

January 2014

Quillen Quick Notes

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Your New Desktop

Within the next couple of weeks, new Clinical Desktop views will be rolled out to all Quillen Allscripts users. Although the system will still function as normally, the new Desktop views should make navigating and viewing patient charts much more efficient.

Only three views will be available for all users, one for providers, another view specifically for nurses, as well as a view for nonclinical staff. Once these views are ready to roll out, a notification will be sent out alerting users when to expect the change (to be done over a weekend).

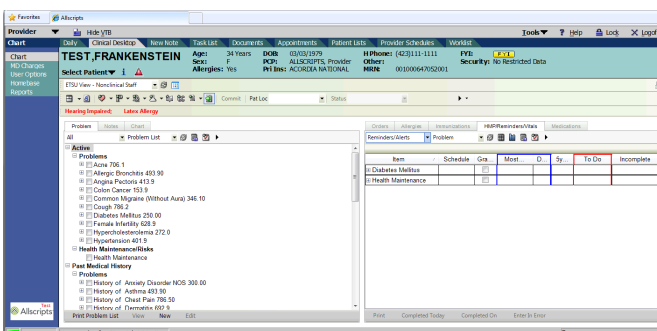
The major difference that most users will notice is the move from a three-component view to a two-component view. Having just two components allows room for a larger viewing area of each of the tabs. The Growth Chart tab is a prime example; most users who access growth charts have to expand the screen to view the curve sufficiently.

Additionally, users will notice that the Problem tab will default to All Problems, so that users will not need to sort through the multiple drop-down menus to view the patient's complete medical history.

The lower menu bars on each tab have also been improved, tailored specifically to the user's role in the clinic. For instance, 'Fax' is a quick menu option for nonclinical staff who often have to fax, and for clinicians, 'Verify' and 'Authorize' are quick menu items because of their frequent need to access them.

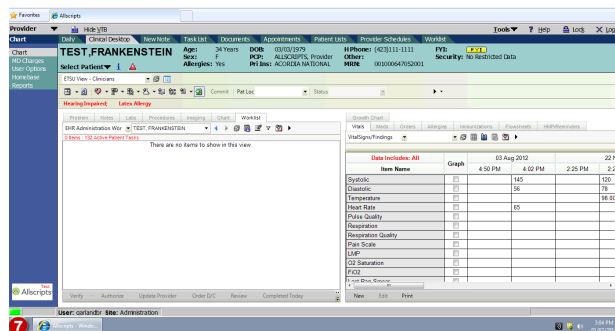
ETSU View – Nonclinical Staff

In the left component of the nonclinical staff view, three tabs are available: Problem, Notes, and Chart. In the right component, five tabs will be available: Orders, Allergies, Immunizations, HMP/ Reminders/Alerts, and Medications.



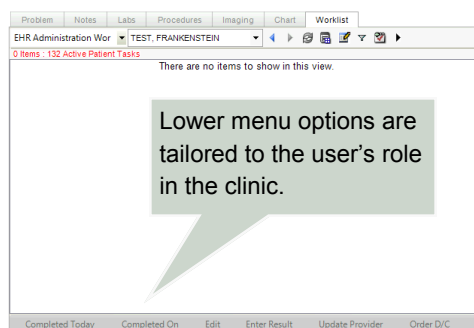
ETSU View – Clinician

The new desktop view for providers will have seven tabs in the left component: Problem, Notes, Labs, Procedures, Imaging, Chart, and Worklist. In the right component, eight tabs are available: Vitals, Meds, Orders, Allergies, Immunizations, Flowsheets, HMP/Reminders, and Growth Chart.



ETSU View – Nurse

The new view for nurses will look almost identical to the



Lower menu options are tailored to the user's role in the clinic.

Clinician view; however, the lower menu options will vary slightly. On the Worklist tab, for example, rather than Verify and Authorize as options, nurses will see Completed Today, Completed On, etc.

We will be testing the new views with a small group of users before they are assigned to all users, as our goal is to make each user's workflow as efficient as possible.

