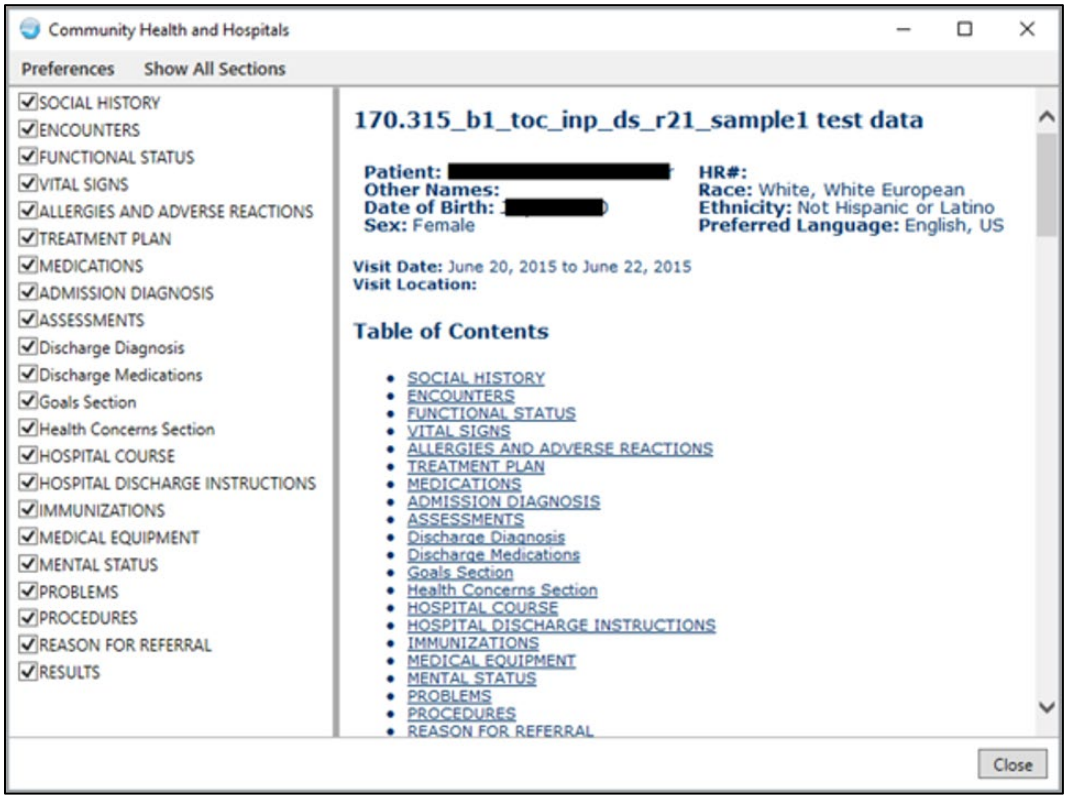


Figure 4-10: Full CCDA window

Clicking any section link in the right-hand pane (within the document content) jumps the user to that section.

Users may adjust the display by clearing the check box in the left-hand pane next to a section they do not want displayed. Users may also move sections by dragging and dropping the section names in the left-hand pane (Figure 4-11). As adjustments are made on the left, the content changes on the right.

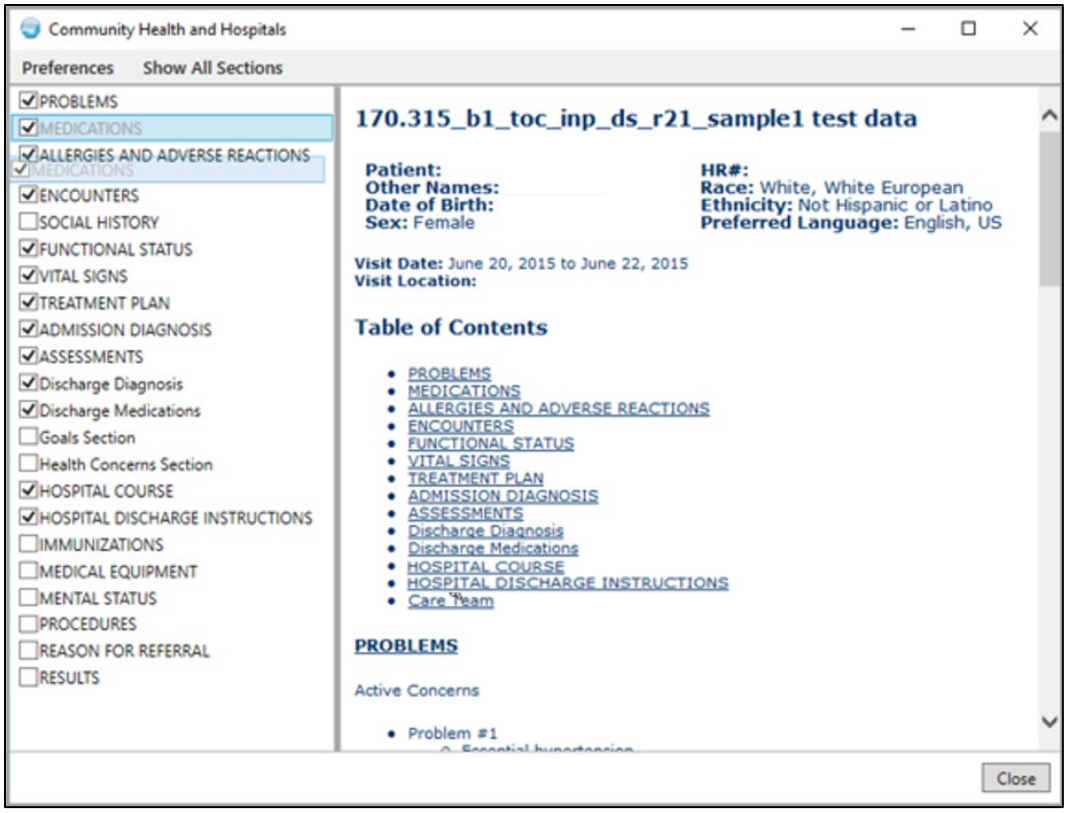


Figure 4-11: CCDA Window – Sections cleared and medications dragged to new location

In order to have these preferences saved for viewing other CCDA documents, select the **Preferences** menu and click **Save** (Figure 4-12).

> **Note:** Because different CCDA documents will have different sections included, the preferences may not be fully accurate for each and every CCDA document that is encountered.

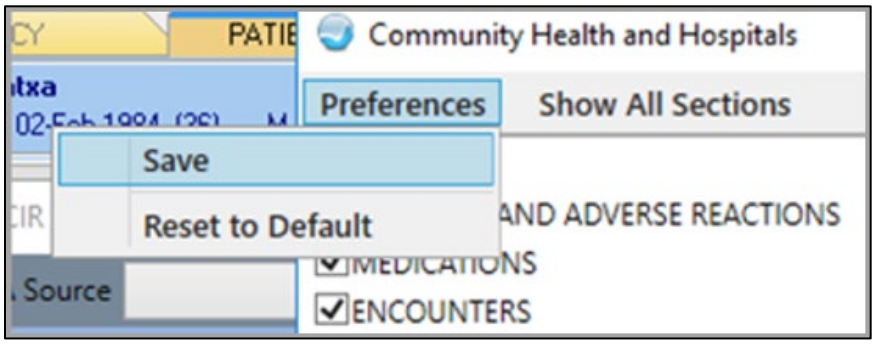


Figure 4-12: CCDA full preferences save

The **Preferences** option of **Reset to Default** will clear the changes and remove the saved preferences. Selecting **Reset to Default** opens the **Reset Preferences** warning (Figure 4-13) for confirmation. Click **Yes** to reset or remove the existing preferences or click **Show All Sections** to restore all sections to the display for the current display only.



Figure 4-13: Reset Preferences confirmation window

4.2.2 Middle Pane

The middle pane of the **CIR Tool** window contains three tabs:

- **Problems**
- **Adverse Reactions**
- **Medications**

The tabs default to **Problems** tab. The **Adverse Reactions** and **Medications** tabs will have asterisks until they are selected to review.

On the left-hand side, the data stored in the local RPMS database is displayed. On the right-hand side, the data from the currently highlighted CCDA document (in the **Generated by CCDA** pane) is displayed. This pane will have a **Set All Reviewed** button when data is present.

The columns present will depend on the tab selected. Sort the lists by any of the columns by clicking the column header. Clicking once will sort A to Z or low to high, while clicking a second time will sort Z to A or high to low.

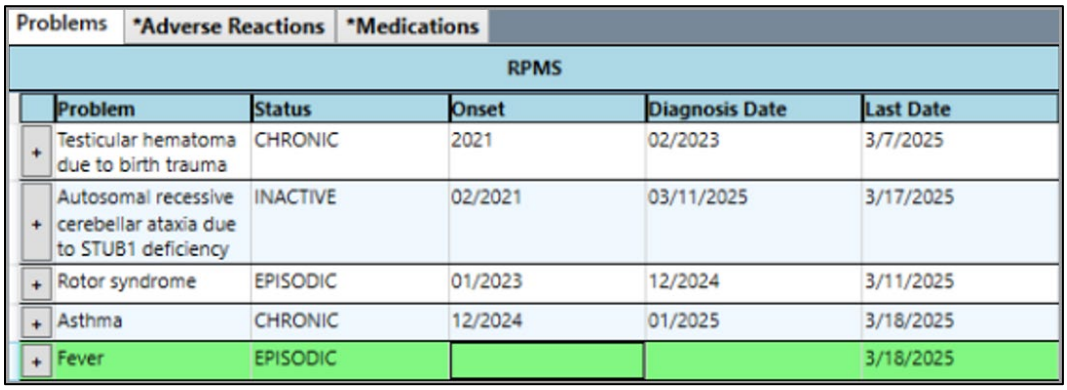
4.2.2.1 RPMS Panel

The **RPMS** panel contains a table of patient information gathered across all their visits specific to the tab that is selected.

The **Problems RPMS** table contains the following columns:

- **Problem:** Snomed CT preferred term
- **Status:** Current status of the patient's problem.
- **Onset Date:** If populated, Onset date of problem.

- **Diagnosis Date:** If populated, Date of Diagnosis for the problem.
- **Last Date:** Date the last time the RPMS problem was updated.



Problems | *Adverse Reactions | *Medications

RPMS

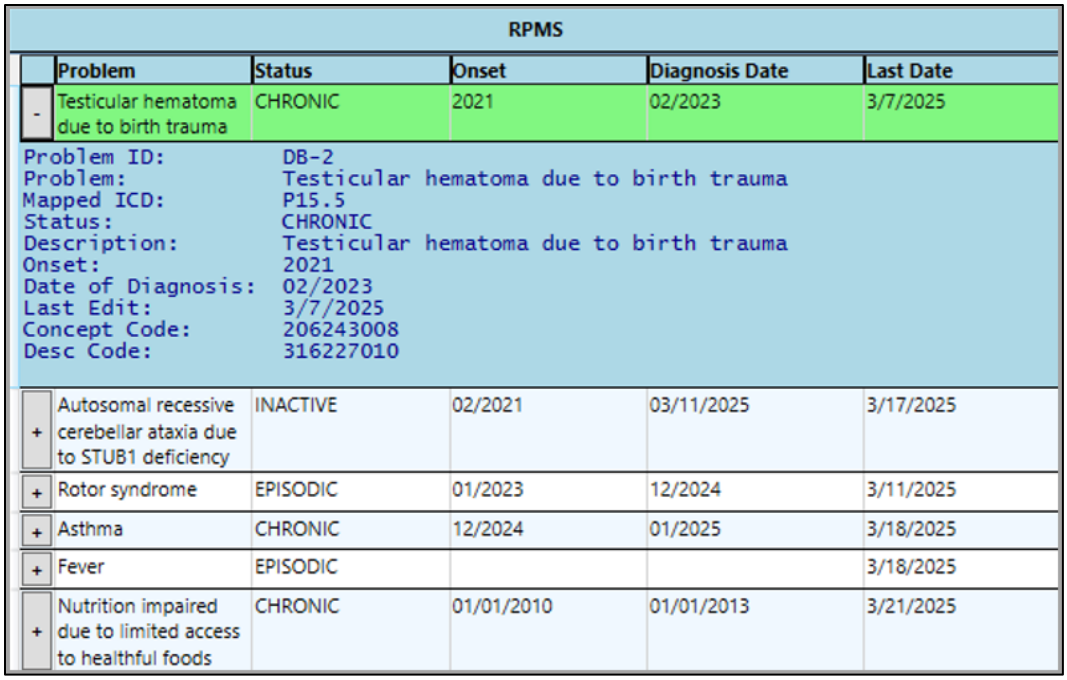
	Problem	Status	Onset	Diagnosis Date	Last Date
+	Testicular hematoma due to birth trauma	CHRONIC	2021	02/2023	3/7/2025
+	Autosomal recessive cerebellar ataxia due to STUB1 deficiency	INACTIVE	02/2021	03/11/2025	3/17/2025
+	Rotor syndrome	EPISODIC	01/2023	12/2024	3/11/2025
+	Asthma	CHRONIC	12/2024	01/2025	3/18/2025
+	Fever	EPISODIC			3/18/2025

Figure 4-14: RPMS Problem Table

Click the **Plus Sign** (+) next to any given problem enables users to see the details of the problem (Figure 4-15). The details may contain information such as:

- SNOMED CT or ICD-10 codes and terms
- Status
- Description
- Onset Date
- Date of Diagnosis
- Date Resolved (if present)
- Date of Last Edit

Click a second time to close the details.



RPMS

	Problem	Status	Onset	Diagnosis Date	Last Date
-	Testicular hematoma due to birth trauma	CHRONIC	2021	02/2023	3/7/2025

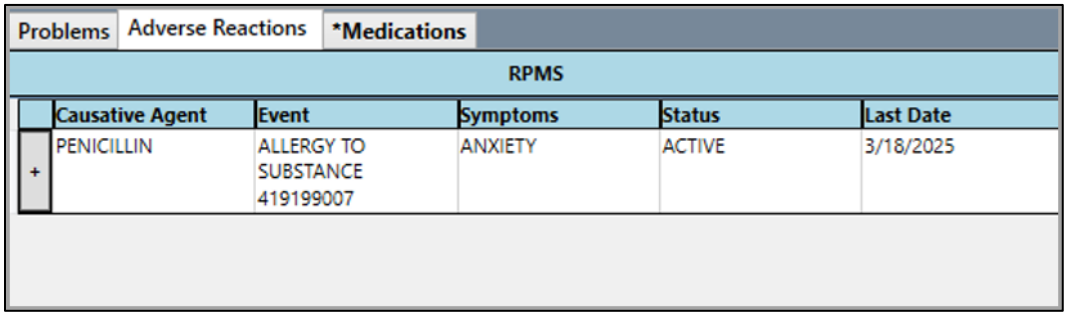
Problem ID: DB-2
Problem: Testicular hematoma due to birth trauma
Mapped ICD: P15.5
Status: CHRONIC
Description: Testicular hematoma due to birth trauma
Onset: 2021
Date of Diagnosis: 02/2023
Last Edit: 3/7/2025
Concept Code: 206243008
Desc Code: 316227010

+	Autosomal recessive cerebellar ataxia due to STUB1 deficiency	INACTIVE	02/2021	03/11/2025	3/17/2025
+	Rotor syndrome	EPISODIC	01/2023	12/2024	3/11/2025
+	Asthma	CHRONIC	12/2024	01/2025	3/18/2025
+	Fever	EPISODIC			3/18/2025
+	Nutrition impaired due to limited access to healthful foods	CHRONIC	01/01/2010	01/01/2013	3/21/2025

Figure 4-15: RPMS Problem expanded

The **Adverse Reactions RPMS** table contains the following columns.

- **Causative Agent:** Substance the patient has adverse reaction to.
- **Event:** Snomed Type of reaction.
- **Symptoms:** Patients symptoms while using agent.
- **Status:** Status of the adverse reaction.
- **Last Date:** Date the last time the adverse reaction was updated.



Problems | Adverse Reactions | *Medications

RPMS

	Causative Agent	Event	Symptoms	Status	Last Date
+	PENICILLIN	ALLERGY TO SUBSTANCE 419199007	ANXIETY	ACTIVE	3/18/2025

Figure 4-16: Adverse Reactions RPMS table

Click the **Plus Sign** () next to any given adverse reaction to see the details of the adverse reaction. The details may contain information such as:

- Causative agent,
- Event Type

- Symptoms
- Drug or Drug Class
- Ingredients
- Source
- Documentation Date
- Last Modification Date

Click a second time to close the details.

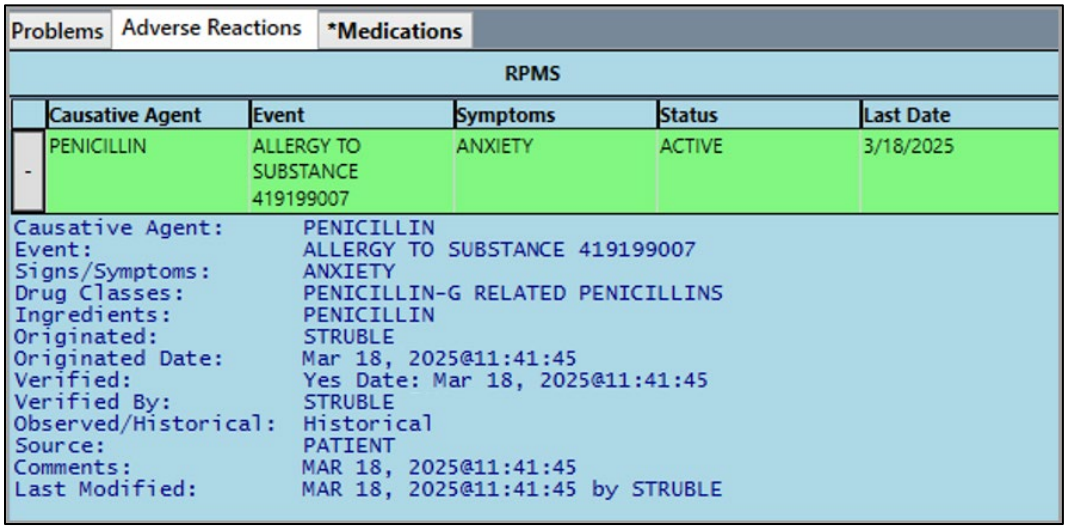


Figure 4-17: RPMS Adverse Reaction expand

The **Medications RPMS** table contains the following columns.

- **Type:** Mouse over the field to view full type name
  - **OP**–Outpatient
  - **CO**–Clinic Order
  - **NV**–Non-VA
  - **IV**–Intravenous
  - **UD**–Unit Dose
- **Medication:** Medication name and dose
- **Description:** SIG
- **Status:** Status of the medication
- **Last Date:** Date the last time the medication was updated

Problems | Adverse Reactions | Medications

RPMS

	Type	Medication	Description	Status	Last Date
+	OP	200 ACTUAT ALBUTEROL 0.09 MG/ACTUAT DRY POWDER INH	INHALE 2 PUFFS VIA INHALER EVERY 6 HOURS	ACTIVE	2/27/2025
+	OP	LEVOTHYROXINE 100MCG TAB	TAKE 0.1MG BY MOUTH DAILY FOR THYROID	ACTIVE	2/21/2025
+	OP	LOSARTAN 100MG TAB	TAKE ONE (1) TABLET BY MOUTH DAILY FOR HIGH BLOOD PRESSURE	ACTIVE	2/21/2025
+	OP	RANITIDINE HCL 150MG TAB	TAKE 150MG BY MOUTH TWICE A DAY FOR STOMACH	ACTIVE	2/21/2025

Figure 4-18: Medications RPMS Table

Click the **Plus Sign** (+) next to any given medication to see the details of the medication. The details may contain information such as:

- Medication
- Prescription #
- Prescriber
- SIG
- Days Supply
- Quantity
- Last Filled
- Type

Click a second time to close the details.

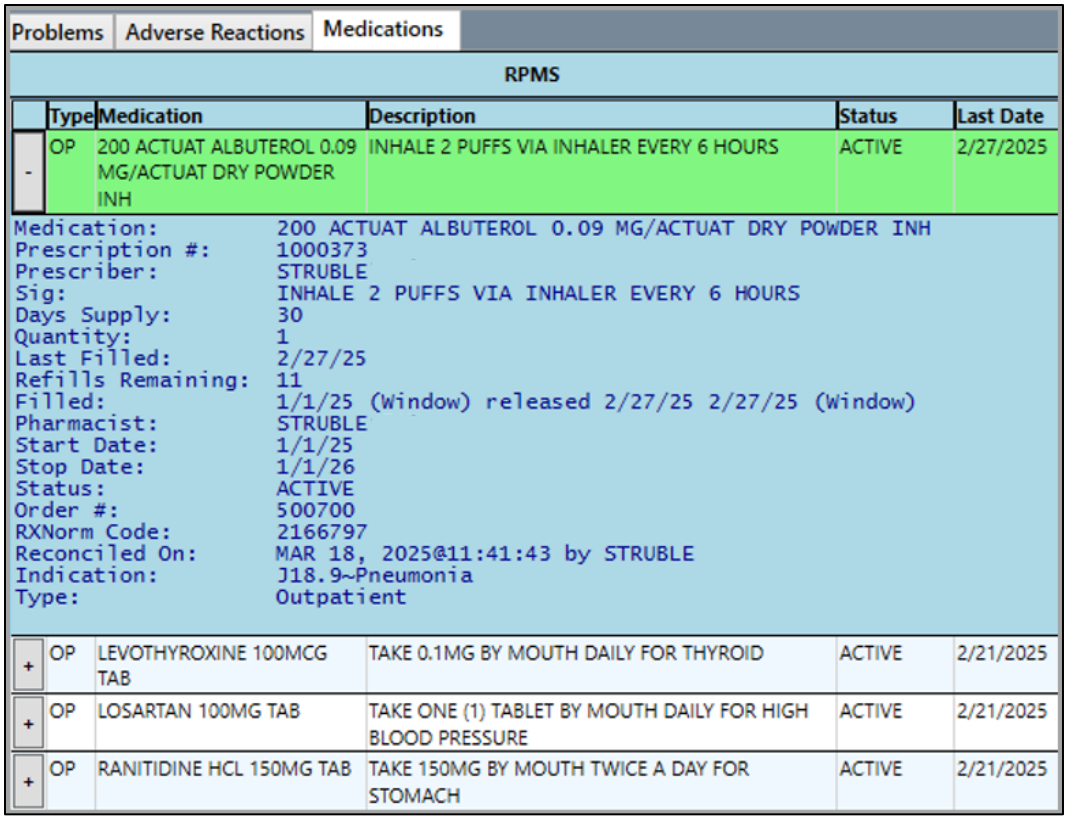


Figure 4-19: RPMS Medication expand

4.2.2.2 Clinical Document Panel

The Clinical Document panel contains a table (Figure 4-20) of patient information (problems) delivered in the received and selected CCDA document.

The Problems Clinical Document contains the following columns:

- **Problem:** Snomed CT preferred term
- **Status:** Current status of the patient's problem
- **Onset:** If populated, Onset date of problem
- **Diagnosis Date:** If populated, Date of Diagnosis for the problem
- **Source:** Provider who documented the problem
- **Last Date:** Date the last time the RPMS problem was updated
- **Action:** Status of the reconciliation process

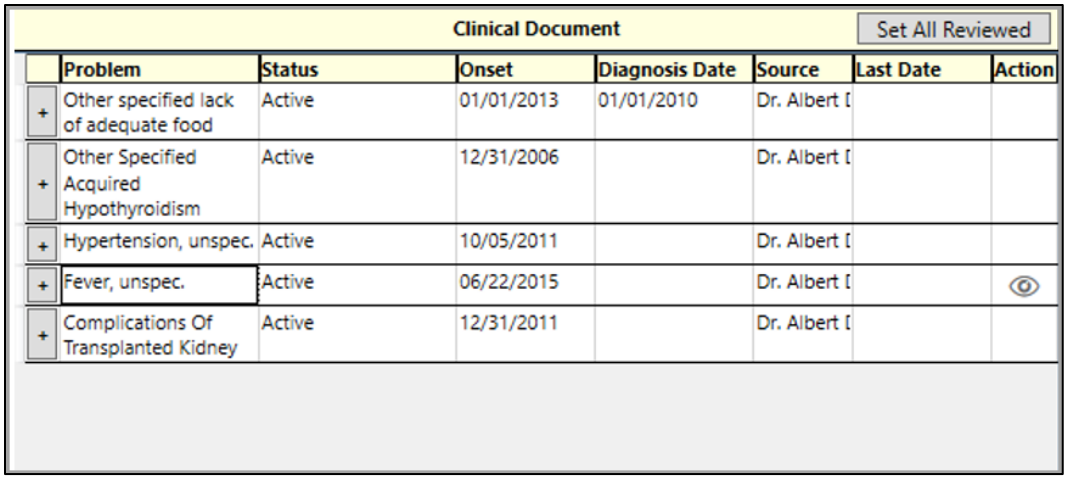


Figure 4-20: Clinical Document Problem table

The **Source** column (Figure 4-21) may contain more information than is visible. The field does not wrap to preserve space, though a mouse hover over the field reveals the full information.

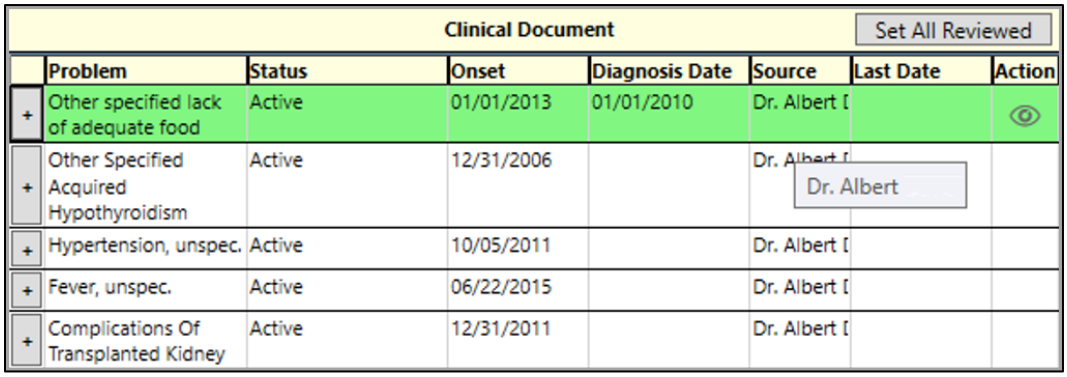


Figure 4-21: Clinical Document Problem Source column mouse over

Click the **Plus Sign** (+) next to any given problem enables users to see the details of the problem (Figure 4-22). The details may contain information such as:

- SNOMED CT or ICD-10 codes and terms
- Status
- Description
- Onset Date
- Date of Diagnosis
- Active Period
- Source

Click a second time to close the details.

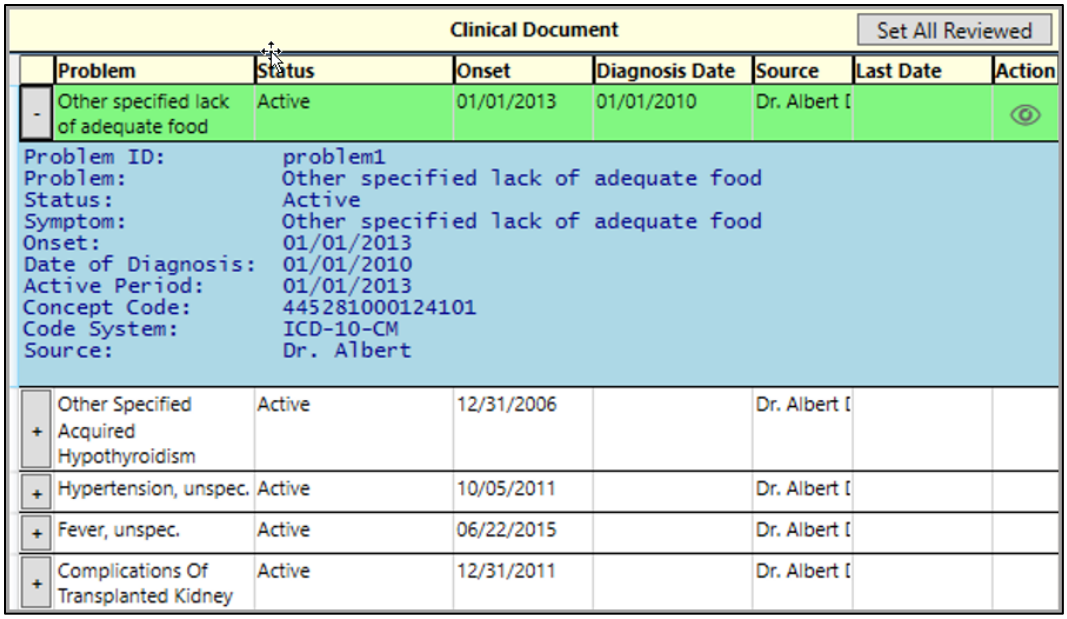


Figure 4-22: Clinical Document Problem expand

The **Adverse Reactions Clinical Document** table (Figure 4-23) contains the following columns.

- **Causative Agent:** Substance the patient has adverse reaction to
- **Event:** Type of reaction described using SNOMED CT terminology
- **Symptom:** Patients symptoms while using agent
- **Status:** Status of the adverse reaction
- **Source:** Provider who documented the adverse reaction
- **Last Date:** Date the last time the adverse reaction was updated
- **Action:** Status of the reconciliation process

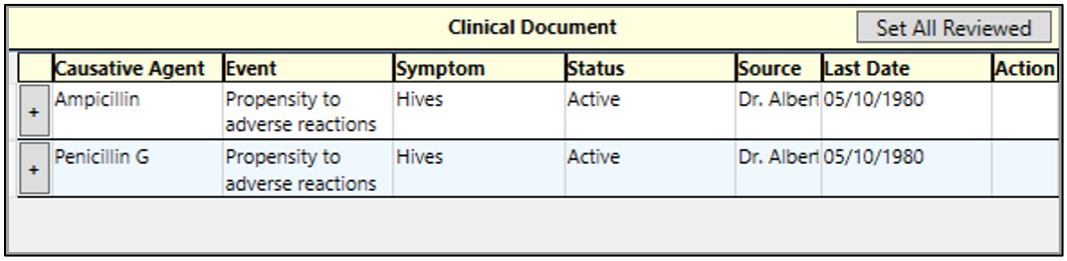


Figure 4-23: Clinical Document Adverse Reaction table

The **Source** column may contain more information than is visible. The field does not wrap to preserve space, though a mouseover on the field (Figure 4-24) reveals the full information.

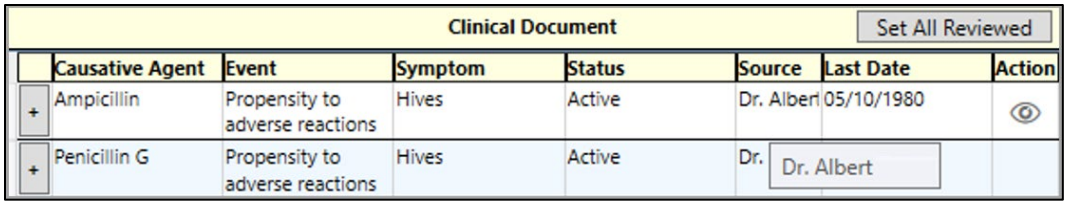


Figure 4-24: Clinical Document Adverse Reaction Source field mouseover

Click the **Plus Sign** (+) next to any given adverse reaction to see the details of the adverse reaction(Figure 4-25). The details may contain information such as:

- Causative Agent
- Reaction
- Status
- Severity
- Drug Code
- Effective Date
- Source

Click a second time to close the details.

