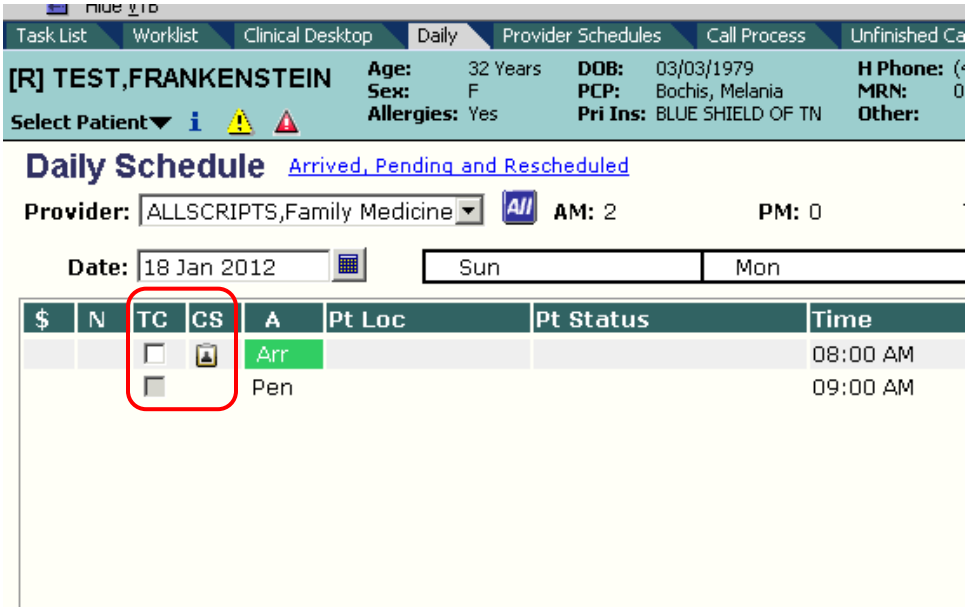
Allscripts Version 11.2 Enhancements Providers, Residents, and Clinical Staff

Section I: Enhancements for Meaningful Use Compliance

Clinical Summary

The **Daily** tab has been enhanced with two new fields:

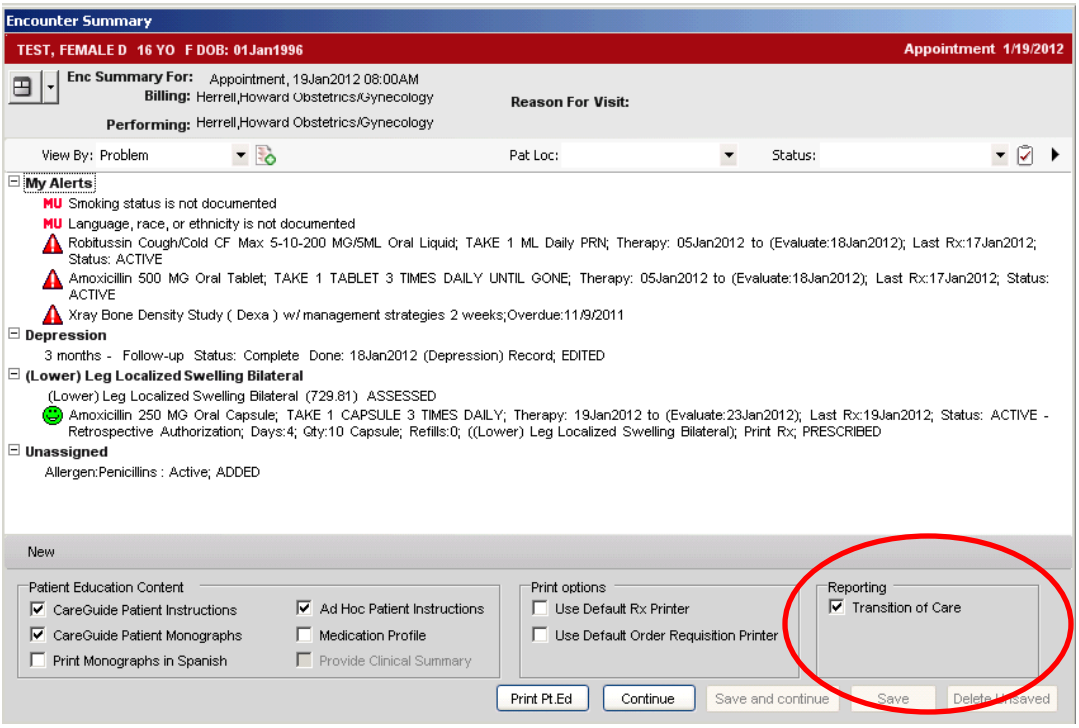
- **Transition of Care (TC)**
- **Clinical Summary (CS)**



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 Incentive** 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.



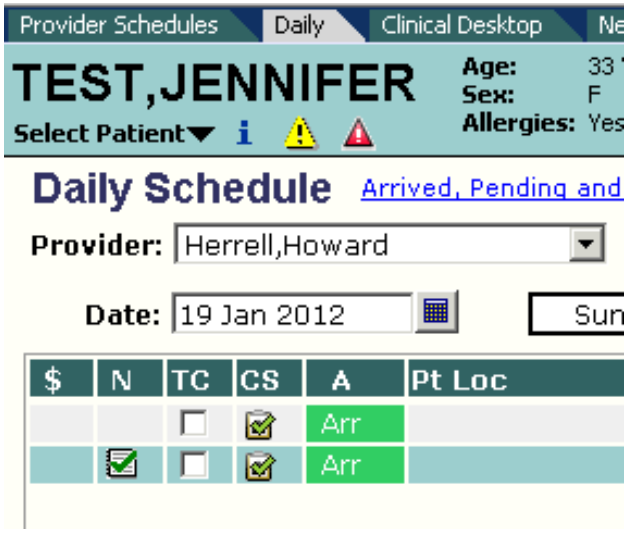
Clinical Summary

Meaningful Use criteria defined by the **EHR Incentive** 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.



