QUILLEN ETSU PHYSICIANS

Allscripts Training Manual
Nursing Staff

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BASIC NAVIGATION

Logging In/Logging Out

Step-by-step: Logging In

1. Login to CITRIX (Step 1)
   a. Click on the Quillen Desktop CITRIX icon on the desktop
   b. Click on the Login ID box
   c. Type your CITRIX Username and Password
   d. Click on the second Quillen Desktop icon (within CITRIX)

2. Login to Allscripts (Step 2)
   a. Click on Allscripts Enterprise icon
   b. Click within the Login ID box and type your Allscripts Username
   c. Click within the Password box and type your Allscripts Password
   d. Click either: New Session or Last Session (or just hit “enter.”)

New Session – Opens a new session of the Electronic Health Record (EHR)
Last Session – Opens the session with the last patient chart being used on this computer.

Usernames and Passwords ARE case sensitive!
Step-by-step: Logging Out

A. Click the **Logoff** button in the upper-right section of screen.

Please do not click the red X at the upper-right corner instead of properly logging out.

B. Click **OK** in the small window that opens saying “This will end your session.” This will end your Allscripts session (**Step 1**).

C. Click on the “**Iron-Start**” button in the lower-left corner of the screen (see Step B below).

D. Click **Log Off** to end your CITRIX session (**Step 2**).

Be sure that you complete **Step 1** and **Step 2** when logging off!
Changing Passwords

Users have the ability to change passwords at any time. Both CITRIX and Allscripts have minimum requirements that must be met. To accommodate both systems, select a password that contains one capitalized letter, contains at least two numbers, and is at least eight characters long. Do not use your own name, or try to use a password that you have previously used with the system.

CITRIX

Upon logging into CITRIX, the applications Main window will display as follows. Click on the Change Password link to open the Change Password window.
Enter your existing password in the **Old Password** field, and then enter and repeat your new password in the **New Password** and **Confirm Password** fields. Click **OK**.

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**Allscripts**

Once logged into **Allscripts**, click on **Tools** located in the right-upper section of the screen. Select **Settings** from the drop-down menu. Select the **Change Password** tab from the HTB, and follow the same steps as above.
Workplace
The workplace is defined by the user role. Your workplace should display either “Clinical Staff” in the upper left-hand section of your screen. This defines everything that the user sees on the screen (according to security privileges) including the Vertical and Horizontal Toolbars.

Upon login, you will be directed to the main default screen for nurses, which is the Daily tab from the Chart menu.

Tools Menu—Located in upper right-hand section of screen, you can reset your password, view keyboard shortcuts, and show/hide the clinical toolbar.

Locking the Screen—You can lock your EHR session, for example, if you need to step away from your workstation, by clicking Lock on the menu bar.

Unlocking the Screen—To unlock a locked EHR session, enter your password in the Session Locked dialog box and click Resume. Or, a different user can click Exit to bypass the locked session and log in.
Vertical and Horizontal Toolbars

**Vertical Toolbar (VTB)**—The VTB is located on the left-hand side of the screen. This contains menus that have been assigned to your workplace.

The VTB can be hidden to expand the screen and eliminate scrolling. To hide the VTB, click on Hide VTB.

**Chart**—enables access to the patient’s chart, your schedule, and your task list, as well as other items that are related to patient information.

**Call Process** – The Call Processing feature provides a method to document incoming calls and route them to the appropriate person.

**User Options**—allows you to view and/or change the site where you are currently practicing—useful for physicians or staff who rotate to different offices. The Print Queue tab allows you to view any print/fax documents that you have sent. Manage Note Locks is available to providers allowing access to unlock a note (when locked by another user).

**Homebase**—contains a series of web links to a variety of useful sites. Clicking on these will open up the website in a separate window, so you can view the site while remaining logged into Allscripts.

**Horizontal Toolbar (HTB)**—The HTB is located horizontally across the top of the screen. Each tab navigates the user to a different section.
Provider Schedules—allows you to view up to four provider schedules simultaneously. You can also set defaults on this page so the same four providers are shown each time you log in.

Daily—The Daily tab allows you to view the daily schedule. You can pull in any provider's schedule by clicking on the blue “All” button and searching for the provider. You can also pull in another date in a variety of ways: clicking along the days of the week tabs across the top of the schedule; clicking on the calendar icon next to the Date field, or clicking the black arrows to the right of the screen. These navigate the schedule forward and backward a week at a time. The icon next to the arrows will return you to the current day's appointment schedule.

Clinical Desktop—This is essentially the patient’s “open chart.” A thorough discussion of each component of the Clinical Desktop will follow.

New Note—is how providers can begin a new note for a patient encounter.

Task List—is defined as requests to either supply information or perform an action— in other words “messages” for individual users or teams of users.

Worklist—is a specific workspace designed to contain order and result items.

Printing Tasks – Allows the user to view, filter, and print tasks.

Patient Lists—are patient lists that we can create for you. This is a nice way to keep track of patient groups such as diabetic patients. If you want to have a list built for your clinic, please let the EHR Team know. We can also give your nurse access to your list if you want them to be responsible for populating and managing the lists.

Appointments—shows all of the patient’s previous and upcoming appointments within the organization.
Select Patient

There are two ways to pull up a patient—using the Select Patient function, or selecting a patient from the Daily appointment schedule by double-clicking on the patient’s name. Double-clicking the patient’s name from the schedule takes you directly into that patient’s Clinical Desktop.

Step-by-step: Select Patient
1. Click on Select Patient ▼
2. Select “Search”.
3. Choose the criteria by which you wish to search (Name, DOB, and so forth...)
4. Type in at least a few letters to begin your search (For example, to search for William Smith, you can search by “smit,wil” to get a list of matches whose last name begins with “smit” and first name begins with “wil”.)
5. Click search or enter.
6. Search results display at the bottom of the screen.
7. Verify the patient’s demographic information matches the person for whom you are searching.
8. Click on the patient.
9. Click OK.

When searching by name, you now have the ability to enter a last name, first name, and date of birth OR year of birth.

You can choose your default search criteria by clicking the blue personalize link in the search box. Notice the gray text listed above the type-in field that tells the format it accepts for the search.

There is an added level of security for patients who are also employees of Quillen ETSU Physicians. Break Glass security requires users to override patient security to continue. Please provide an explanation for access, because Break Glass is audited weekly.
Patient Banner

Choosing a patient from the Select Patient method described above will pull the patient’s name into the Patient Banner. The patient banner displays demographic information of the patient in context. The summary of basic demographic information is created in the Practice Management (PM) system (Experior) and cannot be edited within the EHR.

To meet the Meaningful Use objective of implementing clinical decision rules, Allscripts displays real-time patient alerts to notify you when information has not been entered for the patient or encounter.

The Patient Banner displays a red triangle beneath the patient name to indicate Clinical Alerts exist for the patient.

Step-by-step: View and Resolve a Clinical Alert

1. Navigate to the Patient Banner.
2. Click on the My Alerts icon. The Encounter Summary displays with the My Alerts section expanded.
3. Right-click on the desired alert. A context menu of options displays. Make a selection from the context menu.
4. Choose the appropriate action to resolve the alert.
5. Click Save and Continue to save the changes to the patient’s record and close the Encounter Summary.
Patient Profile

The patient profile provides a complete view of the patient’s demographic, insurance, and pharmacy information. Most demographics are entered in the \textbf{PM}; however, the pharmacy information, FYI, and Chart Alerts are entered in the \textbf{EHR} from the Patient Profile screen.

Step-by-step: View the Patient Profile Dialog

1. Select a patient
2. Click the \textbf{blue “i”} (the information icon) in the patient banner
3. The Patient Profile Dialog window will open.
The FYI and Chart Alert
The FYI and Chart Alert quickly provide pertinent information about the patient. The FYI displays a yellow icon on the patient banner when populated, and the Chart Alerts display in red on the clinical toolbar which shows on all screens.

- **FYI**—For non-urgent information about the patient—such as “patient needs an interpreter;” or “wheelchair needed.” The front desk can add and edit FYI items.

- **Chart Alert**—For urgent clinical information such as latex allergy, or Penicillin allergy. Each patient can have up to three chart alerts. Chart alerts will automatically record all comments with user name, and entered date/time stamp. Front desk folks will be able to read chart alerts, but do not have access to create them.