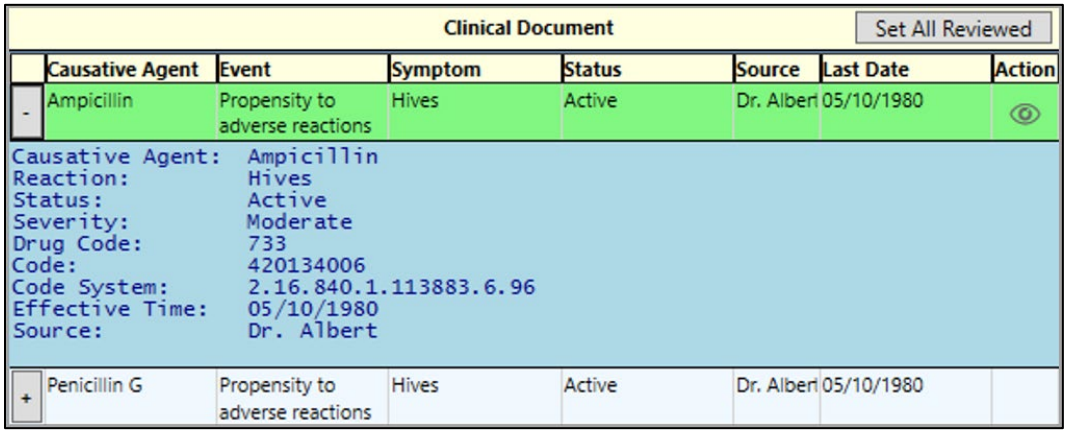
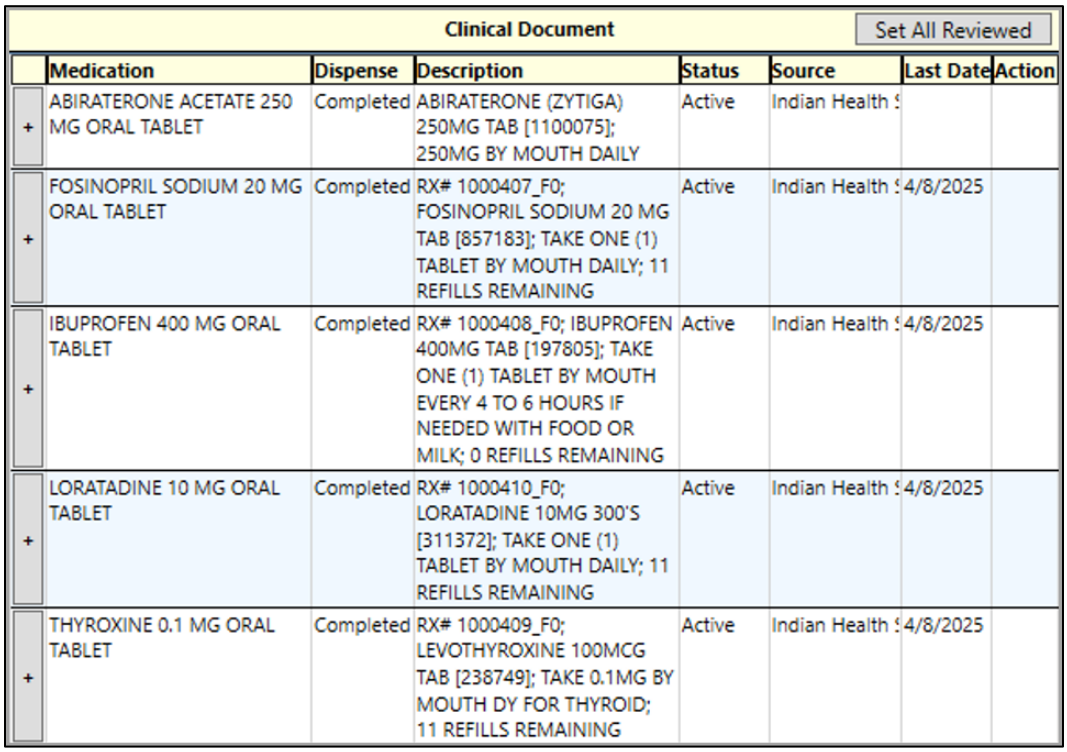


Figure 4-25: Clinical Document adverse reaction expand

Medications Clinical Document table (Figure 4-26) contains the following columns:

- **Medication:** Medication name and dose
- **Dispense:** Status for the prescription dispense
- **Description:** SIG
- **Status:** Status of the medication
- **Source:** Provider who documented the medication

- **Last Date:** Date the last time the medication was updated
- **Action:** Status of the reconciliation process



Clinical Document — Set All Reviewed

	Medication	Dispense	Description	Status	Source	Last Date	Action
+	ABIRATERONE ACETATE 250 MG ORAL TABLET	Completed	ABIRATERONE (ZYTIGA) 250MG TAB [1100075]; 250MG BY MOUTH DAILY	Active	Indian Health S		
+	FOSINOPRIL SODIUM 20 MG ORAL TABLET	Completed	RX# 1000407_F0; FOSINOPRIL SODIUM 20 MG TAB [857183]; TAKE ONE (1) TABLET BY MOUTH DAILY; 11 REFILLS REMAINING	Active	Indian Health S	4/8/2025	
+	IBUPROFEN 400 MG ORAL TABLET	Completed	RX# 1000408_F0; IBUPROFEN 400MG TAB [197805]; TAKE ONE (1) TABLET BY MOUTH EVERY 4 TO 6 HOURS IF NEEDED WITH FOOD OR MILK; 0 REFILLS REMAINING	Active	Indian Health S	4/8/2025	
+	LORATADINE 10 MG ORAL TABLET	Completed	RX# 1000410_F0; LORATADINE 10MG 300'S [311372]; TAKE ONE (1) TABLET BY MOUTH DAILY; 11 REFILLS REMAINING	Active	Indian Health S	4/8/2025	
+	THYROXINE 0.1 MG ORAL TABLET	Completed	RX# 1000409_F0; LEVOTHYROXINE 100MCG TAB [238749]; TAKE 0.1MG BY MOUTH DY FOR THYROID; 11 REFILLS REMAINING	Active	Indian Health S	4/8/2025	

Figure 4-26: Clinical Document medication table

The **Dispense** column (Figure 4-27) contains a mouseover on the value for each medication dispense. It is the definition of what the dispense value means from the outside source.

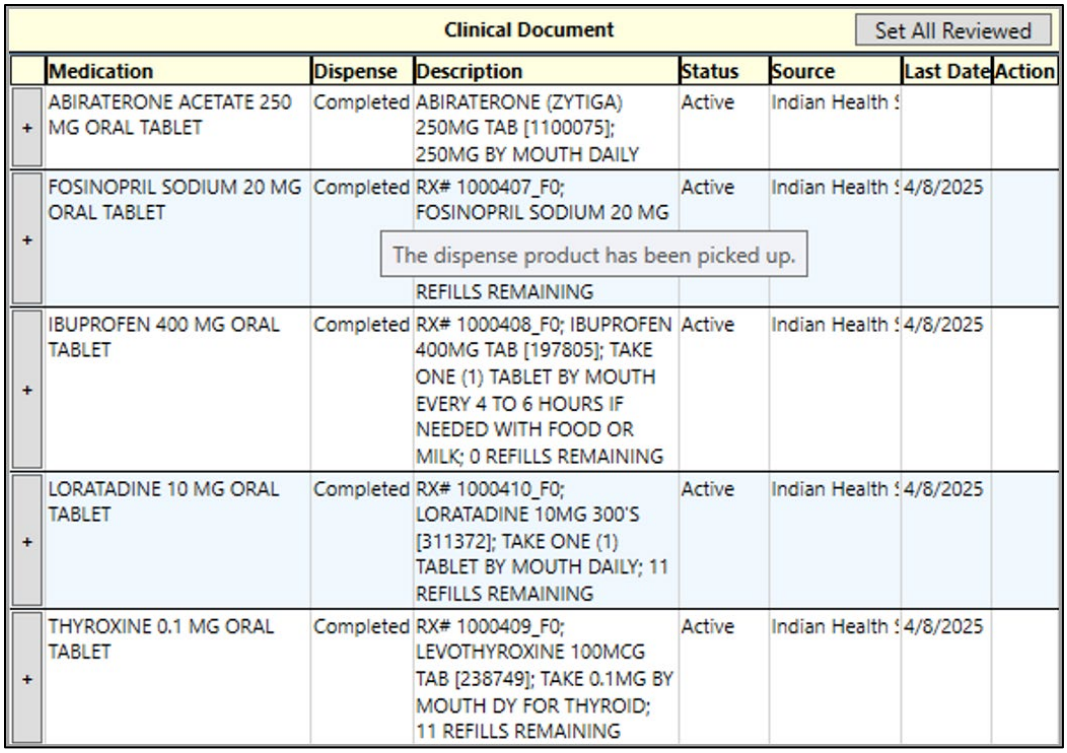


Figure 4-27: Clinical Document medication dispense tooltip

- **Preparation**–The core event has not started yet, but some staging activities have begun (e.g. initial compounding or packaging of medication). Preparation states may be tracked for billing purposes.
- **In Progress**–The dispensed product is ready for pickup.
- **Cancelled**–The dispensed product was not and will never be picked up by the patient.
- **On Hold**–The dispense process is paused while waiting for an external event to reactivate the dispense. For example, new stock has arrived or the prescriber has called.
- **Completed**–The dispense product has been picked up.
- **Entered in Error**–The dispense was entered in error and therefore nullified.
- **Stopped**–Actions implied by the dispense have been permanently halted, before all of them occurred.
- **Declined**–The dispense was declined and not performed.
- **Unknown**–The authoring system does not know which of the status values applies for this medication dispense.

The **Source** column (Figure 4-28) may contain more information than is visible. The field does not wrap to preserve space, though a mouse hover over the field reveals the full information.

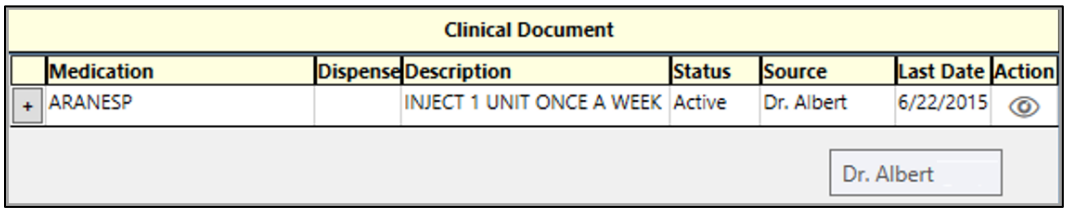


Figure 4-28: Clinical Document Medication Source field mouseover

Click the **Plus Sign** () next to any given medication to see the details of the medication (Figure 4-29). The details may contain information such as:

- Medication
- SIG
- Dispense
- Status
- Source
- Last Filled
- Start Date

Click a second time to close the details.

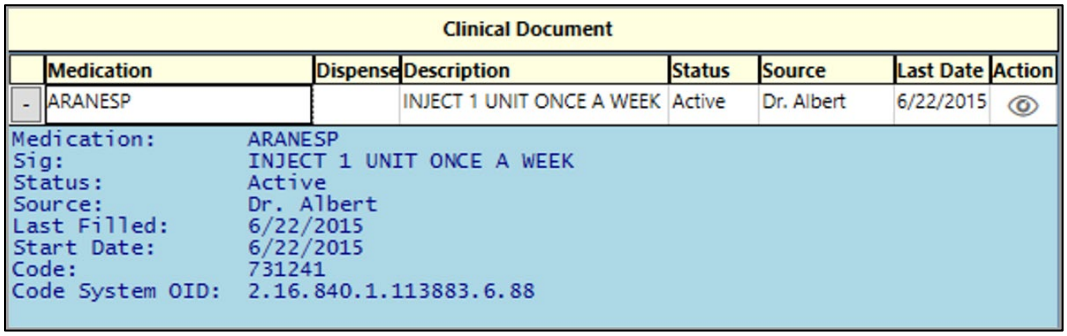


Figure 4-29: Clinical Document medication expand

4.2.3 Bottom Pane

4.2.3.1 Reconciliation Panel

This panel (Figure 4-30) displays the information that has been reconciled for the selected tab in the middle pane of the **CIR Tool**. The columns in this pane will vary depending on the active tab in the middle section. The data from the RPMS pane will automatically populate this section by default. The information from the **Clinical Document** pane displays once an action has been taken on it. Information added manually will also display in this section.

Problems table contains the following columns:

- **Problem**
- **Status**
- **Onset**
- **Action**

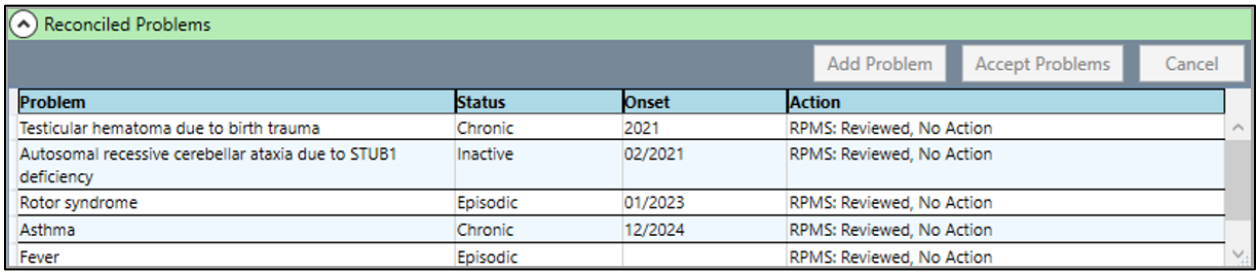


Figure 4-30: Reconciled Problems panel

Adverse Reactions table (Figure 4-31) contains the following columns:

- **Causative Agent**
- **Event**
- **Symptoms**
- **Action**

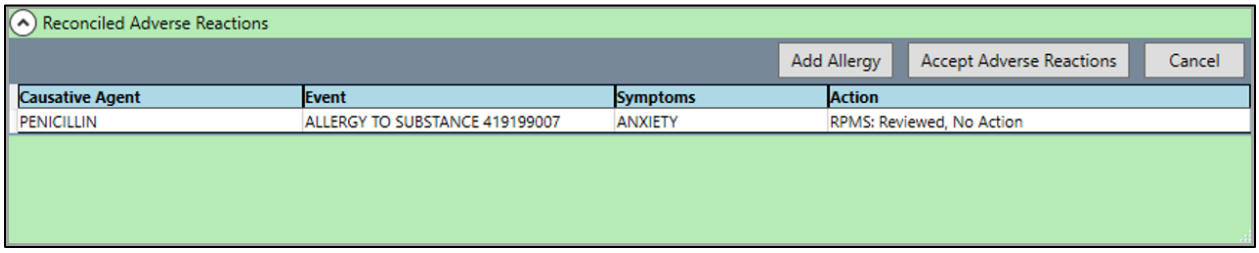


Figure 4-31: Reconciled Adverse Reactions panel

Medications table (Figure 4-32) contains the following columns:

- **Medication**
- **Description**
- **Status**
- **Action**

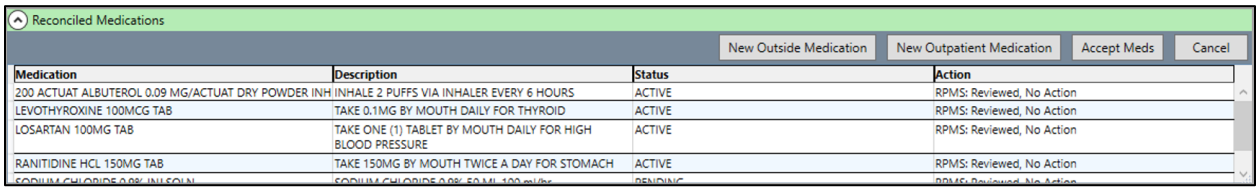


Figure 4-32: Reconciled Medications panel

4.3 Reconciling Clinical Information

Any EHR user with sufficient clinical knowledge may reconcile clinical information; check the site's policies for specifics on who should be performing clinical reconciliation and when clinical reconciliation should be done.

To start, select a patient, then either open the **CIR Tool** and set a visit context using the **Visit** button, or set a visit context using the **Visit** box and then open the **CIR Tool**. Select a source by either select a **CCDA document**, or by selecting one of the sources in the **CCDA Source** field. Clear a selected item by double clicking it. While the user may reconcile more than one document in a session, each document must be reconciled separately.

Once a source is selected, the user may begin to reconcile the problems, adverse reactions, and medications. If a **CCDA document** is selected, the Problems, Adverse Reactions, and Medications from that document populate the **Clinical Document** pane for the appropriate tab in the middle section. For a non-CCDA source such as a medication list or caregiver, the RPMS information is populated but the remaining information must be manually entered if the data is needed in the RPMS database. For the purposes of this manual, it will be assumed from here on out that a **CCDA document** is selected.

The default selection is the **Problems** tab, though the user may reconcile just one type of clinical data or reconcile data from one or more tabs in any order. For the purposes of this manual, the tabs will be reconciled in the following order:

- **Problems**
- **Adverse Reactions**
- **Medications**

The tabs that have not been accessed will have an asterisk on them. Once the tab has been selected, the asterisk disappears regardless of whether any actions were taken on the data in the tab.

4.3.1 Problems

4.3.1.1 Reconciling RPMS Problem Data

The **Reconciled** panel will expand once a source is selected in the **Generated by CCDA** table and will be populated with the problems from the local RPMS database by default, with the action column reading **RPMS: Reviewed, No Action**.

> **Note:** No further action is needed for RPMS problems in the CIR reconciliation process unless there is a need to change i.e. edit an existing RPMS problem or mark an RPMS problem as entered in error.

Selecting a problem in either panel highlights any matching item in the other panel (Figure 4-33), and in the **Reconciled Problems** pane at the bottom of the **CIR Tool** window. A match for a problem is an item where the problem text or the associated **Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)** code match. Keep in mind that if the lists are long, the highlighted item in the other list may be out of sight. Scroll through the lists as needed to see if there are matching items. The user may control-click to remove the highlighting.

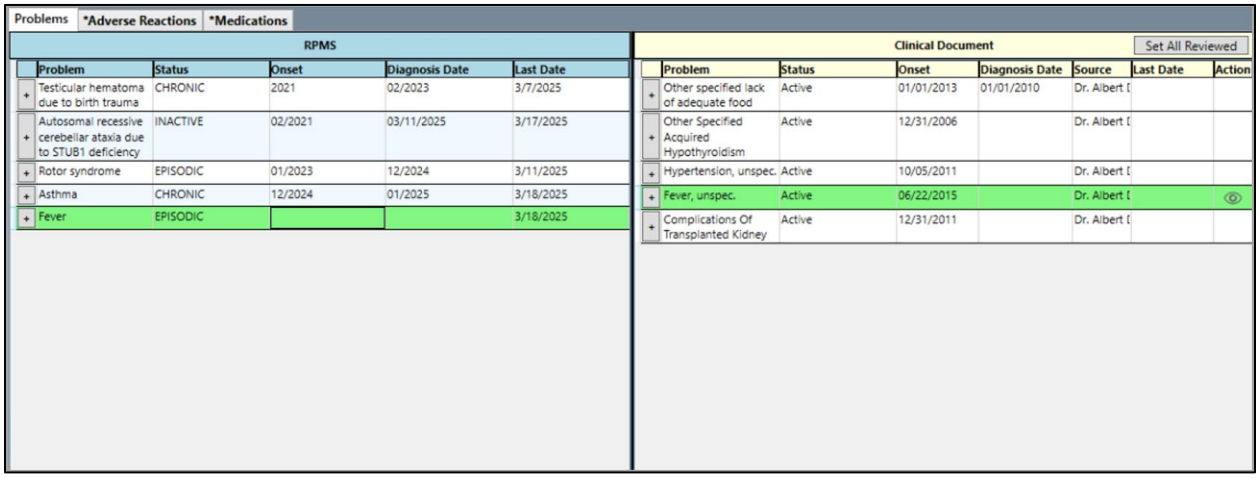


Figure 4-33: Problem Match window

For RPMS problems, right-click menu options (Figure 4-34) include the following:

- **Change**
- **Reviewed, No Action**
- **View Details**

- **Entered in Error**

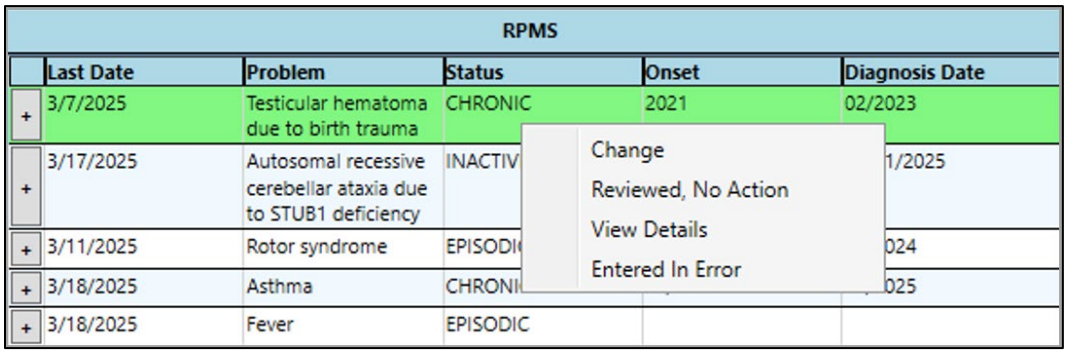


Figure 4-34: RPMS reconciliation right-click menu options

4.3.1.1.1 Change Option

Selecting **Change** opens the **Reconcile RPMS Problem** window (Figure 4-35). Here, users may edit the problem as needed.

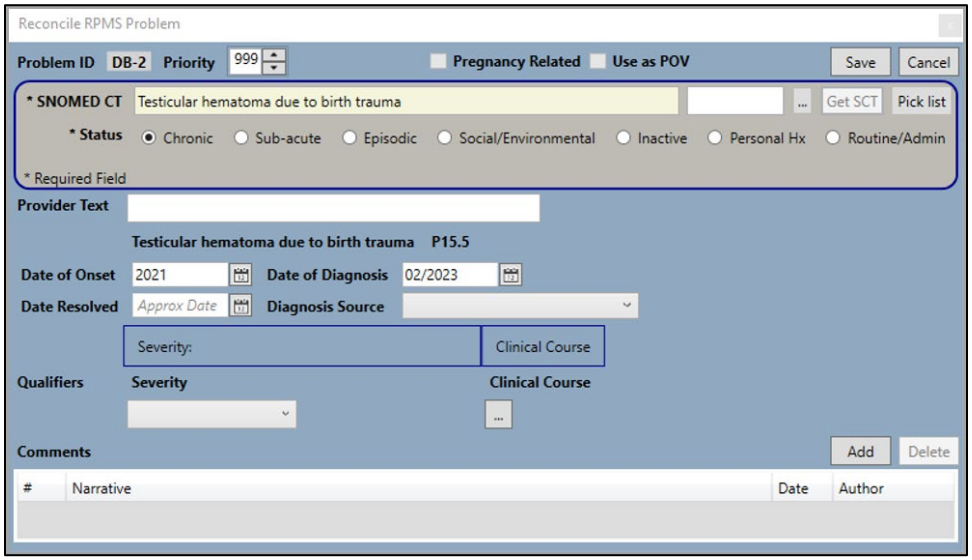


Figure 4-35: Reconcile RPMS Problem – RPMS Change Option window

Once the needed changes have been made, click the **Save** button. The changes will update to the **Reconciled Problems** pane (Figure 4-36). The changes will not be saved to the IPL until the reconciliation is completed.

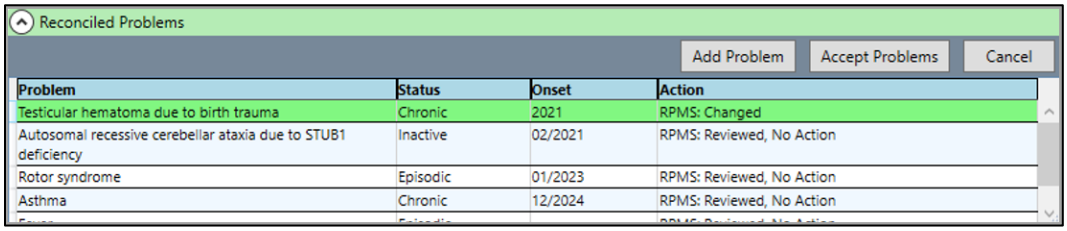


Figure 4-36: RPMS Problem Change pane

4.3.1.1.2 Reviewed, No Action Option

Selecting **Reviewed, No Action** (Figure 4-37) marks the item in the **Reconcile Problems** list. For ease of documentation, this action is the default for all RPMS problems, so users only need to manually select it if some other action was selected first and now want to go back to the **Reviewed, No Action** option.

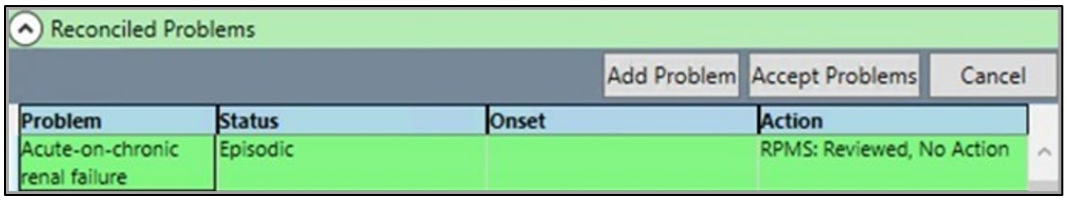


Figure 4-37: RPMS Problem Reviewed, No Action option

4.3.1.1.3 View Detail Option

Selecting **View Details** opens a new window (Figure 4-38) where the problem details are listed. If there is a matching problem in the **Clinical Document** pane, the details for that problem will also be shown.

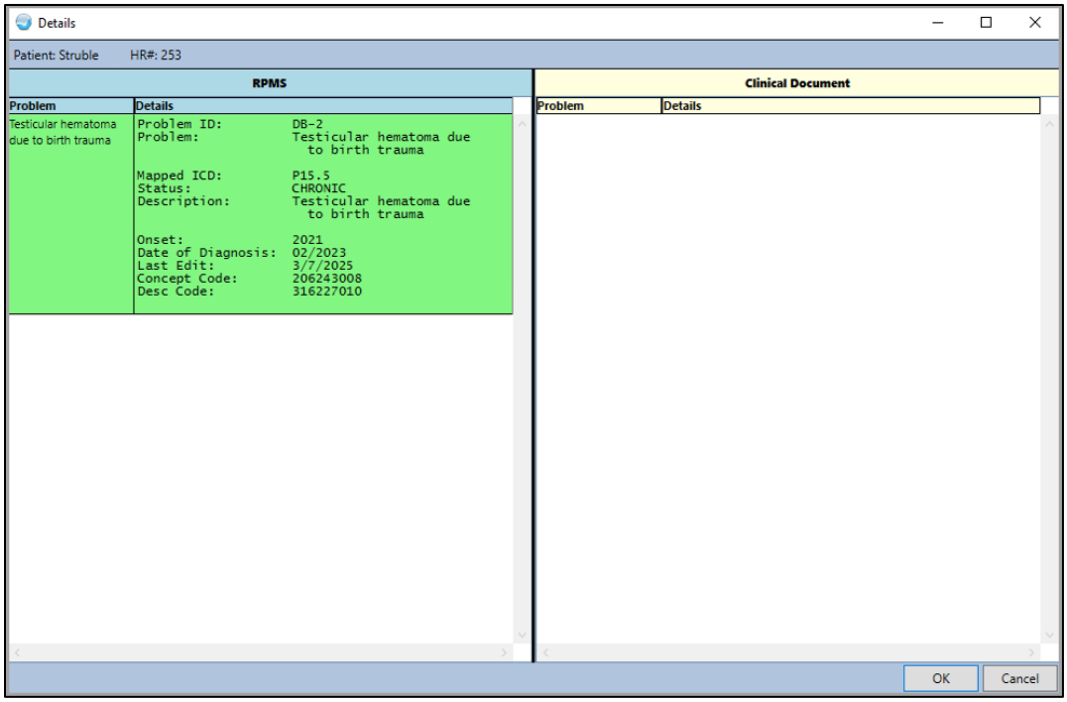


Figure 4-38: RPMS View Detail option dialog

4.3.1.1.4 Entered in Error Option

Selecting **Entered In Error** opens the **Delete RPMS Problem** window (Figure 4-39). Select the appropriate reason or type in another, then click **OK**.

> **Note:** Problems may not be deleted if used for any visit as **Purpose of Visit (POV)**, or if they contain **Visit Instructions**, **Care Planning**, or **Goals**.

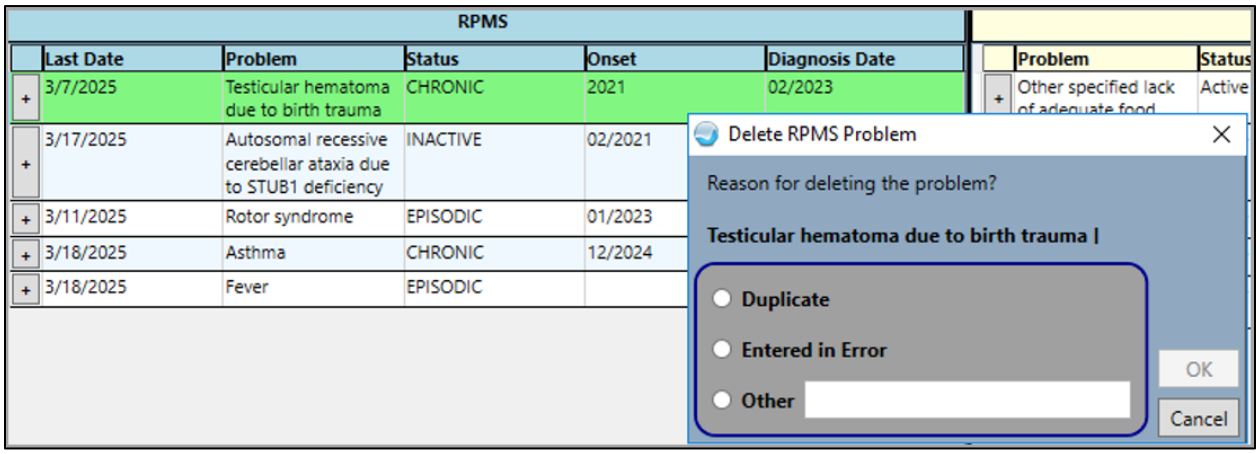


Figure 4-39: RPMS Entered In Error option dialog

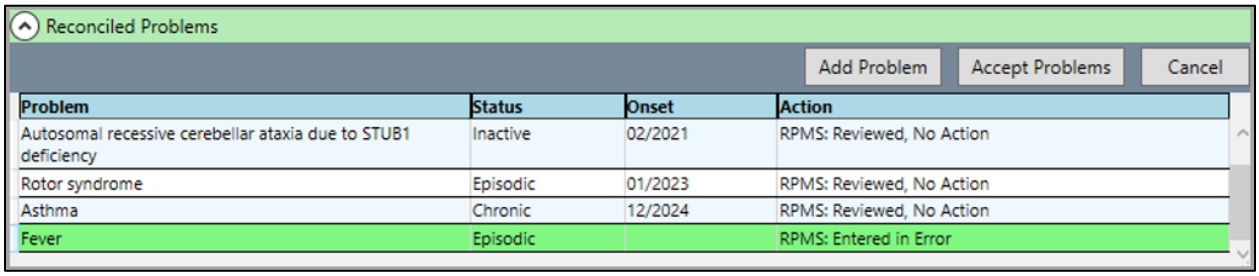


Figure 4-40: RPMS Problem Entered in Error dialog

4.3.1.1.5 Add Problem Button

If a user wants to add a new RPMS problem not displaying in either the **RPMS** or **Clinical Document** panel, use the **Add Problem** button (Add Problem)in the **Reconciled Problems** panel (Figure 4-41).

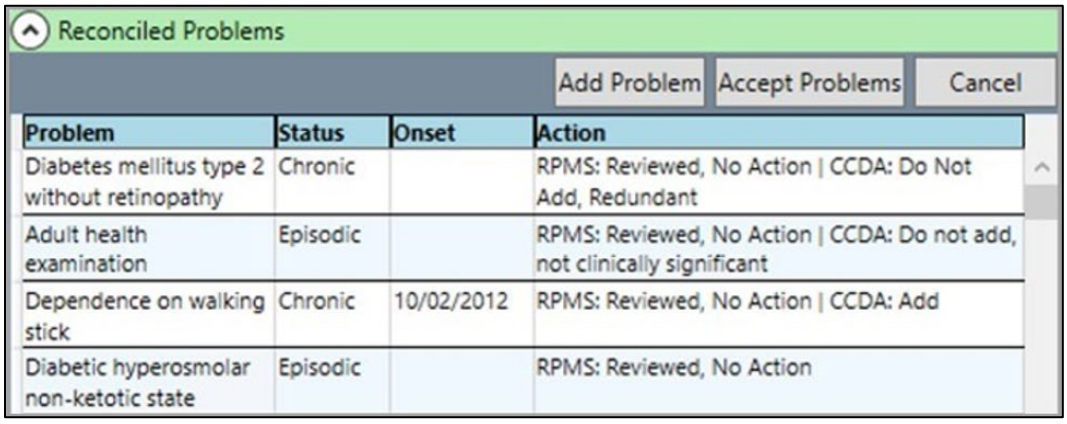


Figure 4-41: Add Problem button on the Reconciled Problems panel

Clicking this button opens the **Add New Problem** dialog. Users may search for a SNOMED CT and complete the remaining information as usual. There is the same check for duplicate **SNOMED CT** codes using this option.

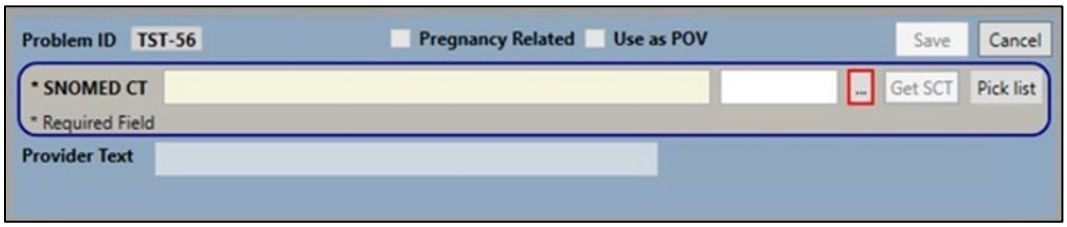


Figure 4-42: Add new problem dialog

4.3.1.2 Reconciling Clinical Document Problem Data

Clicking a problem in either panel highlights any matching item in the other panel (Figure 4-43), and in the **Reconciled Problems** pane at the bottom of the **CIR Tool** window. A match for a problem is an item where the problem text or the associated **Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)** code match. Keep in mind that if the lists are long, the highlighted item in the other list may be out of sight. Scroll through the lists as needed to see if there are matching items. The user may control-click to remove the highlighting.

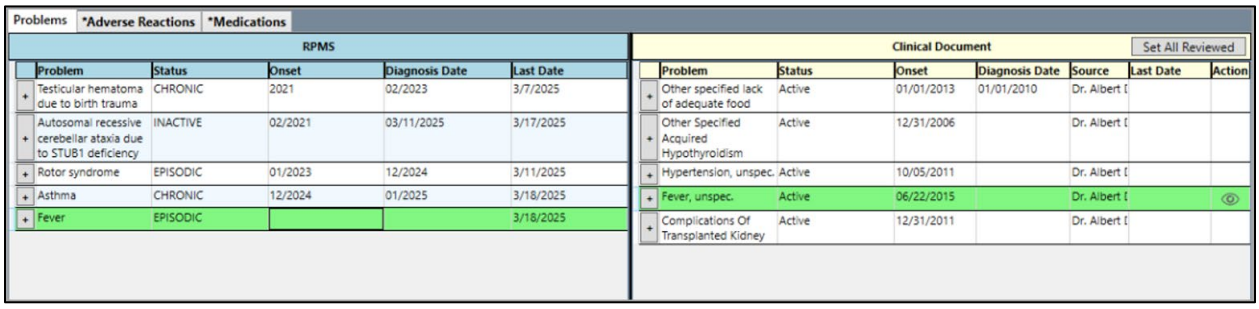


Figure 4-43: Problem Match window

For Clinical Document problems, right-click menu options include the following:

- **Add**
- **Do Not Add, Redundant**
- **Do Not Add, Not Clinically Significant**
- **View Details**

4.3.1.2.1 Set All Reviewed Button

If no reconciliation is need with all the clinical problem data received, the user can click the **Set All Reviewed** button (Figure 4-44). Clicking this button sets all the clinical document problems to be reviewed but will not assign an action to them.

