

# ALLSCRIPTS ENTERPRISE EHR



Training Manual for  
Quillen ETSU Physicians  
Provider and Resident

QUILLEN ETSU PHYSICIANS

# Allscripts Training Manual

## Provider and Resident

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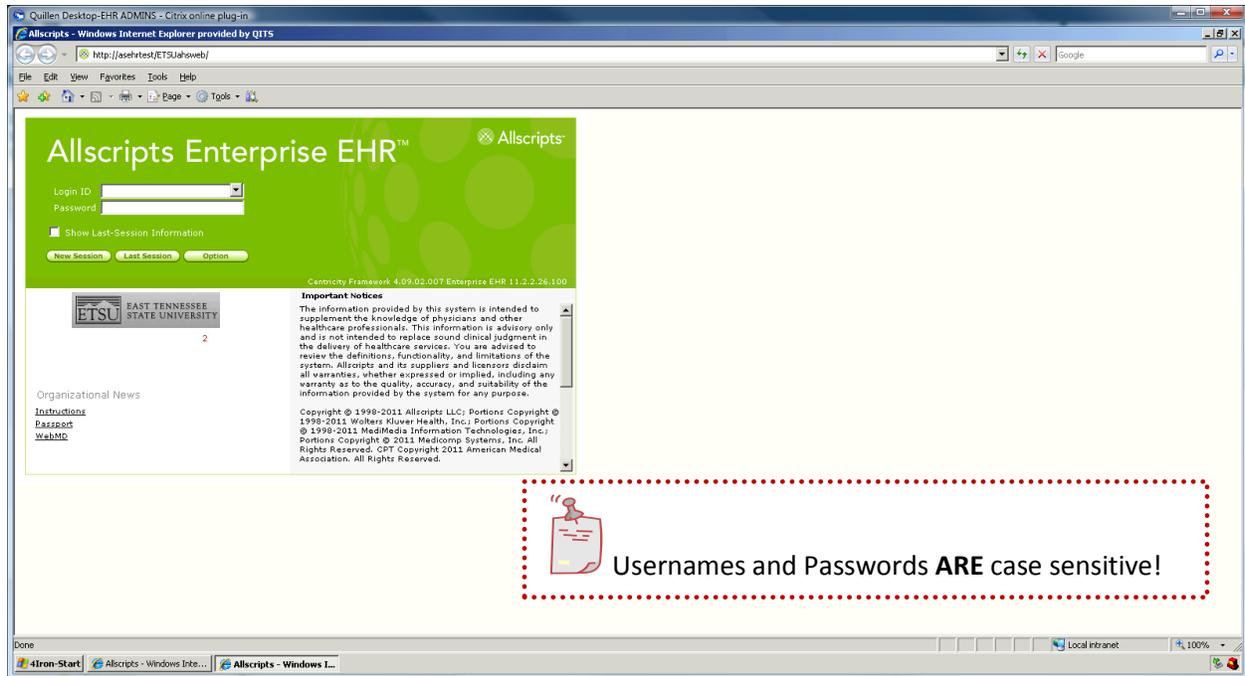
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## BASIC NAVIGATION

### 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.")

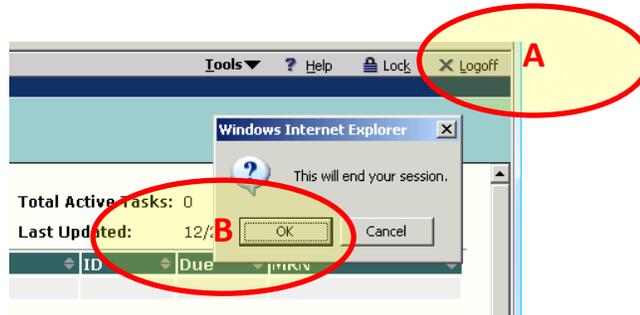


**New Session** – Opens a new session of the **Electronic Health Record (EHR)**  
**Last Session** – Opens the session with the last patient chart being used on this computer.