If a user enters a chart alert message for the selected patient on the Patient Profile form (the blue i), the system displays the message in red text on the Clinical Toolbar.

- **Clinical Information**—contains clinical “demographic” information such as directives and medication history consent.
- **Demographics**—displays the patient’s demographic information, their employer and contact info, insurance, Rx benefit plan, pharmacy, and associated providers. The majority of this information will pull in from the PM.
- **Patient Preferred Communication**—displays patient preferences for receiving the system-generated Clinical Summary and Reminders.
- **Community Information**—This section displays all active and inactive communities. Training will be provided for this section once it is activated.
- **Employer/Contact/Insurance**—These sections display the patient’s employer and contact information which is pulled in from the PM.
- **Rx Benefit Plan**—displays the patient’s prescription benefit plans.
- **Pharmacy**—The system allows for a patient to have up to four retail pharmacies and up to four mail-order pharmacies in their record.
Step-by-step: Adding a New Pharmacy

1. Open the **Patient Profile Dialog** window
2. Scroll to the **Pharmacy** section
3. Click on the binoculars next to **Retail Pharmacy** to open the **Detail Dialog** window
4. Search for the desired pharmacy—type in at least three letters of the name of the pharmacy
5. Type in at least one other criteria (For example, City and State, Phone/Fax, or ZipCode)
6. Click **Search**
7. **Single-click** on the correct pharmacy from the results
8. Click **OK**

**Associated Providers**—Use this section of the **Patient Profile** to specify the role/relationship of each provider associated with a patient such as the primary care provider, attending MD, resident, and so forth.
The Daily Schedule

Many workflows begin by selecting a patient directly from the appointment schedule. A schedule can be viewed for one provider or multiple providers simultaneously. Additional information can be accessed from the schedule such as patient demographics, appointment details, encounter tracking, and patient appt. history. Appointments are populated from the PM.

Daily—is a view of a provider's appointment schedule for any given day. To display a schedule of a specific provider, you can use the drop-down button next to the field to display a provider that you have previously searched on, or you can click the blue “All” button next to it to search for the specific provider.

Changing the Schedule Date—The daily schedule will default to today's date; however there are several options to navigate to other dates.

1. Type directly into the Date box.
2. Click on the Display Calendar button next to the date field.
3. Click on a day of the week which will be the days of the current week.
4. Click the “Go To Today” button.
5. Click on arrows to go forward to back week by week.
The Daily tab has been enhanced with two new fields:

- **Transition of Care (TC)**
- **Clinical Summary (CS)**

**Transition of Care**

Transitions of Care are defined by The Centers for Medicare & Medicaid Services (CMS) as a transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, and so on) to another or from one provider to another.

**Meaningful Use** criteria defined by the EHR Stimulus program requires that Electronic Health Record (EHR) applications be able to provide summary information for transition of care referrals. Allscripts Enterprise EHR Version 11.2 enables you to flag certain appointment types and non-appointment encounters as being “Transition of Care”. Single-click in the checkbox in the TC column to indicate the encounter is a transition of care. You can also flag an encounter as a Transition of Care in the Encounter Summary by clicking in the Reporting section.
Clinical Summary

**Meaningful Use** criteria defined by the **EHR Stimulus** program requires that EHR applications be able to provide a **Clinical Summary (CS)** for at least 50% of all patients your organization sees. To meet this requirement, Allscripts Enterprise EHR Version 11.2 enables you to provide patients with a CS on request each time you see them.

The **CS icon** on the schedule shows whether a **Clinical Summary** has been or needs to be generated for the patient encounter. A printed copy of the summary should be provided to the patient within three business days. A green checkmark on the icon indicates that the **CS** has been provided.

To generate the **CS**, click on the **CS icon** to open the **Print Dialog** window. Select the appropriate printer and letterhead, and print. Each office must decide which staff will perform this action.

**Step-by-step: Provide a Clinical Summary (from the schedule)**

1. Navigate to the **Daily Schedule** or **Provider Schedule**.
2. Click the **Clinical Summary (CS)** icon beside the appointment.
3. Based on the patient’s **Clinical Summary** preference in the **Patient Profile**, the **CS** generates in different ways. If the patient’s **CS** preference is:
   a. **Print**—the application displays the **Print Dialog** so you can choose the printer.
   b. **Save to File**—the application saves the **CS** to any drive/location that you specify. Navigate to the location on your computer where you want to save the file. You can save the **CS** for a CED, or Note to file as a PDF.
   c. **Declined**—the application does not generate the **CS** and the **Provider** or **Daily Schedule** displays N/A for the appointment. We receive credit for attempting to provide the **CS**.
Provide an Electronic Copy of Patient Health Information

**Meaningful Use** criteria defined by the EHR Stimulus program requires that EHR applications be able to provide an electronic copy of their health information within three business days, **upon request** for at least 50% of all patients your organization sees.

**Step-by-step: Provide an Electronic Copy of Patient Health Information**

1. Navigate to the Chart Viewer component of the Clinical Desktop.
2. Click the Print option on the Action Toolbar.
3. Click Download Chart from the list of options.
4. In the Download Chart page, select Previous Inquiry or Create New Inquiry.
5. Verify the Disclosure Reason is set to Patient Request to receive credit for Meaningful Use.
6. Click a Request Date to enter the date that the request was received. To meet Meaningful Use, ensure the electronic copy is provided within three business days of the request date.
7. Click Next.
8. Select the check boxes of the Documents that you want to include in the electronic copy.
9. Choose the Chart Sections that you want to include in the electronic copy.
10. Click Next. You will see a note, indicating that the patient copy was successfully requested.
11. Click Refresh to view the electronic copy when it’s finished processing.
12. In the Previous Inquiries box, click the hyperlink for the electronic copy that you want to view, print, or save.
13. In the File Download dialog box, click Open to view or print the electronic copy or Save to save a copy.
Clinical Exchange Document

Exchange key clinical information using Allscripts Enterprise EHR which allows organizations to exchange clinical documents with other healthcare networks.

1. Navigate to the Chart Viewer component on the Clinical Desktop.
2. Right-click and select Clinical Exchange Document from the available choices.
3. Click Export CED.
4. Use the Local Save To option to save locally.
5. Click the Document Format arrow.
6. Click the appropriate format for the Clinical Exchange Document.
7. Click the From arrow, and select the appropriate sender.
8. Enter a Reason for Referral.
9. Click Next.
11. Click Export.
12. A copy of the exported Clinical Exchange Document is available as a CED—Clinical Summary in the Chart Viewer.

Appointment Details—The schedule displays indicators giving the user a quick view of the appointment status:

- $ – Charge Status (not currently being used).
- N – Note Status: A document symbol indicating that a note has been started. The same symbol with a checkmark over it indicates that the note has been completed/finalized.
- TC – Transition of Care Status: For the 11.2 Upgrade, some Appointment Types may need to be flagged as Transition of Care (TOC). Transition of Care implies that a patient is moving from one provider or
clinic to another within the organization (i.e. hematologist to oncologist).

- **CS – Clinical Summary:** For each arrived appointment in the 11.2 Upgrade, an icon shows whether a clinical summary has been or needs to be generated for that patient.

- **A – Appointment Status:** The system displays “Pen” prior to the patient arriving for the appointment, and the system displays “Art” to indicate the patient has checked in for the appointment.

- **Pt Loc – Patient Location:** Front Desk and Clinical staff will manually change this setting to indicate the patient’s location (Waiting Room, Exam Room, and so forth).

- **Pt Status – Patient Status:** Front Desk and Clinical staff will manually change this setting to indicate the patient’s status in the clinic (Nurse Ready, Provider Ready, or Checked Out).

- **Time** – scheduled time of the patient’s appointment

- **Patient** – the patient’s name (last name, first name, middle initial) as entered in the PM.

- **MRN** – medical record number

- **Type** – appointment type set at the time the appointment is made

- **Dur** – duration of appointment scheduled (15 min., 30 min., and so forth.)

- **Tasks** – the number of active Tasks for this specific patient.

- **Comments** – comments such as “Reason for Appointment” that are entered in the PM.

**Additional Daily Components:**

- **Top of screen**
  - AM, PM, Total—indicates the number of appointments scheduled in the morning, the afternoon, and total for the day.
  - Last Updated—indicates the date/time that the screen was last “refreshed”. The screen can always be manually updated or refreshed by clicking on the blue button.