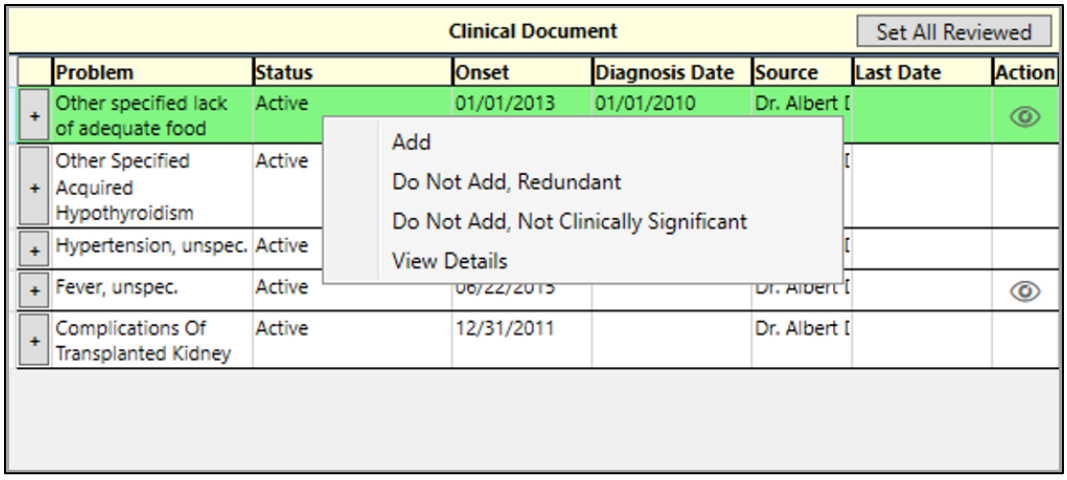


Figure 4-44: Clinical Document reconciliation options

4.3.1.2.2 Add Option

Selecting **Add** opens the **Add CCDA Problem** dialog (Figure 4-45). The available information will be pre-populated. Complete the additional fields as needed and click **Save**. The save adds a check mark in the **Clinical Document** pane and marks the problem in the **Reconciled Problems** pane.

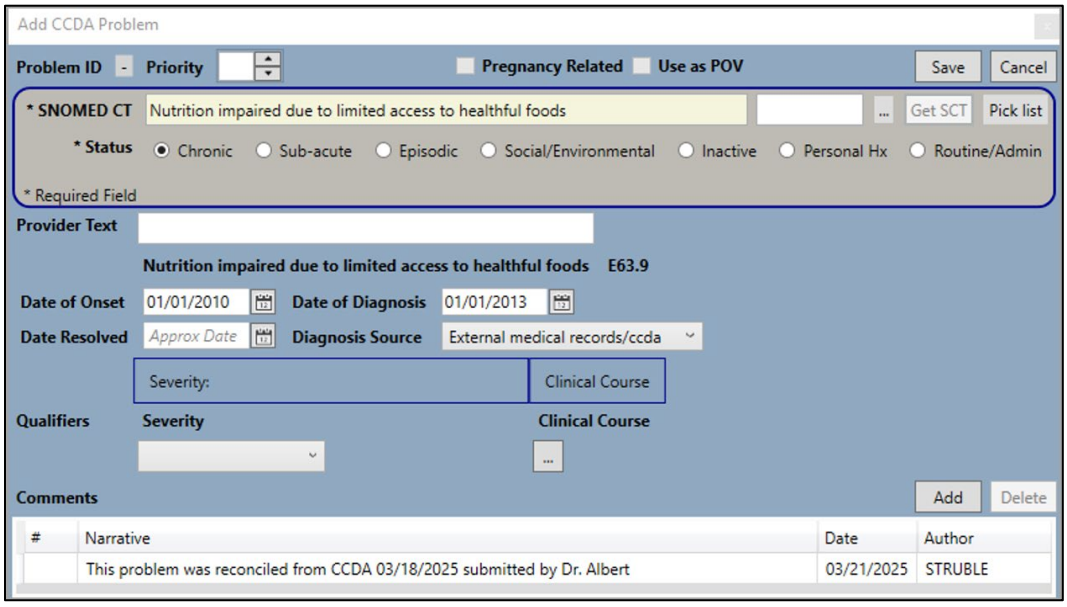


Figure 4-45: Add CCDA Problem Clinical Document dialog

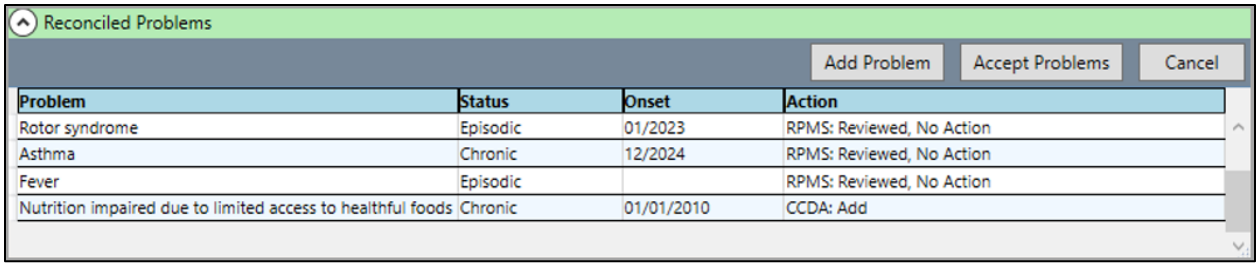


Figure 4-46: Reconciled Problems Clinical Document Add Saved dialog

If a problem with the same SNOMED CT concept ID is already present in RPMS, the following error message appears:

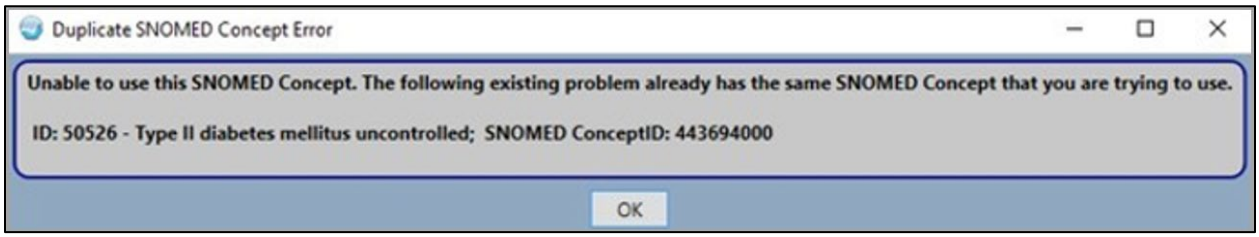


Figure 4-47: Duplicate SNOMED Concept error message

In this case, select action **Do Not Add, Redundant** as shown below.

4.3.1.2.3 Do Not Add, Redundant Option

Selecting **Do Not Add, Redundant** (Figure 4-48) adds a check mark in the **Clinical Document** pane and marks the problem in the **Reconciled Problems** pane.

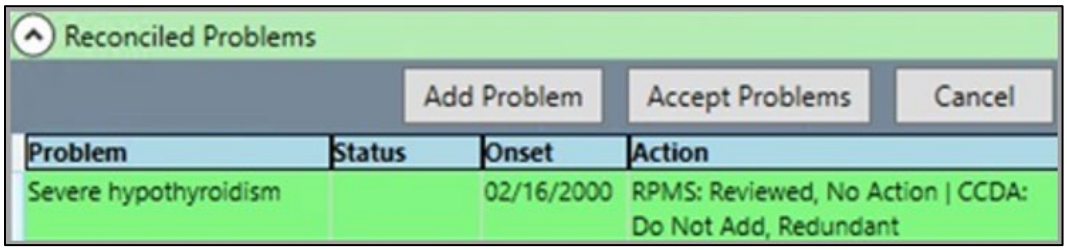


Figure 4-48: Clinical Document Do Not Add, Redundant pane

4.3.1.2.4 Do Not Add, Not Clinically Significant Option

Selecting **Do Not Add, Not Clinically Significant** (Figure 4-49) adds a check mark in the **Clinical Document** pane and marks the problem in the **Reconciled Problems** pane.

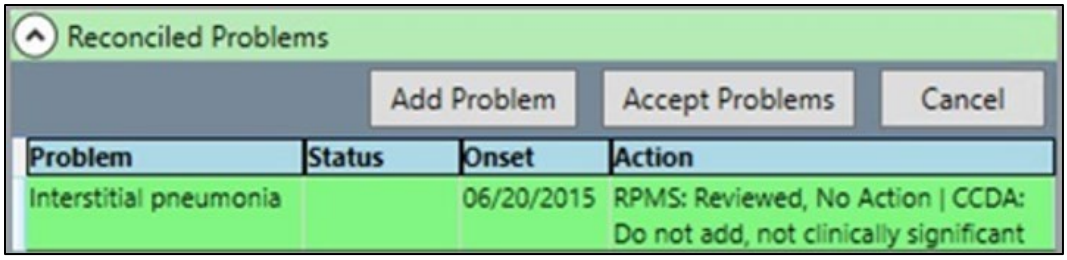


Figure 4-49: Clinical Document Do Not Add, Not Clinically Significant pane

4.3.1.2.5 View Detail Option

Selecting **View Details** opens a new window (Figure 4-50) where the problem details are listed. If there is a matching problem in the RPMS pane, the details for that problem will also be shown.

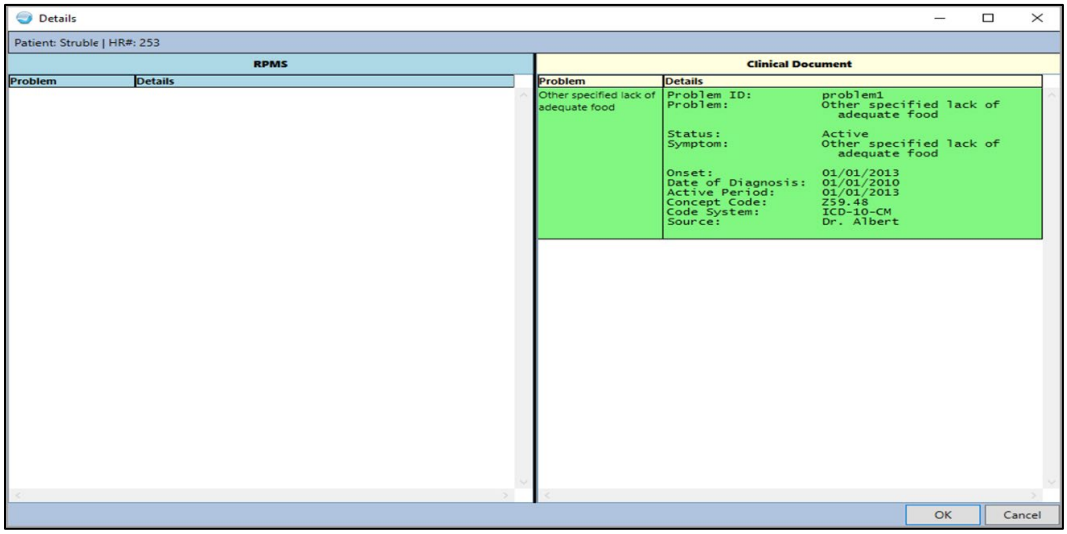


Figure 4-50: Clinical Document View Detail option

> **Note:** If the user is going to reconcile the entire CCDA Document while the CIR Tool is open, including problems, adverse reactions, and medications, the user does not need to click the **Accept Problems** button. Each entry is saved when the user moves to other tabs. In this event, the user will click the **Accept All** button in the top-right area of the tool when all tabs have been reconciled.

4.3.1.3 Reviewing and Finalizing Problem Data

Once all the problems have been reconciled, users may review the items and the actions taken in the **Reconciled Problems** pane (Figure 4-51) at the bottom of the main **CIR Tool** window. Each item from RPMS and each item from the clinical document that had an action taken on it will be listed, along with the status, onset date, and action.

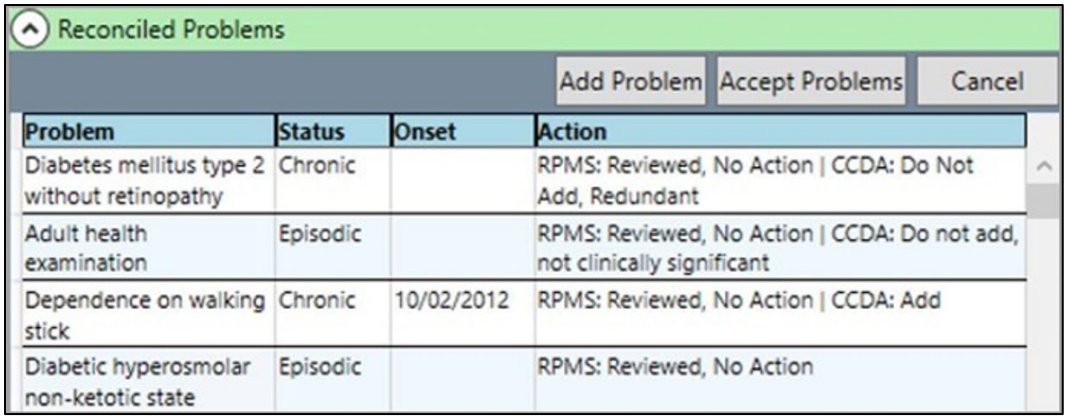


Figure 4-51: Reconciled Problems pane

4.3.1.3.1 Accept Problems Button

Until the reconciled problems are accepted, no changes are made to the record. To accept all the reconciled problem information and not the adverse reaction and medication information, click **Accept Problems**.

If the **Accept Problems** button is used but not all problems have been reviewed, the **Unreviewed items** warning (Figure 4-52) appears.

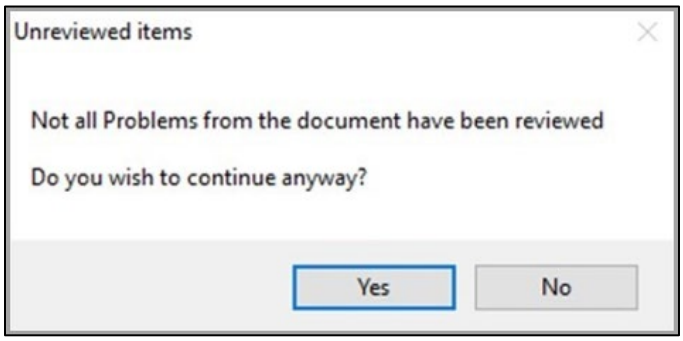


Figure 4-52: Unreviewed items warning for problems message

Click **Yes** to continue anyway, or **No** to go back and review the remaining problems.

If there are no unreviewed problems or if the user chooses **Yes** on the **Unreviewed items** warning, the **Review/Sign Changes for CIR Reconciled Problems** dialog (Figure 4-53) displays. The reconciled items are displayed along with any other items needing signature.

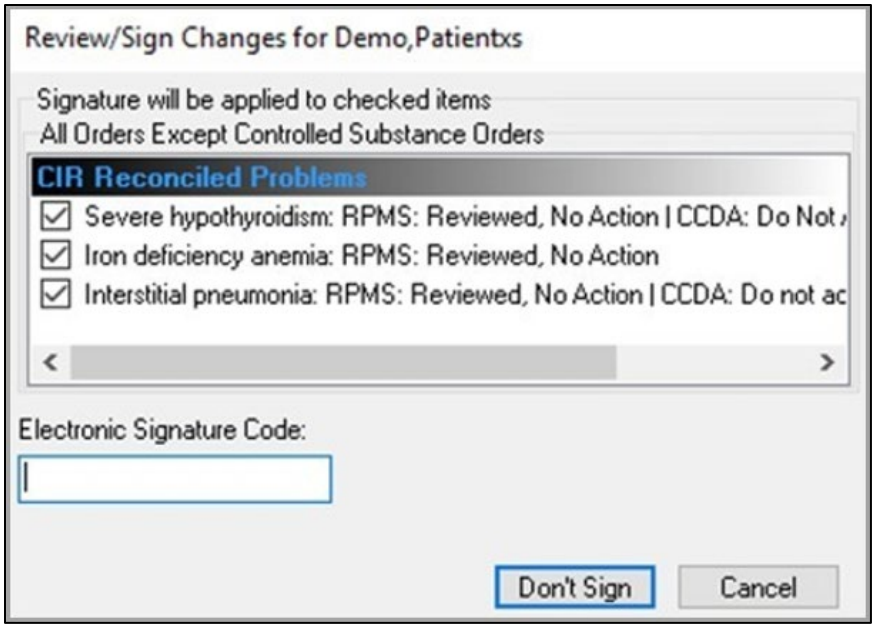


Figure 4-53: Review/Sign Changes for CIR Reconciled Problems dialog

Enter an **Electronic Signature Code** and click **Sign**. The CIR Tool Information for Problems will reset and the CCDA document will reflect the reconciliation type and date.

4.3.1.3.2 Cancel Button

Click the **Cancel** button to not complete the reconciliation of the problems or to undo changes for the problems only. There is no confirmation of this action; clicking Cancel will remove all the previously selected actions for the Problems immediately.

4.3.2 Adverse Reactions

To reconcile the Adverse Reactions, click the **Adverse Reactions** tab. Like the **Problems** tab, this tab contains two panes: **RPMS** and **Clinical Document**. The RPMS pane will show the adverse reactions recorded in the **RPMS Adverse Reactions** package (and not reactions documented in the problem list). It has the following columns:

- **Causative Agent**
- **Event**
- **Symptoms**
- **Status**
- **Last Date**

The **Clinical Document** pane contains the adverse reaction information from the selected CCDA document and has the following columns:

- **Causative Agent**
- **Event**
- **Symptom**
- **Status**
- **Source**
- **Last Date**
- **Action**

The data in each pane may be sorted by any column.

> **Note:** If the adverse reaction is currently active, the **Inactivate** option displays. If the adverse reaction is currently inactive, the **Reactivate** option will display.

Clicking an adverse reaction in either pane will highlight any matching item in the other pane (Figure 4-54), and in the **Reconciled Adverse Reactions** pane at the bottom of the **CIR Tool** window. A match for an adverse reaction is when the first word in the causative agent field matches. Keep in mind that if the lists are long, the highlighted item in the other list may be out of view in the pane. Scroll through the lists as needed to see if there are matching items. Use control-click to remove the highlighting.

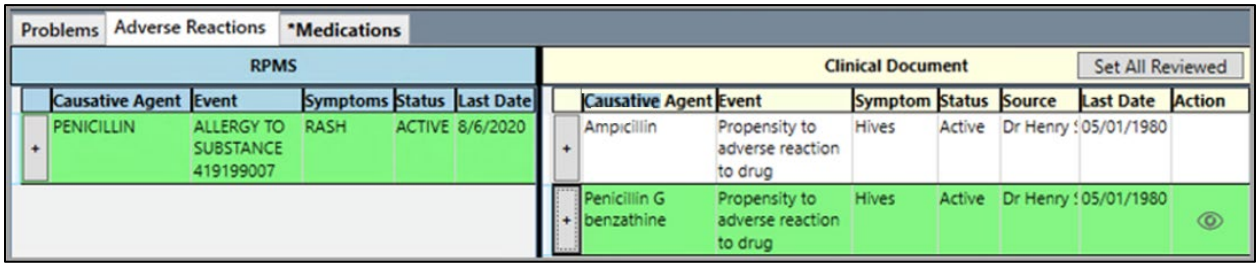


Figure 4-54: Adverse Reactions tab with matching line items highlighted

4.3.2.1 Reconciling RPMS Adverse Reactions Data

The **Reconciled** panel will expand once a source is selected in the **Generated by CCDA** table and will be populated with the adverse reactions from the local RPMS database by default when the adverse reactions tab is selected. The RPMS entries will display with the action column reading **RPMS: Reviewed, No Action**.

For RPMS Adverse Reactions, right-click menu options include the following:

- **Change**
- **Reviewed, No Action**
- **Entered in Error**

- **Inactivate**
- **Reactivate**
- **View Details**

> **Note:** No further action is needed for RPMS adverse reactions in the CIR reconciliation process unless there is a need to change (i.e., edit an existing RPMS adverse reaction or mark an RPMS adverse reaction as inactivated, reactivated or entered in error).

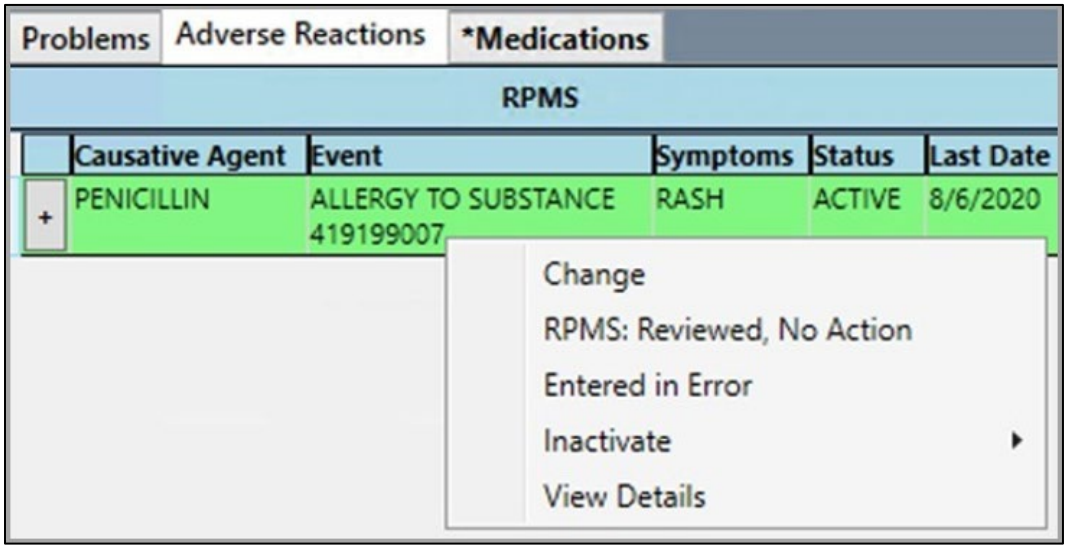


Figure 4-55: RPMS Adverse Reactions right-click menu options

4.3.2.1.1 Change Option

Selecting **Change** opens the **Edit Adverse Reaction** window (Figure 4-56). The user may change the event code, source of information, add signs/symptoms, and source of a sign/symptom, and add comments. The user may not change the causative agent, remove the originally documented signs/symptoms, or adjust the date/time of the original signs/symptoms.

> **Note:** No further action is needed for RPMS adverse reactions in the CIR reconciliation process unless there is a need to change (for example edit an existing RPMS adverse reaction or mark an RPMS adverse reaction as inactivated, reactivated or entered in error).

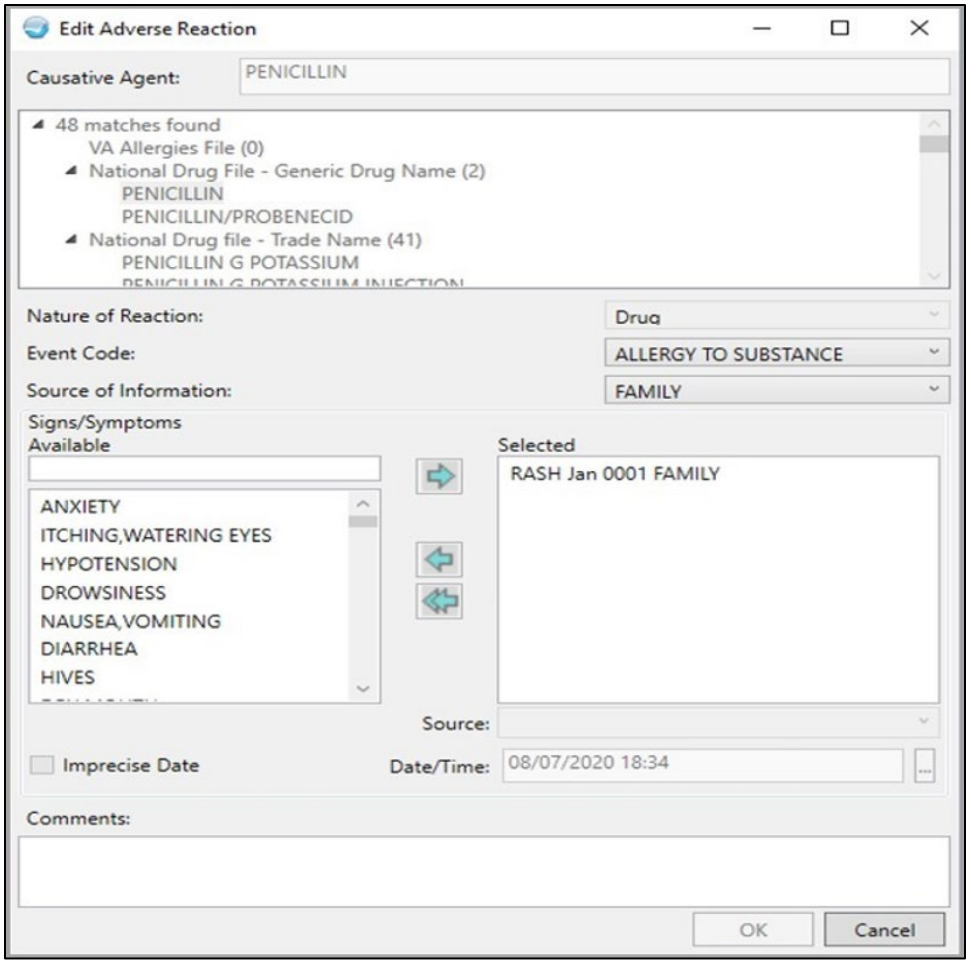


Figure 4-56: Edit Adverse Reaction RPMS Change option

Once the needed changes have been made, click **Save** to save the changes to the **Reconciled Adverse Reactions** pane. The changes will not be saved to the **Adverse Reactions** component until the session is finalized.

4.3.2.1.2 Reviewed, No Action Option

Selecting **RPMS: Reviewed, No Action** marks the item in the **Reconciled Adverse Reactions** pane. For ease of documentation, this action is the default for all RPMS adverse reactions, so the user only needs to manually select it if some other action was selected first and the user wants to go back to the **RPMS: Reviewed, No Action** option.

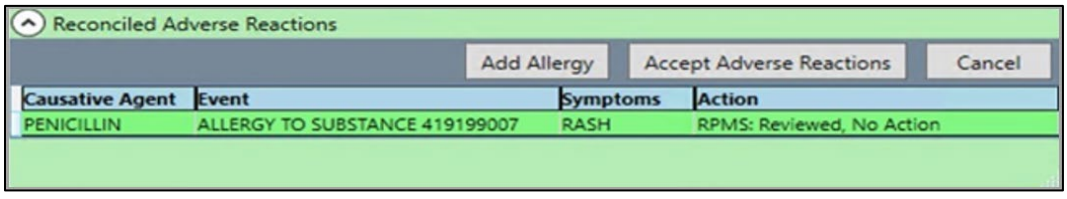


Figure 4-57: RPMS Adverse Reactions Reviewed, No Change

4.3.2.1.3 Entered in Error Option

Selecting **Entered in Error** opens the **Entered in Error** comment dialog (Figure 4-58). Enter a reason and click **OK** to logically delete the entry. The entry will still exist in the system but will be marked as entered in error, will not show in the patient chart, and will not be used in order checks. It can still be found in the RPMS system for audit and legal purposes.

> **Note:** No further action is needed for RPMS adverse reactions in the CIR reconciliation process unless there is a need to change (for example, edit an existing RPMS adverse reaction or mark an RPMS adverse reaction as inactivated, reactivated or entered in error).

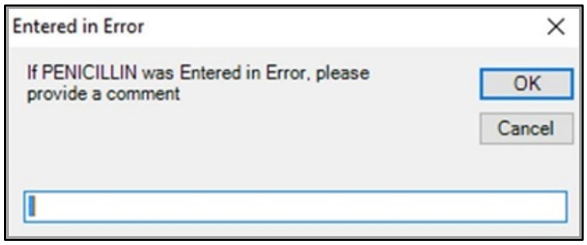


Figure 4-58: RPMS Adverse Reactions Entered in Error comment dialog

The adverse reaction displays in the **Reconciled Adverse Reactions** pane with an action of **RPMS: Entered in Error** (Figure 4-59).

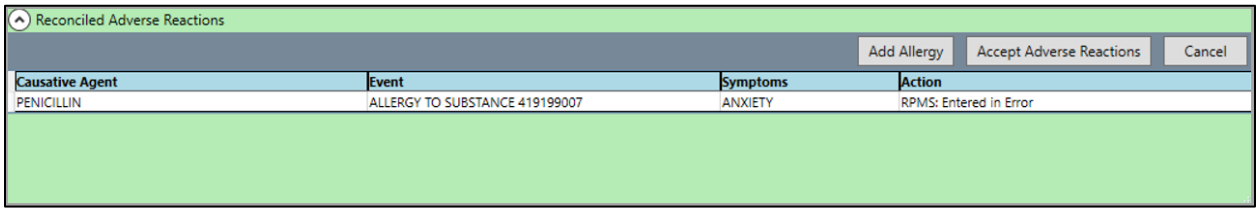


Figure 4-59: Reconciled Adverse Reactions pane with RPMS Entered in Error

4.3.2.1.4 Inactivate Option

Selecting **Inactivate** opens secondary options of **No Longer Allergic** and **Reaction is Tolerable** (Figure 4-60). Selecting one of these options will mark the adverse reaction as inactive with the selected reason. These adverse reactions will be available to view in the patient chart but will not be used in order checks.

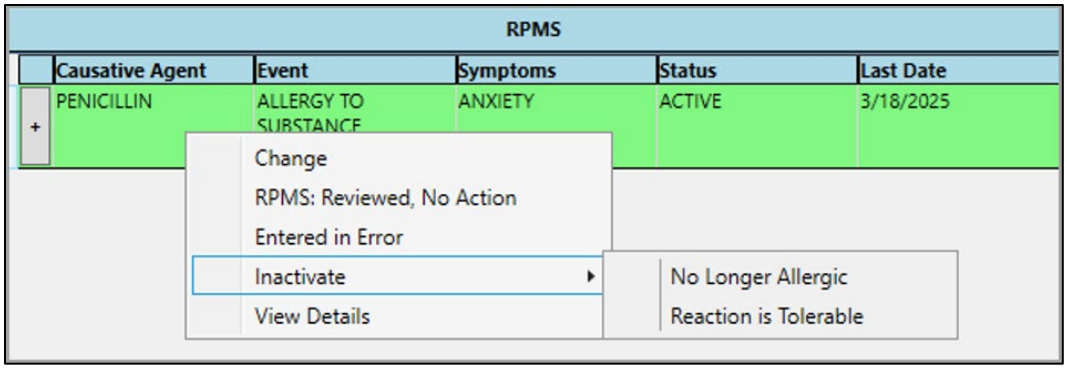


Figure 4-60: RPMS Inactive Option reasons

The adverse reaction displays in the **Reconciled Adverse Reactions** pane with an action of **RPMS: Inactivate Reaction is Tolerable** or **RPMS: Inactivate No Longer Allergic** (Figure 4-61) depending on the reason selected.

> **Note:** No further action is needed for RPMS adverse reactions in the CIR reconciliation process unless there is a need to change (for example, an existing RPMS adverse reaction or mark an RPMS adverse reaction as inactivated, reactivated or entered in error).

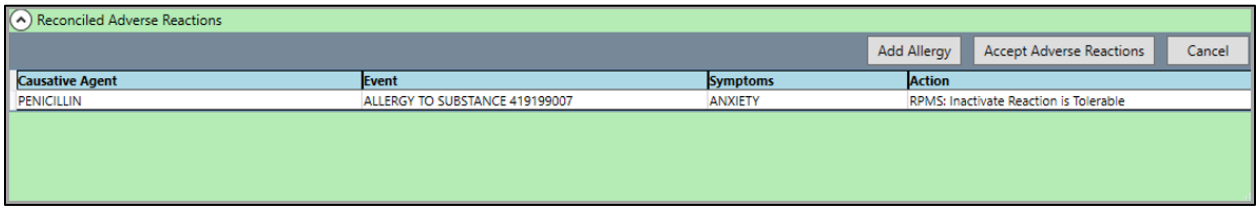


Figure 4-61: Reconciled Adverse Reactions RPMS: Inactivate Reaction is Tolerable window

4.3.2.1.5 Reactivate Option

Selecting **Reactivate** will mark the item in the **Reconciled Adverse Reactions** list (Figure 4-62) and reactivate the item. The adverse reaction will display in the **Reconciled Adverse Reactions** pane with an action of **RPMS: Reactivate**.

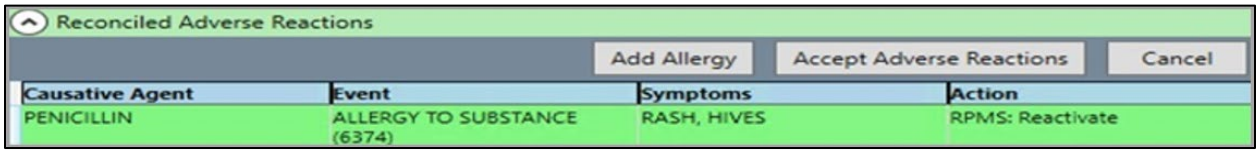


Figure 4-62: Reconciled Adverse Reactions RPMS: Reactivate window

4.3.2.1.6 View Details Option

Selecting **View Details** (Figure 4-63) opens a new window where the adverse reaction details are listed. If there is a matching adverse reaction in the **Clinical Document** pane, the details for that adverse reaction will also be shown.

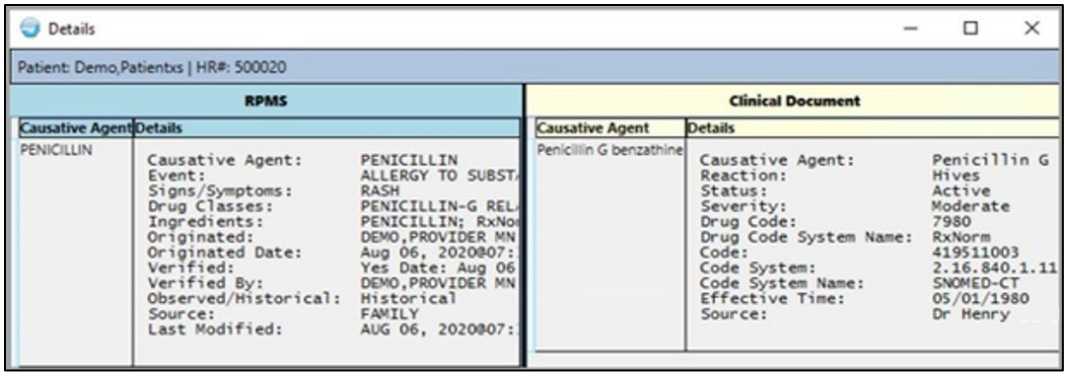


Figure 4-63: RPMS view details window

4.3.2.1.7 Add Allergy Button

If needed, users may add a completely new allergy or adverse reaction by using the **Add Allergy** button in the **Reconciled Adverse Reactions** panel. Clicking this button opens the **Add Adverse Reaction** window (Figure 4-64). The user may search for a Causative Agent and complete the remaining information as usual.