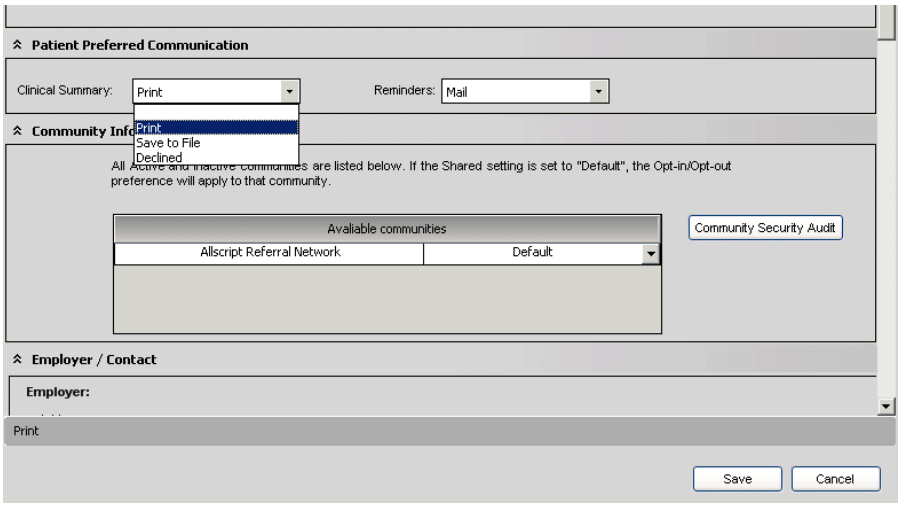
Step-by-step: Provide a Clinical Summary (from the schedule)

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 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.**

Not currently available

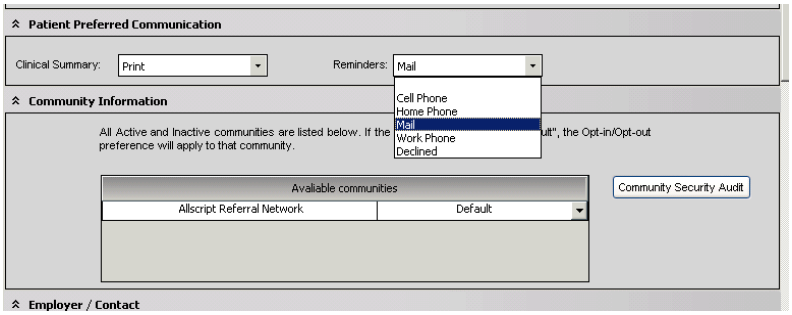
Step-by-step: Add Patient Preferred Method for Clinical Summary

1. From the **Patient Banner**, click the **blue i** icon to open the **Patient Profile.**
2. In the **Patient Preferred Communication** section, click the **Clinical Summary** arrow.
3. Select an available option (Print, Save to File, or Decline) and **Save.**



Step-by-step: Record patient preferred communication for reminders

1. From the **Patient Banner**, click the **blue i** icon to open the **Patient Profile.**
2. In the **Patient Preferred Communication** section, click the **Reminders** arrow.
3. Select a reminder option.
4. Click **Save.**



Provide an Electronic Copy of Patient Health Information

Meaningful Use criteria defined by the **EHR Incentive** 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

Not currently available

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

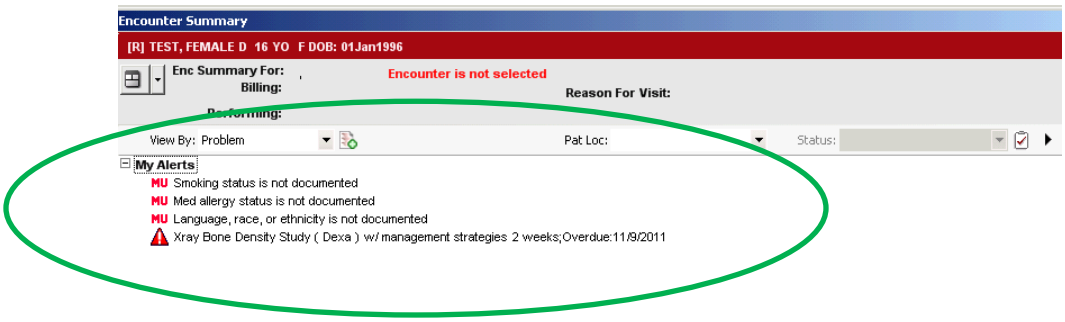
Exchange key clinical information using Allscripts Enterprise EHR which allows organizations to exchange clinical documents with other healthcare networks.

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 either 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.**
10. A preview of the **Clinical Exchange Document** appears.
11. Click **Export.**
12. A copy of the exported **Clinical Exchange Document** is available as a **CED—Clinical Summary** in the **Chart Viewer.**

Patient Banner

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.**

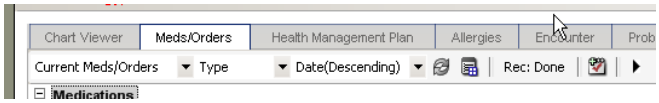
Reconcile Meds/Allergies

The "core set" of **MU** objectives requires clinics to maintain an active medication list and an active medication allergy list. To document, 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.

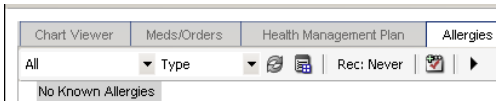
Medication and Allergy Reconciliation has been available, but now, it is more prominent.

- 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**".



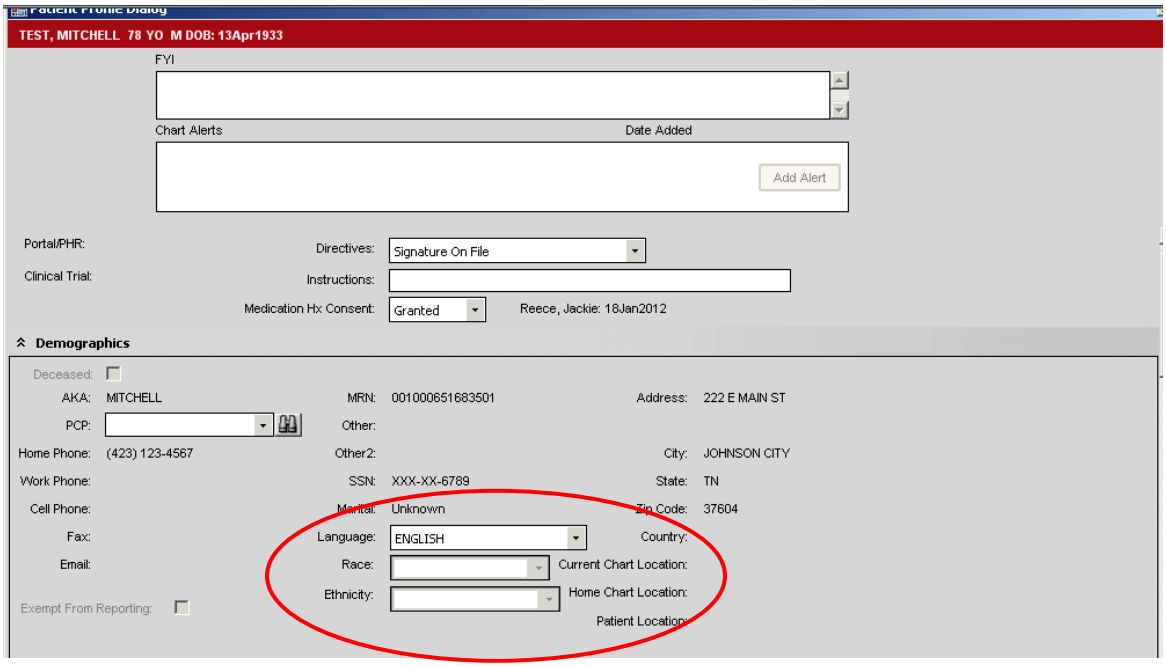
To reconcile the Medication or Allergy List, simply click the "**Rec…**" button whether it is highlighted or not (if an encounter is not already selected, you will be prompted to choose one).