- **Bottom of screen**
  - **Patient Insurance**—displays insurance information entered in the PM.
  - **Patient Profile**—launches the same Patient Profile Dialog window that the blue “i” launches.
- **Appt Details**—displays additional appointment details
- **Patient Appts**—lists the patient’s appointments (past, present, and future).
- **Print Schedule, Print Chart**—contains printing ability from the schedule.
- **New Task**—creates a new task from schedule.

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**Preferences**

Preferences can be set at the user level by clicking on the blue link (Personalize) displayed in the upper-right section of the screen on certain tabs of the HTB.

**Daily Tab**—Personalize opens a Personalize—Webpage Dialog window:
- **Default Provider**—Setting a Default Provider will cause the Daily tab to default to this provider when the daily schedule is accessed.
- **Automatic Refresh**—determines the frequency (number of minutes) to have the schedule refresh automatically.
- **Double-Click Action**—indicates where you are directed when you double click on a patient’s appointment. It is recommended to set this on “Chart” based upon the intended workflows.
- **Schedule contents**—Users have the ability to filter on certain appointments based upon the appointment status. It is recommended to set this on “Arrived, Pending, and Rescheduled”.
- **All Provider View**—allows the user to combine the schedules of up to 20 providers into one screen for easier management of multiple schedules.
- **Provider Schedules**—allows the user to set up to four default providers to display on the Provider Schedules tab.

**Task List Tab**—Personalize also opens a Personalize—Webpage Dialog window:
- **User or Team** radio buttons are available so the user can choose a default setting that new Tasks will automatically go do the user’s preference.
• **Default Assigned To**—allows the user to set a default user or team for new **Tasks** to go to.

• **Default Task Type**—allows the user to set a default task type that will automatically display in a new **Task**.

• **Automatic Refresh**—determines the frequency (number of minutes) to have the application to refresh automatically.

• **Always Show Note Selector When Copy Task to Note** is the recommended setting when “Copy to Note” is chosen.

**Provider Schedules tab**—Another schedule option which exists is found on the Provider Schedules tab on the **HTB**. This section allows you to view up to four provider schedules simultaneously. Pulling in a provider schedule works the same way as it does on the **Daily** schedule tab—you can click on the blue “All” button, and search for the desired provider, or you can check the drop down box to see if the provider’s name is populated in the search field.

To set default schedules for these fields, click on the blue **Personalize** hyperlink in the upper right-hand corner, and the same **Personalize** box will appear that you saw in the **Daily** schedule. This time, however, you’ll be working out of the panel on the right. Click on the blue “**All**” button, choose your physician, and repeat in the remaining three fields (if desired). Click OK.

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**Patient Check-in**

• **Arriving the Patient**—is performed in the **Practice Management (PM)** system, and will automatically update the **EHR**.

• **Update Patient Status & Location**—Clerical staff will update these fields to indicate when the patient is “Nurse Ready”. Nursing staff will update these fields to indicate when the patient is “Provider Ready”.

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Clinical Desktop
This workspace provides the user access to all areas of a patient's record. It is highly configurable by the use of preferences, sorts, and filters.

The Clinical Desktop is comprised of the following elements:

The Clinical Toolbar is always docked on the Clinical Desktop and provides a menu of shortcut icons to quickly navigate to various clinical workspaces for commonly used actions.

- Q-Chart allows users to have a second window open displaying the chart. When the user clicks this icon, the system launches the qChart page. The qChart page is a floating version of the Clinical Desktop (Chart). This allows a user to keep a separate workspace open with the chart displayed in another browser, creating greater efficiency for the user.
• The **Encounter Summary** allows a user to view entries for the current patient encounter. When the user clicks this icon, the system launches the **Encounter Summary** page, from which the user can view, edit, add, and delete items for the current encounter. The **Encounter Summary** also allows the user to review and act on the Drug Utilization Reviews (DURs), and duplicate order alerts that have accumulated during the encounter.

• The **Vitals** icon opens the vitals panel for data entry. When the user clicks this icon, the system launches the **Vital Sign Details** screen from which the user can add vitals for the selected patient. If no encounter is currently in context, the system displays the **Encounter Selector**. Once the user has selected or created an encounter, then the system displays the **Vital Sign Order Details** screen.

![Vitals Panel](image)

**Vitals (Height, Weight, BMI, BSA, Blood Pressure)** – These values are required. Body Mass Index (BMI) and Body Surface Area (BSA) are now automatically calculated when **Height** and **Weight** values are recorded on the **Vitals** panel only. BMI/BSA values are visible in the **Order Viewer, Vital Signs/Findings,** and **Flowsheets.**
Variations in calculations:

- For patients 25 years or older, and only weight is entered, the previous height is used to calculate BMI/BSA.
- For patients under 25 years old, height and weight must be recorded on the same clinical date to calculate BMI/BSA.
- If only height is entered, the system calculates using a weight that was entered on the same clinical date. If weight was not entered on the same clinical date, then BMI/BSA is not calculated.

Individual height and/or weight values can be Entered in Error, and the BMI/BSA also becomes Entered in Error. However, the other values remain valid. If the height and/or weight is edited, then BMI/BSA is re-calculated with the new values.

- The Problems icon takes the user into the History Builder section of the ACI (Add Clinical Item screen). The system default is set to go to the Active Problems tab when the Add New Problem icon is selected. The user can also click the drop down arrow beside the icon to navigate to any other tab in the History Builder section.

- The Rx icon takes the user directly to the Medication section of the ACI to add a new medication. The user can also click the drop down arrow beside the icon to navigate to either Rx or Medication Administration.

- The Orders icon will take a user directly to the Labs section of the ACI to add a new lab order. The system default is set to go to Lab/Procedures when the Add New Order icon is selected. The user can also click the drop down arrow beside the icon to navigate to other
secondary tabs to order Imaging, Follow Up/Referral, Instructions, Immunizations, or Supplies.

- When the user clicks the Problem-Based Orders icon, the system launches the ACI at the Problem Based Orders tab.

- The Chief Complaint icon launches the ACI at the History Builder tab on the Chief Complaint secondary tab.

- When the user clicks the Note Authoring icon, the system launches the Note Selector from which the user can specify the characteristics of the note he/she is about to create. If no encounter is currently in context, the system displays the Encounter Selector; once the user has selected or created an encounter, then the system displays the Note Selector form. There is an arrow next to the Note Authoring icon. When the user clicks the arrow, the system displays the following options:
  - Go to Note—allows you to edit the note that has already been started for this encounter. Go to Note is disabled when no note is in context.
  - Start New Note—displays the Note Selector form, from which the user can specify the characteristics of the note he/she is about to create. If no encounter is currently in context, the system displays the Encounter Selector; once the user has selected or created an encounter, then the system displays the Note Selector form.
  - Close Note—closes the note in context without changing the status; the system continues to display the current form; it does not change anything visible on the workspace.
• **When the user clicks the Post to Encounter icon,** the system posts the activities that have not yet been saved to an encounter. If an encounter is not in context, the system displays the Encounter Selector.

• **When the user clicks the yellow Commit button,** the system saves the changes made to the patient’s record during the current work session for the current encounter.

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**Add Clinical Item (ACI)**

The ACI brings all of the orders, medications, and medical history together into a single workspace.

Patient history data is added within the **History Builder** tab of the ACI.
Patient orders are entered within the **Rx/Orders** tab of the ACI.

The **Viewing Pane** on the left side of the screen displays three views allowing users to review information in the patient’s chart without navigating back to the **Clinical Desktop**.

- **Problems**—displays by **Problem Category** or **ALL**
- **Meds/Orders**—displays in a variety of ways by drop-down menu, and is compliant with **Meaningful Use Med Reconciliation** requirements.
- **Allergies**—displays by Medication, Non-Medication, or **ALL**, and is compliant with **Meaningful Use Allergy Reconciliation** requirements.