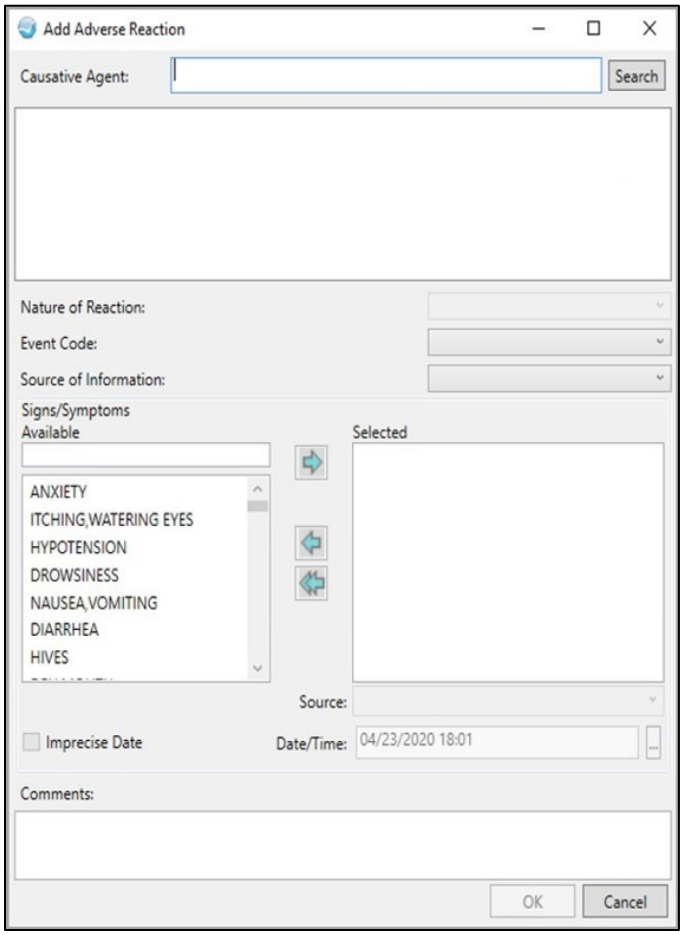


Figure 4-64: RPMS Add Adverse Reaction dialog

4.3.2.2 Reconciling Clinical Document Adverse Reactions Data

For **Clinical Document Adverse Reactions**, right-click menu options (Figure 4-65) include the following:

- **Add**
- **CCDA: Do Not Add, Redundant**
- **CCDA: Do Not Add, Not Clinically Significant**
- **View Details**

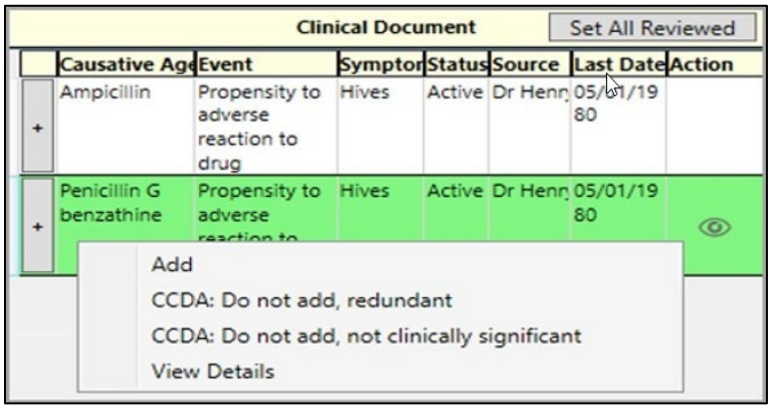


Figure 4-65: Clinical Document right-click menu options

4.3.2.2.1 Set All Reviewed Button

If no reconciliation is need with all the clinical adverse reactions data received, the user can click the **Set All Reviewed** button. Clicking this button sets all the clinical document adverse reactions to be reviewed but will not assign an action to them.

4.3.2.2.2 Add Option

Selecting **Add** allows users to add the item to the adverse reactions in RPMS.

If one or more symptoms from the clinical document cannot be matched to the symptoms in RPMS, the **Pick Symptom Translations** window (Figure 4-66) displays.

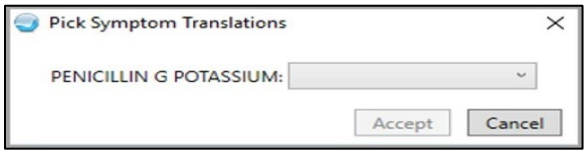


Figure 4-66: Pick Symptoms Translations dialog

Click the **down arrow** to see the list of available symptoms. Select the best match or select **No Equivalent** or **Not Applicable** if there is not a direct match. Once a selection has been made, click the **Accept** button.

If there is a match to the RPMS symptoms or if the user clicks **Accept** on the **Pick Symptom Translations** dialog, the **Add Adverse Reaction** dialog (Figure 4-67) opens. The available information will be pre-populated, and the source will be **EXTERNAL SOURCE**. Complete the additional fields as needed and click **OK**.

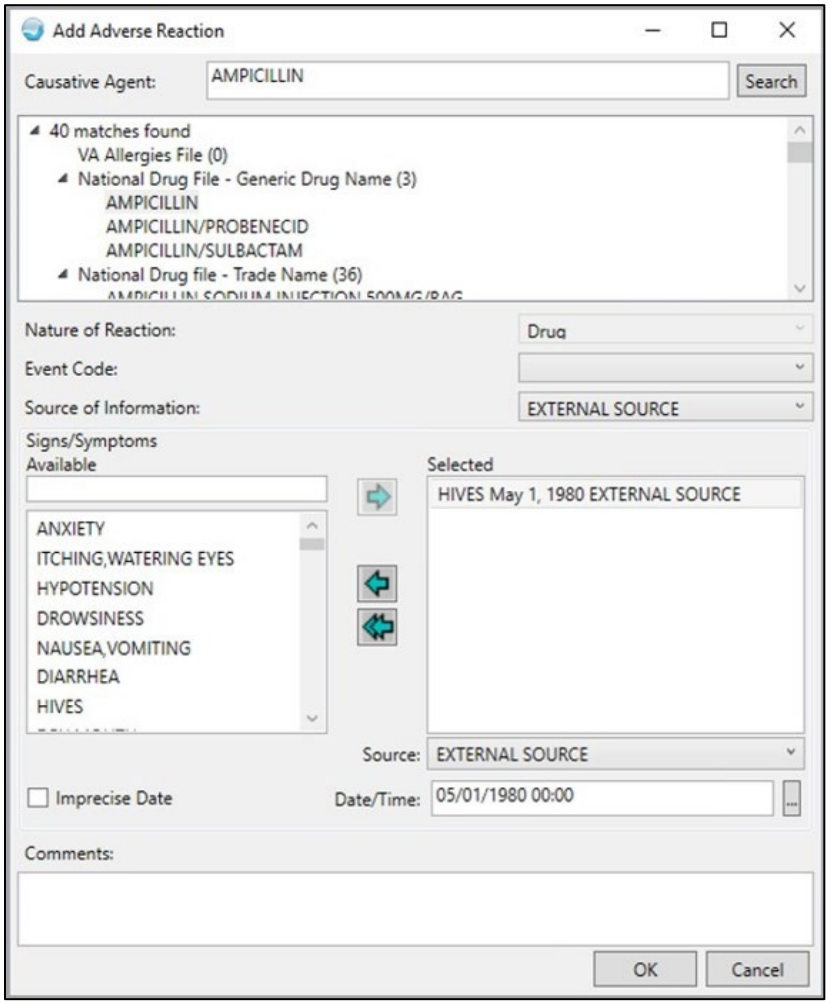


Figure 4-67: Add Adverse Reaction Clinical Document Add option dialog

After adding the information and clicking **OK**, the adverse reaction displays in the **Reconciled Adverse Reactions** pane (Figure 4-68) with an action of **CCDA: Add**.

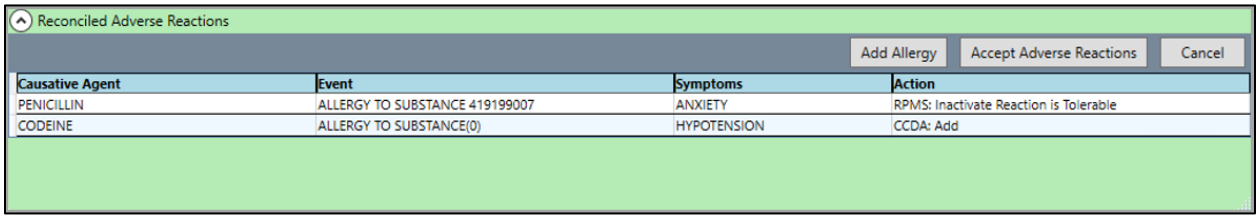


Figure 4-68: Reconciled Adverse Reactions Clinical Document Add pane

If an adverse reaction is already documented for the selected causative agent, the following error message (Figure 4-69) appears:

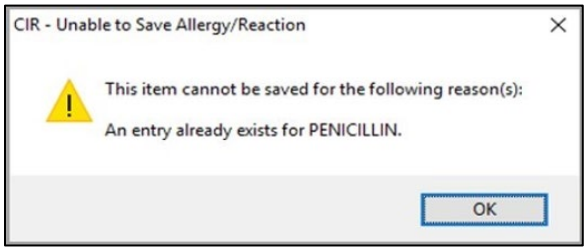


Figure 4-69: Unable to Save Allergy/Reaction warning message

In this case, the user should select the action **CCDA: Do not add**, redundant as shown below.

4.3.2.2.3 CCDA: Do Not Add, Redundant Option

Selecting **CCDA: Do not add, Redundant** (Figure 4-70) adds a check mark in the **Clinical Document** pane and marks the adverse reaction in the **Reconciled Adverse Reactions** pane.

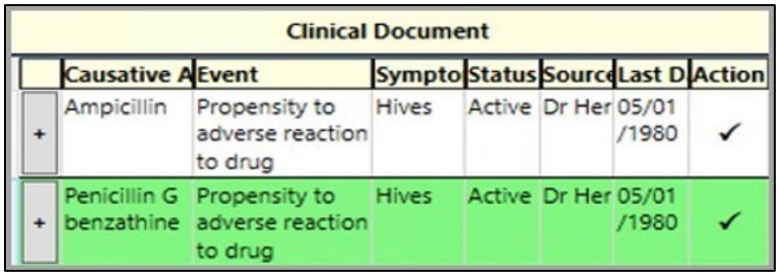


Figure 4-70: Clinical Document CCDA: Do Not Add, Redundant

4.3.2.2.4 CCDA: Do Not Add, Not Clinically Significant Option

Selecting **CCDA: Do Not Add, Not Clinically Significant** adds a check mark in the **Clinical Document** pane and marks the reaction in the **Reconciled Adverse Reactions** pane (Figure 4-71).

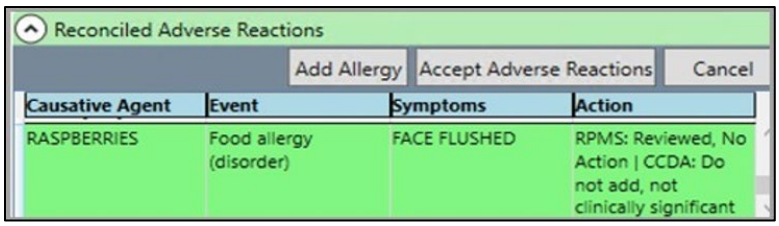


Figure 4-71: Clinical Document CCDA: Do Not Add, Not Clinically Significant pane

4.3.2.2.5 View Details

Selecting **View Details** opens a new window (Figure 4-72) where the adverse reaction details are listed. If there is a matching adverse reaction in the RPMS pane, the details for that adverse reaction will also be shown.

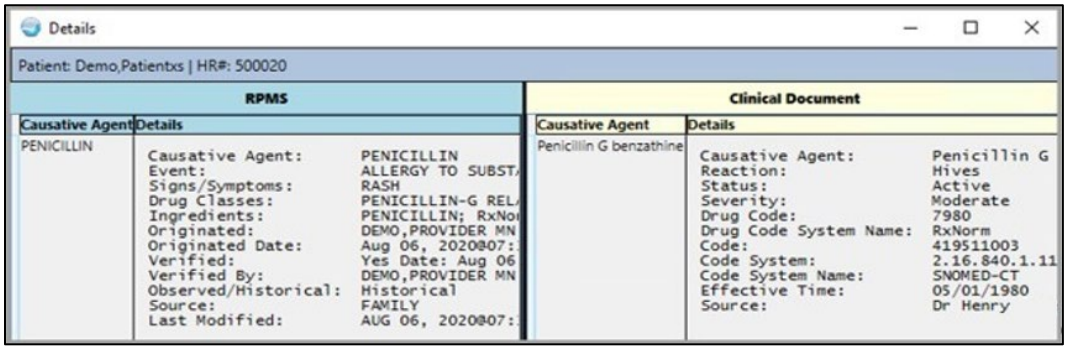


Figure 4-72: Clinical Document View Details pane

4.3.2.3 Reviewing and Finalizing Adverse Reactions Data

Once all the adverse reactions have been reconciled, users may review the items and the actions taken in the **Reconciled Adverse Reactions** pane (Figure 4-73) at the bottom of the main **CIR Tool** window. Each item from RPMS and each item from the clinical document that had an action taken on it will be listed, along with the status, onset date, and action.

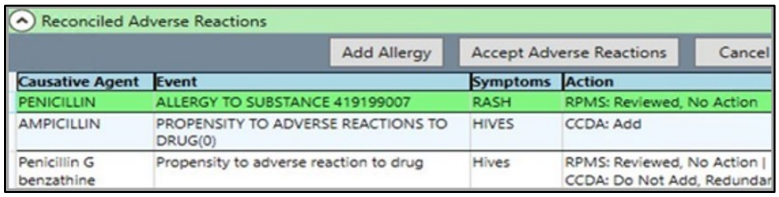


Figure 4-73: Reconciled Adverse Reactions pane

> **Note**: If the user is going to reconcile the entire CCDA document while the CIR tool is open including problems, adverse reactions and medications, the user does not need to utilize the **Accept Adverse Reactions** button. Each entry is saved when moved to other tabs. In this event use the **Accept All** button in the top-right area of the tool when all tabs have been reconciled.

4.3.2.3.1 Accept Adverse Reactions Button

Until the reconciled adverse reactions are accepted, no changes are made to the record. To accept all the reconciled adverse reactions information and not the problems and medication information, click **Accept Problems**.

If the **Accept Problems** button is used but not all problems have been reviewed, the **Unreviewed items** warning message (Figure 4-74) appears.

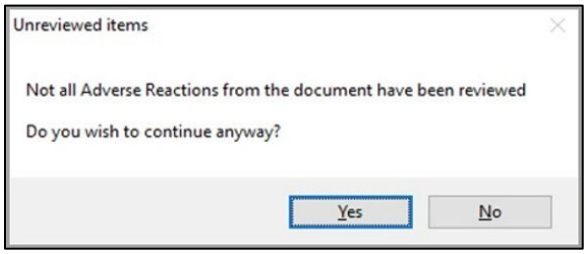


Figure 4-74: Unreviewed items for Adverse Reactions warning message

- Click **Yes** to continue anyway, or **No** to go back and review the remaining problems.

If there are no unreviewed problems or if the user chooses **Yes** on the **Unreviewed items** warning, the **Review/Sign Changes** window displays. The reconciled items are displayed along with any other items.

- Click **Yes** to continue anyway, or **No** to go back and review the remaining adverse reactions.

If there are no unreviewed adverse reactions or if the user chooses **Yes** on the **Unreviewed items** warning, the order check system will run against the patient's medications. If there are potential issues, the **Adverse Reaction Order Checking – Source: Veterans Health Administration and First Databank** window (Figure 4-75) displays.

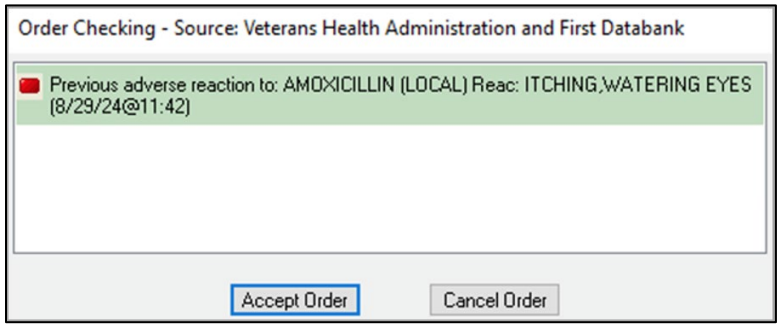


Figure 4-75: Adverse Reaction Order Checking – Source: Veterans Health Administration and First Databank window

If there are no potential issues or if the user clicks the **OK** button on the warning, the **Review/Sign Changes** window (Figure 4-76) displays. The reconciled items are displayed along with any other items needing signature.

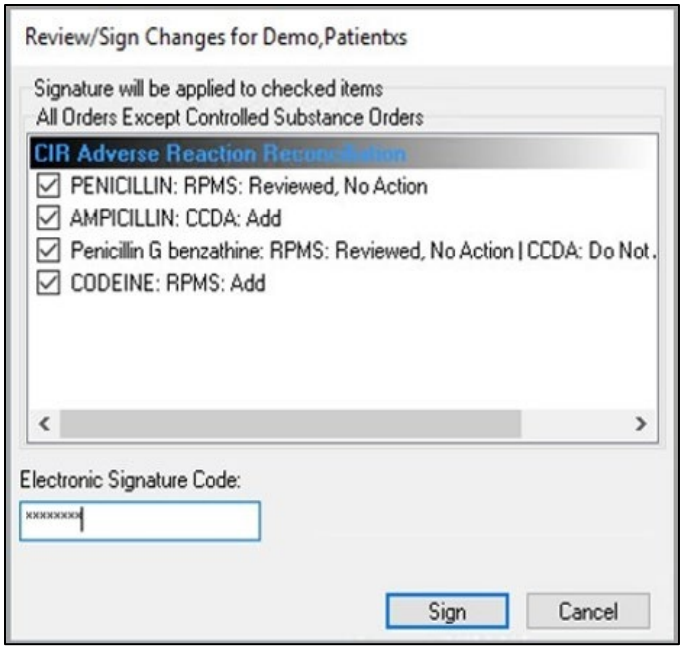


Figure 4-76: Review/eSign Changes window for Adverse Reactions

Enter an **Electronic Signature Code** and click **Sign**. The CIR Tool information for Adverse Reactions will reset and the CCDA document will reflect the reconciliation type and date.

4.3.2.3.2 Cancel Button

Click the **Cancel** button to not to complete the reconciliation of the adverse reactions, or to undo the changes for the adverse reactions only. There is no confirmation of this action. Clicking **Cancel** removes all the previously selected actions for Adverse Reactions immediately.

4.3.3 Medications

To reconcile the Medications, click the **Medications** tab (Figure 4-77). Like the **Problems** and **Adverse Reactions** tabs, this tab contains the **RPMS** pane and the **Clinical Document** pane. The RPMS pane displays the medications recorded in the **RPMS Pharmacy** package. It has the following columns:

- **Type**
- **Medication**
- **Description**
- **Status**
- **Last Date**

The **Clinical Document** pane contains the medication information from the selected CCDA document and has the following columns:

- **Medication**
- **Dispense**
- **Description**
- **Status**
- **Source**
- **Last Date**
- **Action**

The data in each pane may be sorted by any column.

Clicking a medication in either pane will highlight any matching item in the other pane, and in the **Reconciled Medications** pane at the bottom of the **CIR Tool** window. A match for a medication is when the code system and code match exactly, or if the name of the medications match exactly (case-insensitive, but matching does include spaces so that 500mg and 500 mg are considered different). Keep in mind that if the lists are long, the highlighted item in the other list may be out of view in the pane. Scroll through the lists as needed to see if there are matching items. Use control-click to remove the highlighting.

> **Note:** No further action is needed for RPMS Medications in the CIR reconciliation process unless there is a need to change (i.e., edit, Discontinue, or Renew an existing RPMS medication).

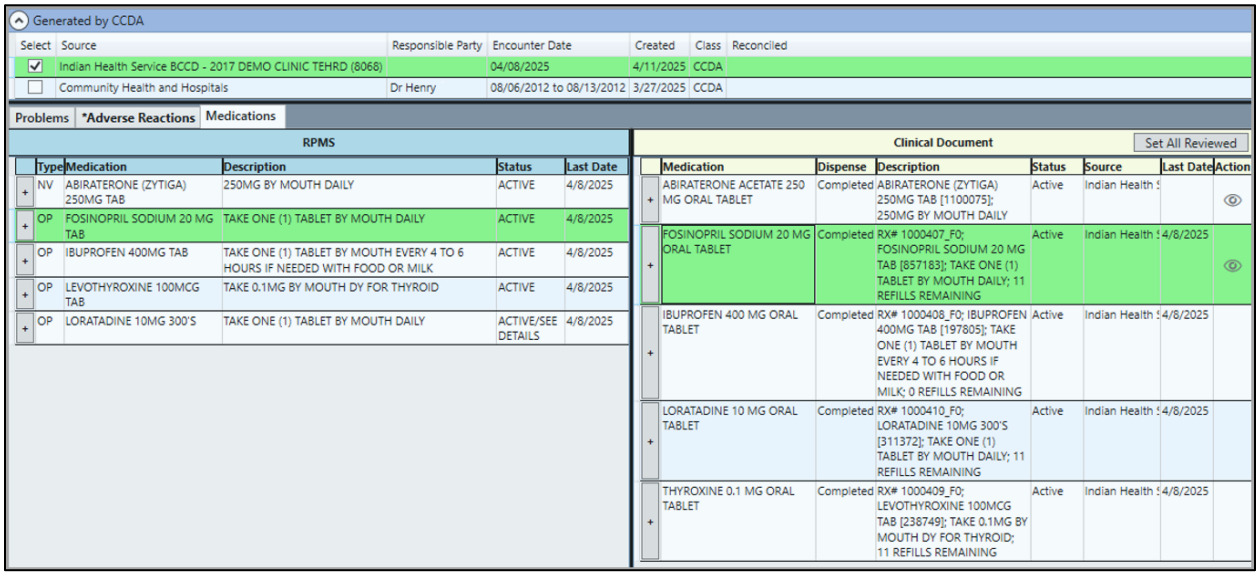


Figure 4-77: Medications tab with matching line items highlighted

4.3.3.1 Reconciling RPMS Medications Data

The **Reconciled Panel** will expand once a source is selected in the Generated by CCDA table and will be populated with the medications from the local RPMS database by default when the **Medications** tab (Figure 4-78) is selected. The RPMS entries will display with the action column reading **RPMS: Reviewed, No Action**.

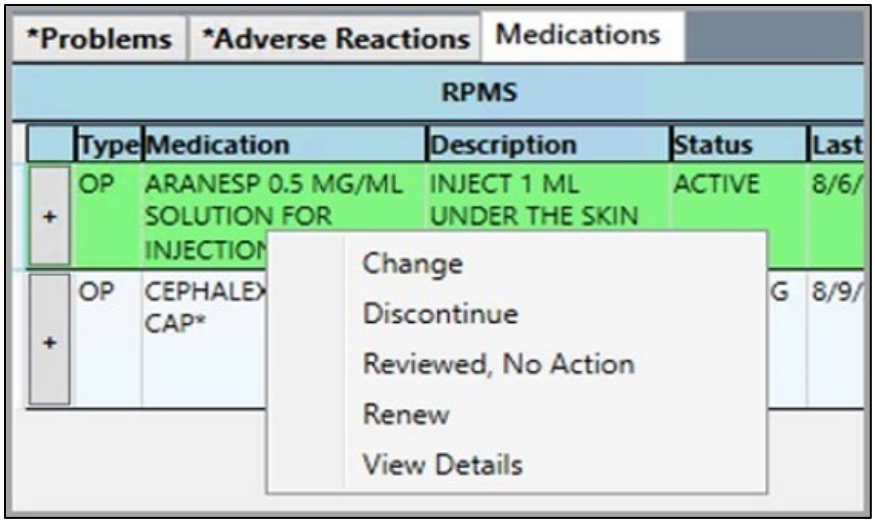


Figure 4-78: RPMS Medication right-click menu options

For RPMS medications, right-click actions include:

- **Change**
- **Discontinue**
- **Review, No Action**
- **Renew**
- **View Details**

4.3.3.1.1 Change Option

Selecting **Change** opens the **Edit Medication** dialog (Figure 4-79). In this window, the user may change all fields except the medication.

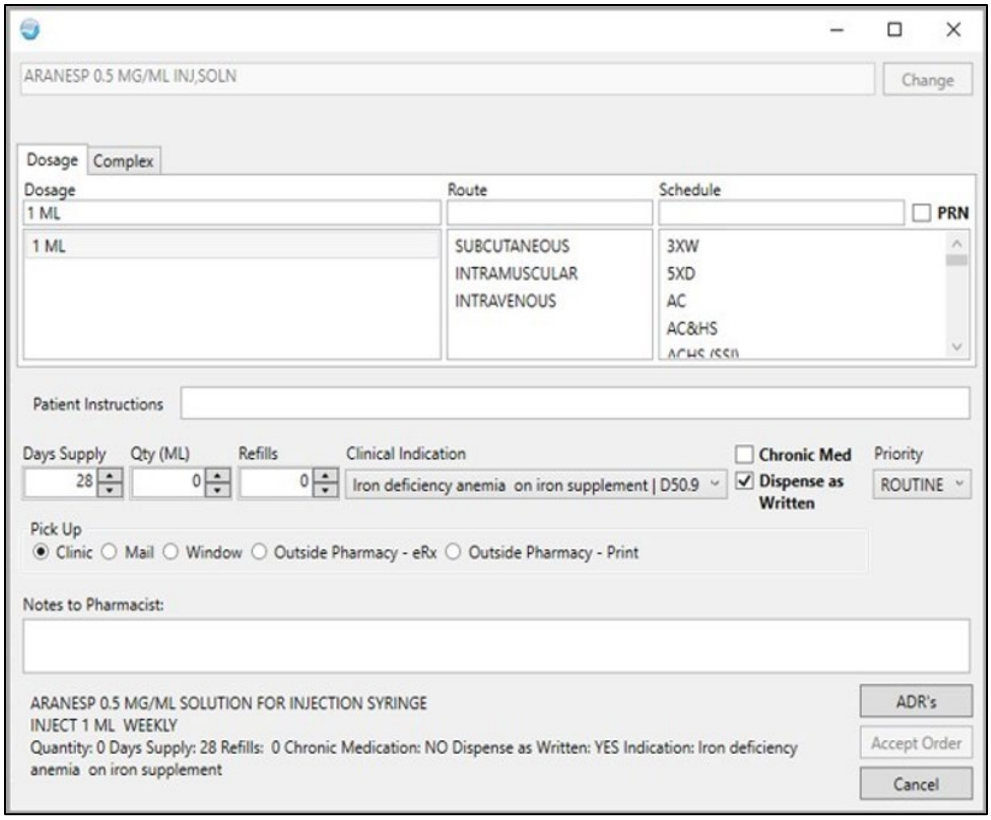


Figure 4-79: RPMS Edit Medication dialog

The **CIR Tool medication order** dialog will contain the same validations for doses, quantities, and other required fields as occurs with medication ordering outside of the CIR Tool.

Selecting **Change** on an eligible medication triggers the **Order Checking** system, and if an issue exists the **Order Checking – Source** dialog (Figure 4-80) displays. If the reaction is serious, the user may need to type in an override reason.

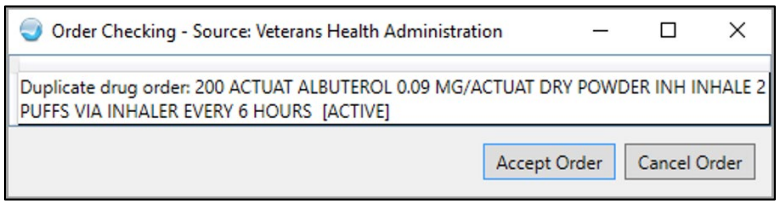


Figure 4-80: RPMS Change Order Checking dialog

Once the needed changes have been made, click **Accept Order** to save the changes to the **Reconciled Medications** pane (Figure 4-81). The order is created.

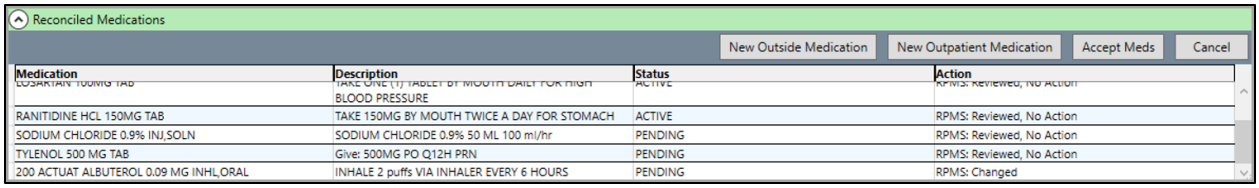


Figure 4-81: Reconciled Medications pane

4.3.3.1.2 Discontinue Option

Selecting **Discontinue** opens the **Discontinue / Cancel Orders** dialog (Figure 4-82). This window shows the selected order information at the top, and potential reasons at the bottom. The user may select an appropriate reason and then click **OK** to discontinue the order.

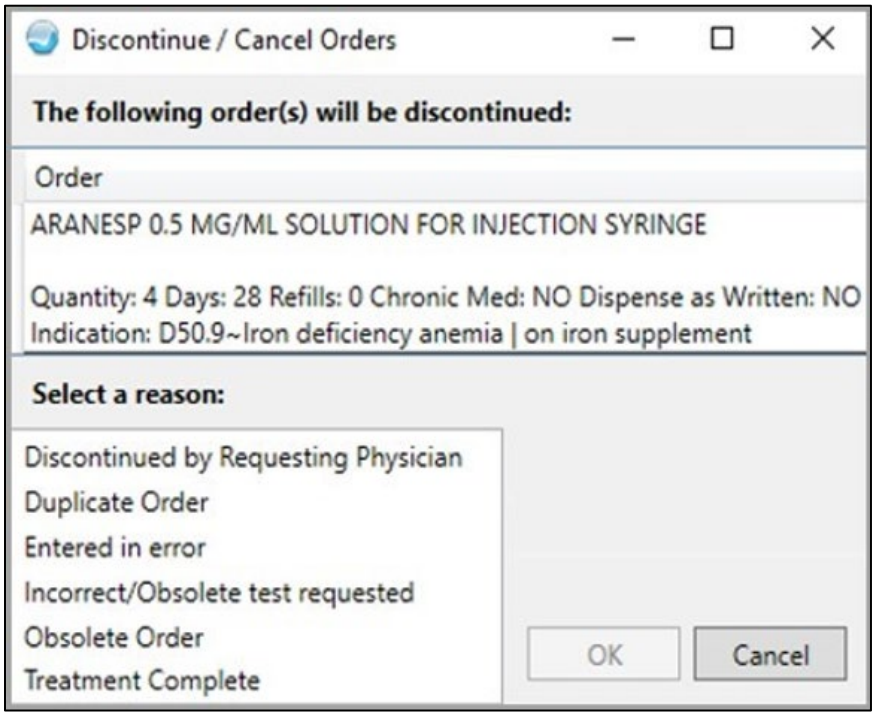


Figure 4-82: RPMS Discontinue/Cancel Orders dialog

Once the appropriate reason is selected, click **OK** to save the changes to the **Reconciled Medications** pane (Figure 4-83).

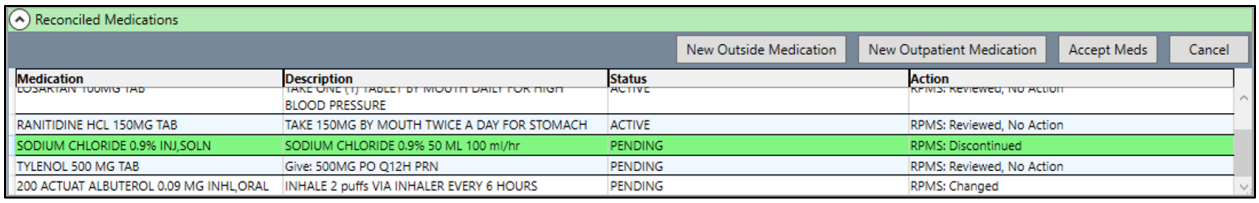


Figure 4-83: Reconciled Medications pane

4.3.3.1.3 Reviewed, No Action Option

Selecting the **Reviewed, No Action** option marks the item in the **Reconciled Medications** pane (Figure 4-84). For ease of documentation, this action is the default for all RPMS medications. The user only needs to select it if some other action was selected first and they want to go back to the **Reviewed, No Action** option.

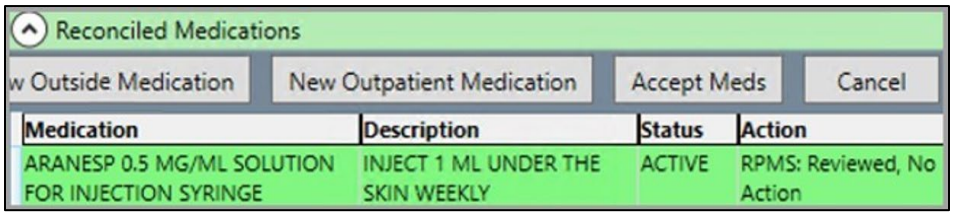


Figure 4-84: Reconciled Medications pane Reviewed, No Action option

4.3.3.1.4 Renew Option

Selecting **Renew** allows users to renew a medication order in the same manner as may be done in the **Medication Management** component. If the medication is ineligible to be renewed (e.g., the order is in a pending state or is an outside medication) the **Unable to Renew Order** warning message (Figure 4-85) displays.