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.

Patient Profile Dialog (Demographics)

Another core requirement of **MU** is recording demographics. The demographic elements now include: Advance Directives, Language, Race, and Ethnicity.

These data will be collected and entered in **Experior** and will populate the **Electronic Health Record** by interface. **Medication Hx Consent** will still be selected in the **EHR** within the **Patient Profile Dialog** window.



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

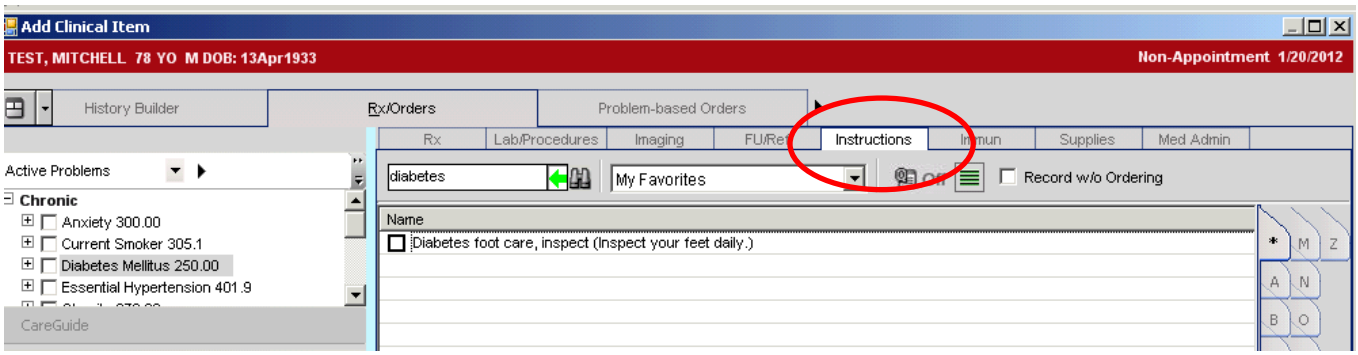
1. Click the **Add New Problem** icon on the **Clinical Toolbar.** This takes you to the **History Builder** primary tab and **Active** secondary tab in the **ACI.**
2. Click on the **Social History** secondary tab.
3. Select a smoking-related problem. **Note: The choices that qualify for Meaningful 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.

Language, Race & Ethnicity – These items will be included on the **Patient Profile (blue "i").** This information will be viewable in the EHR, but only editable in **Experior**.

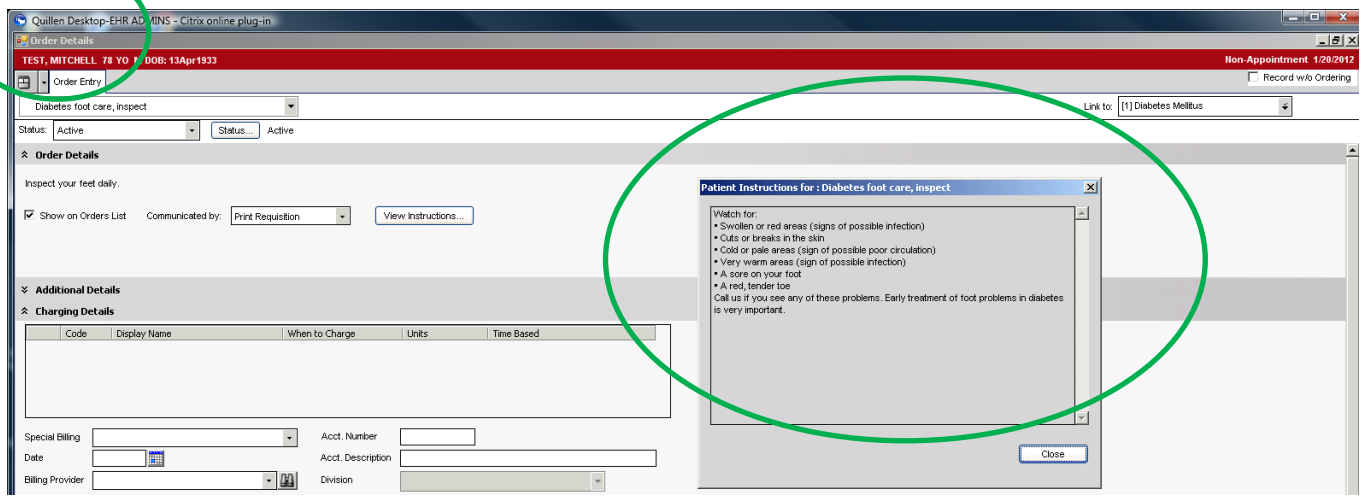
Ordering Interventions for Meaningful Use

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.



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.

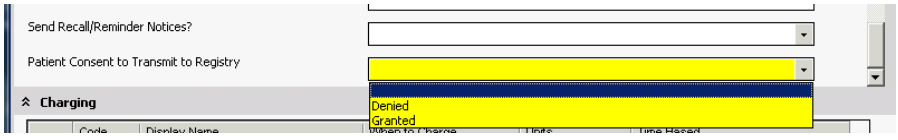


Immunization Reporting

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. Search for and select 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.