**Search functionality**—The ACI features built-in controls to facilitate quicker searches and increased usability by automatically performing incremental searches as you are typing the characters in the search field. Every component has three lists that can be referenced when searching for specific problems/orders:

- **Master List**—comprehensive listing of all items
  - After typing a minimum of three letters, user can click on the binoculars button or hit the **ENTER** key on your keyboard.
  - Alpha tabs down the right side of the screen can be used in a master list to scroll the user to the area of the list that contains items beginning with that letter and bolding them.
• **Favorite Item**—is a subset list comprised of the user’s personal favorites that the user selects to save in this category. The user can add/remove favorites at will.
  - To make an object a Favorite Item, right-click and select “Favorite Item” from the drop-down menu.
  - As characters are typed in the search field, the favorites list is being searched automatically.

• **Quick List Item**—This list is the “favorite of favorites” that is recommended to be kept limited for the ease of quick selection.
  - To make an object a Quick List Item, right-click and select “Quick List Item” from the drop-down menu.
  - Adding an item to the Quicklist will automatically add it to the “My Favorites” list.

• **Active Filters**—enables the user to return problem searches within three categories.
  - Return Results with ICD9s Only
  - Return Symptoms & Diagnoses Only
  - Exclude Physical Exam Findings

The **History Builder** tab has secondary tabs that allow the user to enter information into each section by clicking from one to the next, never leaving the **ACI**, and committing the information one time when the history entry is completed.

"Single-clicking on the item **ONLY** highlights the item. Single-clicking on the item, and then clicking OK, will **NOT** add the item to the record. This is a common misunderstanding with new users.

When you have found the item that you want to add to the record, there are two ways to select the item:

• Checking the check box next to an item adds the item to the appropriate list. If there are required detail fields for the item, the detail page will automatically open.

• Double-clicking on the item name adds the item to the appropriate list **AND** opens the detail page. You can also right-click on the item and select “Edit” and get the same result.
EHR Preloading Tips

- **No Active Problems**
  - Disable the “Return Results with ICD9s Only” filter
  - Search “No Active Problems” (We suggest making this a Favorite.)
- **PMH: Denial of Significant Medical History**
  - Disable the “Returns Results with ICD9s Only” filter
  - Search “Denial of Significant Medical History”
- **PSH: No Past Surgical History**
  - Search “History of Prior Surgery”
  - Right-click, and select Deny
- **Fam Hx: No Past Family Medical History**
  - Search “Denial of Any Significant Medical History”
- **Social Hx: Denial of Substance Abuse**
  - Search for substance (e.g., Alcohol, Caffeine, Drug, Tobacco)
  - Right-click, and select Deny
- **Allergies: No Known Allergies**
  - Search for “No Known”
- **Med Hx: No Medications**
  - Search “No Reported Medications”

**Smoking Status** – an item must be entered in Active Problems or Social History for MU compliance. The easiest way to document smoking status is by clicking on the View Clinical Alerts icon, and selecting one of the options from the drop-down menu.

**Step-by-step: Record Smoking Status**

1. Click the Add New Problem icon on the Clinical Toolbar. This takes you to the History Builder primary tab and Active secondary tab in the ACI.
2. Click on the Social History secondary tab.
3. Select a smoking-related problem. **Note:** The choices that qualify for Meaningful Use Credit each have (MU) displayed at the beginning of each problem listing.
4. Click OK to close the ACI.
5. Click Commit to save the changes in the patient’s record.
No Active Problems will automatically be added into favorites list once there are other problem favorites. Also, it will be auto-removed from a problem list once an active problem is added.

Step-by-step: Document No Active Problems
1. From the Clinical Toolbar, click the Add New Problem button. This takes you to the History Builder primary tab and the Active secondary tab in the ACI.
2. Select the No Active Problems check box.
3. Click OK to close the ACI.
4. Commit to save the changes to the patient's record.

No Known Allergies – functions the same as “No Reported Medications”.
Step-by-step: Document No Known Allergies
1. From the Clinical Toolbar, click the Add New Problem button. This takes you to the History Builder primary tab and the Active secondary tab in the ACI.
2. Click the Allergies secondary tab.
3. Select the No Known Allergies check box.
4. Click OK to close the ACI and Commit.

Step-by-step: Adding Patient History Data
1. From the clinical toolbar, click on the “Add New Problem” button.
2. Add three active problems:
   a. Abdominal Pain—add to Quick List, with onset date approximately two weeks prior to visit date, severity: Episodic
   b. Type II Diabetes Mellitus—add to Favorites List, with onset date approximately six years prior to visit date, include in PMHx
   c. Esophageal Reflux (can also type in “gerd”)
3. Add two Past Medical History items:
   a. Diabetic Dermatitis
   b. Foot Ulcer – diabetic related; left fourth toe; approximately one year prior to visit date
4. Add two Past Surgical History items:
   a. Gallbladder surgery
b. Appendectomy
5. Add two Family History items:
   a. Father – Type II diabetes
   b. Maternal GM – breast cancer
6. Add two Social History items:
   a. Denies smoking
   b. Alcohol—two mixed drinks daily
7. Add two Allergies:
   a. Tetracyclines – Note that it causes nausea as a reaction
   b. Shellfish – Note that symptoms include anaphylaxis and hives
8. Add two Medications:
   a. Claritin D – 24 hr. tablets as needed
   b. Omeprazole 20 mg – 1 daily
   c. Afrin nose spray – was taking but stopped one week ago
9. Add one Immunization item:
10. Add Chief Complaints:
    a. Abdominal Pain
    b. Fever
11. Click OK
12. Click Commit
13. Review Encounter summary
14. Click Save and Continue

Anywhere in the EHR, clicking OK will close the window and apply/save the changes just made, and clicking Cancel will close the window and NOT apply/save the changes made.

The Clinical Desktop

Prior to beginning the patient exam, a review of the patient’s chart information is necessary. Go to the Clinical Desktop tab of the HTB, and view the data in each component.

Component 1 contains six tabs: Problem, Notes, Labs, Procedure, Imaging, and Chart.
Component 2 contains five tabs: Patient Worklist, Meds, Allergies, Orders, and Appointment (Appt).
The following screenshot demonstrates a “test patient” with **Active Problems** displaying in **Component 1**, **Meds** displaying in **Component 2**, and **Vital Signs** displaying in **Component 3**.

When a nurse wants to review existing notes for a patient, simply click on the **Notes** tab to display all the notes for the patient in context. Double-click on any item to view the contents. To print or fax a document, either single-click on the item, and select **Print** or **Fax** from the toolbar below, or right-click on the document, and select from the options in the drop-down menu.

To comply with **Meaningful Use**, it is important that providers/nursing staff reconcile the patient’s medications and allergies with each encounter. Click on the icon to record the action. The system will track compliance.

**E-prescribing in Allscripts**

To order medication on a patient, you will first need to add an Active Problem. Allscripts **will not allow** you to order anything, whether it is a medication, lab, or immunization, without attaching it to an active problem. **Rx/Orders**—Once you have added your active problem, you can order your medication. Click on the Rx/Orders tab at the top of the screen. This automatically takes you to the Rx secondary tab.
To order a medication,

1. Make sure that your active problem is highlighted in the History Builder section.
2. Type your medication into the search field and hit “enter” (or click the binoculars). **Note: It is often better to enter only a few letters rather than the entire name of the medication.**
3. Check the box next to the appropriate medication, and the Medication Details screen will open. This is where you will enter the dosage, quantity, and pharmacy.
4. Please note that the only fields that are REQUIRED to be filled out on this page are highlighted in yellow.
Additional Options

There are several other options on this screen that you might find useful.

**Verify receipt of Rx by the Pharmacy** – when a script is sent to a pharmacy electronically, the pharmacy can confirm the script was received. It will be noted in the Medication Details window.

- **Before verification from the pharmacy**

- **After verification from the pharmacy**

**Cancelling a Med, message to pharmacy** – When changing the status of a medication to Entered in Error or Discontinued, a message will be sent to the pharmacy. This information will be shown in the Status of the medication (seen on the Medication Details window or the Clinical Desktop)

- **Before any response by the pharmacy**
• After approval of the cancellation by the pharmacy

• After denial of cancellation by the pharmacy

**Linking Active Problems**

If the **active problem was highlighted in the History Builder pane**, then the **Link To** field should **automatically** have populated with your active problem. If you did not highlight the problem, then this field will be in yellow, and you will need to click on the drop down arrow and choose the appropriate selection. You can also link multiple problems if needed. **If you get to this point, and you have forgotten to add an active problem, you can click on “Add New Problem” from the Link To drop-down menu, and be taken to a new ACI screen where you can search for and add the new problem.**
Please Note: Choosing the Health Maintenance option (V70.0), which is available on every patient, is rarely an acceptable choice, as insurance will not pay for the majority of meds if it is linked to a Health Maintenance diagnosis.