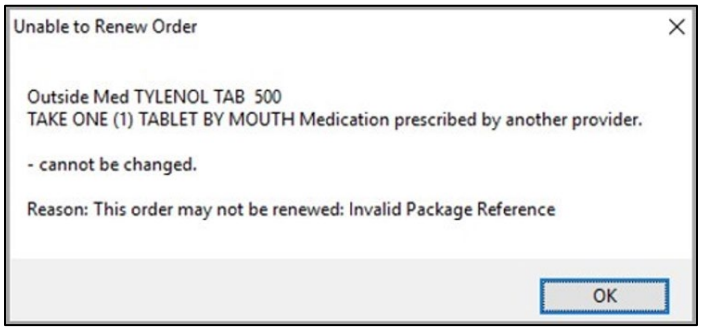


Figure 4-85: Unable to Renew Order warning message

Selecting **Renew** on an eligible medication triggers the **Order Checking** system, and if an issue exists the **Order Checking – Source** window displays. If the reaction is serious, the user may need to type in an override reason.

To cancel the renewal, click **Cancel Order**. To continue to renew the medication, click **Accept Order**. If there are no order checking issues or if the user clicks the **Accept Order** button, the **Renew Order** dialog (Figure 4-86) opens. The user may adjust the number of refills and pick up location but may not edit any other field using the renew function.

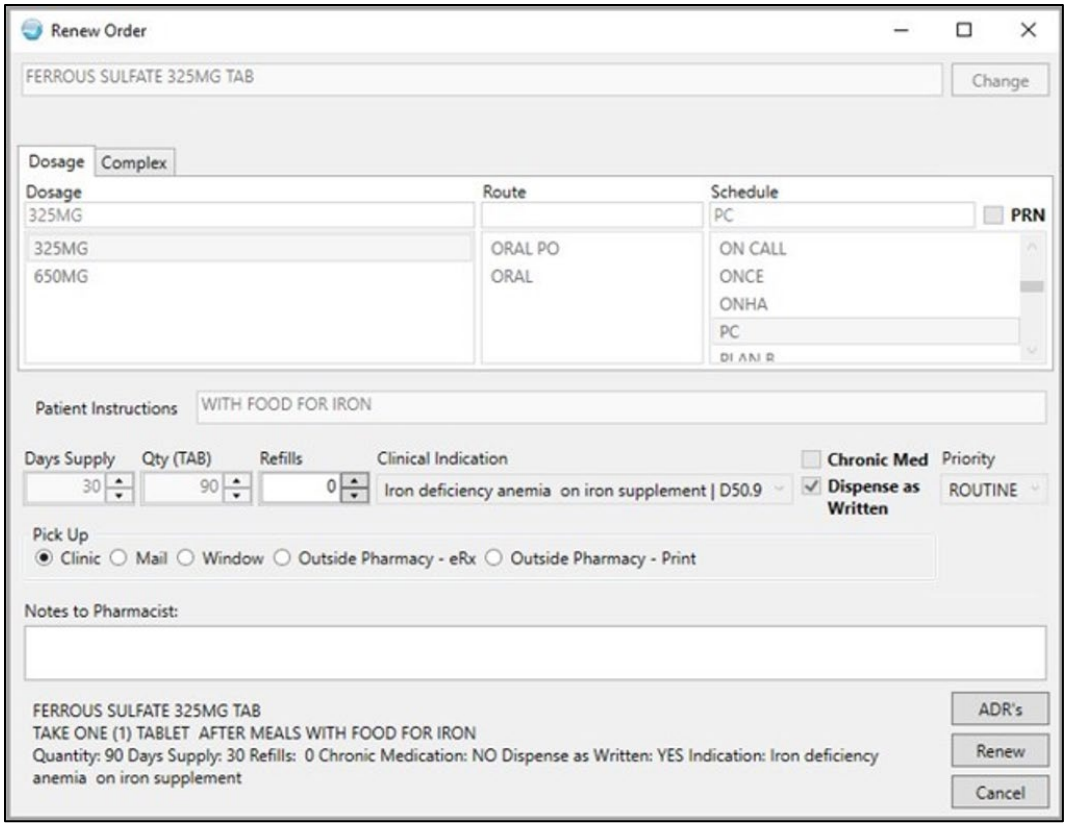


Figure 4-86: Renew Order dialog

Once the information is correct, click **Renew** to save the changes to the **Reconciled Medications** pane (Figure 4-87).

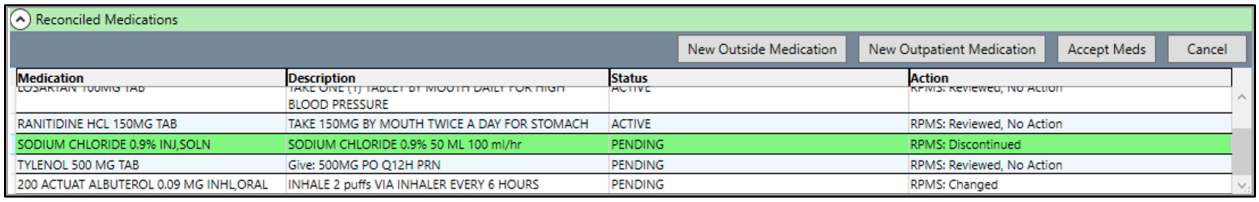


Figure 4-87: Reconciled Medications Renew option

4.3.3.1.5 View Details Option

Selecting **View Details** opens a new window (Figure 4-88) where the medication details are listed. If there is a matching medication in the **Clinical Document** pane, the details for that medication will also be shown.

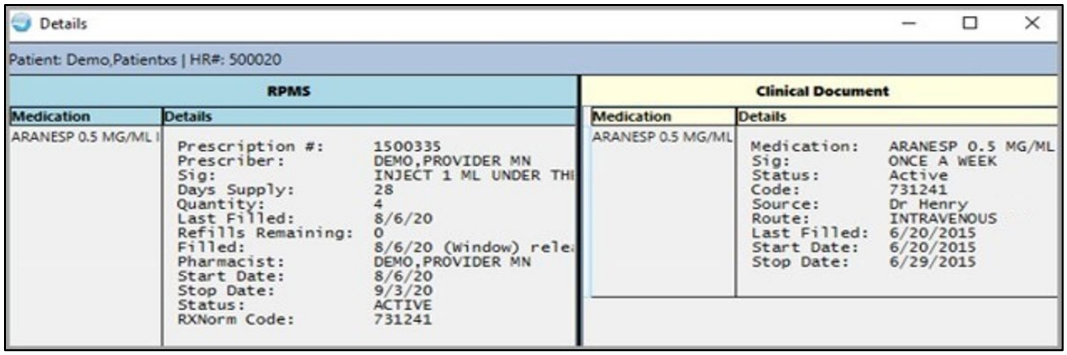


Figure 4-88: View Details option pane

4.3.3.1.6 New Outside Medication

If needed, the user may add a completely new Outside Medication by using the **Outside Medication** button in the **Reconciled Medications Reactions** panel. Clicking this button opens a blank **Add Non-VA Medication** dialog (Figure 4-89). The user can search for a medication and complete the remaining information as usual.

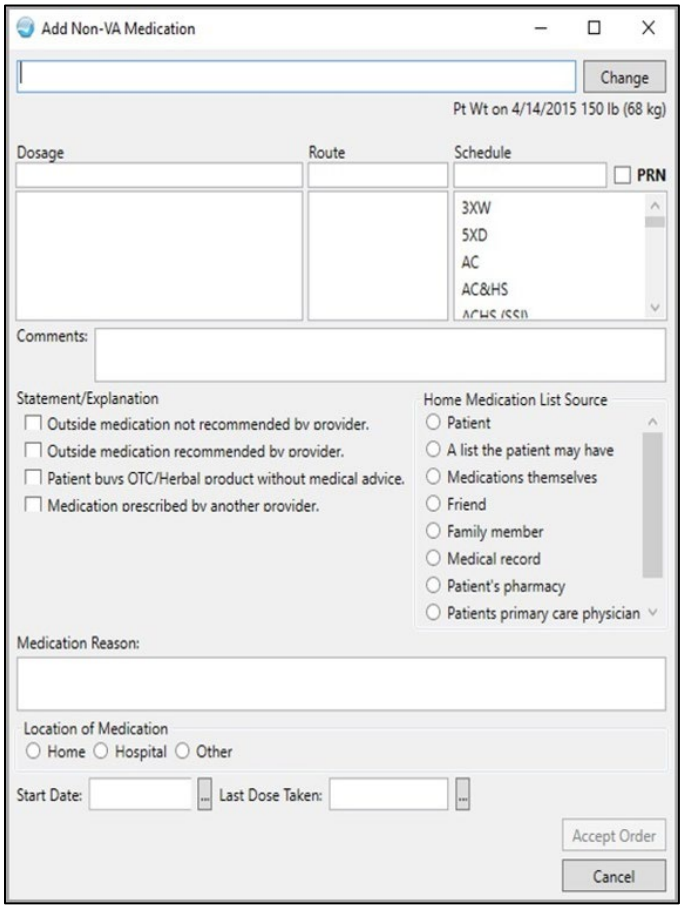


Figure 4-89: Add Non-VA Medication dialog

The **CIR Tool medication order** dialogs contain the same validations for doses, quantities, and other required fields as occurs with medication ordering outside of the CIR Tool.

4.3.3.1.7 New Outpatient Medication

If needed, the user may add a completely new Outpatient medication by using the **Outpatient Medication** button in the **Reconciled Medications Reactions** panel. Clicking this button opens a blank **Add Outpatient Medication** dialog (Figure 4-90). The user can search for a medication and complete the remaining information as usual.

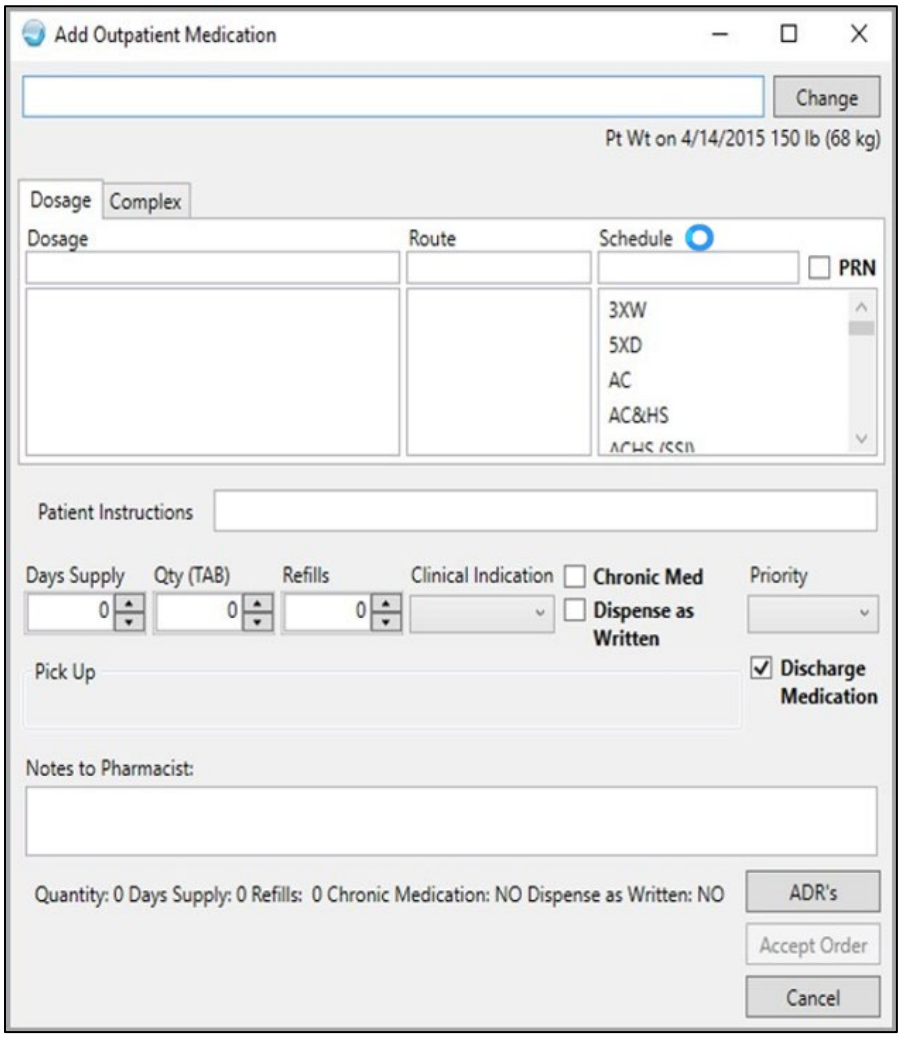


Figure 4-90: Add Outpatient Medication dialog

The **CIR Tool medication order** dialogs contain the same validations for doses, quantities, and other required fields as occurs with medication ordering outside of the CIR Tool.

4.3.3.2 Reconciling Clinical Document Medications Data

For Clinical Document medications (Figure 4-91) right-click actions include:

- Add to Outside Medications
- Add as Outpatient Medication
- Do Not Add, Discontinued
- Do Not Add, Redundant
- View Details

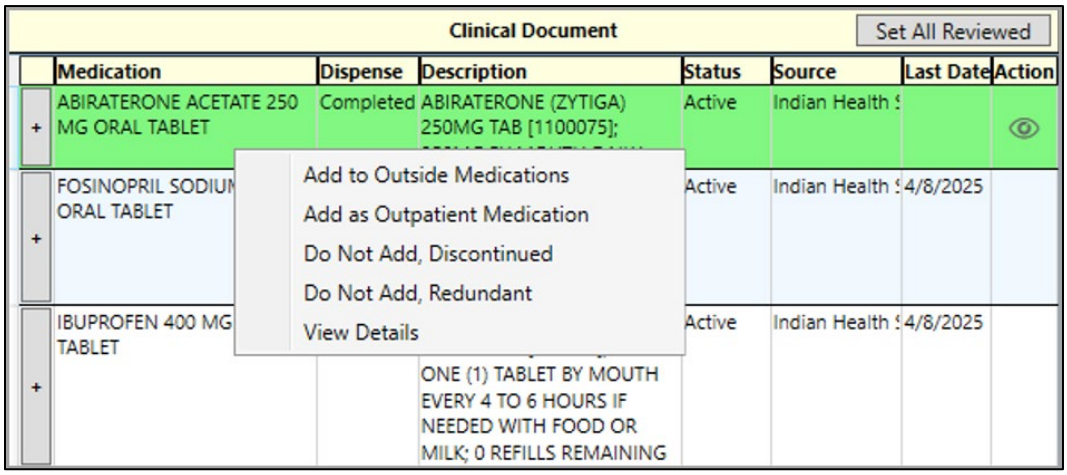


Figure 4-91: Clinical Document right-click menu options

4.3.3.2.1 Set All Reviewed Button

If no reconciliation is need with all the clinical medications data received, the user can click the **Set All Reviewed** button. Clicking this button sets all the clinical document medications to be reviewed but will not assign an action to them.

4.3.3.2.2 Add to Outside Medications Option

Selecting **Add to Outside Medications** allows users to document a medication in the EHR without creating an order to be filled by a pharmacy. This selection triggers the **Polypharmacy Order Check** and displays the **Order Checks warning message** (Figure 4-92) if the patient exceeds the locally set number of medications.

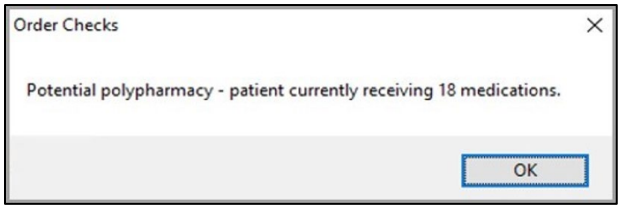


Figure 4-92: Outside Medication Order Checks warning message

If there is no polypharmacy warning or if the user clicks **OK** on the warning, there may be an additional warning if the medication cannot be matched to an active entry in the **RPMS Drug** file.

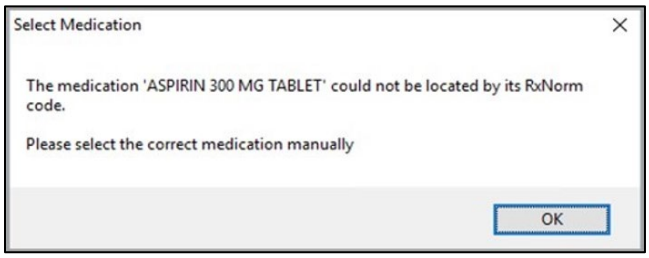


Figure 4-93: Select Medication not matched warning message

Click **OK** to continue. The **Search Medications** dialog (Figure 4-94) opens with the medication name already populated.



Figure 4-94: Search Medications dialog

The user may need to adjust the search text to find the appropriate medication. If the medication is not present in the drug file, exit the process and contact the pharmacy informaticist or person who maintains the drug file. If the medication is in the drug file, select it to continue.

If the medication was able to be matched or the user manually selected a medication, the **Add Non-VA Medication** dialog (Figure 4-95) opens. Only the medication is required here, but the user should add as much detail as is available.

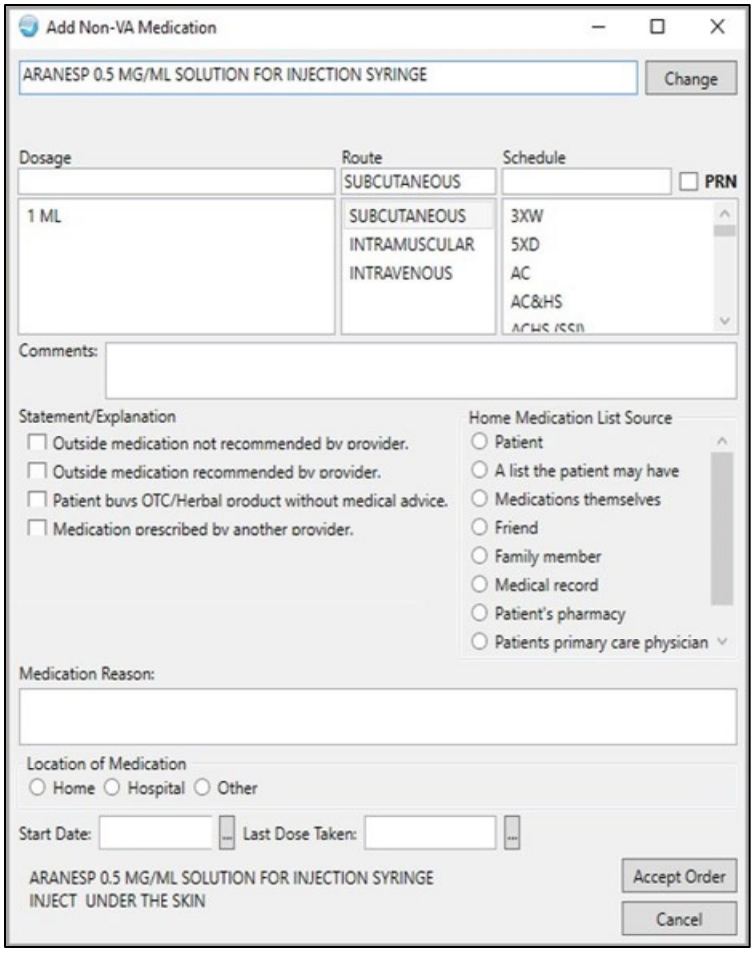


Figure 4-95: Clinical Document Add Non-VA Medication dialog

The **CIR Tool medication order** dialogs contain the same validations for doses, quantities, and other required fields as occurs with medication ordering outside of the CIR Tool.

After adding the information and clicking **Accept Order**, additional order check information may appear if applicable. The added medication displays in the **Reconciled Medications** pane with an action of **CCDA: Add Outside** (Figure 4-96). The order is created.

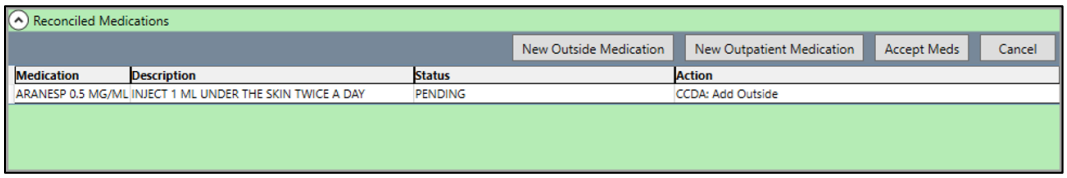


Figure 4-96: Reconciled Medications CCDA: Add Outside

4.3.3.2.3 Add as Outpatient Medication Option

Selecting **Add as Outpatient Medication** allows the user to create a medication order in the EHR that will ultimately be filled by a pharmacy. This selection will trigger the order checks and medication look ups.

Once any warnings are handled or if no warnings were given, the **Add Outpatient Medication** dialog (Figure 4-97) opens with as much information filled in as possible. The order must be completed in the same way an order would be completed outside the CIR Tool.

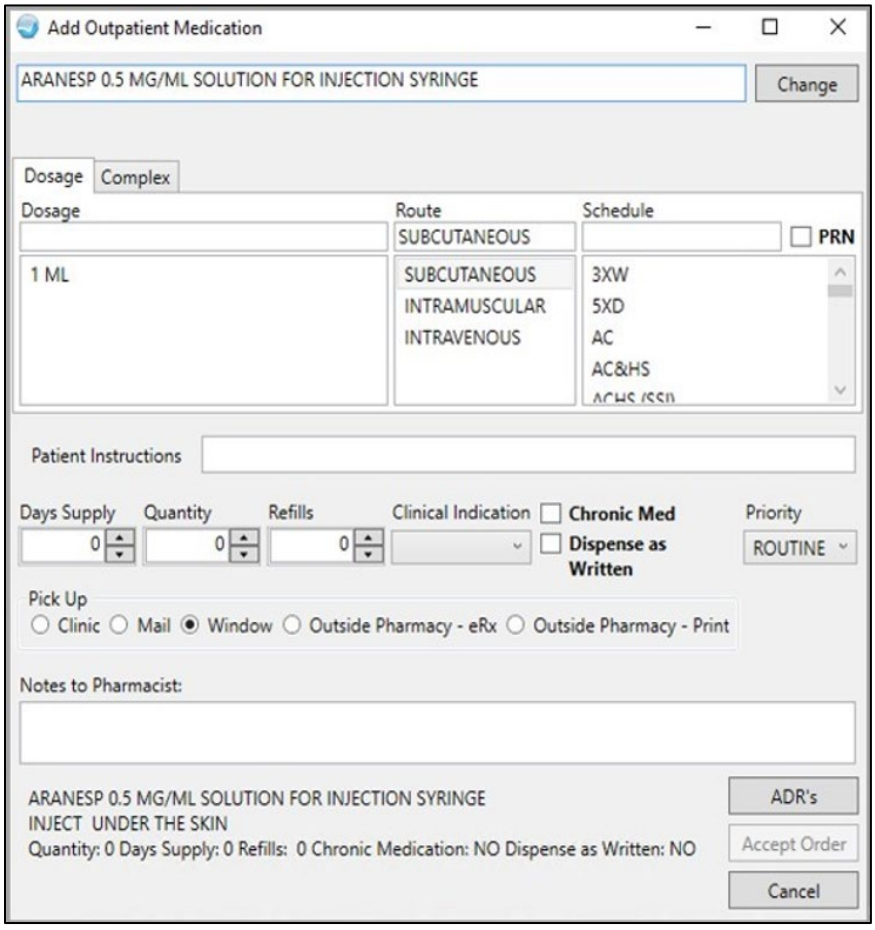


Figure 4-97: Clinical Document Add Outpatient Medication dialog

The **CIR Tool Medication Order** dialogs contain the same validations for doses, quantities, and other required fields as occurs with medication ordering outside of the CIR Tool.

After adding the information and clicking **Accept Order**, the medication will display in the **Reconciled Medications** pane with an action of **CCDA: Add Outpatient** (Figure 4-98). The order is created.

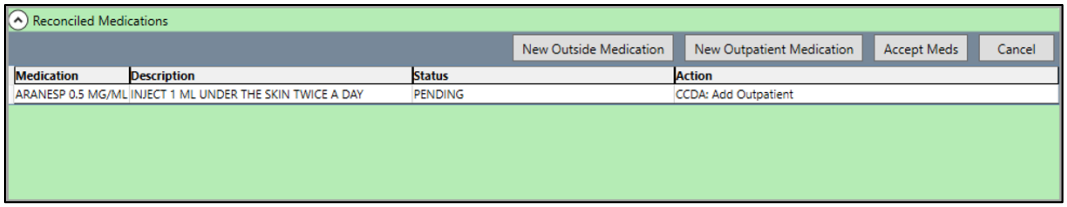


Figure 4-98: CCDA: Add Outpatient Medication pane

4.3.3.2.4 Do Not Add, Discontinued

Selecting **Do Not Add, Discontinued** adds a check mark in the **Clinical Document** pane and marks the medication in the **Reconciled Medications** pane (Figure 4-99).

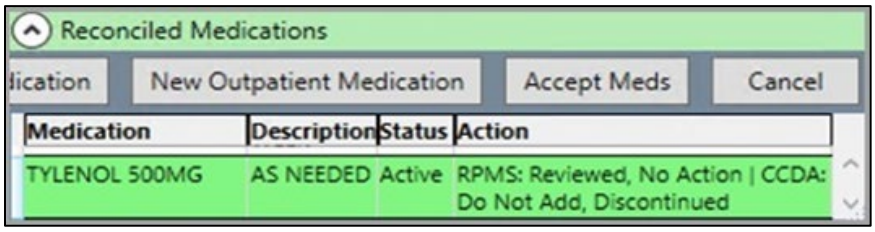


Figure 4-99: Reconciled Medications dialog with Clinical Document Do Not Add, Discontinued

4.3.3.2.5 Do Not Add, Redundant

Selecting **Do Not Add, Redundant** marks the medication in the **Reconciled Medications** dialog (Figure 4-100) at the bottom.

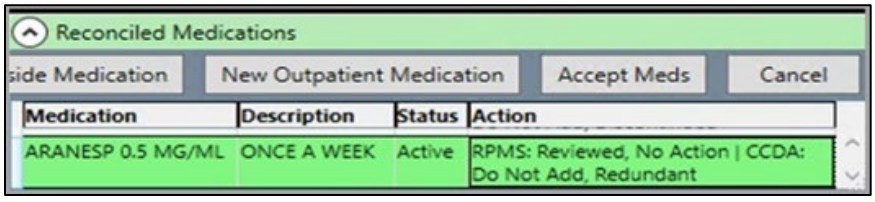


Figure 4-100: Reconciled Medications dialog with Clinical Document Do Not Add, Redundant

4.3.3.2.6 View Details

Selecting **View Details** opens a new window (Figure 4-101) where the medications details are listed. If there is a matching medication in the RPMS pane, the details for that medication will also be shown.

> **Note:** If the user is going to reconcile the entire CCDA Document while the CIR tool is open including problems, adverse reactions, and medications, the user does not need to click the **Accept Meds** button. Each entry is saved when moving to other tabs. In this event the user will click the **Accept All** button in the top-right area of the tool when all tabs have been reconciled.

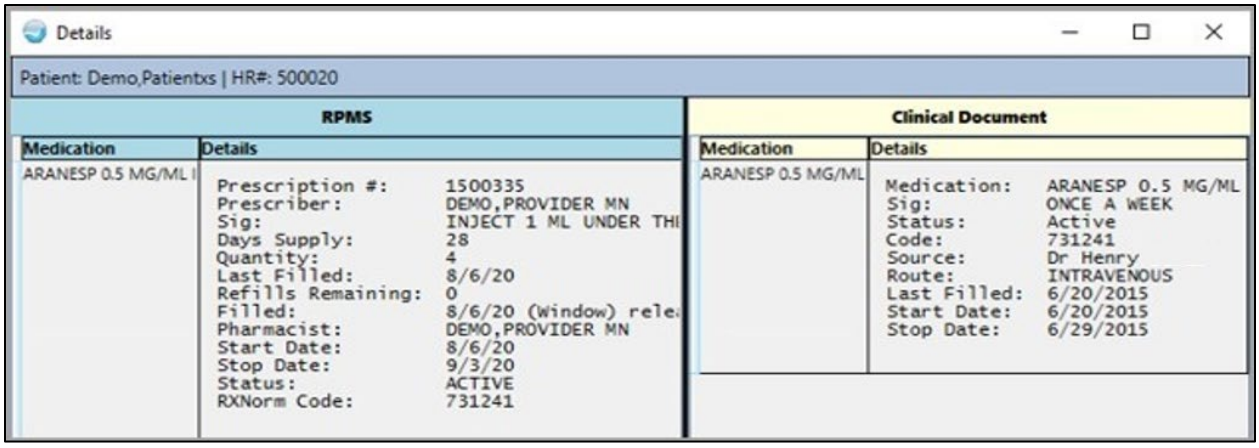


Figure 4-101: Clinical Document View Details window

4.3.3.3 Reviewing and Finalizing Medications

Once all the medications have been reconciled, the user may review the items and the actions taken in the **Reconciled Medications** pane at the bottom of the main **CIR Tool** window.

4.3.3.3.1 Accept Meds Button

Until the reconciled medications are accepted, the changes are not finalized to the record. To accept all of the reconciled medication information and not the problem and adverse reaction information, click **Accept Meds** button.

When the **Accept** button is used but not all medications have been reviewed, the **Unreviewed items** warning message (Figure 4-102) appears.

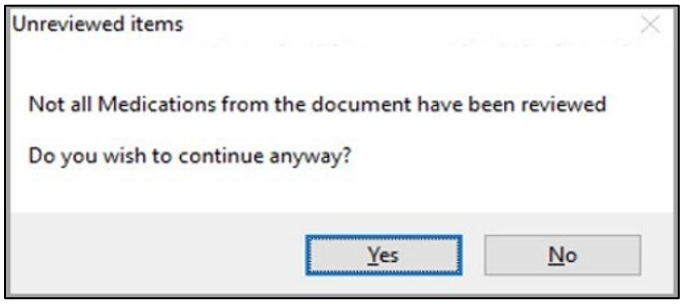


Figure 4-102: Unreviewed items warning message for medications

Click **Yes** to continue anyway, or **No** to go back and review the remaining medications.

If there are no unreviewed medications or if the user chooses **Yes** on the **Unreviewed items** warning, the **Review/Sign Changes** dialog (Figure 4-103) displays. The reconciled items display along with any other items needing signature.

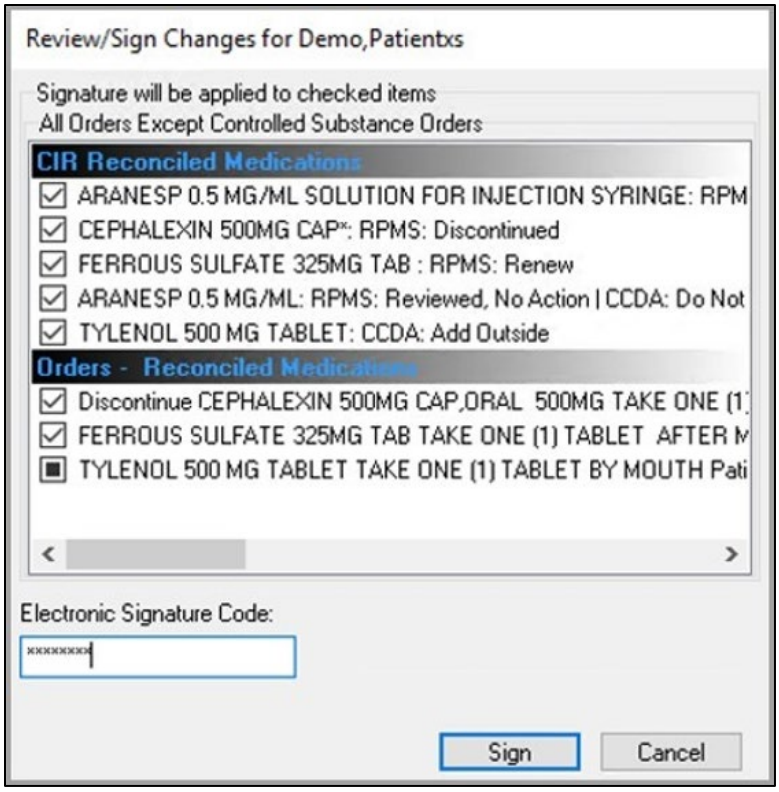


Figure 4-103: Review/eSign Changes for Medications dialog

Enter an **Electronic Signature Code** and click **Sign**. The CIR Tool information for medications resets and the CCDA document reflects the reconciliation type and date.

4.3.3.3.2 Cancel Button

Click the **Cancel** button to not complete the reconciliation of the medications, or to undo the changes for the medications only. There is no confirmation of this action. Clicking **Cancel** removes all the previously selected actions for medications immediately. To reset the entire CIR Tool, use the **Cancel All** button instead.

4.3.4 Finalizing Reconciliation for the Entire CCDA

4.3.4.1 Accept All Button

If the user reconciled items on more than one tab without utilizing the following tabs individual accept buttons:

- Accept Problem
- Accept Adverse Reactions
- Accept Meds

Users can use the **Accept All** button (Figure 4-104) when finished reconciling data to finalize the session and sign the information and orders. This process presents one **Review/eSign** dialog for all reviewed problems, adverse reactions and medications.



Figure 4-104: Accept All button

If the user clicks **Accept All** and there is data on other tabs that has not been reviewed, the **Not all sections are reviewed** warning (Figure 4-105) appears.

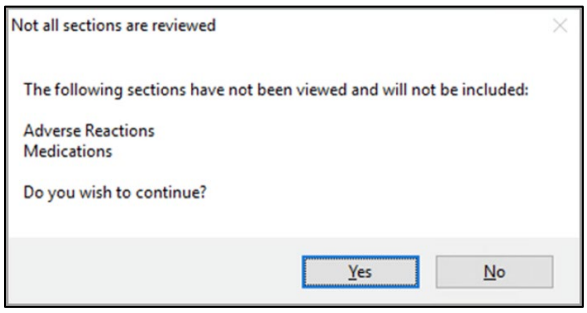


Figure 4-105: Not all sections review warning message

Click **Yes** to continue with accepting only the reconciled data or click **No** to reconcile other data on other tabs.

> **Note:** If the user reconciled each tab individually by using **Accept Problem**, **Accept Adverse Reactions**, and **Accept Meds** this this section will not be relevant.

If all data was reviewed or if the user clicks **Yes** on the **Not all sections reviewed** warning, the **Order Check** system will fire. If any issues are found, the **Order Checking – Source** window displays.

Click **OK** to continue or **Cancel** to return to the CIR Tool. If the user clicks **OK**, the **Review/Sign Changes** window (Figure 4-106) displays. The reconciled items display along with any other items needing signature.