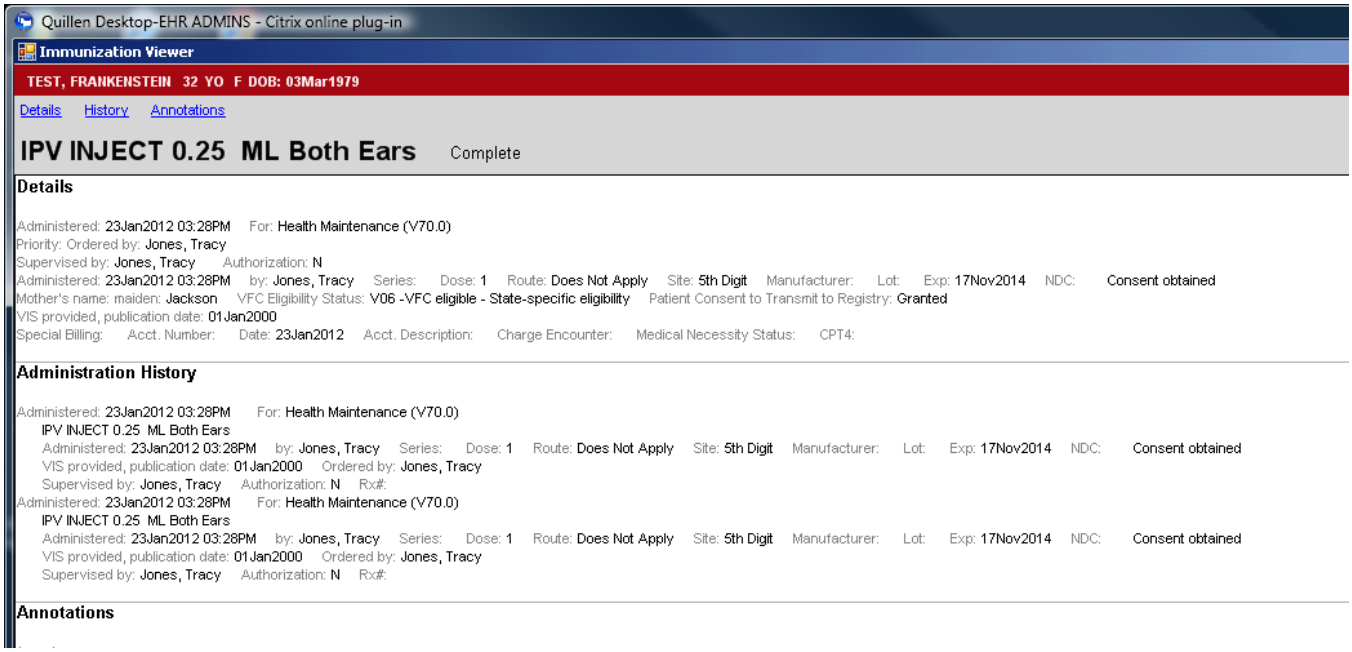


As mentioned above, the light yellow **Clinical Questions** box indicates that the order will go into an "On Hold" status, if the answer is not entered. An **Immunization Documentation** task will be generated, which is in a **Hold for Documentation** status.

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

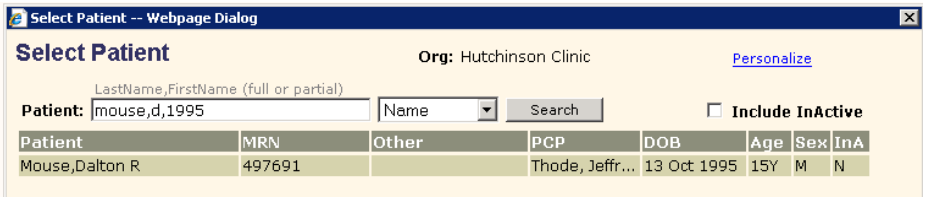
1. Navigate to the **Task List** tab on the horizontal toolbar.
2. Double-click on the **Immunization Documentation** task, which is in a **Hold for Documentation** status. The **Immunization Details** page displays.
3. In the **Clinical Questions** section, the boxes in light yellow need to be entered 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.
4. Click **OK** to close the **Immunization Details** page.
5. 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.



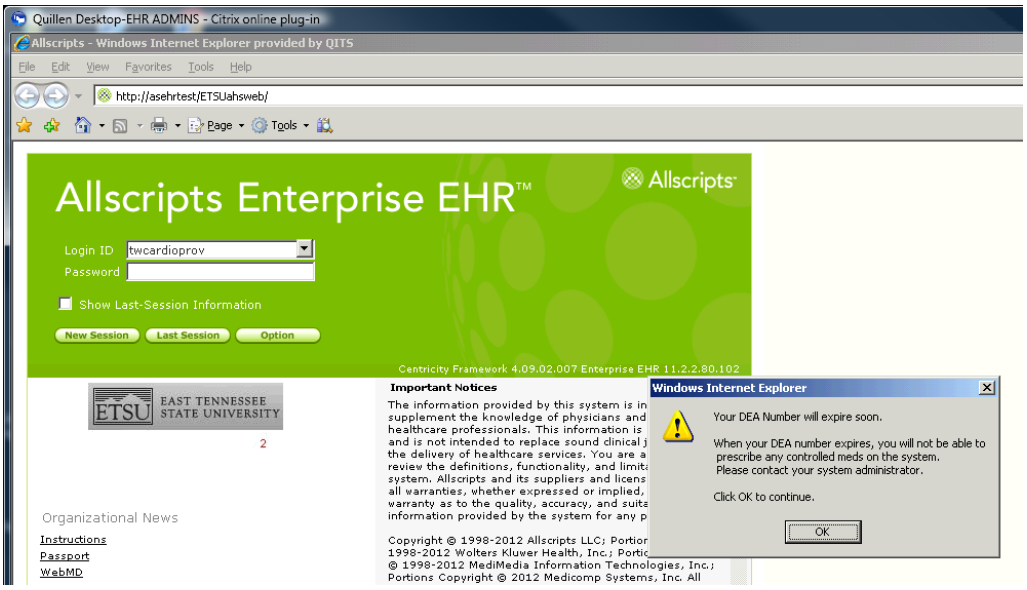
Section II: Enhancements to Improve User Efficiency

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



DEA Expiration Warning

A new warning displays when your **Drug Enforcement Agency (DEA)** will expire in one week.



NPI Required in All Pharmacy Routing

The **National Provider Identifier (NPI)** is now required in all pharmacy routing transactions. The **NPI** is verified for each transaction to ensure the most recent information is included. If the **NPI** is blank, you will receive a warning at login. The system administrator is also notified.

Add Clinical Items (ACI) Enhancements

- "**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.

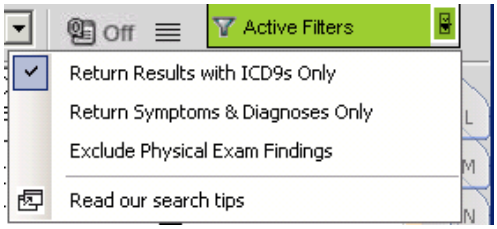
  Step-by-step: Document No Active Problems

  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.