**Sig Options**

Most of the medications will have several common “sigs” preloaded, from which you can choose. However, you do also have two other options: New Structured and New Free Text.

![Medication Details](image)

The New Structured option will give you some basic choices, from which you can choose a specific dosage, and the New Free Text radio button allows you to free text your sig.

**Medication Status**

The field that is populated with the word “Evaluate” is where you can indicate if a medication is an on-going med that you will want to renew, or if it is a one-time prescription.
The choices here are **Evaluate, Complete, and Renew**. “Evaluate” means that it will remain an “active” medication until you manually complete it. “Complete” means that the medication will become “inactive” on the date that you put in the date field. It is **CRUCIAL** that if you decide to use this field that you remember to put in an **appropriate date**, as just leaving it at “complete” with an **empty** date field will “complete” the med on the current date, and it will **NOT** go to the pharmacy.

Checking the DAW box \[ \square \text{DAW} \] will instruct the pharmacy to dispense the prescription as written and not substitute a generic.

**Script Action Options**

The “**Send to Retail**” field is the default for most of the medications; however, this can be changed to **Call Rx, Dispense Sample, or Print Rx**, to name a few. Medications that cannot be sent electronically, like scheduled drugs, will automatically default to the **Print Rx** option.
Scheduled drugs cannot be electronically sent, but will need to be printed and signed. After a wet signature has been added, the schedule 3 through 5 drugs can be faxed to the pharmacy, but they cannot be sent electronically through Allscripts. Schedule 2 drugs will need to be printed, wet-signed, and hand-carried by the patient to the pharmacy. Of note, since these drugs are not electronically submitted, they do not count toward the government reporting statistics.

Adding a Pharmacy

If you are e-prescribing on patients who have not had their information pre-loaded into the system, you will probably need to add the pharmacy. To add a pharmacy, click on the binoculars next to the Pharmacy field and follow the instructions listed on Page 11 of this document.

Split Rx

The Split Rx box allows you to split the order, so that you can provide the patient with a one-month supply from a local pharmacy, and send the remaining months to a mail order pharmacy.
Choosing a Mail Order Pharmacy

To choose a mail order pharmacy for one of the scripts, change the “Send to Retail” field to “Send to Mail Order,” and then click on the binoculars next to the Pharmacy field and choose the appropriate Mail Order Pharmacy.

Additional Details

The Additional Details section allows you to free text Pharmacy Instructions, and gives you the option to change the “Ordered by” and “Supervised by” fields. You can also add specific dates for the scripts in this section.
Appropriate Names

The **Ordered by** and **Supervised by** fields will need to be filled in appropriately.

- **Nurses** will order medications under the provider’s name. This can only be a resident physician if he/she has a valid **DEA** number in the system (currently Family Medicine clinics only).
- The **Ordered By** and **Managed By** fields should contain the ordering provider’s name.

Dates

The **Rx Date and Expires date** are not in yellow, and therefore, do not need to be changed. However, if you have a patient who is on a pain contract, and you want to write two distinct scripts, for example, a one-month supply of a particular medication, you can do this by changing the dates in these fields to reflect the expiration date of the script.
When these are printed out, the expiration date does print at the bottom of the page and may be missed by the pharmacy, so it is suggested that you circle these dates before giving the script to the patient.

Once all of the required fields have been filled in, the options of “Save and Return to ACI” and “Save and Close ACI” will become available. If you have finished entering prescriptions, you can choose “Save and Close ACI.” If you have more prescriptions to order, choose the “Save and Return to ACI” option.

Once back in the ACI, you can view the medication that you have just entered in the **History Builder** section under **Current Meds/Orders**. It will be in magenta, as it has not yet been saved.
To save this medication **and send it to the pharmacy**, 

1. Click **OK** and get back to the Clinical Desktop. (Note: You can also view the medication from the Meds tab in the 2nd component of the desktop.)

2. Click on the yellow “**Commit**” button.

Once you click the yellow “Commit” button, you will get an **Encounter Summary**, which will detail everything that you are saving.

If the items listed are correct, click **Save and Continue**, and your script will be sent electronically to the pharmacy (or available for printing).

**Reconcile Meds/Allergies**

The “core set” of **MU** objectives requires clinics to maintain an active medication list and an active medication allergy list. The patient’s medications and allergies should be reconciled with each encounter.

Medication and allergy reconciliation can be performed within the **ACI**. The **Note Authoring Workspace (NAW)** will indicate when reconciliation has not been performed, and the user can open the **Quick Chart** while within the note and reconcile the lists without leaving the note workspace.

**Medication and Allergy Reconciliation** has been available, but now, it is more prominent.

- If an encounter has been selected and reconciliation HAS occurred, you will see “**Rec: Done**” and it will NOT be highlighted (signifying it has already been completed).

- If an encounter has been selected and reconciliation has NOT occurred, you will see “**Rec: Needed**”, and it **WILL** be highlighted (signifying that it is still waiting to be completed on this visit).
If no encounter has been selected, or you enter a patient’s chart from the schedule, but the patient has not “Arrived”, then you will see either “Rec: Previous Date” (showing that actual date the list was last reconciled), or “Rec: Never”.

To reconcile the Medication or Allergy List, simply click the “Rec...” button whether it is highlighted or not (if an encounter is not already selected, you will be prompted to choose one).

No Reported Medications – If the patient is not currently on any medications, this will need to be added to the patient’s chart. If medication is added to a patient’s chart that shows “No Reported Medications” the new med will replace the old text of “No Reported Medications”. When all entered medications are completed or removed, “No Reported Medications” will return to the chart.

Printing Drug Education Information for Patients

Once a drug has been entered in the Electronic Health Record, drug education information can be printed for distribution to the patient if desired.

Step-by-step: Instructions using Drug Education

1. Click the Rx/Orders icon on the Clinical Toolbar.
2. Select the check box for any desired medications.
3. Enter the appropriate information in the Medication Details page.
4. Click Save and Close ACI.
5. Commit.
6. The **Encounter Summary** opens. Single-click to highlight the medication and **Drug Ed** becomes active on the action toolbar.

7. Select **Drug Ed** to open the **Patient Medication Handout** window.

8. **Print** the material.

**Step-by-step: Drug Education from the Patient’s Chart**

1. Navigate to the **Clinical Desktop**.
2. Click on the **Meds** tab.
4. Right-click, and select **Drug Ed** from the drop-down menu.
5. The **Patient Medication Handout** window opens.
6. **Print** the material.

**Order Entry**

There are different types of orders that can be created such as:

- **Ad hoc orders/prescriptions**—creating prescriptions and orders (labs, diagnostic, and so forth.)
• Medication management—a variety of actions that a provider may take during the patient visit on existing prescriptions such as renewing, continuing, discontinuing, completing, or replacing currently active medication orders.
• Immunizations—including recurring scheduling and administration during the visit.
• Future Orders, Recurring Orders, Scheduled Orders.
• Follow-up/ Referral Orders.

Step-by-step: Adding a New Ad Hoc Order

1. Click the Problem tab in Component 1 on the Clinical Desktop. Active problems display for your patients.
2. Select the Esophageal Reflux check box. Hint: Make sure that Esophageal/Reflux (GERD) is highlighted.
3. Click the Add New Order button on the Clinical Toolbar. ACL workspace opens displaying the Rx/Orders and Lab/Procedures secondary tab.
4. Type Amylase into the search field, and select. Amylase is linked to GERD and added to the current orders list. Fill out Order Entry information and click Save and Return to ACI.
5. Click the Imaging tab.
6. Search for x-ray abdomen and select the check box. Fill out appropriate details information and click Save and Close ACI.
7. Commit
8. Save and Continue

View the new medication on the Clinical Desktop in Component 2 within the Meds tab.