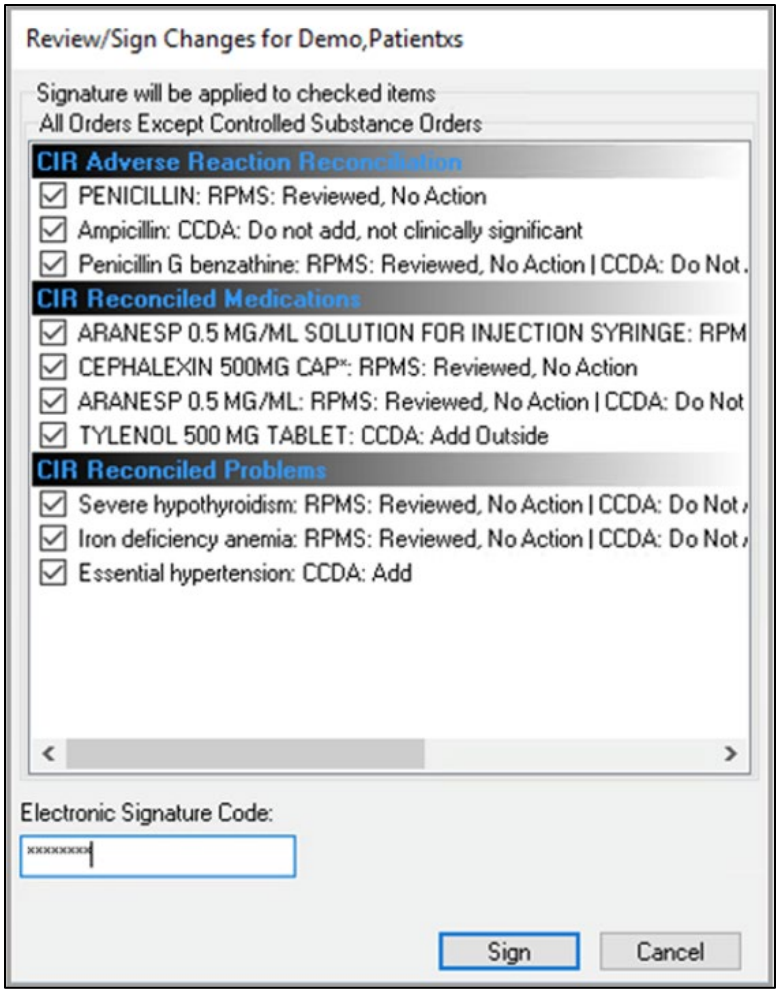


Figure 4-106: Review/eSign for All Tabs

The CIR Tool information resets and each reconciled CCDA document will reflect the reconciliation type and date.

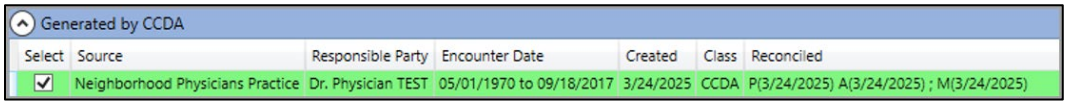


Figure 4-107: CCDA Reconciled column updated

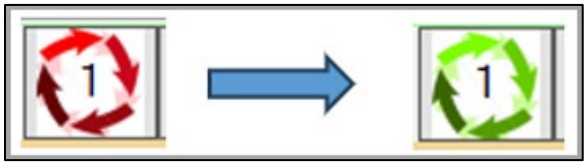


Figure 4-108: CIR Icon after Reconciliation of all tabs

4.3.4.2 Cancel All Button

Click the **Cancel All** button (Figure 4-109) to not complete the reconciliation or to undo all changes so far. The **Remove All Reconciliation Changes** warning message (Figure 4-110) displays.



Figure 4-109: Cancel All button

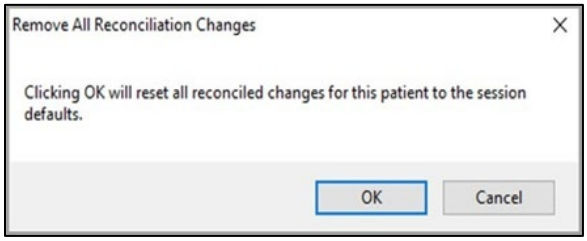


Figure 4-110: Remove All Reconciliation Changes warning message

Clicking **Cancel** will return the user to the CIR Tool with the existing changes intact. Clicking **OK** will remove all of the previously selected actions for **Problems**, **Adverse Reactions**, and **Medications**.

5.0 Consolidated Clinical Document Architecture (CCDA)

The **Consolidated Clinical Document Architecture (CCDA) Generation** component employs stylesheet templates that are declared at the document, section, and entry level of CDA documents.

5.1 Introduction

A **Consolidated Clinical Document Architecture (CCDA)** document summarizes current and pertinent historical information about an individual patient's health care record at the facility allowing exchange with outside entities to improved care coordination between healthcare providers.

The **Consolidated Clinical Document Architecture (CCDA)** component () utilizes standardized formats for sharing of a patient's health information between healthcare providers. It includes a summary of a patient's medical history, medications, allergies, and other relevant information.

These formats (**Clinical Summary (CS)** and **Transition of Care (TOC)**) are utilized to generate documents that are used to transition care and provide external providers access to needed patient longitudinal data.

The clinical content of the formats is limited to the most relevant patient data captured during one or more encounters to ensure continuity of patient care. Depending on whether the encounter selected is a visit or a referral the user has the ability to determine whether they will be able to select the option button for a Clinical Summary or Transition of Care.

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

> **Note:** The ToC is also used for Inpatient Discharges to other facilities.

The EHR displays the Clinical Summary or ToC, as a single document. When the GENERATE CCDA for Full Visit/Referral History is used and multiple visits are selected; one document per selected visit is generated.

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

5.2 Patient Information

Although not every document format (CS or TOC) contains every section, the current IHS implementation of the CCDA standard supports the following sections:

- Patient name
- Sex
- Date of birth
- Date of Death – if patient is deceased
- Race
- Ethnicity
- Preferred language
- Allergies
- Assessment and Plan
- Care Team
- Case Reporting
- Consultation Notes
- Discharge Diagnoses (inpatient visits only)
- Discharge Summary Notes (inpatient visits only)
- Encounters
- Functional Status
- Goals
- Health Concerns
- History and Physical Notes
- Hospital Course (inpatient visits only)
- Hospital Discharge Instructions (displayed for observation [O] and day surgery [S] visits, in addition to inpatient visits)
- Immunizations
- Instructions
- Medical Equipment
- Medications
- Mental Status
- Problems/Encounter Diagnoses

- Procedures (includes Procedure Notes)
- Progress Notes
- Reason for Hospitalization (inpatient visits only)
- Reason for Referral (ambulatory visits only)
- Reason for Visit (ambulatory visits only)
- Results
- Security and Privacy Prohibitions
- Social History (Smoking Status)
- Vital Signs

> **Note:** If the patient refuses or declines the Clinical Summary, the SNOMED refusal type, **422735006 – Reason Refused**, is stored.

5.3 Completing CCDA Tasks

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

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

2. Briefly rest the mouse pointer over the **CCDA** button (C|C D|A) to view a tooltip (Figure 5-1 and Figure 5-2) on how a left single-click will function based on if an encounter/visit is selected by the user.

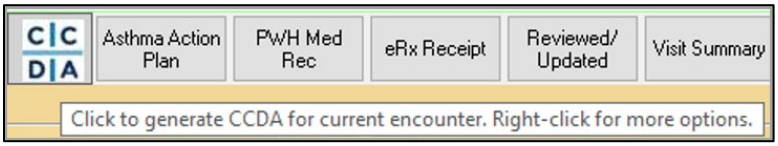


Figure 5-1: Tooltip for CCDA generation with a visit selected

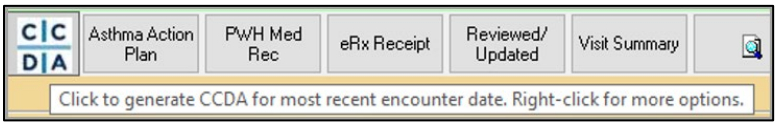


Figure 5-2: Tooltip for CCDA generation without a visit selected

Alternatively, the user can right-click to view the menu option available when a visit is selected or not selected by the user. The **CCDA Menu** (Figure 5-4) appears with the following options. Click the links below to view steps for each option.

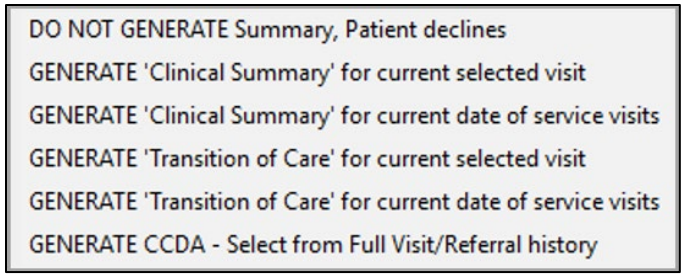


Figure 5-3: CCDA right-click menu options with visit selected

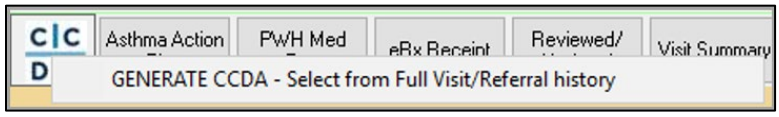


Figure 5-4: CCDA right-click menu option without a visit selected

- DO NOT GENERATE Summary, Patient has active PHR:
  - This option is only visible if the patient has active PHR data captured in RPMS and stores a patients' education.
- DO NOT GENERATE Summary, Patient Declines:
  - The SNOMED Refusal Type 422735006 is stored in the background.
- Generate CCDA–Most Recent Encounter Date
- Generate Clinical Summary for Current Selected Visit
- GENERATE Clinical Summary for Current Date of Service Visits
- GENERATE Transition of Care for Current Selected Visit
- GENERATE Transition of Care for Current Date of Service Visits
- GENERATE CCDA for Full Visit/Referral History

5.4 Generate CCDA–Most Recent Encounter Date

To generate a Clinical Summary where no visit is selected (Figure 5-5), select a **patient without a visit** and left-click on the **CCDA** button (). The option button defaults to **Clinical Summary**. Then select one of the actions below.

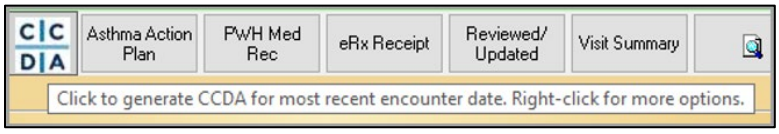


Figure 5-5: CCDA generation without a visit selected

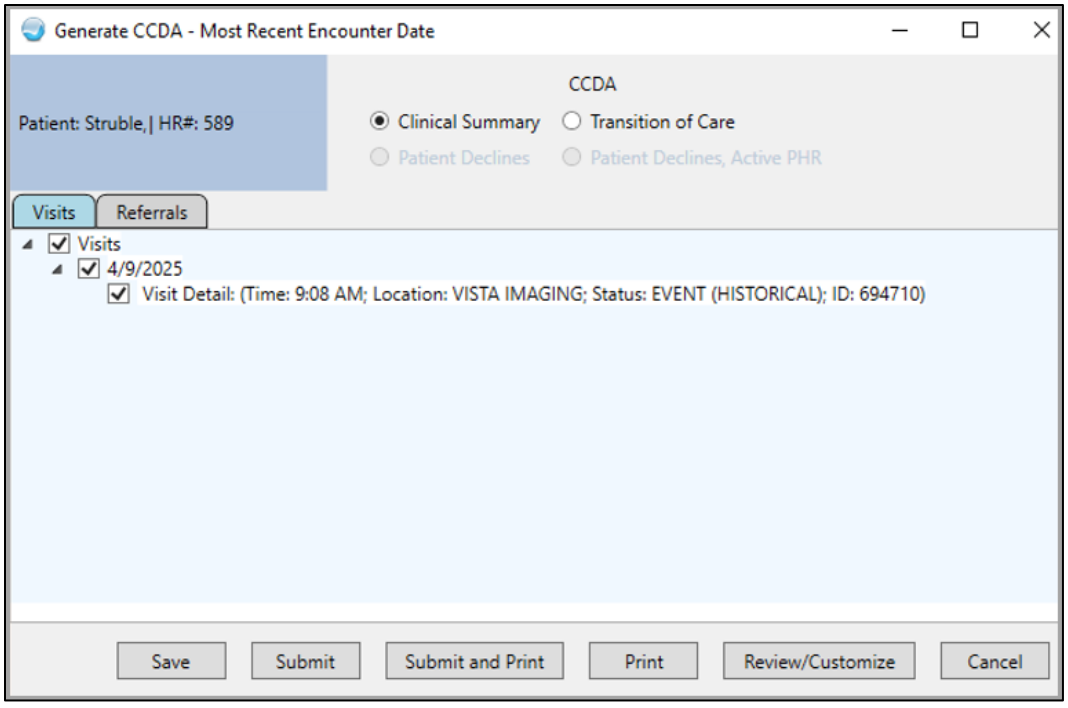


Figure 5-6: Clinical Summary for most recent encounter date dialog

Submit

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

1. Click **Submit**. The **Direct Email Form** dialog (Figure 5-7) opens.

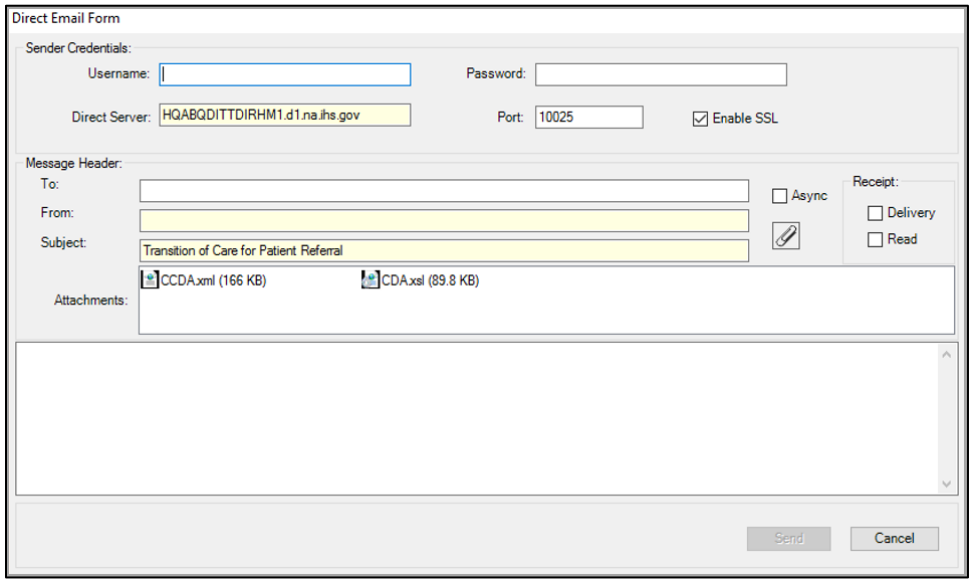


Figure 5-7: Direct email form dialog

2. Enter the direct email **username** and **password**.

3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click **Send**.

   If **Cancel** is clicked, users are prompted with the **Select Alternative Submission Method** dialog.

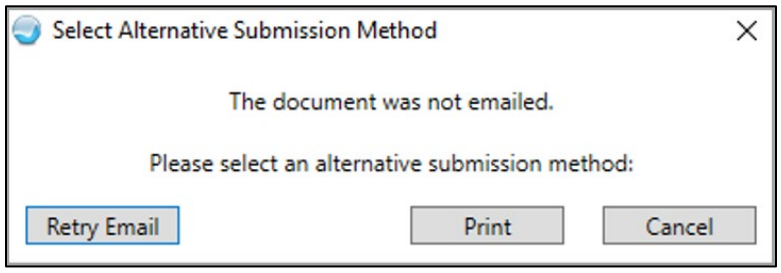


Figure 5-8: Select Alternative Submission Method dialog

Submit and Print

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

1. Click **Submit** and **Print.** The **Direct Email Form** dialog (Figure 5-14) opens.
2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click **Send**.
5. The **Print** dialog opens. Select a **printer** and click **Print**.

Print

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

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

Review/Customize

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

1. Click the **Review/Customize** option. The **CCDA Clinical Summary** dialog (Figure 5-9 and Figure 5-10) opens.

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

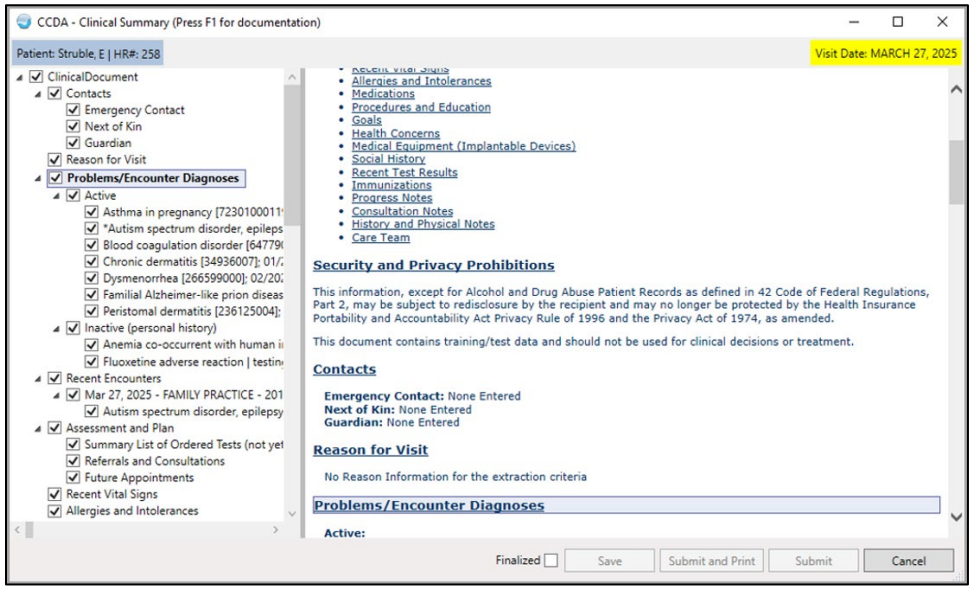


Figure 5-9: CCDA Clinical Summary dialog not finalized

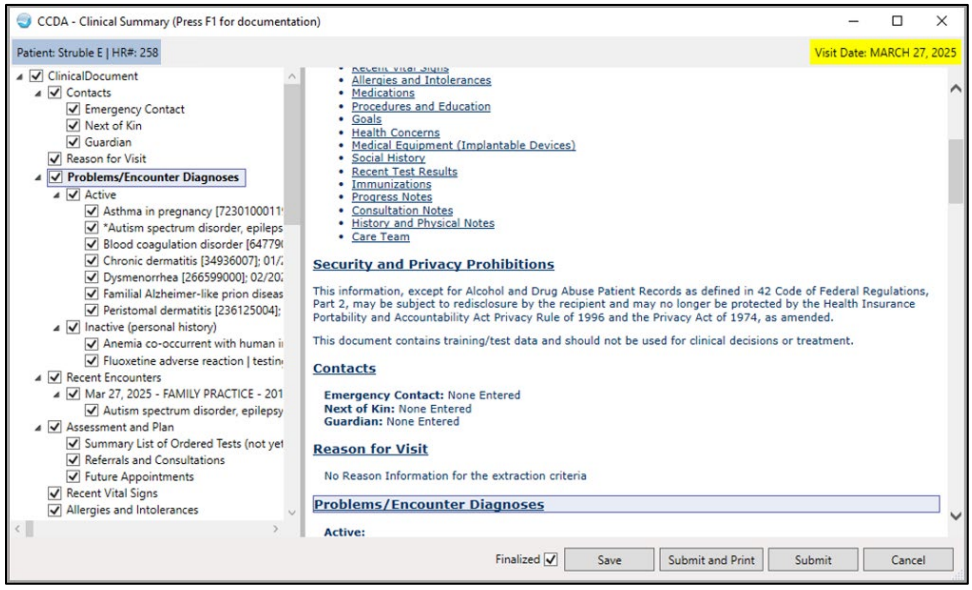


Figure 5-10: CCDA Clinical Summary dialog finalized

2. Clear the **check boxes** next to any items to be removed from the Clinical Summary.

   Clearing a check box also clears any check boxes below it. For example, clearing the **Allergies** check box also clears all allergy items listed individually below it. Select any check boxes for individual sub- topics, as needed.

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

- The topic data is cleared when the check box is cleared but the heading remains, and the word **Redacted** appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains, and the word **Redacted** appears below it.
- The following note appears at the top of the Clinical Summary (Figure 5-11):

  Some information may have been redacted at patient's request or legal requirement.

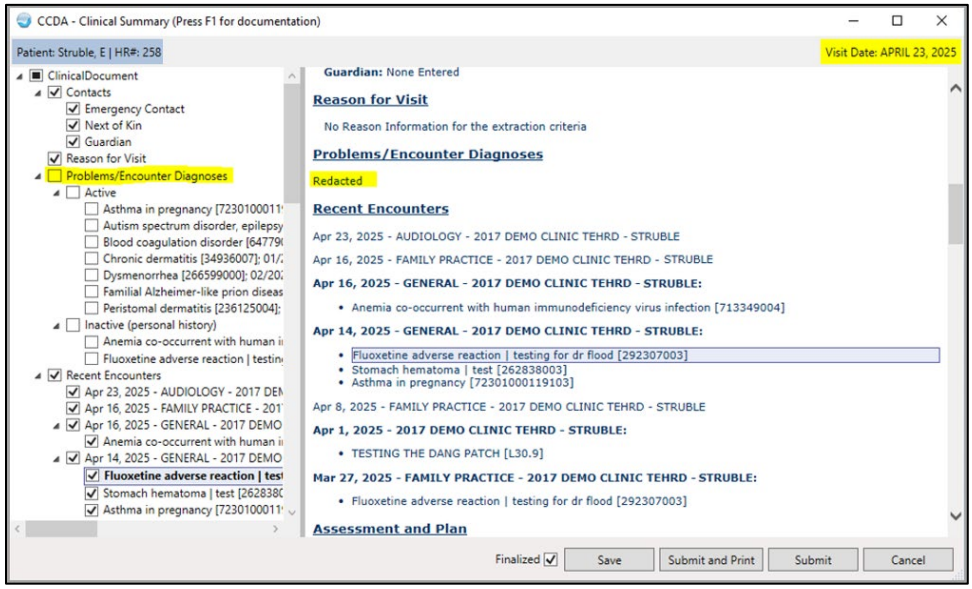


Figure 5-11: Redacted Clinical Summary dialog

Important: Users can only submit using the **Clinical Summary** dialog if the **Finalized** check box is selected.

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

3. Click the **Collapse** button ( ) to collapse subheadings, as needed.
4. When the selections are completed, select the **Finalized** check box at the bottom of the **CCDA Clinical Summary** dialog. All buttons become active.

Save

To save a Clinical Summary for the current date of service visits, click the **Save** option.

The document is saved to the location set in **BEHOCCD SAVE** by the Site Manager.

5.5 Generate Clinical Summary for Current Selected Visit

To generate a Clinical Summary for the current selected visit (Figure 5-12), left-click the **CCDA** button or right-click and select **Generate Clinical Summary for Current Selected Visit** (Figure 5-13) from the menu option. The option button defaults to **Clinical Summary**. Then select one of the following actions.

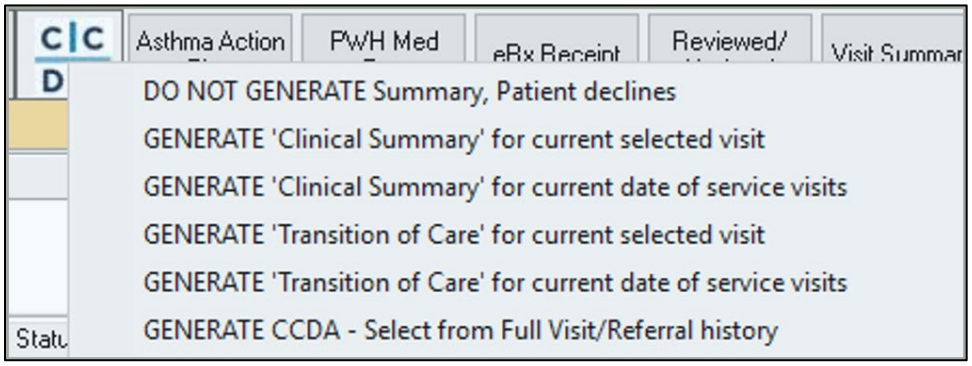


Figure 5-12: CCDA right-click menu options

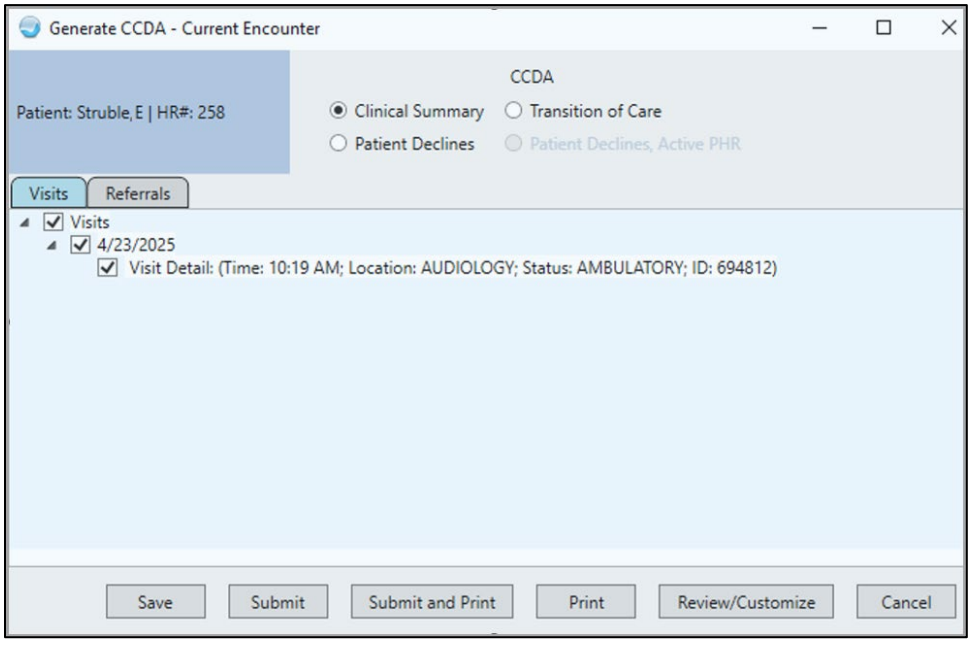


Figure 5-13: Clinical Summary for Current Selected Visit

Submit

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

1. Click the **Submit** button, the **Direct Email Form** dialog (Figure 5-14) opens.

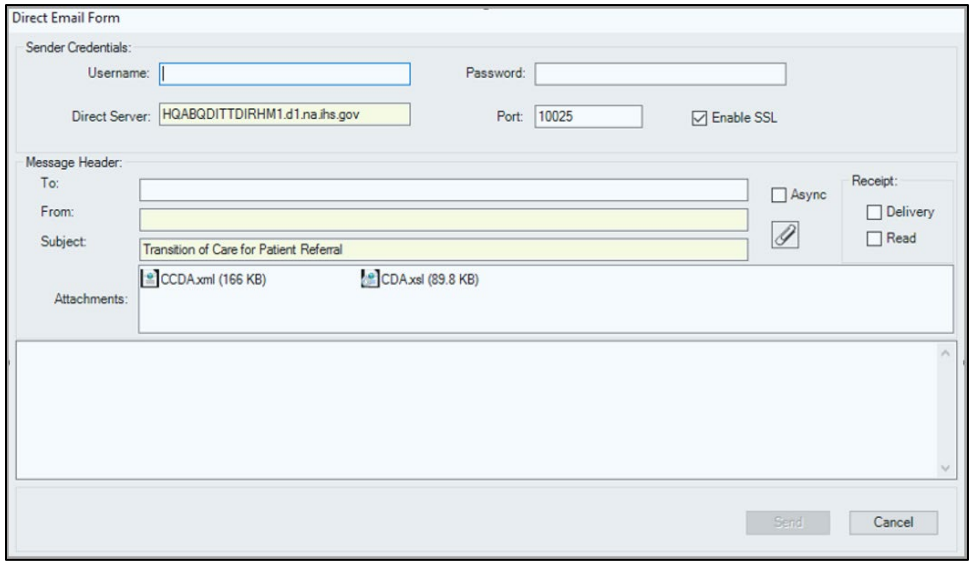


Figure 5-14: Direct Email Form dialog

2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button.
5. If the user clicks the **Cancel** button, they will be prompted with the **Select Alternative Submission Method** dialog (Figure 5-15).

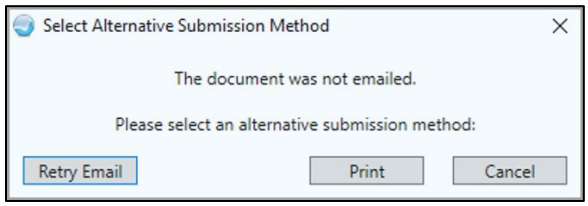


Figure 5-15: Select Alternative Submission Method dialog

Submit and Print

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

1. Click the **Submit** and **Print** button and the **Direct Email Form** dialog (Figure 5-14) opens.

2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button.
5. The **Print** dialog opens. Select a **printer** and click the **Print** button.

Print

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

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

Review/Customize

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

1. Click the **Review/Customize** option. The **CCDA Clinical Summary** dialog (Figure 5-16) opens.

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

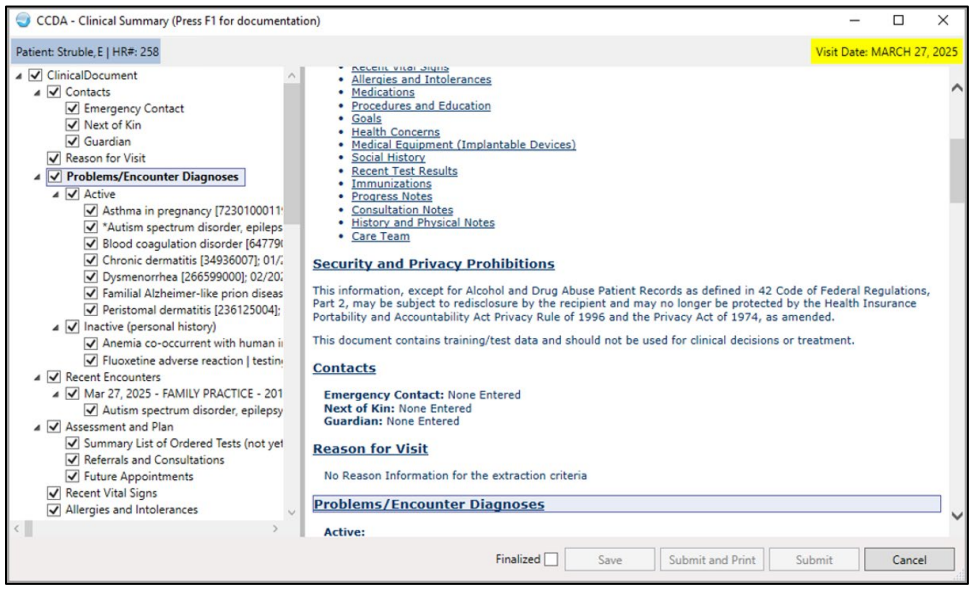


Figure 5-16: CCDA Clinical Summary dialog Not Finalized

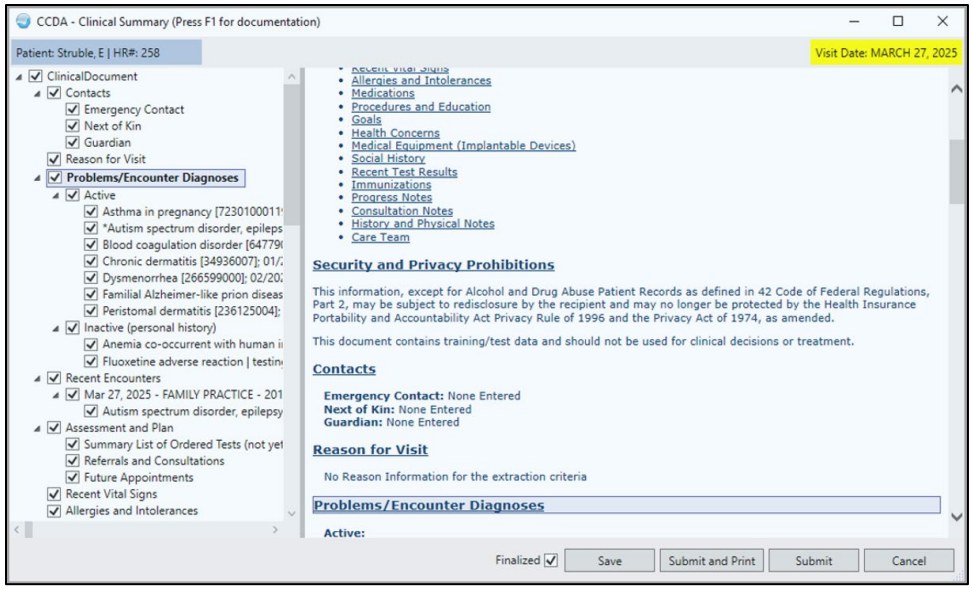


Figure 5-17: CCDA Clinical Summary dialog finalized

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

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

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

- The topic data is cleared when the check box is cleared but the heading remains, and the word Redacted appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains, and the word Redacted appears below it.
- The following note appears at the top of the Clinical Summary (Figure 5-18):

  Some information may have been redacted at patient's request or legal requirement.