Although the change may take a little time to get used to, users should adapt quickly and navigation and viewing should become much more streamlined.



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EHR Challenge

December Challenge

Which one of our test patients has an allergy to buckwheat? Answer: **Tracy Test**

Our December Challenge winner is **BJ Cope**. BJ is a technician in the Ophthalmology Department.

We will be presenting BJ with her prize pack in the very near future.

Congratulations!

January Challenge

How do you learn about updates and changes to the EHR? Is it the newsletter, emails, Facebook, the EHR website, office meetings, Gold Alerts, other staff members?

Tell us how you prefer to learn about changes or updates by sending an email to EHR-Help@qetsu.org. From all responses, one person will be chosen randomly to win the January prize pack.

Good Luck!

Focus on...

On rare occasions, QETSU providers have been required to document patient encounters with a paper note rather than electronically—resulting in paper documents for scanning into the Electronic Health Record (EHR).

Be sure to assign the correct **Document Date** to the note. If the note is dated 12/18/2013, then the **Document Date** and the **Encounter** must correspond (see below).

Enterprise Scan: Document Properties

Document Properties

Document #: 1142850

Document Name: Office Notes

Document Date: 12/18/2013

Acquired: 12/18/2013 2:34:00 PM

Encounter: Appointment, 12/18/2013 8:00:00 AM, ALLSCRIPTS.Provider

Owner: ALLSCRIPTS.Provider

Signed By:

Status:

* Items in bold must be provided

Save Close

Scanned Paper Notes



When scanned correctly, the note will be easy for providers, auditors, and others to locate.

Daily Clinical Desktop New Note Task List Documents Appo

TEST, FEMALE D Age: 71 Years DOB: 01/26/1942

Sex: F PCP: KITCHENS

Allergies: NKA Pri Ins: UHC COMM

Select Patient

Clinician

PQRS Eligible - Diabetes

Problem Notes Labs Procedures Imaging Chart

All Notes

366 of 1349 Chart Items (113 Invalid and 708 Audit Items) - Filters Applied

sOffice Notes - ALLSCRIPTS, Provider, Enc: 18Dec2013

Clinical Summary (Psychotherapy with Office Visit) - Moor

EHR “Access”

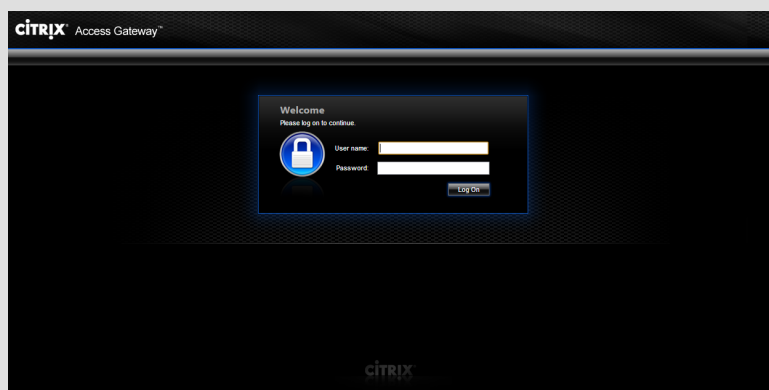
Logging in from Home

Allscripts Access from your Home Computer

Open up Internet Explorer (or Safari, if using a Mac). In your browser window, type the following:

access.getsu.org.

Hit enter on your keyboard. If you have already downloaded the Citrix Receiver onto your personal computer, you will get the log-on page for Citrix. Enter your Citrix username and password to access Allscripts.



We recommend bookmarking or adding this web address to your Favorites for ease of future access.

If you have NOT already downloaded the Citrix receiver, you will need to download the software at **receiver.citrix.com**. Follow the step-by-step instructions for download.

The “Black” Screen

If you are running Internet Explorer 10, you may get a black screen instead of the log-on screen seen above. If this happens, you will need to run Internet Explorer in compatibility mode. To do this, find the icon on the browser bar that looks like a ripped piece of paper.



Simply click on this icon, and the log-on screen should appear. To learn more about Compatibility View, read the **[Microsoft Help](#)** page on compatibility settings.