Step-by-step: Associating Multiple Problems to an Order

1. Click the Add New Order icon, the beaker.
2. In the patient’s Active Problem list in the upper left box, check the box beside all problems you are assessing.
3. Search for and select your test by checking the box next to it.
4. If the Order Details box does not open, right click on the test name and select Edit.
5. In the upper-right corner, the **Link To** box shows only the last problem that was checked.
6. In the **Link To** drop down, click on the next problem you want associated to that order. Repeat that step for each problem you want linked to that order.
7. When you have finished, click **Save and Close** the ACI. **Commit, Save & Continue.**

Now the order will appear as associated to all of those problems, and they will all print on the order requisition.

**Ordering Tests for Different Problems**

The key to connecting the correct diagnosis to each test ordered and assessing only the appropriate problems is to **Order then Assess**, using highlighted problems to order and checked boxes to assess. Remember, if you want the ordered items to automatically populate your note, order from the open note by clicking the note section “Orders” and the “Add” button to bring up the ACI.

**Step-by-step**

1. In the ACI, Rx/Orders tab, click on the name of the active problem in the upper left corner. This will highlight the problem name. Do not check the box next to the problem name.
2. Once you have highlighted the problem, search for the appropriate orderable test and check the box beside it.

3. If you are ordering multiple tests for that diagnosis, search for and check the box beside each test. Then click to highlight the name of the next problem that you will be associating to an order. This will remove the highlight from the previous problem.

4. Search for and check the box beside the test you are ordering for this diagnosis.

5. Continue these steps for each orderable item.
When you have finished ordering, then assess.

6. Check the box beside each problem in the patient’s active problem list that you are assessing during this visit. Only the problems that have the boxes checked will populate in the Assessment section of your note.

Even though the boxes beside the orderable items are checked when you check the box beside the Assessed Problem, that problem will not associate to those items because it was not checked until AFTER the tests were checked.

7. Click OK on the bottom of the ACI.

If you were in a note when you ordered, the Orders and Assessment will automatically populate your note.

Continue your note. There is no need to click Commit until you finish your note. When you either sign or save the note, that will automatically commit the information to the chart.
Ordering Interventions for Meaningful Use

Another requirement for MU compliance is that we track patient-specific education resources through the use of the EHR. For example, patients with hypertension, diabetes, or obesity as well as current smokers should receive educational intervention.

To order patient instructions, Open the Add Clinical Item (ACI) and go to the Rx/Orders tab, and the Instructions secondary tab. Highlight the active problem (to link to the order), and search for the condition. In the example below, Diabetes Mellitus (250.00) is highlighted, and “diabetes” was used as search criteria. Order instructions by checking the box next to the choice you prefer.

![Image](image_url)

The Order Details window displays the various options available to the user (see below), including the instructions that will print for the patient. The system tracks this activity for reporting purposes, which is why patient instructions must be ordered within the EHR system.
Immunization Reporting

Meaningful Use also requires that we demonstrate the capability to submit electronic data to immunization registries. Allscripts Version 11.2 has the ability to submit clinical data, and this requires the consent of the patient.

Step-by-step: Record and Submit Immunization Information

1. Click the Add New Order button on the Clinical Toolbar. This takes you to the Rx/Orders primary tab and Lab/Procedures secondary tab in the ACI.
2. Navigate to the Immunizations secondary tab.
3. Select the check box of an immunization. The Immunizations Details page displays.
4. In the Order Entry tab, complete the appropriate order details for the immunization.
5. Click the Record Admin tab.
6. In the Administration Details section, add or edit the appropriate information.
7. In the Clinical Questions section, questions in different levels of requirement conditions display for the Immunization Registry that is linked to the user’s current site. A white box indicates that an answer is
not required. The light yellow box indicates that the order will go into an “On Hold” status, if the answer is not entered. The bright yellow box indicates that an answer must be entered before being allowed to save changes. Complete the Clinical Questions. The answers comprise the data, which is sent to the Immunization Registry when the order is completed.

8. Click the Patient Consent to Transmit to Registry
9. Indicate if the patient denies or grants consent to transmit.
10. Click Save and Continue.
11. Commit to save the changes to the patient’s record.

As mentioned above, the light yellow Clinical Questions box indicates that the order will go into an “On Hold” status, if the answer is not entered. An Immunization Documentation task will be generated, which is in a Hold for Documentation status.

Step-by-step: Resolve a Hold for Documentation Status

1. Navigate to the Task List tab on the horizontal toolbar.
2. Select the appropriate Task View.
3. Double-click on the Immunization Documentation task, which is in a Hold for Documentation status. The Immunization Details page displays.
4. In the Clinical Questions section, the boxes in light yellow need to be entered before the Hold for Documentation status can be removed. Once the information is completed, it can be submitted to the Immunization Registry. Complete the missing information.
5. Click OK to close the Immunization Details page.
6. The Immunization Documentation task is completed and removed from the Task List. The information has been sent to the Immunization Registry.
In the **Immunization Viewer**, you can see a record of the immunization data that was sent to the Registry Region.

**Documenting a Patient Visit**

Documenting a patient visit includes starting a note or selecting an existing note and entering the patient encounter information into the note. If the provider is selecting an existing note, the note icon can be single-clicked from the daily schedule to go straight into the note, or click on the patient’s name from the daily schedule to navigate to the clinical desktop.

**Starting a note** is typically done by either the nurse or physician depending upon the workflow decision made. From the **Daily** schedule, the user will highlight the patient, and click the **New Note** tab on the HTB. You can also click on the **Start New Note** icon on the floating toolbar.
The **Note Selector** screen will open.

The following fields that are included in the **Note Selector** screen:

- **Note**—The default setting indicating a structured note used in our current version of Allscripts.
- **V10 Note**—(Prior version note type—not used).
- **Unstructured**—Note forms containing no structured sections such as Chief Complaint, HPI, Assessment, and so forth. This is where the ACOG forms reside.
- **Admin Forms**—Indicates administrative functions. There are currently no Admin forms available; however, if you need some to be built, please let us know.
- **Specialty**—Allows users to choose the specialty from which you want to select a visit type. The system defaults to the current user's specialty. All active specialties are available from the drop-down list.
- **Visit Type**—The type of clinical visit for which you want to create a note. The visit types that are available are driven by the selected specialty.
- **Owner**—Indicates the owner of the new note. The default is the current provider’s name. The **Owner** field is driven by ownership authority.
- **Incomplete Notes**—Lists existing notes pending finalization that can be selected. Do not change this default when starting a new note.
- **Add/Remove Chief Complaints**—Displays the **Chief Complaint(s)** for a particular patient visit. Chief Complaints drive the note content. **Chief Complaints** as well as **Active Problems** determine which note forms are automatically pulled into the HPI and Physical Exam sections of the note input.

**Note Authoring Workspace (NAW)**

Once the note form has been selected from the Note Selector, the Note Authoring Workspace (NAW) displays where the user will document the patient encounter.

The NAW is opened in a separate internet browser window which allows the user to toggle between it and the main window.
The NAW has many components to it which allows for quick access to information within the chart in addition to documenting the patient encounter:

- **Patient information**—Patient Name, Age, and DOB
- **Appointment Selector**—The appointment to which the note is linked (can be changed if needed).
- **Clinical Toolbar**
- **Clinical Desktop Component tabs**—such as Note, Chart Viewer, HMP, and so forth.
- **Visit Type and Note Owner**—changeable if needed.
- **Table of Contents**—note sections listed down the left side of the NAW which serves the following functions:
  - easy navigation between the sections.
  - note section additions/deletions.
  - quick reference to sections containing information by bolding and directing the user to the section.
- **Note Input** window—where the patient information is entered or where cited from the **Clinical Desktop**. Information can be entered by utilizing the form options, free texting, dictating, or using voice recognition.
- **Note Accumulator**—where the information entered in the note sections is rendered as well as free texting, voice recognition, and dictating.
- **Output Documents**—lists multiple documents that are available for this particular note form by default.
- **Copy Forward**—allows the user to copy certain information from an existing note into the new note.

**Entering information into a note**

There are multiple methods for entering information into a note input form such as note forms, cited information, free texting, images, and dictation.

