

# Quillen Quick Notes



Volume 4, Issue 4

June 2014

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## The Quillen EHR Team

**Monaco Briggs**  
EHR Administrator

**Tracy Jones**  
EHR Analyst

**Tony Houston**  
EHR Analyst

**Bridget Garland**  
EHR Analyst

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EHR Analyst

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Student Intern

**Help Desk**  
(423) 282-6122

## Mission Accomplished

### *11.4 Upgrade Complete*

As anticipated, May 2014 turned out to be a busy, challenging month for the Quillen EHR team and users. The Go Live for the 11.4 version of Allscripts took place on May 5th, but the weekend preceding it was filled with delays and frustration for the EHR team. The scheduled release of the software for final configuration and testing was delayed over and over again by the Allscripts upgrade team and was not released until Sunday morning. When the EHR team was finally allowed into the system, testing by the team and physician superusers took most of the day but was fortunately completed in time for use on Monday morning.

“Upgrades are never easy to accomplish and the 11.4 upgrade was exceptionally challenging,” said Monaco Briggs, EHR Administrator.

“However, we made the best of what time we were given to prepare, and it seems

that most users have adapted to the new software well.”

Now that the upgrade is complete, the EHR team is working with Allscripts to fix any unresolved issues or to develop new workflows related to known issues that are not fixable in this version of Allscripts.

In addition, the EHR team is also working with Allscripts toward another smaller upgrade -- the addition of the Meaningful Use (MU) package, which adds a few more features which are required for MU attestations. According to the information provided by Allscripts, the EHR team anticipates that the MU upgrade will be an easy transition and that very few changes will be noticeable to end users.

Training materials will be provided before the upgrade, and an exciting new addition to the training materials

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## What You Need To Know Now

### *EHR Updates*

Psychiatry Residents  
6/17/2014 1pm

Pediatric Resident Training  
6/24/2014 1pm

Internal Medicine Residents  
6/25/2014 8am

Family Medicine Residents  
6/25/2014 1pm

OB/GYN Residents  
6/26/2014 8am

Bristol Family Medicine  
6/30/2014 1pm

#### **QITS Helpdesk Tickets**

As we have mentioned in previous editions of the newsletter, in an effort to provide better support to all of our users, the EHR team asks that all requests for assistance be documented in a helpdesk ticket or task.

Some users routinely open tickets for assistance, but if you haven't, please see the information available on the Quillen EHR website on how to open a ticket.

We understand that some assistance requires a phone call, but if your request is not urgent, please use the ticket system.

#### **Website Quick Access**

A quick link to the Quillen EHR website is accessible on the vertical toolbar from within Allscripts. The link will launch the website while your Allscripts sessions is still active.

We will be actively adding content to the website, demonstrating how-to's, relaying important information about the system upgrades, as well as providing access to training presentations for subsequent review.

#### **Medication Hx Consent**

Unfortunately, Medication Hx Consent is no longer working correctly with the 11.4 upgrade. For sites that were using this feature before the upgrade, please be advised that this feature will not be fixed with this version of Allscripts. Going forward, the default will be set to declined, and we suggest that your site no longer have the consent form signed.

#### **Orders Tab**

We have made a slight change to the default sort on the Orders tab on the Clinician desktop. The default is now set to sort by problem, and then alphabetically.

#### **Resident Training**

New resident training will begin this month. A list of dates and times have been provided (this page, left) for each session. Residents will be completing online training initially before being admitted to live training. These training sessions are being coordinated with the resident coordinators. For more information about your department's training, please contact the coordinator. All training will be located at the Quillen ETSU Physicians Downtown Center. For directions, please visit the [EHR website](#).

### **One Click!**

**Quick access to the EHR Website on your Vertical Toolbar**

### **Contact Us**

- Call 282-6122, *option 1*
- Open a Helpdesk Ticket by *clicking the Help Desk icon on desktop*
- Task *Allscripts Help Team*
- E-Mail [EHRmail@qetsu.org](mailto:EHRmail@qetsu.org)

## Mission Accomplished

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is the ability for providers to receive CME credit for completing the training.