Coming up in 2014

As we begin a new year, there are several EHR projects being planned and will be implemented over the next few months. Keep watching for updates for the exact dates these projects will be rolled out.

*All dates are tentative.

January

Charge testing, Live Chat testing, Hardware updates for 11.4 upgrade, Patient Portal decision, Meaningful Use attestations

February

Charge go-live, Live Chat go-live, 11.4 upgrade in Test, 11.4 training

March

11.4 upgrade testing, Patient Portal go-live

April

11.4 go-live, Meaningful Use Stage 2 training

June

New resident training

July

New resident training and onsite support

October

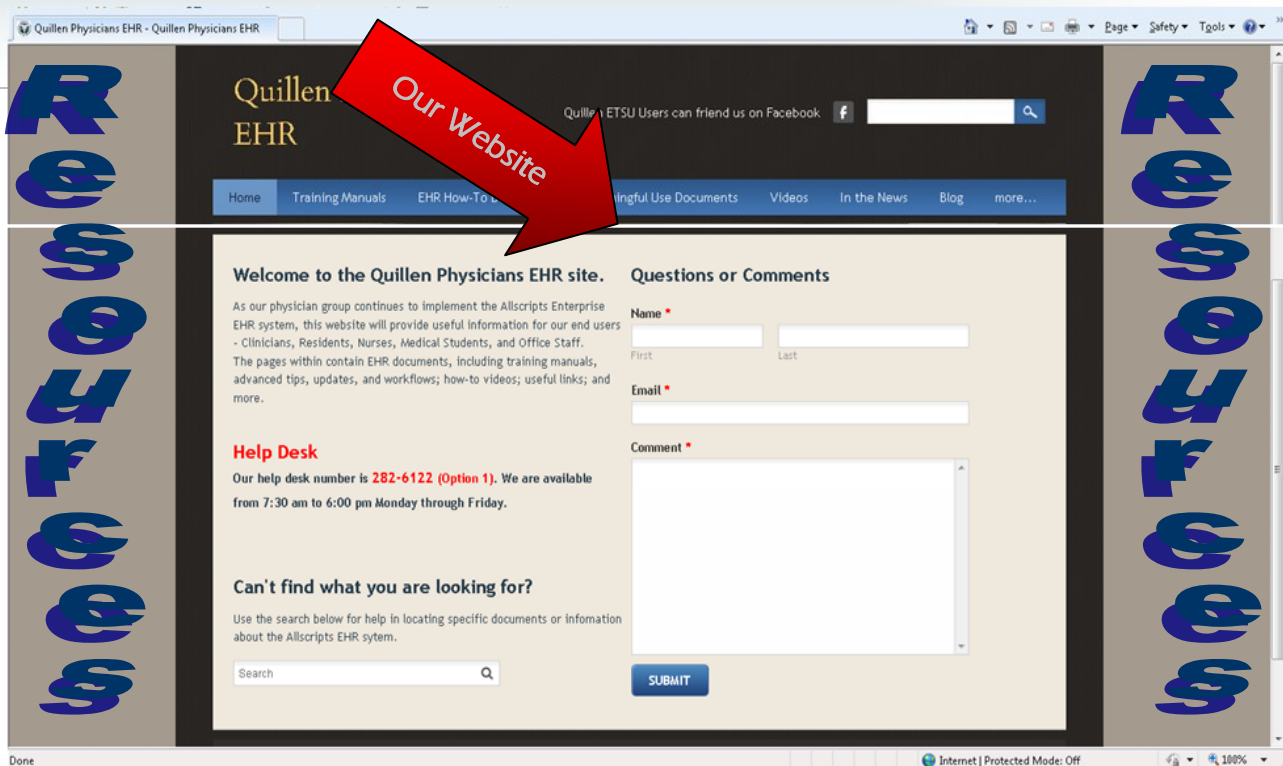
Begin using ICD-10

Unscheduled Projects

St. Jude's go-live, equipment interface (blood pressure cuffs, e.g.), radiology interface, dashboard