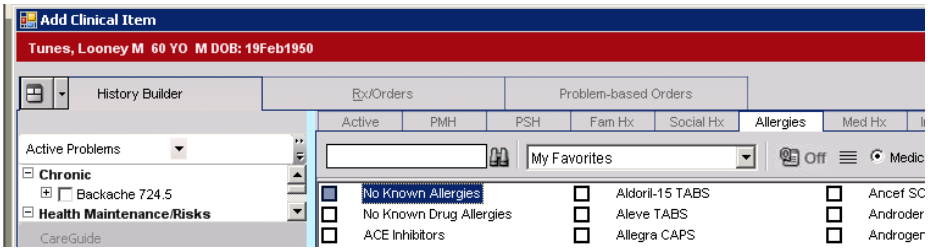
  The system removes the **No Active Problem** indicator from the patient's chart if a new active problem is added. The **No Active Problems** indicator is added again when the patient's last active problem is resolved, removed, or suppressed.

- Visual indicators show whether a **QuickList** filter is **On** (green color) or **Off** (gray color). 

- A single button toggles between single column and multi-column data display.
- Users can now copy annotations from an old problem to the new "Transitioned To" problem.
- The **Problem** right-click menu has been updated to change status, laterality, make secondary to, assess, and make active.
- **Active Filters** enable the user to return selected results or findings based on the setting chosen (see below).



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.**
5. **Commit** to save the changes to the patient's record.

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.**

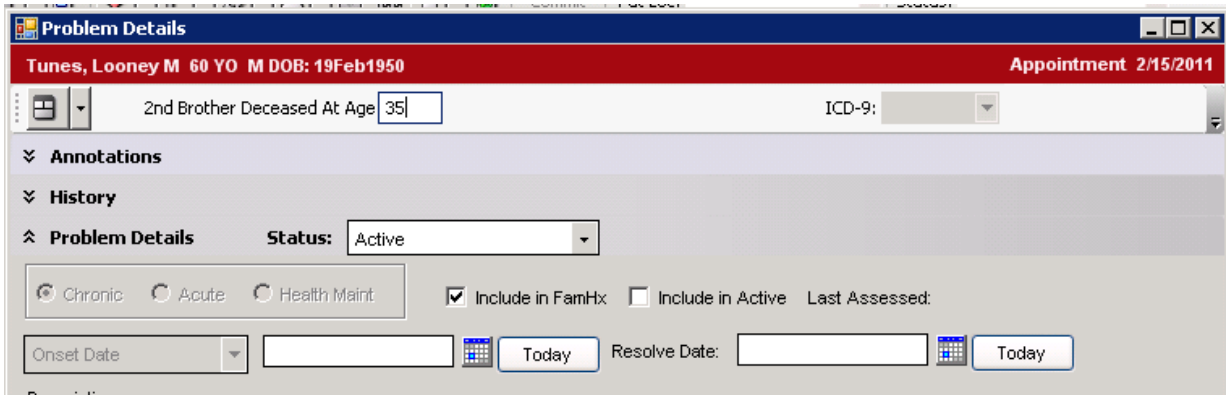
Variations in calculations:

- 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.

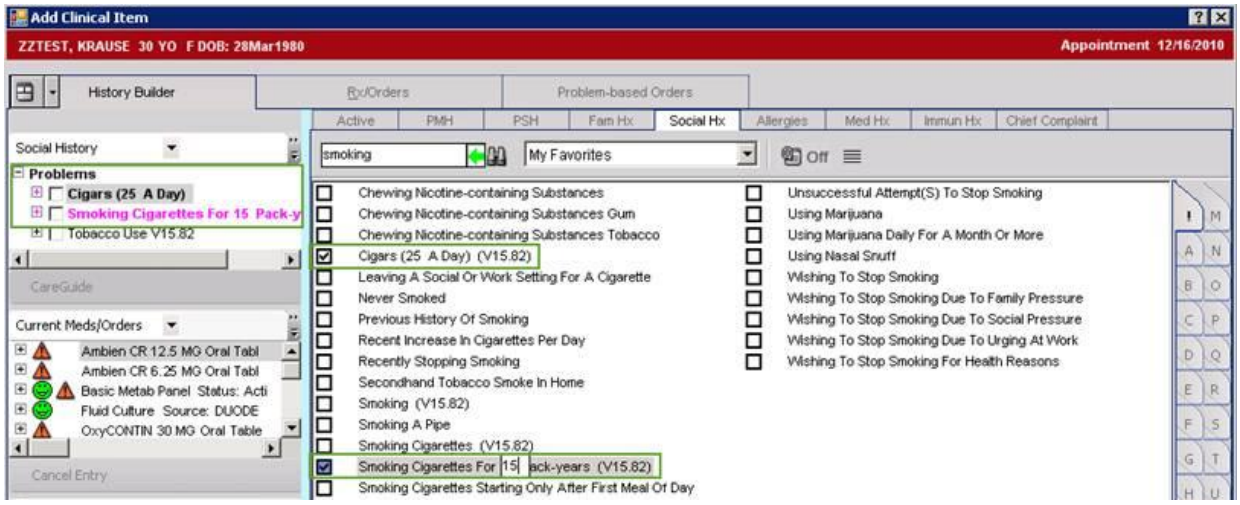
Individual height and/or weight values can be **Entered in Error**, and the BMI/BSA also becomes **Entered in Error**. However, the other values remain valid. If the height and/or weight is edited, then BMI/BSA is re-calculated with the new values.

Fill-in-the-Blank Problems – now when there is a problem (Active, PMH, PSH, Fam Hx, Soc Hx) that includes a blank in the description, you will be able to type a value directly into the blank space within the name of the problem.

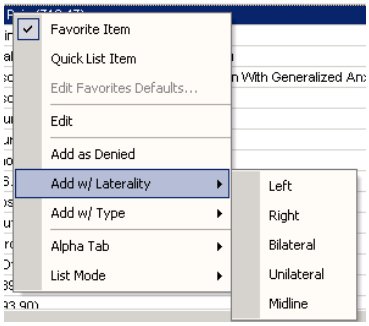
- For a problem already on the patient's chart, **Edit** the problem, and enter the value in the blank at the top of the **Problem Details** window.