A date has not been determined for the MU upgrade, but once that has been set, all EHR users will be alerted. Additionally, more information about the MU upgrade and CME credit will be avail-

able soon.

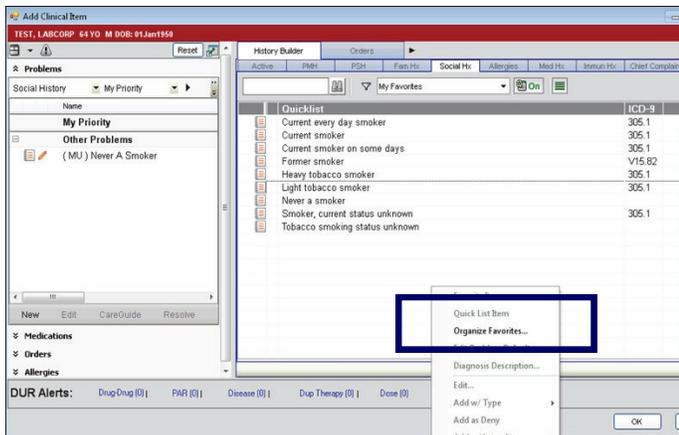
For more information about Meaningful Use Stage 2, please see [page 5](#).

## Quillen Quick Tips

### Creating an Order Group Folder for History Items

*Note: The folders that are created for the History Builder items cannot be saved to your QuickList, so to find it, you will have to click the QuickList button to turn it off before you will see your folder(s).*

To set up a folder: Click on one of the history tabs (Active, PMH, PSH, Fam Hx, etc.). In the white area, right click and choose **Organize Favorites**.

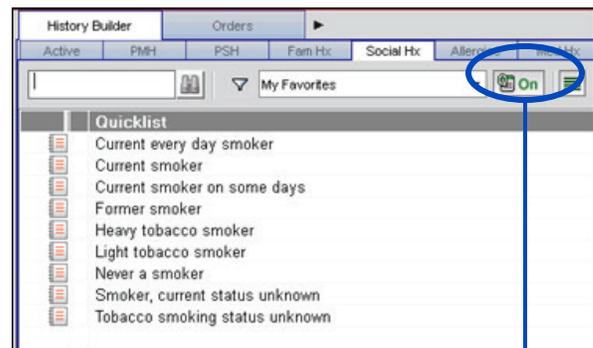
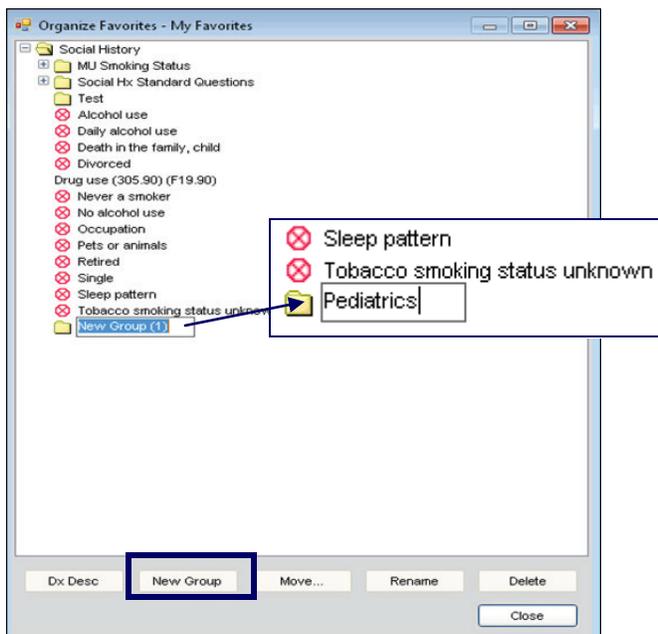


If the item you want to add to the folder is on your favorites list (and available on the Favorites screen), you can just drag it into the appropriate folder.