The Quillen Physicians EHR website is a tremendous resource at your fingertips. You can easily access our Training Modules, How-To Documents, Manuals, Videos, and more. <http://quillenphysiciansehr.weebly.com/>



STAY INFORMED

MEAC GOLD ALERTS

Have you signed up for the MEAC Gold Alerts? To get signed up for a text/email alert for any weather-related closings or Allscripts alerts, you can now register using your ETSU email address. Go to <https://www.getrave.com/login/etsu> and click on the "Register Now" link in the lower left-hand corner. Follow the instructions to register. Once you have registered, Rave will send an email to your etsu.edu email address. You will also receive a text message on your cell phone with a 4-digit code. To complete your registration, enter the 4-digit code in the space provided in the email and click send. Stay safe, everyone!

NEED EHR HELP?

EHR Help Desk

- ♦ Call 282-6122, option 1
- ♦ Task: Allscripts Help Team
- ♦ E-Mail: EHRhelp@etsu.org
- ♦ Open: Help Desk Ticket by clicking the Help Desk icon on desktop

HELP DESK SUPPORT

7:30AM TO 6:00PM

MONDAY through FRIDAY

Are You a Meaningful User?

Click like it's 2014?

CMS Extends Timeline for EHR Incentive Program

A few weeks ago, the Centers for Medicare & Medicaid Services (CMS) proposed a new timeline for the implementation of meaningful use. The new timeline extends Stage 2 through 2016, and Stage 3 will begin in 2017 for providers who have completed at least two years in Stage 2. The extension was made for two reasons: one, to allow CMS “to focus efforts on the successful implementation of the enhanced patient engagement, interoperability and health information exchange requirements in Stage 2”; and, two, to have access to the data from Stage 2 to inform policy decisions for Stage 3. The three stages are set up to transition participants, from *creating* information in Stage 1, to *exchanging* information in Stage 2, to *improving* outcomes in Stage 3.

According to CMS, the new timeline would have several benefits:

- More analysis of feedback from Stage 2
- More available data on Stage 2 adoption and measure calculations – especially on new patient engagement measures and health information exchange objective
- More consideration of potential Stage 3 requirements
- Additional time for preparation for enhanced Stage 3 requirements
- Ample time for developers to create and distribute certified EHR technology before Stage 3 begins, and incorporate lessons learned about usability and customization.

CMS plans to release a notice of proposed rulemaking for Stage 3 in the fall of 2014. The final rule with all requirements for Stage 3 would follow in the first half of 2015. All comments from those individuals with a direct interest will be “reviewed and carefully considered” before the final rules are released.

What this means for Quillen Providers

Although this announcement doesn't immediately affect us, it does give us a little more breathing room, as many of our providers were early participants in the program. For any provider who started the program in 2011, the new timeline will look similar to the following:

2011	Adopt, Implement, Upgrade
2012	Demonstrate 90 days of Stage 1
2013	Demonstrate a Full Year of Stage 1
2014	Demonstrate 90 days of Stage 2
2015	Demonstrate a Full Year of Stage 2
2017	Begin Stage 3

Not all of our providers started in 2011, so your particular timeline may look a little different. CMS offers a [timeline tool](#) that participants can use to see a personalized timeline.

As we enter a new year and start working on a new timeline, perhaps the song below won't be as applicable, but just in case you are still in a panic about Meaningful Use, here's a song for you!



I was panicking when I wrote this
Forgive me if it goes astray
But when I got to work this mornin'
Could of sworn it was Attestation Day.

The computer screen was all black
There were patients waitin' everywhere
Tryin' to get relief from sickness
But CMS didn't seem to care.

'Cause they say two thousand one three
Stage One is over, oops out of time
So today I've got to click like it's 2014
(Sorry, couldn't make it rhyme)

I was panicking when I wrote this
So sue me if I go too fast
Stage 2 is not a party
And clicking is not a blast.

The EHR is all around us
My eyes say too much screen time
But if I gotta click
I'm gonna make it by the deadline.