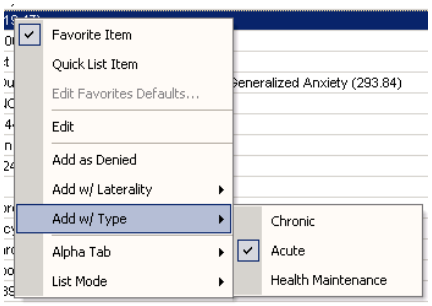


- For a new problem, click the blank area and enter the value

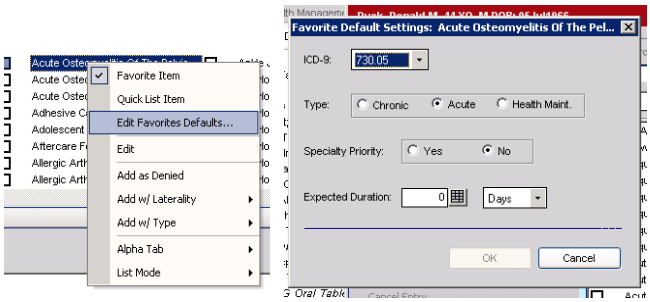


- **Problem Type/Laterality –** when entering problems, you can right-click to add the **Type** or **Laterality** directly from the **Add Clinical Item** window.



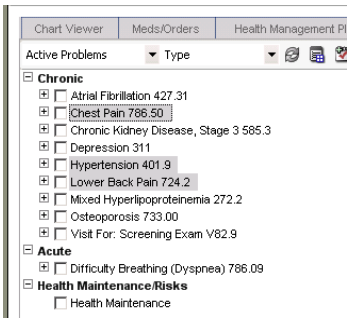


Set Favorites Defaults for Problems – From the **Add Clinical Item** window, you can more easily change your default settings on a problem-by-problem basis. You can **Edit Favorites Defaults** in a new dialog. The requested edits display in **Problems Details.**

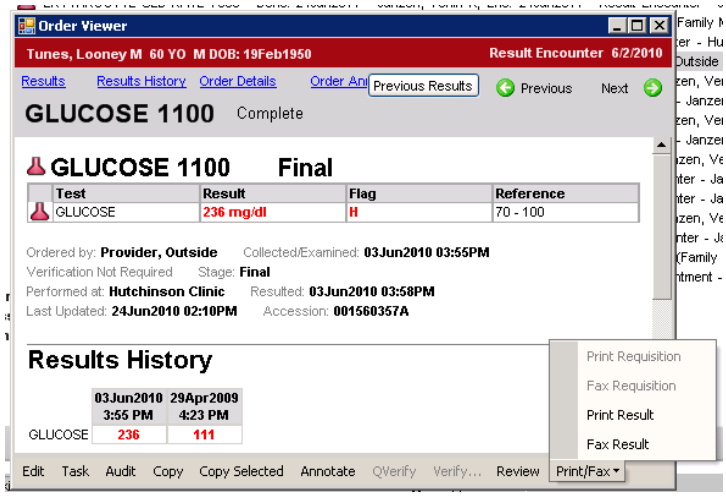


Linking Multiple problems to orders from **Add Clinical Item** window or **Clinical Desktop**

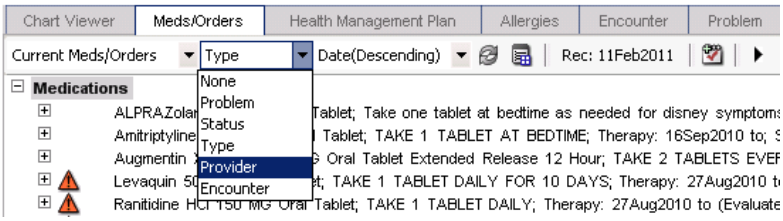
- By holding down the Control (Ctrl) key, you are allowed to highlight multiple problems to link to an order



Print or Fax Results – Now you can easily identify the difference between printing or faxing a requisition while viewing the results.



New grouping options on **Meds/Orders** tab of the **Clinical Desktop** – you can now group **Meds/Orders** into categories of Provider or Encounter.



New sorting options on **Meds/Orders** tab of the **Clinical Desktop** – you can now view **Meds/Orders** chronologically in ascending or descending order.

Printing Drug Education Information for Patients

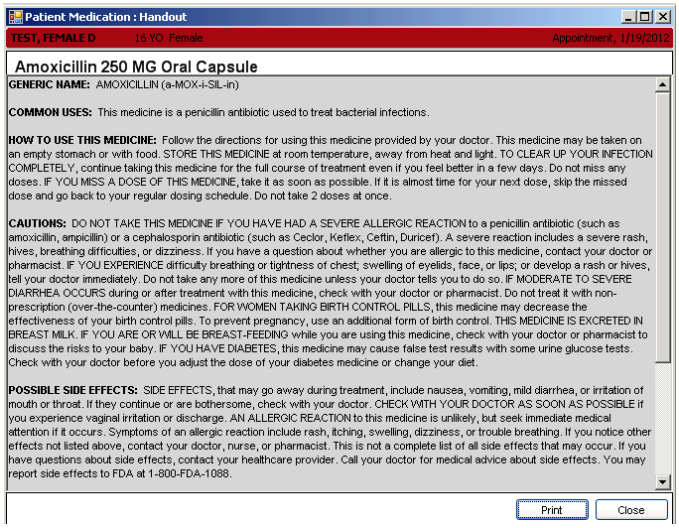
Once a drug has been entered in the Electronic Health Record, drug education information can be printed for distribution to the patient if desired.

Step-by-step: Instructions using Drug Education

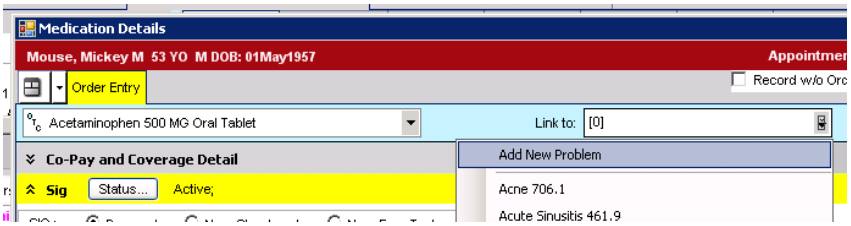
1. Click the **Rx/Orders** icon on the **Clinical Toolbar.**
2. Select the check box for any desired medications.
3. Enter the appropriate information in the **Medication Details** page.
4. Click **Save and Close ACI.**
5. **Commit.**
6. The **Encounter Summary** opens. Single-click to highlight the 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.
3. Single-click to highlight a medication.
4. Right-click, and select **Drug Ed** from the drop-down menu.
5. The **Patient Medication Handout** window opens.
6. **Print** the material.