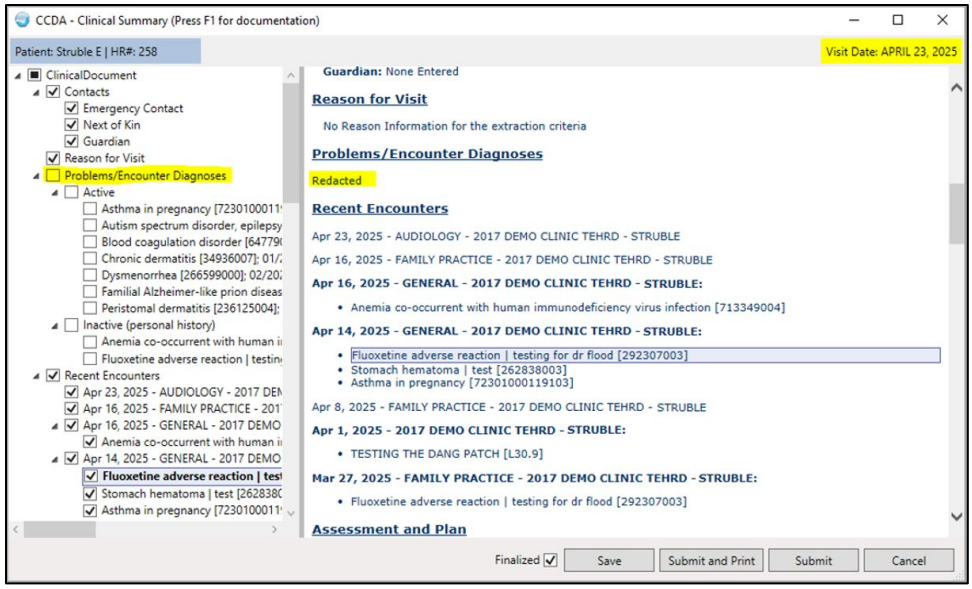


Figure 5-18: Redacted Clinical Summary dialog

Important: Users can only submit using the **Clinical Summary** dialog if the **Finalized** check box is selected.

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

3. Click the **Collapse** button ( ) to collapse subheadings, as needed.

4. After completing the selections, select the **Finalized** check box at the bottom of the **CCDA Clinical Summary** dialog. The **Print All** buttons becomes active.

Save

To save a Clinical Summary for the current date of service visits, click the **Save** option.

The document is saved to the location set in **BEHOCCD SAVE** by the Site Manager.

5.6 GENERATE Clinical Summary for Current Date of Service Visits

To generate a Clinical Summary for the current date of service visits (Figure 5-19) (multiple visits for one date), from the CCDA menu, select Generate Clinical Summary for Current Date of service visits. The option button defaults to Clinical Summary. Then select one of the following actions.

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

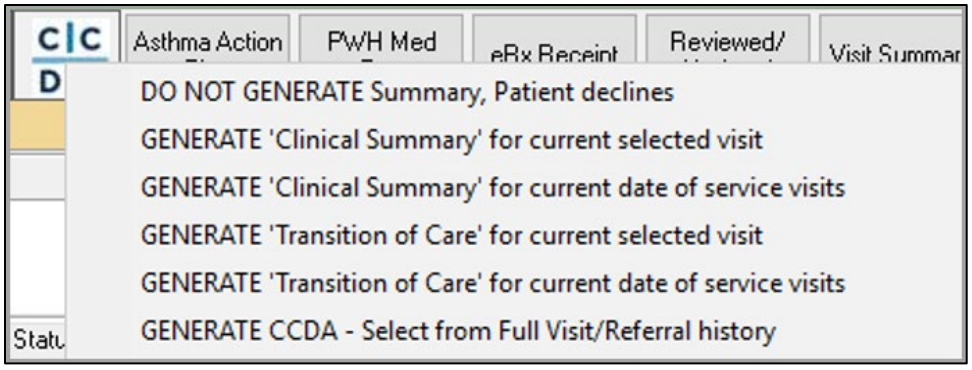


Figure 5-19: CCDA right-click menu options

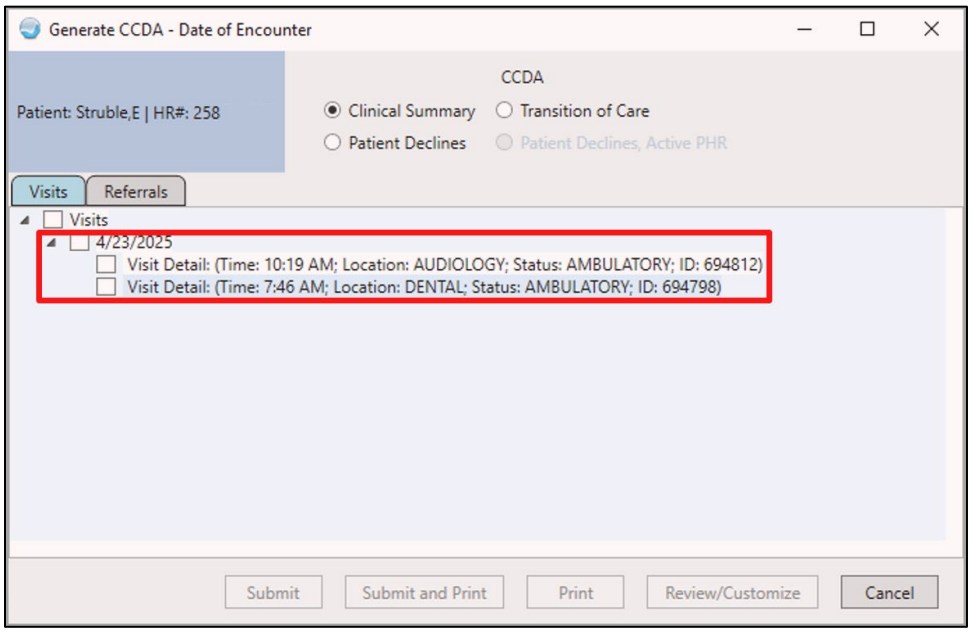


Figure 5-20: Clinical Summary for Current Date of Service Visits

Submit

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

1. Click the **Submit** button. The **Direct Email Form** dialog (Figure 5-21) opens.

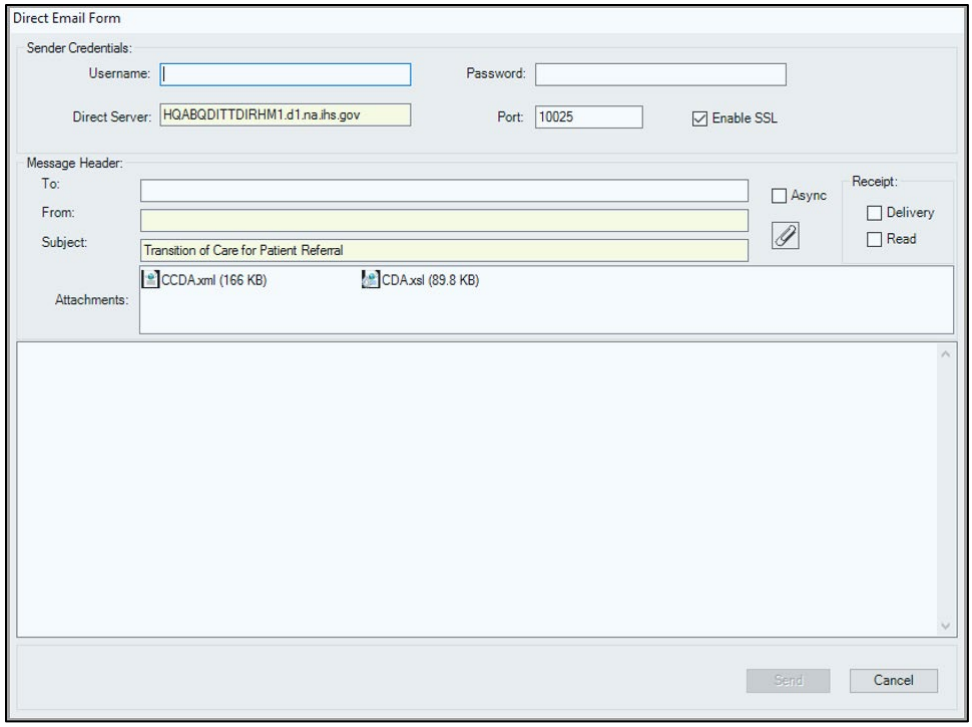


Figure 5-21: Direct Email Form dialog

2. Enter the Direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button.
   - If the user clicks the **Cancel** button, they are prompted with the **Select Alternative Submission Method** dialog.

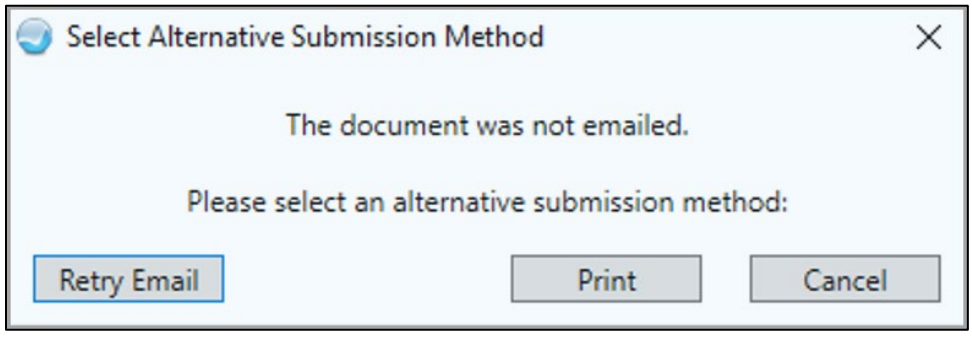


Figure 5-22: Select Alternative Submission Method dialog

Submit and Print

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

1. Click the **Submit** and **Print** button. The **Direct Email Form** dialog (Figure 5-21) opens.
2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button. The **Print** dialog opens.
5. Select a **printer** and click the **Print** button.

Print

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

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

Review/Customize

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

1. Click the **Review/Customize** option. The **CCDA Clinical Summary** dialog (Figure 5-23 and Figure 5-24) opens.

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

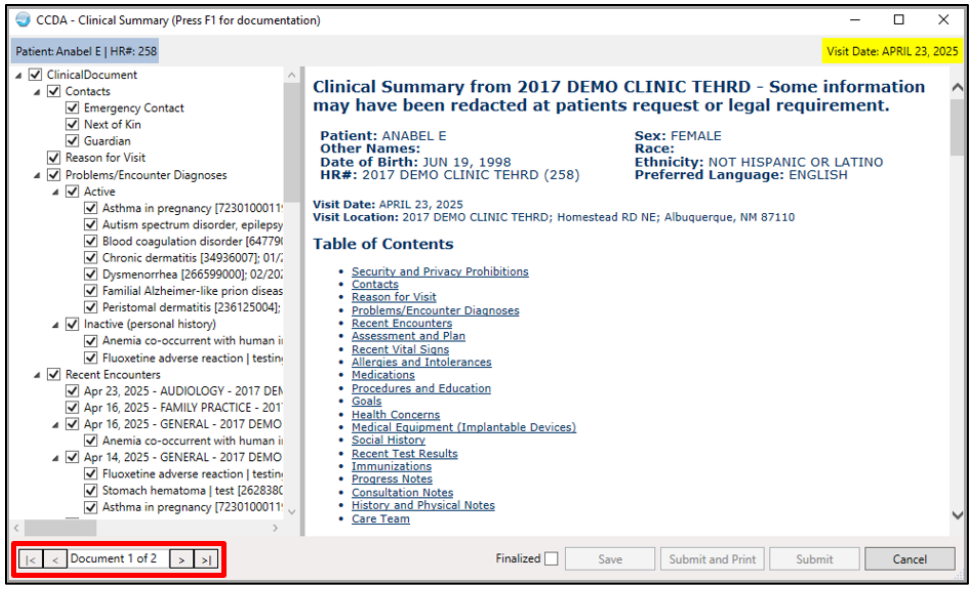


Figure 5-23: CCDA Clinical Summary Dialog Not Finalized



Figure 5-24: CCDA Clinical Summary Dialog finalized

2. Clear the **check boxes** next to any items the user wants to remove from the Clinical Summary.

   - Clearing a check box also clears any check boxes below it. For example, clearing the Allergies check box also clears all allergy items listed individually below it.
   - Select any check boxes for individual sub- topics, as needed.

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

- The topic data is cleared when the check box is cleared, but the heading remains, and the word **Redacted** appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains, and the word **Redacted** appears below it.
- The following note appears at the top of the **Clinical Summary** (Figure 5-25):

  Some information may have been redacted at patient's request or legal requirement.

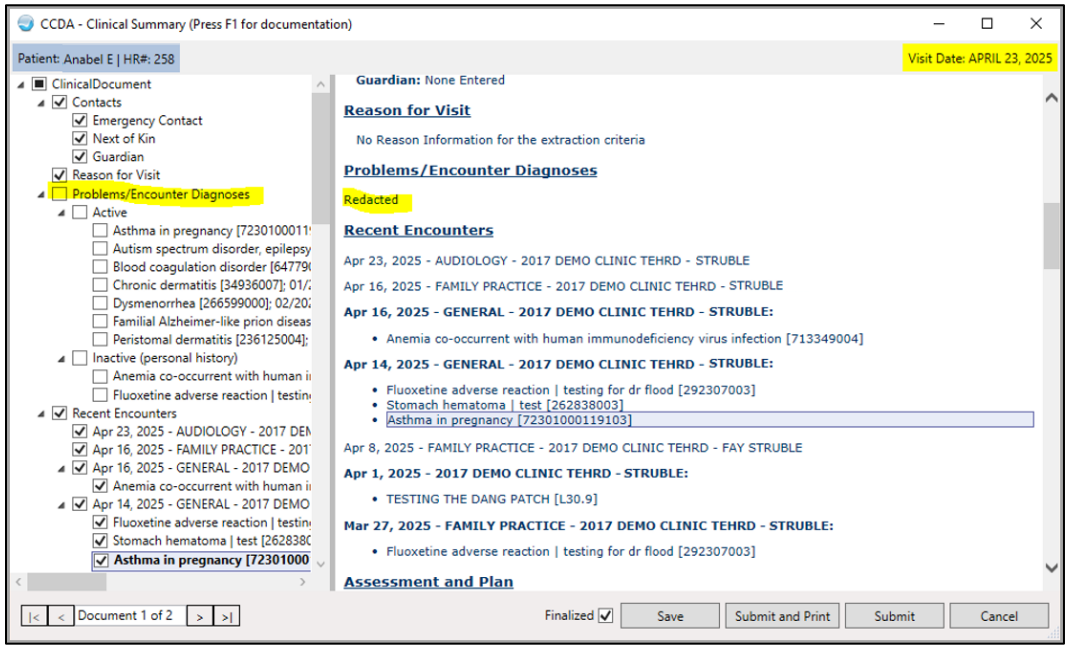


Figure 5-25: Redacted Clinical Summary dialog

Important: Users can only submit using the **Clinical Summary** dialog if the Finalized check box is selected.

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

3. Click the **Collapse** button ( ) to collapse Subheadings, as needed.
4. After completing the selections, select the **Finalized** check box at the bottom of the **CCDA Clinical Summary** dialog. All buttons become active.

Save

To save a Clinical Summary for the current date of service visits, click the **Save** option.

The document is saved to the location set in **BEHOCCD SAVE** by the Site Manager.

5.7 GENERATE Transition of Care for Current Selected Visit

To generate a Clinical Transition of Care (ToC) for the current selected visit, select **Generate Transition of Care for Current selected visit** from the CCDA right-click menu option (Figure 5-26) and note the following:

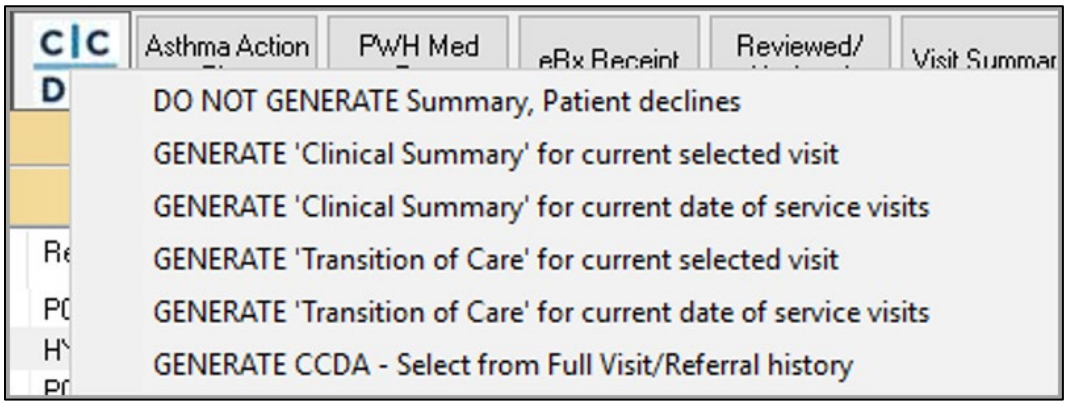


Figure 5-26: CCDA right-click menu options

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

- If the visit selected is associated with a referral (Figure 5-27), the **Referrals** tab with the **ToC** option button selected opens (default).

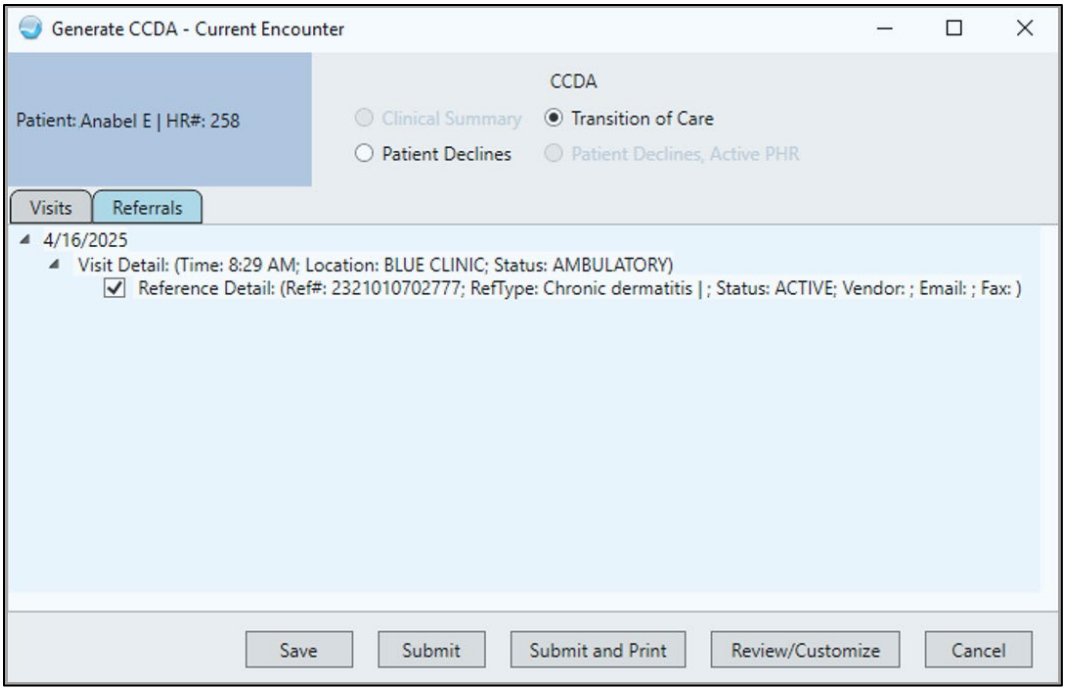


Figure 5-27: CCDA Visit Selected associated with referral

  - If the **Visits** tab is selected, the **Clinical Summary** and the **Transition of Care** option buttons are active.
  - If the **Referrals** tab is selected, only the **Transition of Care** option button is active.
- If the visit selected is not associated with a referral (Figure 5-28), the **Visit** tab with the **ToC** option button selected opens (default).

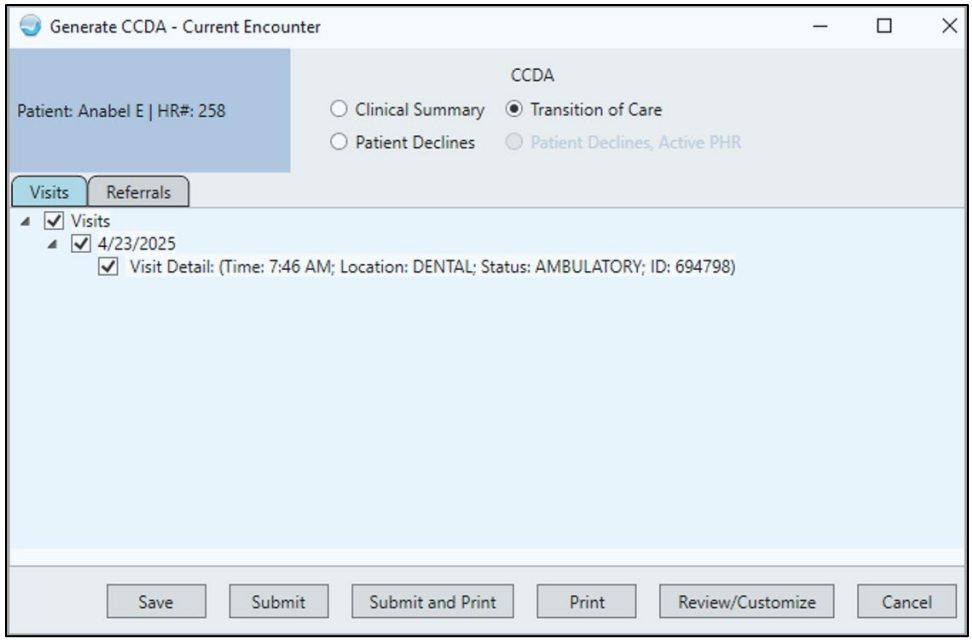


Figure 5-28: CCDA Visit Selected associated without referral

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

Submit

To submit a Transition of Care for the current selected visit, follow these steps:

1. Click the **Submit** button.

   a. If a fax number is provided in the **Vendor** file, the following information message (Figure 5-29) confirms that the image was sent to **VistA Imaging** for faxing. Click **OK**.

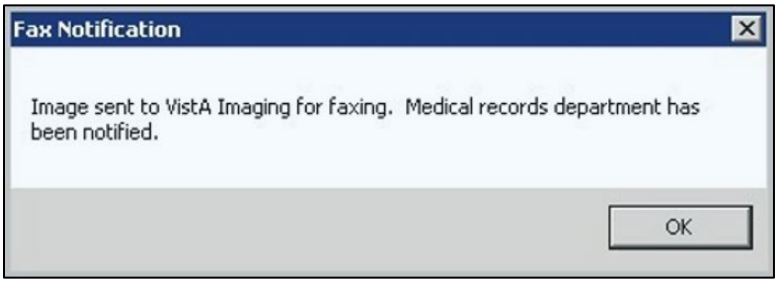


Figure 5-29: Imaging Confirmation message

   If no fax number is present for the vendor or provider, the Direct Email Form (Figure 5-30) opens.

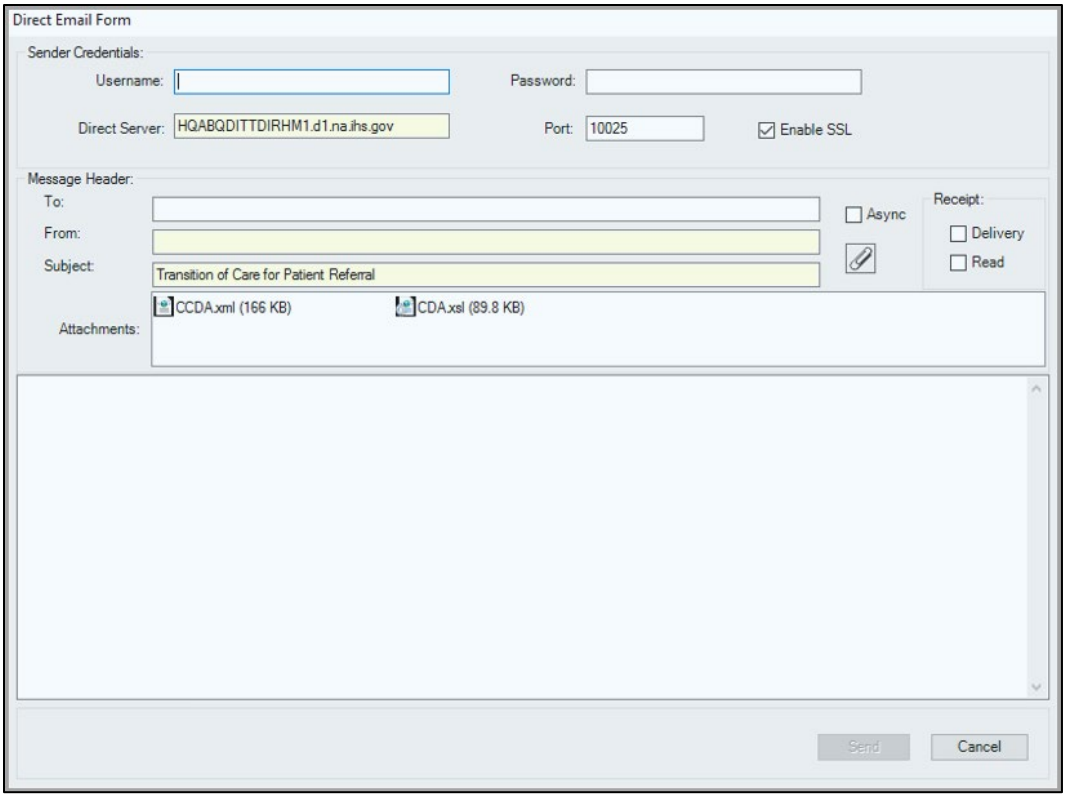


Figure 5-30: Direct email form

2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button.

   If the user clicks the **Cancel** button, they will be prompted with the **Select Alternative Submission Method** dialog (Figure 5-31).

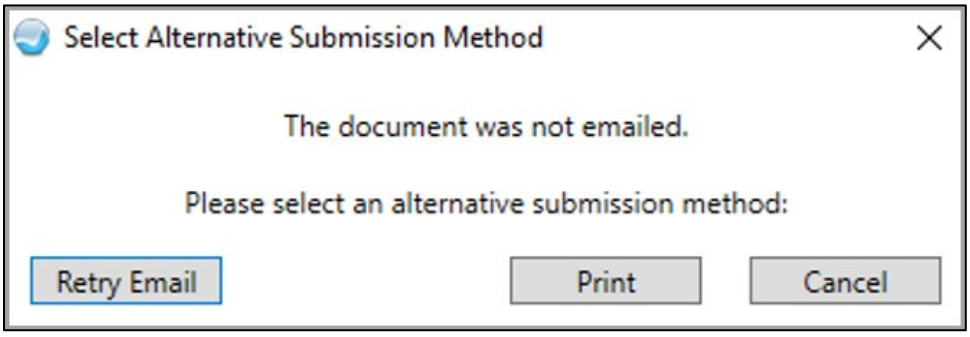


Figure 5-31: Select Alternative Submission Method dialog

Submit and Print

To submit and print a Transition of Care for the current selected visit, follow these steps.

1. Click the **Submit** and **Print** button, **Direct Email** form opens.
2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button.
5. The **Print** dialog opens. Select a **printer** and click the **Print** button.

Print

To print a Transition of Care for the current selected visit, follow these steps:

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

Review/Customize

To review or customize a Transition of Care for the current selected visit, follow these steps:

1. Click the **Review/Customize** option. The **CCDA Transition of Care** dialog (Figure 5-32 and Figure 5-33) opens.

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

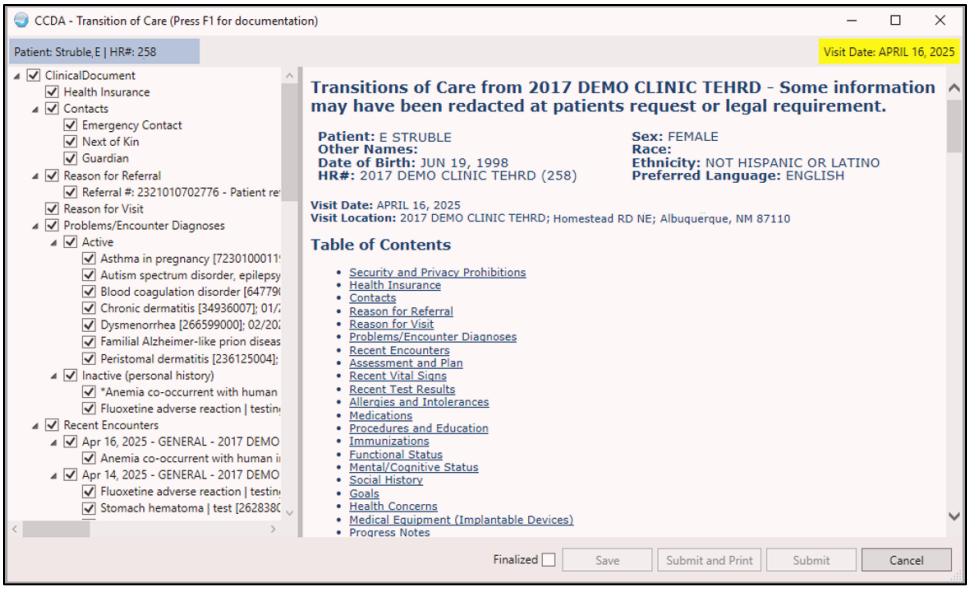


Figure 5-32: CCDA Transition of Care dialog not finalized

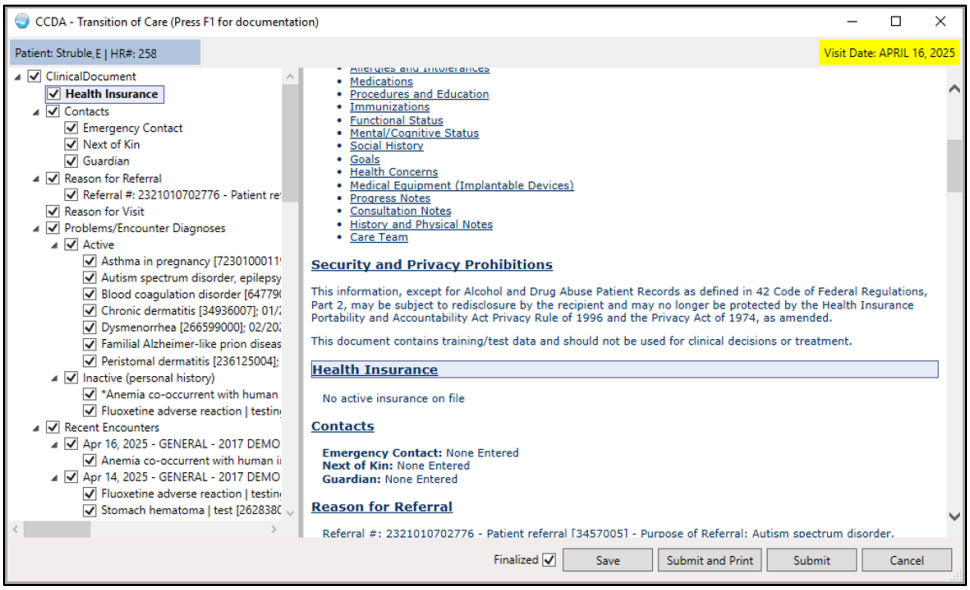


Figure 5-33: CCDA Transition of Care dialog finalized

2. Clear the **check boxes** next to any items the user wants to remove from the Transition of Care.

   Clearing a check box also clears any check boxes below it. For example, clearing the **Allergies** check box also clears all allergy items listed individually below it. Select any check boxes for individual sub- topics, as needed.

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

- The topic data is cleared when the check box is cleared but the heading remains, and the word **Redacted** appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains, and the word **Redacted** appears below it.
- The following note appears at the top of the Transition of Care (Figure 5-34):

  Some information may have been redacted at patient's request or legal requirement.

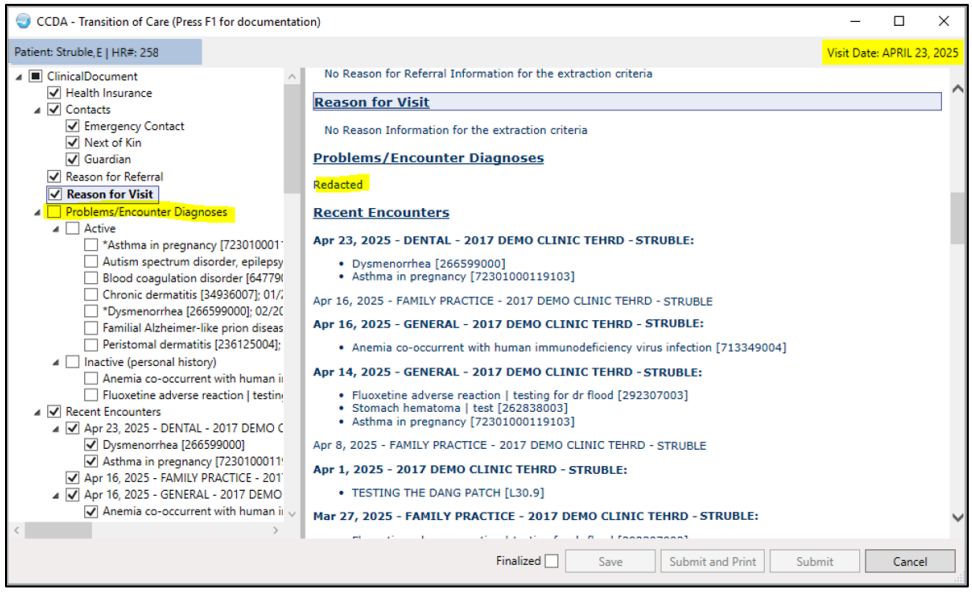


Figure 5-34: Redacted Transition of Care dialog

Important: Users can only submit using the Transition of Care dialog if the **Finalized** check box is selected.

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

3. Click the **Collapse** button ( ) to collapse subheadings, as needed.
4. After completing the selections, select the **Finalized** check box at the bottom of the **CCDA Transition of Care** dialog. All buttons become active.

Save

To save a Transition of Care for the current date of service visits, click the **Save** option.

The document is saved to the location set in **BEHOCCD SAVE** by the Site Manager.