Yeah, they say two thousand one three
Stage One is over, oops out of time
So today I've got to click like it's 2014.
(Sorry, couldn't make it rhyme)

Lemme tell ya somethin'
If you didn't come to document
Don't bother seeing patients
We got CMS wanting data
And, doc, we're runnin' outta time!

The Ethical EHR

Can you order labs and medications for yourself or a family member?

Q: *I'm a nurse in Internal Medicine, and my daughter is sick with a fever and sore throat. I'm pretty sure she needs an antibiotic. Can I order a lab and medication under her pediatrician's name? Every time my daughter has these symptoms, her doctor always orders a strep screen and amoxicillin.*



A: **No**, as healthcare professionals, we may think that treating ourselves, family members, or colleagues is harmless enough, particularly if the diagnosis seems obvious. However, there are several ethical and perhaps legal issues that the above scenario presents, especially in regards to sharing an EHR.

1. Never put in lab or medication orders for yourself, a family member, or close employees, even under a physician's name, with or without consent. In the above scenario, the nurse is asking to order both a lab and medication without the physician's knowledge or approval.

Physicians are held accountable for diagnostics and treatments they order and must document the "what and why," both for billing and for past medical history during future encounters. Furthermore, the physician hasn't had an opportunity to examine the patient or make a diagnosis. There may be situations where symptoms of one condition mimic another condition. Only a licensed professional should make the diagnosis, and the physician should put the necessary order in himself (or his designated staff member), not the patient or family member.

2. Ordering labs and medications for one's self or family members is not recommended. Not only is the nurse in the scenario above asking to put in an order without permission, she is also asking to put in the order for a family member and is making a diag-

nosis for a family member. As suggested by the American Medical Association (AMA), "**professional objectivity** may be compromised when an immediate family member or [one's self] is the patient" and "**patient autonomy and informed consent**" can be brought into question. Although it is not illegal for a physician to treat one's self, a family member, or an employee, most professional healthcare associations highly discourage the practice.

3. Accessing your chart or a family member's chart without permission is a violation of the HIPAA privacy rule. Although individuals have a right to view and obtain a copy of their personal health record, they must first request (ask for) access, and, if obtaining a copy, put the request in writing. As the owner of the medical record (chart), the physician also has rights (and security requirements that must be documented) under the privacy rule. **An audit trail is kept on each chart to ensure compliance of the privacy rule.** In addition, it is the corporation's policy (see Confidentiality of Information policy) that for an

employee to view her own medical record, she must fill out a medical release.

It may seem like a simple request; you may even think you're saving the physician the hassle, but putting in orders for yourself or a family member is not in the patient's best interest

"For an employee to view his own medical record, he must fill out a medical release."

and is not permissible. If you are a physician, even if you hate putting in orders, don't be tempted to let your staff members seeking medical treatment put in orders for themselves. You should take responsibility for the orders and document the encounter just like you do for your regular, non-employee patients.



EHR Out and About



Pictured left to right: Marisa Bowery, Christine Mays-LeBlanc, Leslie Paduch, Surgery; Danielle Crumly, Janie Plemons, Pediatrics; Dr. Melania Bochis, KIM; Whitney Estep, CEB II



Left to right: Amber Arsenault, Suzanne Hammonds, CEB II; Dr. Patricia Conner, BFM; Pam Wiggins, Donna Stewart, KIM; Courtney Holloway, Monaco Briggs, EHR Team; Melissa Sells, Pediatrics



Left to right: Carrie Sanders, KFM; Mary Collier, Fertility; Tracy Jones, Courtney Holloway, EHR team; Connie Huddleston, Kim Wright, Fertility



Left to right: Suzanne Lavoie, OB/GYN; Michelle Moser, Heather Moore, Judy Archer; Psychiatry; Patti Espinoza, Sarah Musselwhite JCFM; Janet Robins, Pediatrics



Left to right: Jennifer Logan, EHR Team; Susan Luna-Denton, Kathy Whalen, Osteoporosis Center; Courtney Holloway, Tracy Jones, EHR Team; Dr. Daniel Haynes, Surgery; Mabel Yates, Psychiatry; Missy Assad, Fertility