*It is recommended to use cited information and the note forms where possible which captures discrete data that can be used for research, statistics, flowsheets, and so forth.*
The Note Form
A note form typically has various controls within them:
- Yes/No selections
- Option buttons (radio buttons)
- Free text fields

Step-by-step: Documenting a New Note
1. From the Clinical Toolbar, with the patient in context, click on the drop down arrow next to the Note Authoring button and select Start New Note. This will open the Note Selector window.
2. Select the following options:
   a. Make sure that “Note” is selected as the Style.
   b. Specialty: Family Medicine
   c. Visit Type: Established (under Office Visits)
   d. Owner: Default should display your name (providers/residents)
   e. Add Red Eye as the Chief Complaint.
3. Click OK. This will open the Note Authoring Workspace (NAW).
4. The forms that pull into the HPI are based upon the Chief Complaints and Active Problems.
5. To add a form that isn’t already loaded into the note type, you can click on the section where you want the form added, right click, and choose “Add Form Top” (or Add Form Bottom). Pull in the desired form.
6. Each of the sections has options for adding information or editing information that is already populated. For example, if you open the Problem Section, and you want to add a new item, just click New on the gray toolbar. Please note, however, if you add a new assessed problem, you will need to select Recompile to pull in associated forms or should you plan on using that diagnosis to link any medications or lab orders.
7. Go through note sections and add information. Navigate by using the Table of Contents on the left side of the screen.
8. View the note.
9. Save and Close the note, to resume documentation later; or Sign the note to commit all changes.
   a. Providers will finalize the note upon signature. The note may be amended and re-signed (if applicable).
   b. Residents will be prompted to Task their preceptor for Review and Co-Signature.
Order/Result Management

Worklists
A Worklist is a specific workspace that contains order and result items and provides an efficient way to monitor, track and work the items. The Worklist allows the user to address the order or result from a single workspace, regardless of the order status, without the need of assigning a task to it to facilitate user interaction. Allscripts Enterprise EHR provides two types of Worklists – Patient-Centric and Cross-Patient.

Patient-Centric Worklist
The Patient-Centric Worklist is located on the patient’s Clinical Desktop and is also located on the HTB. Tasks drive the user to this location to respond to an action such as medication authorization or result verification. The Patient-Centric Worklist contains different views depending on what action needs to take place. For example, you may need to provide coverage for another provider and verify order results in his/her absence. Navigation to other patient results may be accomplished from this same location by using the drop-down menu or the blue left/right arrows.
1. Begin from the Task List and double-click the appropriate task. Examples include: Verify Patient Results or Authorize Medication. The Clinical Desktop displays with the Worklist component tab active in the appropriate view for the task being worked.

OR

2. With a patient in context in the Patient Banner, select the Clinical Desktop tab on the HTB.
3. Navigate to the Worklist component tab on the Clinical Desktop.
4. Select the appropriate Worklist view.

Cross-Patient Worklist

The Cross-Patient Worklist provides efficient access to all orders and results to work from a single location. Patient names automatically display on the left of the page. Once a patient’s name is highlighted the items requiring attention display on the right side of the workspace.
1. From the **VTB**, select **Chart**.
2. From the **HTB**, click the **Worklist** tab.
3. Select the appropriate **View** from the drop-down menu. A list of patients displays on the left side of the page.
4. Highlight the desired patient name. A list of items requiring attention displays. It’s important to pay attention to the list of items as they may or may not all pertain to you.

**E-Prescribing-Related Tasks**

Once you begin sending scripts electronically, you will start getting Rx-related tasks, such as the **Rx Renew Request** (which comes directly from the pharmacy), the **Rx Xmit Fail**, (which comes in to your task list when the script fails in the system), and the **Rx Change Request**, which is generated from the pharmacy, and may include a request to substitute a generic drug.

These tasks will go to the appropriate nurse first. The nurse will then filter and reassign these tasks to you as needed.
You will need to keep a close eye on your task list, even on the days when you aren't e-prescribing, as the Rx Renew Requests may come in at any time.

**Tasking**

**Working with Tasks** – A Task is a message to perform an action or supply information that may or may not be associated with a patient. However, it is highly recommended that all tasks are associated with a patient and not personal in nature. Tasks can go to a person or a team, be generated almost anywhere within the EHR application, and are generated in two ways:

- **System-Generated Tasks** are generated by the EHR based on specific workflows. System-Generated tasks typically drop-off a user’s task list automatically once the user completes the action specified by the task.
- **Manual** tasks are initiated and sent by one user to another within Enterprise EHR. Once the action specified by the task has been completed, the user must manually complete the task in order to have the task removed from the task list. Simply click the **Done** button.
Task List workspace – description columns on the Task List page:

- **P – Priority:** Level of urgency.
  - Indicates a task that should be completed on an Urgent basis.
  - Indicates a task that should be completed ASAP.
  - No indicator displayed indicates a task that should be completed on a Routine basis (within seven days).
- **D – Delegated:** Indicates whether responsibility for the task has been delegated.
- **Task:** Describes the particular information or action required by the task.
- **Patient:** Patient with whom the task is associated. If blank, the task is not associated with a specific patient.
- **Assigned To:** The person or team to whom "ownership" of the task is assigned.
- **Created By:** Indicates whether the task was manually created (name of the person who created the task) or system-generated.
- **Created On:** Date and time the task was created.
- **Status:**
  - **Active**—Indicates a task for which the activate date has been reached, but has not yet been completed.
  - **In Progress**—Indicates a task that is currently being performed.
  - **Complete**—Indicates a task that has been performed or completed.
  - **Inactive**—Indicates a task for which the activate date has not yet been reached.
  - **Removed**—Indicates a task which has been removed rather than completed.
- **Due:** Task due status. Indicates a task for which the due date has been reached, but has not yet been completed.
  - No indicator displayed indicates a task for which the due date has not yet been reached.
- **MRN:** Medical Record Number (MRN) of the patient with whom the task is associated.
Working and Completing the Task List – The task list can be sorted by the various columns, and the following options are available:

- **Details**: Highlighting a task and selecting Details displays the Task Details page.
- **In Progress**: Selecting the task and clicking In Progress displays who performed this action in the Comments box.
- **Go To**: Selecting the task and clicking Go To displays the workspace from which a task's action must be performed. For example, if you are working a Sign Note task, clicking Go To displays the Note Authoring Workspace.
- **Reassign**: Selecting the task and clicking Reassign allows you to send the task to a specific user or team.
- **Remove**: Selecting the task and clicking Remove allows you to remove the task from the system. The system requires that you indicate the reason why you are removing the task, and you can enter additional comments, as needed.
- **Reply**: Selecting the task and clicking Reply allows you to send a reply back to the original sender of the task. You can also edit the task’s priority if appropriate.
- **Copy to Note**: Selecting the task and clicking Copy to Note allows the task to be copied into a note. If a note is not in context, then the system displays the Note Selector for selecting the appropriate note.
- **Undelegate**: Selecting the task and clicking Undelegate will send the task back to the Assigned To user. The user must manually remove the task after undelegating it. (This only undelegates the one task selected and not all future tasks.)
- **Print List**: Selecting Print List prints the entire task list for that particular view.
- **Print Task**: Highlighting a task and selecting Print Task will print the task.
- **Original**: When a user receives a notification that a task was completed, they highlight the task and click Original to view the original task previously sent.
- **Done**: Selecting Done will complete the task and remove it from the active list.

The system displays the Done button instead of Go To if a task must be performed manually outside of Enterprise EHR. In this case, click Done to complete the task. This action does not delete the task from the system; it changes the status of the task to Removed.
Managing Tasks

Working these tasks is easy. Simply double click on the task, and it will open up in a separate screen. The following is an *Rx Renew Request* task.

![Rx Renew Request Task](image)

The **Rx Renew Request** contains all of the patient’s demographic information (which we have removed from the above screen shot, as it was on a real patient), as well as the name of the medication, and the sig information from the previous prescription, which can be altered. The Rx Renew Request can be **granted, refused or canceled** directly from this screen.

Make sure to check your **Task List** at the end of every session, so you can ensure that all of the electronic prescriptions went through, and you can handle any **Rx Renew Requests** that may have come in from the pharmacies.

**Rx Renew Requests without a name in the Patient Field**

Occasionally, if a patient’s medication is recorded in Allscripts as “history,” but is not actually sent to the pharmacy, if the pharmacy does an automatic refill request through Allscripts, you may get a Rx Renew Request task that has no name in the Patient field.
To fix this, double click on the task.

The following box will open. The “Patient Info in Request” field should have the patient’s name, DOB and address, but the Patient Info in EHR field will be empty.
Trying to grant or refuse this request without having the patient’s name in this field will generate an error.