5.8 GENERATE Transition of Care for Current Date of Service Visits

To generate a Clinical Transition of Care (ToC) for the current date of service visit from the CCDA right-click menu option (Figure 5-35), select **Generate Transition of Care for Current Date of Service Visits** and note the following:

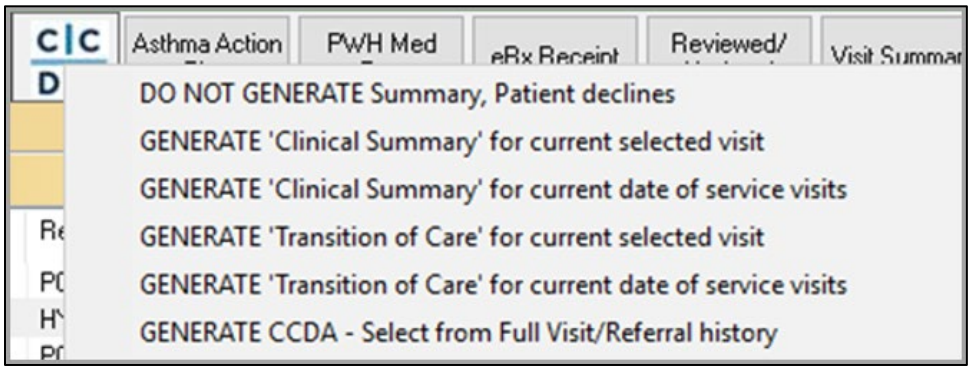


Figure 5-35: CCDA right-click menu options

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

- If the visit selected is associated with a referral (Figure 5-36), the **Referrals** tab with the **ToC** option button selected opens (default).

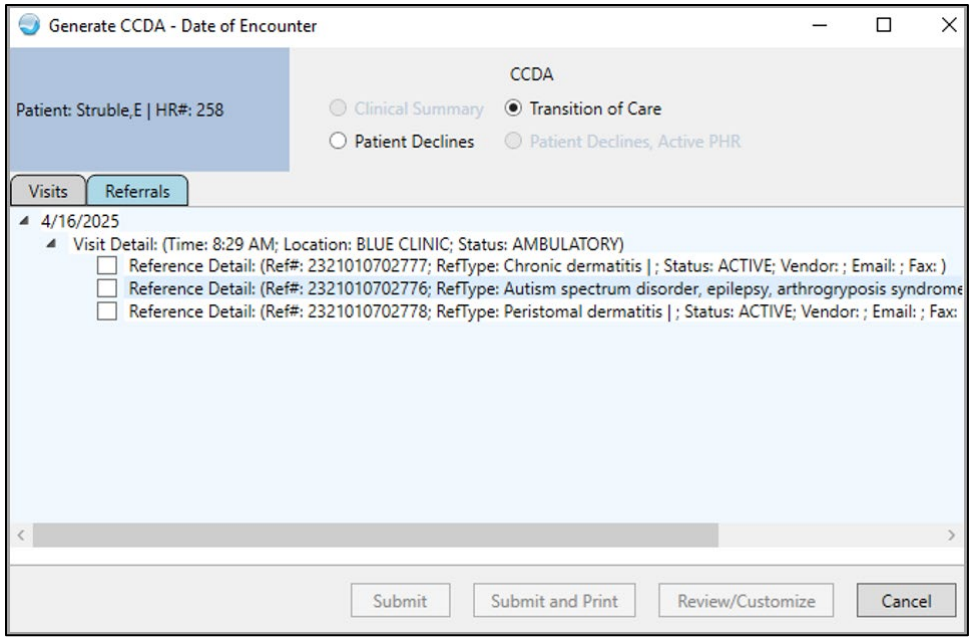


Figure 5-36: CCDA visit selected associated with multiple referrals

- If the **Visits** tab is selected, the **Clinical Summary** and the **Transition of Care** option buttons are active. If the **Referrals** tab is selected, only the **Transition of Care** option button is active.
- If the visit selected is not associated with a referral, the **Visit** tab with the **ToC** option button selected opens (default) (Figure 5-37).

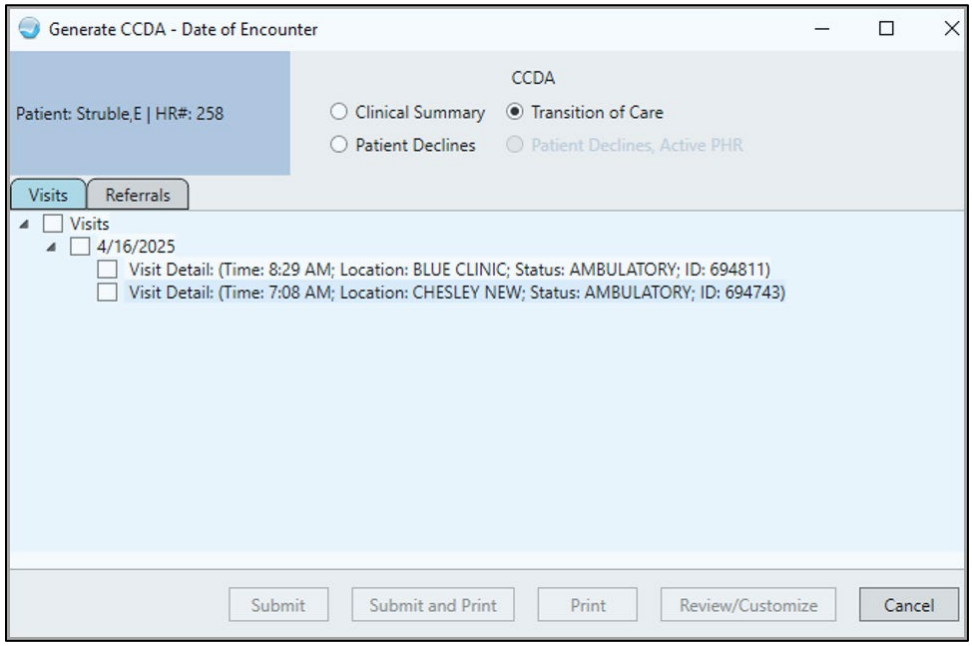


Figure 5-37: CCDA multiple visit selected associated without referral

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

Submit

To submit a Transition of Care for the current selected visit, follow these steps.

1. Click the **Submit** button.

   If a fax number is provided in the **Vendor** file, the following information message (Figure 5-38) confirms that the image was sent to **VistA Imaging** for faxing.

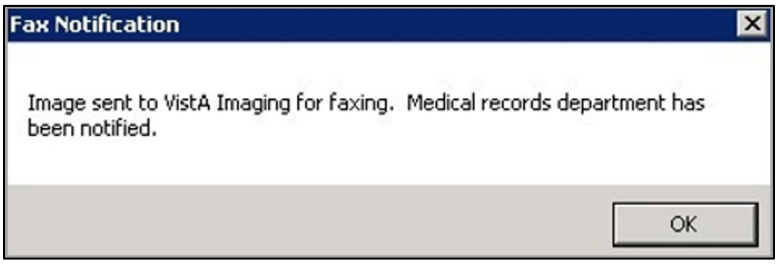


Figure 5-38: Imaging Confirmation message

2. Click **OK**.

   If no fax number is present for the vendor or provider, the **Direct Email Form** (Figure 5-39) opens.

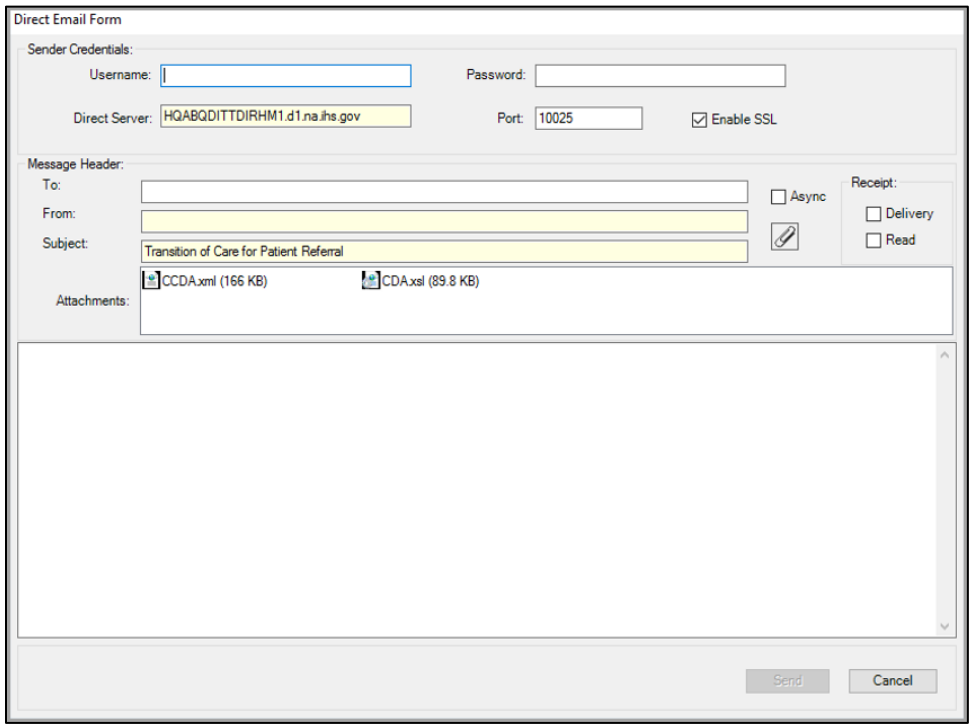


Figure 5-39: Direct email form

3. Enter the direct email **username** and **password**.
4. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
5. Click the **Send** button.

   If the user clicks the **Cancel** button, they are prompted with the **Select Alternative Submission Method** dialog.

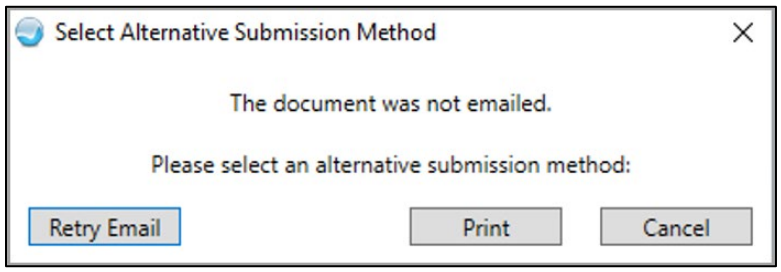


Figure 5-40: Select Alternative Submission Method dialog

Submit and Print

To submit and print a Transition of Care for the current selected visit, follow these steps.

1. Click the **Submit and Print** button. The **Direct Email Form** opens.
2. Enter the direct email **username** and **password**.
3. Enter the **To:** information. Multiple valid email addresses can be entered by separating them with a semicolon (**;**) comma (**,**) or a period (**.**).
4. Click the **Send** button. The Print dialog opens.
5. Select a **printer** and click the **Print** button.

Print

To print a Transition of Care for the current selected visit, follow these steps:

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

Review/Customize

To review or customize a Transition of Care for the current selected visit, follow these steps:

1. Click the **Review/Customize** option. The **CCDA Transition of Care** dialog (Figure 5-41 and Figure 5-42) opens.

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

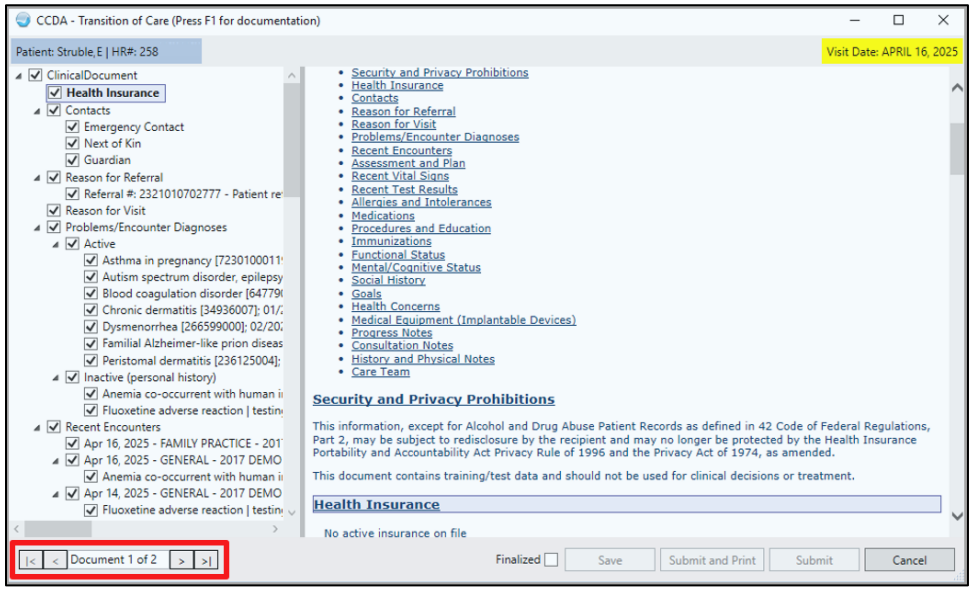


Figure 5-41: CCDA Transition of Care Dialog Not Finalized

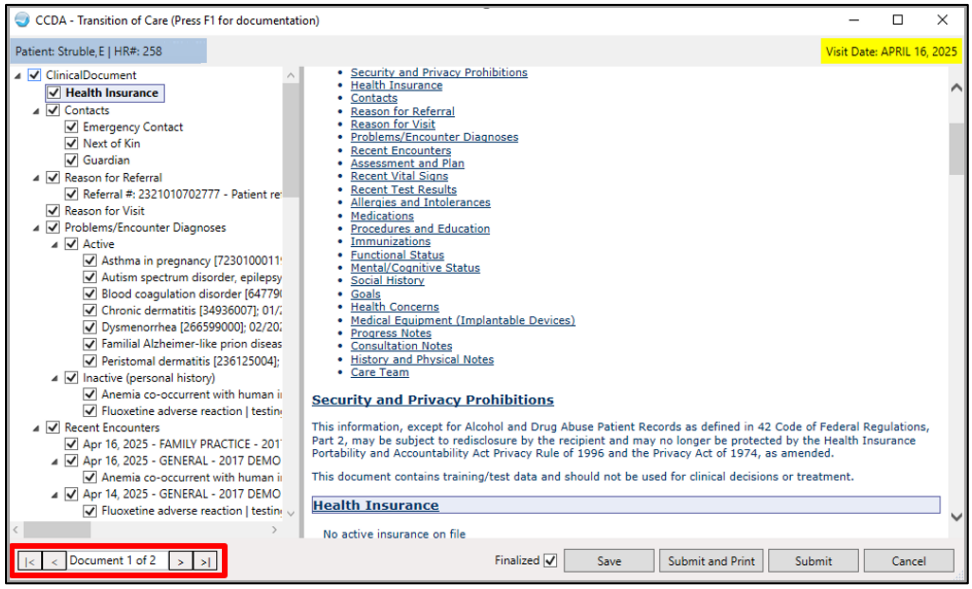


Figure 5-42: CCDA Transition of Care Dialog finalized

2. Clear the check boxes next to any items to be removed from the Transition of Care.

   Clearing a check box also clears any check boxes below it. For example, clearing the **Allergies** check box also clears all allergy items listed individually below it. Select any check boxes for individual sub-topics, as needed.

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

- The topic data is cleared when the check box is cleared but the heading remains, and the word Redacted appears below the heading of the section that was cleared.
- When a subheading check box is cleared, the subheading remains, and the word Redacted appears below it.
- The following note appears at the top of the Transition of Care (Figure 5-43):

  Some information may have been redacted at patient's request or legal requirement.

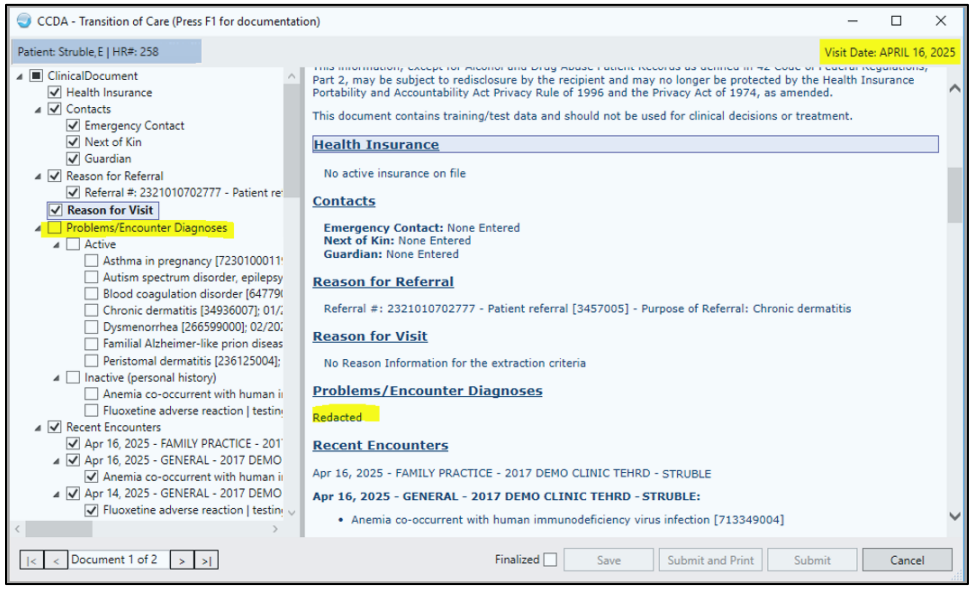


Figure 5-43: Redacted Transition of Care dialog

Important: Users can only submit using the **Transition of Care** dialog if the **Finalized** check box is selected.

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

3. Click the **Collapse** button ( ) to collapse Subheadings, as needed.
4. After completing the selections, select the **Finalized** check box at the bottom of the **CCDA Transition of Care** dialog. All buttons become active.

Save

To save a Transition of Care for the current date of service visits, click the **Save** option. The document is saved to the location set in **BEHOCCD SAVE** by the Site Manager.

5.9 GENERATE CCDA for Full Visit/Referral History

The **CCDA for Full Visits/Referral History** option displays all of the visits and referrals for a patient by date of service, sorted from newest to oldest visit.

To generate a CCDA Clinical Summary or Transition of Care for a visit or referral, select the right-click menu option **Generate CCDA for a Full Visits/Referral History** (Figure 5-44). This allows for creation of multiple documents for each checked request. Follow these steps:

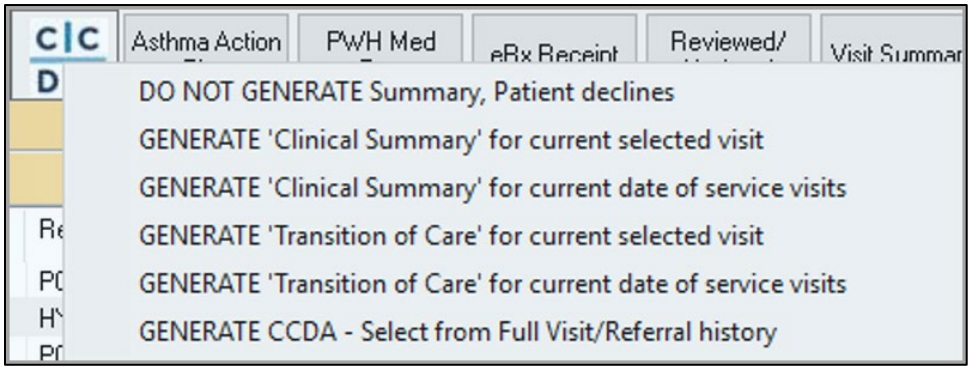


Figure 5-44: CCDA right-click menu options

1. In the **Generate CCDA – All Visits** dialog (Figure 5-45 and Figure 5-46), click the **Visits** tab. The **Clinical Summary** option is the default (and selected), but the **Transition of Care** option is also active.

Note:	If the **Referrals** tab is selected, only the **Transition of Care** option is the default.

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

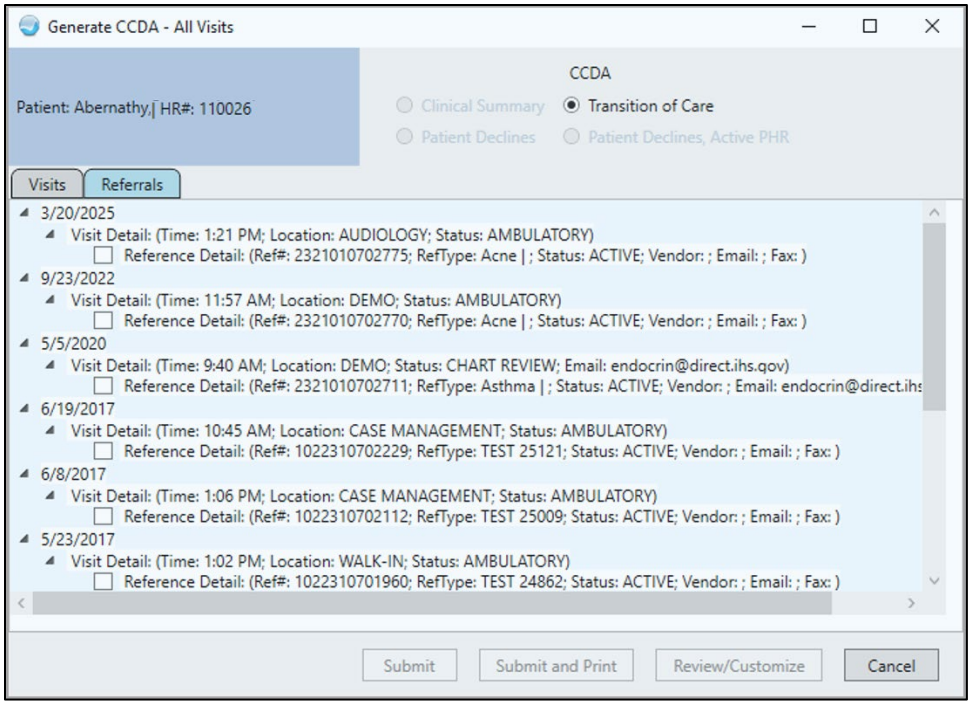


Figure 5-45: Generate CCDA for Full Visits/Referral history Transition of Care for Referrals

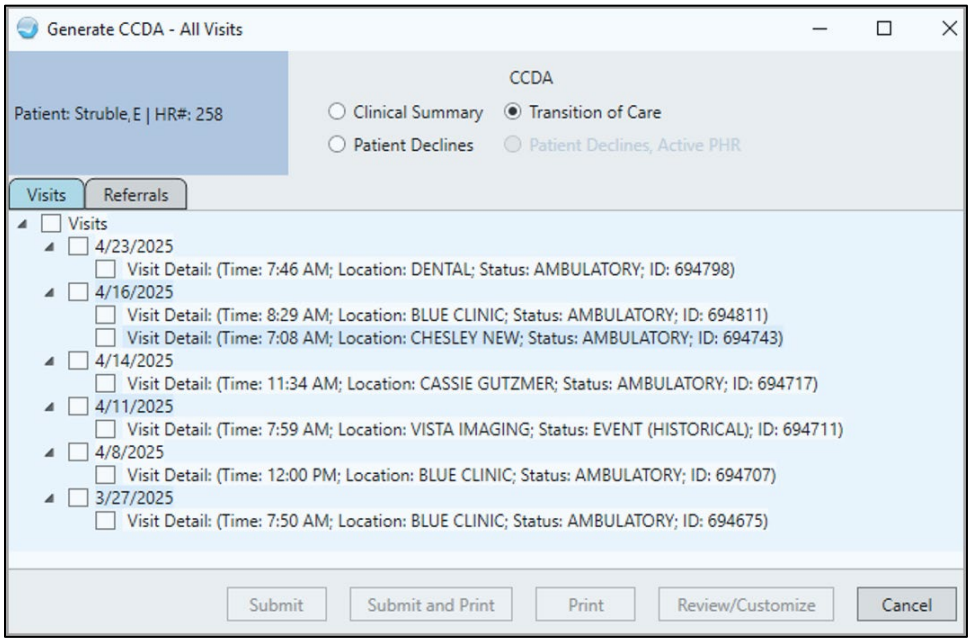


Figure 5-46: Generate CCDA for Full Visits/Referral history Transition of Care for Visits

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

   - Clinical Summary:

a. Click the **Expand** button ( ) to expand or the **Collapse** button ( ) to collapse the document list. The list is fully expanded by default.

b. Select the check boxes to select or to clear the selection next to any items the user wants to add or remove from the list.

c. Refer to the **Generate Clinical Summary for Current Date of Service Visits** topic for details on how to **Submit**, **Print**, **Review/Customize**, **Save**, and **Cancel**.

- Transition of Care:

a. Click the **Expand** button ( ) to expand or the **Collapse** button ( ) to collapse the document list. The list is fully expanded by default.

b. Select the check boxes to select or to clear the selection next to any items the user wants to add or remove from the list.

c. Refer to the **Generate Transition of Care for Current Selected Visits** topic for details on how to **Submit**, **Print**, **Review/Customize**, **Save**, and **Cancel**.

5.10 Direct Email

5.10.1 Adding Attachments

Transition of Care attachments may be added to a message by clicking the **Paper Clip** button, and dragging and dropping the file into the body of the message from Windows Explorer.

1. Click the **Paper Clip** button ( ) on the **Direct Email Form** dialog (Figure 5-47).

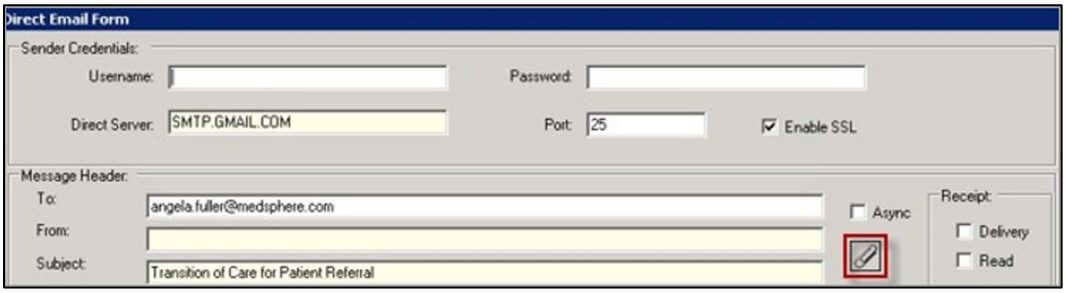


Figure 5-47: Paper Clip button on Direct Email Form dialog

Windows Explorer (Figure 5-48) opens displaying a list of files.

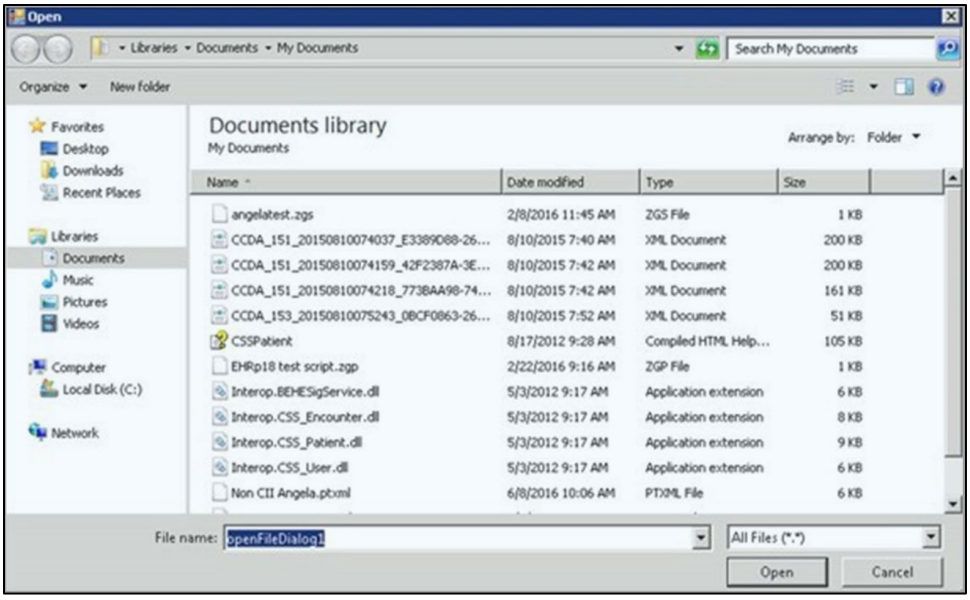


Figure 5-48: Windows Explorer dialog

2. Select the **file (or files)** to attach to the email (Figure 5-49) and click **Open**. The file displays in the Attachments pane of the email.

> **Note:** Users can also attach files by selecting them in Windows Explorer, then dragging and dropping them into the body of the message.

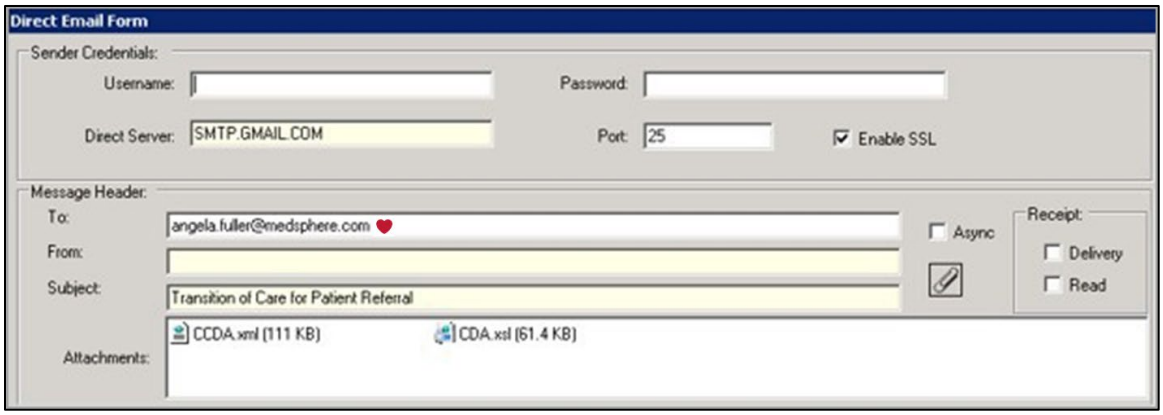


Figure 5-49: Email with Attachments

5.10.2 Removing Attachments

Transition of Care attachments may be individually removed or all removed from an email message.

1. Select a **file** in the **Attachments** pane of the **Direct Email Form** dialog (Figure 5-50) and right-click. The following message appears:

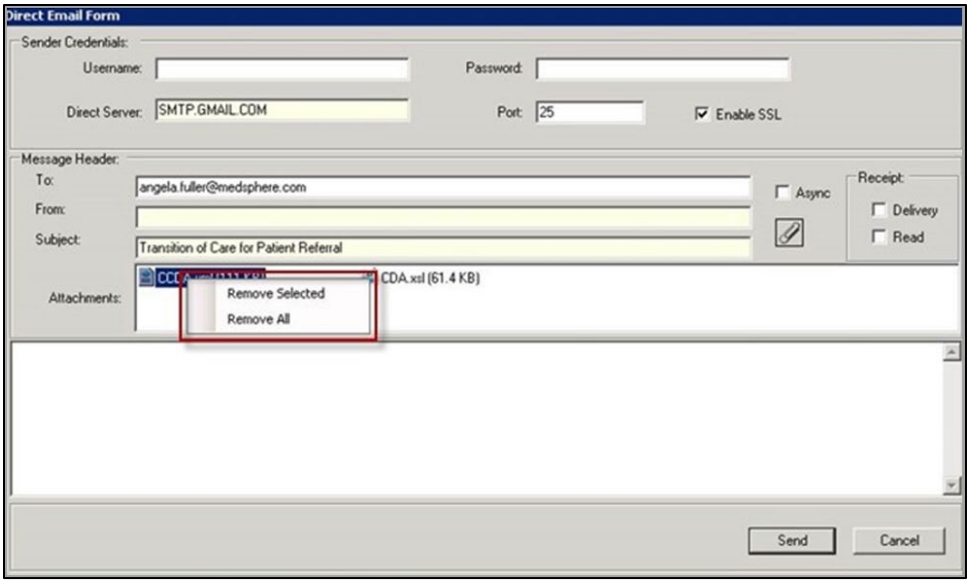


Figure 5-50: Remove Selected Attachment(s) dialog

2. Select **Remove Selected** to only remove the selected file, or select **Remove All** to remove all attachments.

Note:	Attachments may also be removed by right-clicking in the **Attachments** pane, selecting one or more items (hold down the **<Ctrl>** key when selecting multiple items), and pressing **<Delete>**.

5.10.3 Restoring Removed Attachments

To restore an attachment or attachments that have been removed, right-click the **Paper Clip** button and select **Restore Original Attachments** (Figure 5-51).

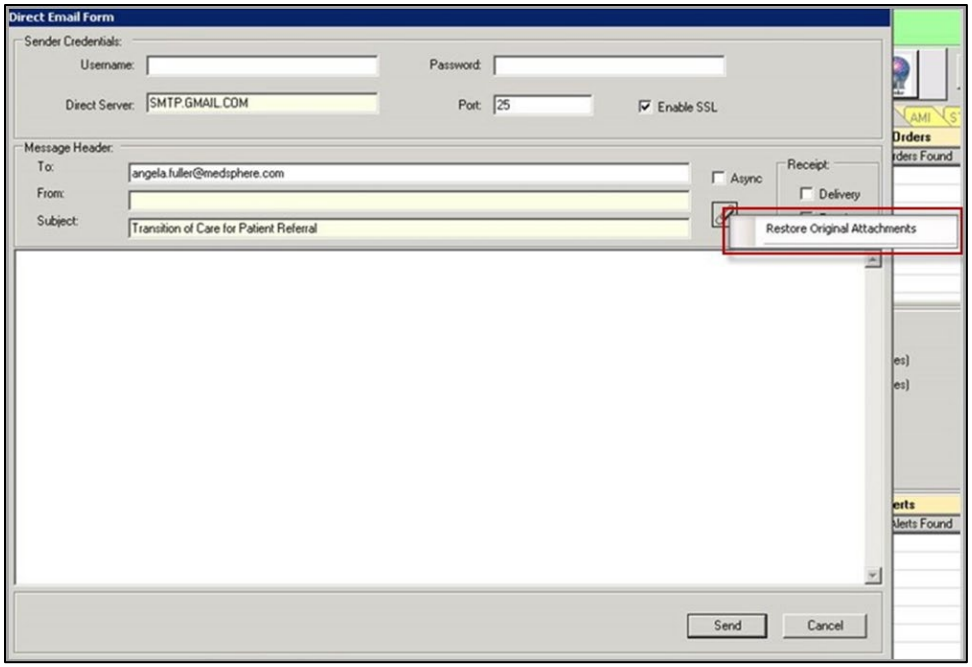


Figure 5-51: Restore Original Attachments dialog

Acronym List

Acronym	Term Meaning
IHS	Indian Health Service
CAC	Clinical Application Coordinator
CCDA	Consolidated Clinical Document Architecture
CS	Clinical Summary
RPMS	Resource and Patient Management System
HIM	Health Information Management
ISSO	Information System Security Officer
RPMS	Resource and Patient Management System
TOC	Transition of Care
VIC	Veterans Health Information System and Technology Architecture (VistA) Imaging Capture tool

Contact Information

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