If the item is not available on this list, go ahead and click Close and go back to the ACI. **The folder will not be visible if you have your QuickList on, so turn that off to view the folder.**

Click the **New Group** button. In the field next to the new folder, erase "New Group (1)" and type the name your new folder.



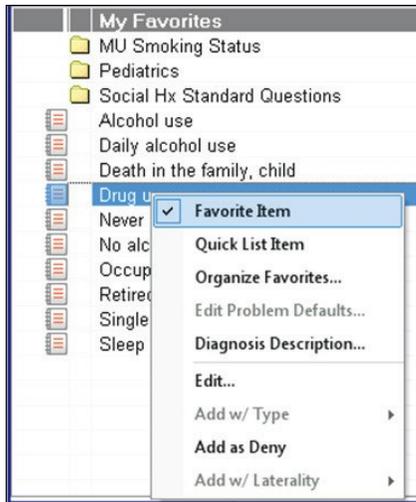
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## Quillen Quick Tips

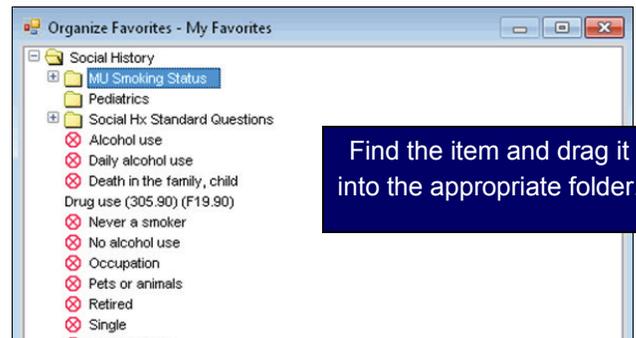
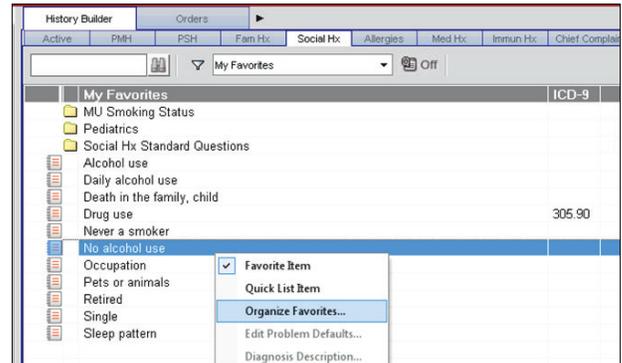
### Creating an Order Group Folder for History Items

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Right click on the item you want to add to the folder and save it as a favorite.



Right click the item again and choose Organize Favorites.



## 11.4 Known Issues

The following is a list of problems that have been identified as known issues in 11.4. There is no fix at this time for these issues. Users must work around the problem.

**Medication Hx Consent** See [page 2](#).

### Notes

- When going to a resident's or nurse's note from the **co-sign task**, the note appears to be blank. Users should "X" out of the view and go to edit to complete/sign it.
- When going to a note from the **co-sign note task**, the name of the note type may not be visible in the top left-hand corner. To see the note type, you must go to the "View" mode.
- When a user verifies a lab and selects "**Verify and Go to Note**," the note authoring work space is covered up. You have to slide the bar over to reveal it.
- The **Copy Forward** function does not copy forward free text data entry.



### Appointments Tab

Appointments are not displaying accurately on the Appointments tab. You may see multiple "commas" in place of the provider's name.

### Immunizations

The NDC number gets erased when editing a previous immunization.

### Printing

- When printing an order requisition, the order comments do not show up on the Order Requisition-ETSU. From the Document Info list in the Print Dialog, choose **Lab Order Requisition-ETSU** to print the requisition.
- The Medication Flowsheet does not print correctly.

### Results History

When opening lab results, the lab history appears to be blank. Users must click out and back in to see the history.

### ACI Expanded View

The tabs on the left-hand side of the ACI do not expand correctly.

## Are You a Meaningful User?

*With Great Power Comes Great Responsibility*

Are your spidey senses tingling yet? Meaningful Use Stage 2 attestations are right around the corner, and while Stage 2 isn't the Green Goblin or Doctor Octopus (I promise!), Meaningful Use (MU) can seem like the villain when it comes to remembering what to document, when to document it, and how to document it to get it to count.