To fix this, click on the gray “Patient Info in EHR” button and search for your patient. Click OK, and the patient’s name and address will flow into this field.

Fill the rest of the script out as normal, and click “Grant.”
Call Processing

Documenting a Call – The Call Processing feature allows users to document incoming calls and route them to the appropriate person or team as a Task. Calls may be processed whether or not a patient is associated with a call. Text templates are also available for improved efficiency of capturing call data.

Information that can be entered in the Call Processing workspace:

- **Patient**—If a patient is in context (in the Patient Banner), the system will assume the call is regarding the current patient and will default the Patient Name and Prev Appointment, if available. Users can populate a patient by clicking on Select Patient, or Clear Patient to remove the current patient information.

- **Patient is Caller**—indicates the patient in context is the caller. When this box is selected, the patient information will populate the Caller, Relation, and Phone Number fields.

- **Date and Time of Call**—indicates the date and time on which the call was received. The default value for new calls is the current date and time.

- **Caller**—indicates the name of the person initiating the call. If the caller is the patient (and thus, the Patient is Caller option is selected), then this information is completed automatically.
• **Phone Number** – If the Patient is Caller checkbox is selected, the phone number populates automatically. This information originates from and must be updated in the PM.

• **Relation**—If the patient is not the caller, this field is to indicate the relationship of the caller to the patient. If the patient is the caller, then the system displays Self.

• **Route To options**—This field is to designate the user or team responsible for completing any tasks resulting from the call. If the User option is selected, then the default value is the current user's name or is indicated by the user preference on the Personalize page.

• **Reason for Call** - Select a reason for the call from the provided options in the drop-down menu.

• **Comments** – Details can be free-texted into the comments box or a text template can be used to “check” off information.

**Step-by-step: Documenting a Call**

1. Select Call Processing from the HTB.
2. Select “Patient is Caller” check box.
3. Route to a User by clicking the radio button.
4. Choose your recipient from the drop-down menu (or search).
5. In the Reason for Call drop-down list, select Medical Complaint.
6. In the Comments section, click on the Text Templates button at the bottom of the screen (or free text in this section).
7. From the column on the right that lists the various templates, select Medical Complaint.
8. Fill in information (to select something, you double-click on it to bold it).
9. Click OK.
10. Copy to Task.
11. Define a task in the drop-down menu.
12. Click OK.
Unfinished Calls

When a call cannot be completed at the time it was started, the user can click the Finish Later button which will place the call on the Unfinished Calls page to be accessed and/or finished at another time. For example, if a call was cut short or dropped in the middle of capturing the call’s data, clicking Finish Later enables a user to complete the call that was interrupted earlier.

Clicking on the Unfinished Calls tab from the HTB displays the Unfinished Calls Page.
Several actions may be taken from the **Unfinished Calls** page. Highlight the incomplete call to activate the buttons across the bottom of the page to work the call. The information captured displays in the bottom portion of the screen.

- **Delete** – enables a user to delete the in-progress call.
- **Start New** – navigates the user away from the **Unfinished Calls** page to the **Call Process** page to begin capturing new call data.
- **Edit** – navigates to the **Call Process** page. The incomplete call data populates, and the user can resume documentation.
- **Copy to Note** – enables the user to copy the captured call data to a **Note** stored in the patient’s record.
- **Copy to Task** – provides the ability to send the captured call data as a **Task** for a person or team to act upon.
**TouchWorks Scan**

Enter **Username** and **Password** (select ETSU Database).

- Enter **User Name** and **Password**
- Select **ETSU Database**

*Users must use the site-specific *Generic Login* to scan into the archive folders.*

**User Screen:**

**User Options:**
- **File:** The only **File Option** available to Scan Users is to close the application.
- **Configure:**
  - **Change Password** is available to Scan Users change an existing password. A **Change Password** window will open, and the user will enter the Old Password, then enter and confirm the New Password, and click **OK**.
  - **User Preferences** is available to Scan Users so they can change the “**Initial Patient Search Focus Field**” default from Name to another
preference (MRN, DOB, Phone, or SSN). All other User Preference settings should remain unchanged.

Menu Options:

- **Search**
  - Patient Charts (to select a patient)
  - Documents (to open a Document Search window)

- **Chart Lists**
  - This will pull up the last several patients that you have scanned into

- **Batch** (to open the Batch Basket window)
  - This will be used when several documents of the same kind come in (labs) and you can sort later.

- **Task** (to open the user's Task Basket window)

- **New Task** (to open the Create New Task window) Scan Users can **task** a document that requires attention (e.g., those that are in the wrong patient chart, poor resolution, scanned upside down or sideways, or in the wrong folder).

- **Suspend** (to close the current session without logging completely out)

- **Close** (to end the current session)
Step-by-step: Scanning a New Document into the Patient Chart

1. Login to **TouchWorks Scan**
2. Click **Search** to open the **Patient Search** window.
3. Search just as you would in Allscripts by Last Name, First Name (You can also search by Date of Birth, Phone Number, Social Security Number, etc...).
4. Select the correct patient from the search results to display the patient’s information in the **Demographics** pane. Verify you have the correct patient.
5. Highlight the folder you wish to add the new document into.
6. Select **Scan** from the menu along the bottom of the screen.
7. The **Scan Documents** window opens.

8. Select the correct **Date** associated with the document.
9. Select the **Provider** associated with the document (if applicable).
10. Click **Scan**.
11. The document will be placed into the selected folder.
12. To view, **double-click** on the document in the document window.
View Documents Toolbar

- **Print**
- **Move Forward** in the selected document
- **Move Forward** to a different document within the folder
- **Flip** the document 45 degrees to the right
- **Zoom In** and **Zoom Out** of a displayed document
- Change the **Width** and **Height** of a displayed document
- **Adjust the Contrast** of a displayed document
- **Undo** changes

**Right-click** on a highlighted document to perform the following:

- **Create** new task
- **View** document
- **Print** document
- **Copy** document
- **Cut** document
- **Unlock** document (requires password)
- **Move** documents to Batch Basket
- Send to **Search MD** (not currently active)
- **Properties** (allows users to change the name or setup of a document)
Cut and Paste – may be used when a document has been scanned into the wrong folder. A document will never be deleted, but can be moved to the correct location.

Allscripts SCAN Import Process

1. Select:
   - File
   - Import
   - Import Documents

2. The Import Documents window displays.

3. Select:
   - Source Path (such as Drive D for the CD drive)
   - Source File
   - Batch Basket

4. Click: Import

5. Click: OK and Close.

6. Search for and select the patient for the import.
7. Single-click on the appropriate folder to receive the contents.
8. Click on the **Batch Basket** display the file to import into the record.

9. Select: **Sort to Chart**

10. Search for the correct patient again. The **Current Folder** displays the folder you have already highlighted with a single-click.
11. Click **File Document** (and **File Remaining Pages**, if the document has multiple pages).
12. Close the current window, and view your document(s) in the selected folder.
Help Desk Support

Utilizing the Help Desk is simple:

➢ Select the QITS Help icon on the desktop

Or

➢ Send an e-mail to: EHRhelp@qetsu.org

Or

➢ Call: 423-282-6122

Using the Help Desk is the best way to contact support – and provide tracking for requests.

Just choose EHR Support in the Request Type field and fill out the Request Detail field. Don’t forget to add your location, and then Save.

NOTE: To practice from home, launch Internet Explorer Browser and type in nophi.qetsu.org in the browser window (no www or http).
The Quillen Physicians EHR website is easy to use, and the contents are current. Simply visit the website (see link below), and click on the helpful links.

Welcome to the Quillen Physicians EHR site.
As our physician group continues to implement the Allscripts Enterprise EHR system, this website will provide useful information for our end users—Clinicians, Residents, Nurses, Medical Students, and Office Staff.

Questions or Comments
Name *
Email *

Here is a view of the Training Manuals page. Users can view or download each manual. The EHR How-To Documents are just as easy to view and download.

Left, a view of helpful links within the website—the Help Desk, our Facebook page, and even the Quillen Physicians website.

Please visit the website, and provide feedback. Our goal is to provide meaningful, helpful information that can be accessed at any time.

Http://quillenphysiciansehr.weebly.com/
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