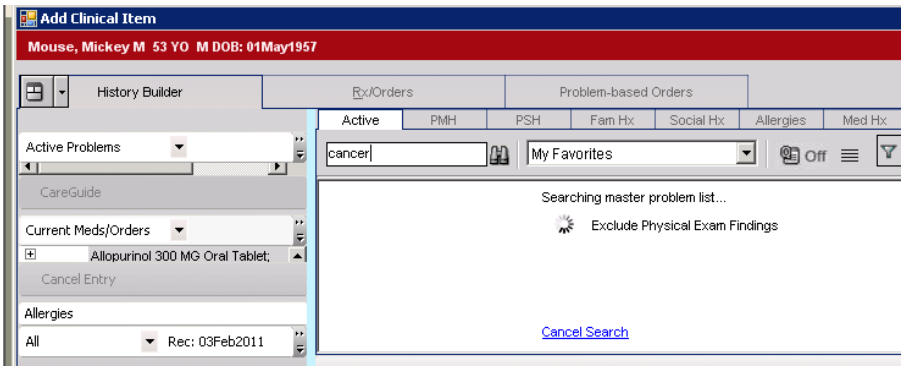


Add New Problem on Med/Order Details – When looking at the Order or Medication Details window on the **Link To** drop-down list, you can "**Add New Problem**" without closing the **Details** window (in case the problem is not already identified on the patient's chart)



Medication Adherence Indicator—increases visibility into patients' medication adherence for single or all prescriptions. Based on information from SureScripts, color-coded **Medication Adherence Indicators** advise how well a patient is adhering to a prescribed regimen. The patient must have granted that medication history is OK to receive.

Cancel Search – When doing a search on the **Add Clinical Item** window that is taking too long, you can now click the link that says "**Cancel Search**".



QuickChart – located on multiple windows including Task Details, Medication Details, Order Details, Script Message (Refill Requests) & Encounter Summary.

QuickAppointments – located on multiple windows including Task Details, Medication Details, Order Details, Script Message (Refill Requests) & Encounter Summary. The **Quick Appointment List** currently only shows current and past appointments.

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

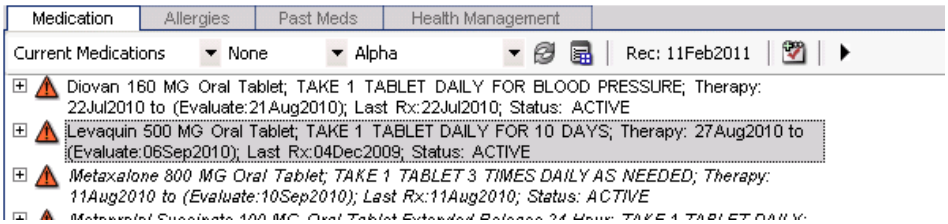
Cancelling a Med, message to pharmacy – When changing the status of a medication to Entered in Error or Discontinued, a message will be sent to the pharmacy. This information will be shown in the Status of the medication (seen on the Medication Details window or the Clinical Desktop)

- Before any response by the pharmacy

- After approval of the cancellation by the pharmacy

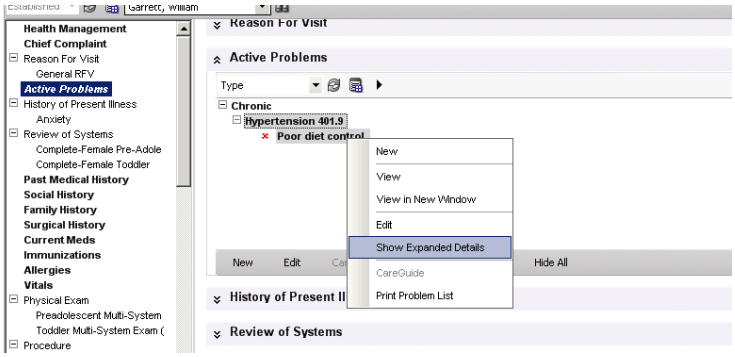
- After denial of cancellation by the pharmacy

Last Rx Date – This date is now included on the **Clinical Desktop.**



Note Enhancements

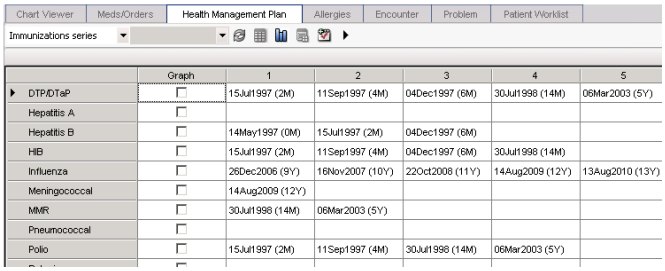
- The **Close** button in the **NAW** will ask you if you would like the changes saved before closing.
- Text entered in the **Descriptions** field of **Problem Details** will display in the note. Right-click and select "Show Expanded Details".



Immunization Registries

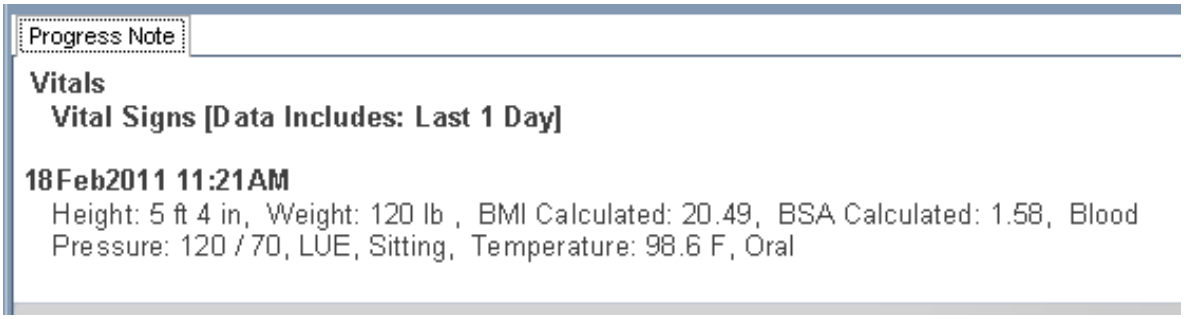
Another core objective of **MU** is the capability to exchange key clinical information among providers of care and patient-authorized entities electronically. Allscripts provides a list of state and regional registries we can activate for data exchange. It will be important to capture all immunization activity within the EHR system.

Immunization Series – when the date of administration of an immunization is listed on the **Immunizations Chart**, you will see the age of the patient in parenthesis next to the date. If the patient's age at the time of the immunization is 18 or older, the age will not be shown.