So, if Stage 2 is the villain, guess who gets to be the superhero?

Let's start by taking Uncle Ben's advice, "With great power comes great responsibility." And the first responsibility you'll have as "MU Man" or "MU

Woman" is learning everything you can about the requirements for attestation.

We will soon be posting a training presentation (eligible for CME credit) which will detail what and how to document the Stage 2 requirements, but as a quick summary, below are the **17 core measures** and **3 menu measures** that are required for Stage 2.



### Stage 2 Core and Menu Measures

#### Core Objectives (17 total)

- (1) Use **computerized provider order entry** (CPOE) for medication (>60%), laboratory (>30%) and radiology orders (>30%) directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.
- (2) Generate and transmit permissible **prescriptions electronically** (>50%).
- (3) Record the following **demographics**: preferred language, sex, race, ethnicity, and date of birth (>80%).
- (4) Record and chart changes in the following **vital signs**: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI (>80%).
- (5) **Record smoking status** for patients 13 years old or older (>80%).
- (6) Use **5 clinical decision support interventions** to improve performance on high-priority health conditions (these must be related to Clinical Quality Measures) AND enable and implement **drug-drug and drug-allergy checks**.
- (7) Provide patients the ability to **view online, download, and transmit** their health information within four business days of the information being available to the EP (>50%).
- (8) Provide **clinical summaries** for patients for each office visit (>50%).
- (9) Protect electronic health information created or maintained by the Certified EHR Technology through the **implementation of appropriate technical capabilities**.
- (10) Incorporate **clinical lab-test results** into Certified EHR Technology as structured data (>55%).
- (11) **Generate lists of patients** by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
- (12) Use clinically relevant information to identify patients who should receive **reminders** for preventive/follow-up care and send these patients the reminders, per patient preference (>10%).
- (13) Use clinically relevant information from Certified EHR Technology to identify **patient-specific education resources** and provide those resources to the patient (>10%).
- (14) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform **medication reconciliation**.
- (15) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a **summary care record** for each transition of care or

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## Under Construction 2014

### *EHR Projects and Plans*

#### ICD-10

Although the 11.4 Upgrade was designed to be ICD-10 compliant, most of the ICD-10 components will not be turned on until needed. The mandatory October 2014 deadline was delayed for one year as a result of recent legislation. Further implementation of programs related to ICD-10 coding have been put on hold until more information is available.

#### Charge

As a reminder, the implementation of the charge component into Allscripts has been put on hold, pending new ICD-10 legislation that was passed, delaying the mandatory implementation date. Watch for updates.

#### Patient Portal

Quillen ETSU Physicians has signed an agree-

ment to adopt the FollowMyHealth™ patient portal. More information will be forthcoming about the implementation of the portal, which will allow us to send clinical summaries, lab results, and more to our patients electronically. Implementation of a patient portal is a requirement for Stage 2 of Meaningful Use.



#### LiveChat

As we have mentioned previously, our organization has been selected to beta test a new support product called LiveChat. Once the EHR team has tested the program to ensure any technical issues have been resolved, the program will be made available to our users.

## Are You a Meaningful User?

*With Great Power Comes Great Responsibility*

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referral (>50%).

(16) Capability to **submit electronic data to immunization registries** or immunization information systems except where prohibited, and in accordance with applicable law and practice (Yes/No).

(17) Use **secure electronic messaging** to communicate with patients on relevant health information (>5%).

#### Eligible Professional Menu Objectives (3 of 6)

(1) Record **electronic notes** in patient records (>30%).

(2) **Imaging results** consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT (>10%).

(3) Record patient **family health history** (1st degree rela-

tive) as structured data (>20%) .

If you're still learning the ropes on how to use your superpowers (a.k.a. EHR documentation skills), this Stage 2 summary may have you rethinking your superhero status, but no one ever promised saving the world was easy.

And I haven't even mentioned CQMs!