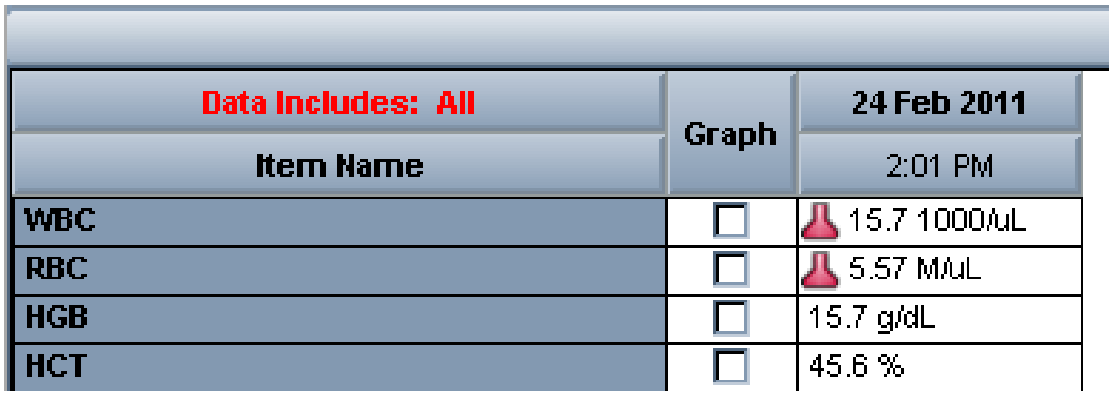


	Graph	1	2	3	4	5
DTP/DTaP	☐	15Jul1997 (2M)	11Sep1997 (4M)	04Dec1997 (6M)	30Jul1998 (14M)	06Mar2003 (5Y)
Hepatitis A	☐					
Hepatitis B	☐	14May1997 (0M)	15Jul1997 (2M)	04Dec1997 (6M)		
HIB	☐	15Jul1997 (2M)	11Sep1997 (4M)	04Dec1997 (6M)	30Jul1998 (14M)	
Influenza	☐	26Dec2006 (9Y)	16Nov2007 (10Y)	22Oct2008 (11Y)	14Aug2009 (12Y)	13Aug2010 (13Y)
Meningococcal	☐	14Aug2009 (12Y)				
MMR	☐	30Jul1998 (14M)	06Mar2003 (5Y)			
Pneumococcal	☐					
Polio	☐	15Jul1997 (2M)	11Sep1997 (4M)	30Jul1998 (14M)	06Mar2003 (5Y)	

Vitals in Structured Notes – In the **Note Authoring Workspace**, **Vitals** will still be shown as a list with only one item per line. In the output, the vitals will now be shown with multiple items on one line.



Flowsheets will show icons for unverified and/or abnormal results.

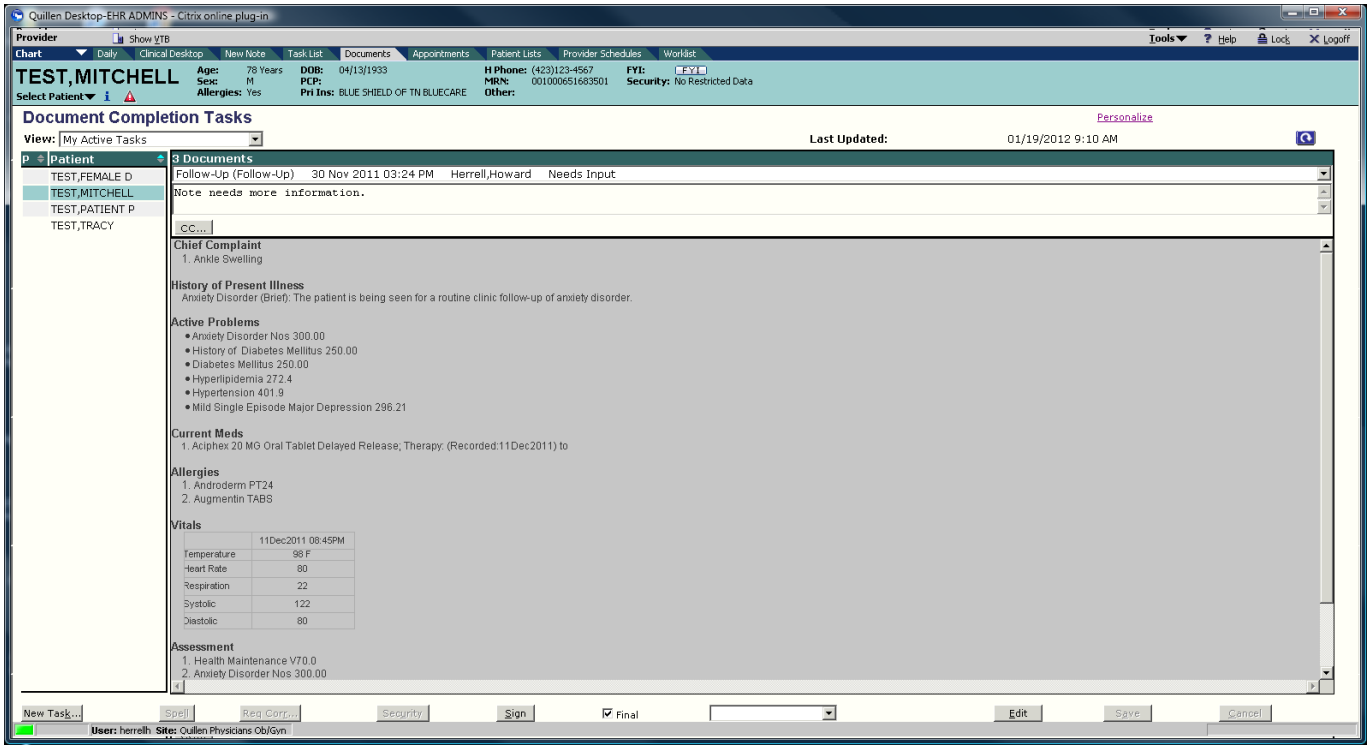


Task List

The functionality of the **Task List** tab is the same, but the appearance has been slightly changed. The **Comments** and **Task About** windows are larger now, so it is easier to read the task details without opening the **Task Detail** window.

Documents (Providers/Residents)

The **Documents** tab on the **HTB** has been enhanced. This tab now displays the tasks associated with documents allowing physicians to view, edit, or sign directly from this screen. Simply highlight a patient name, and perform the necessary actions (see below).



Once the action has been performed, the task will drop from the **Task List** tab as well as the **Documents** tab.