## 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**).



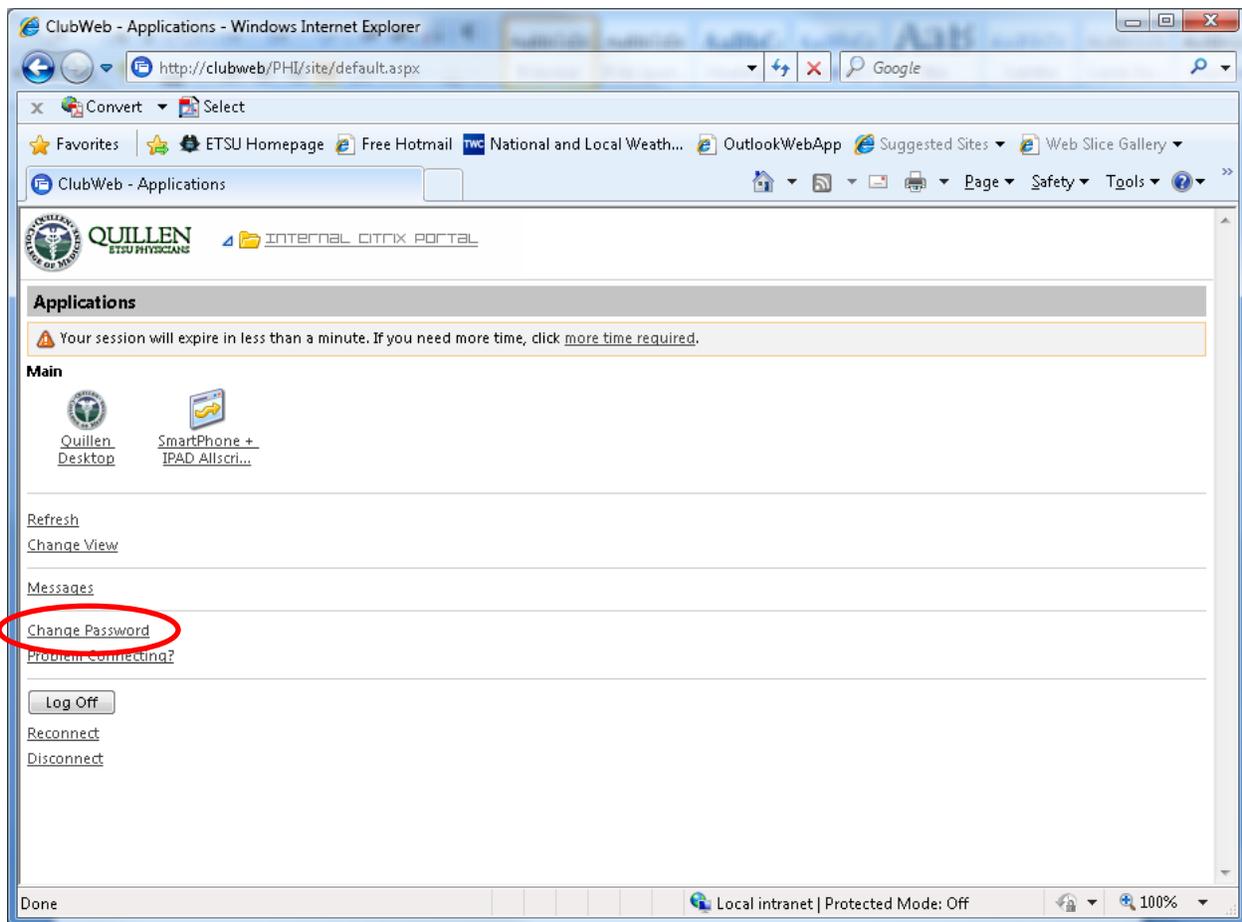
*Be sure that you complete **Step 1** and **Step 2** when logging off!*

## 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.

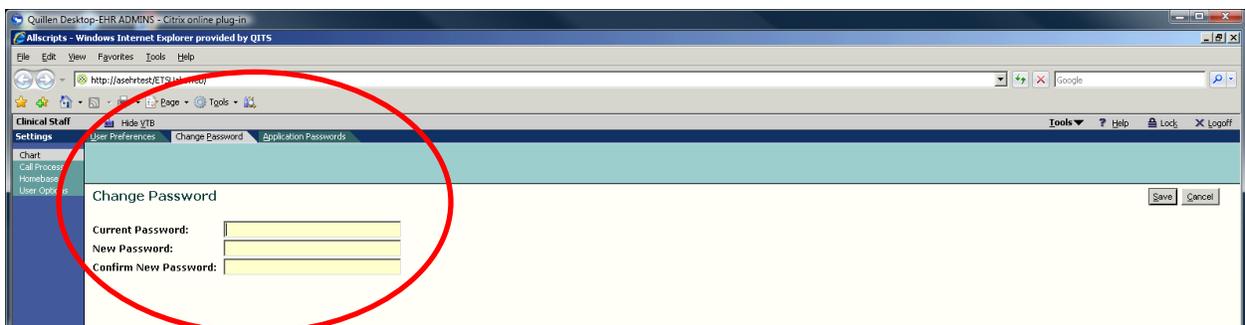
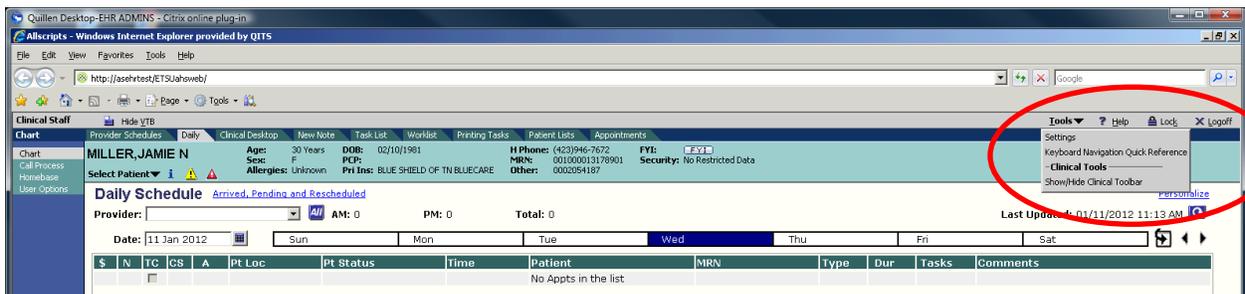


Enter your existing password in the **Old Password** field, and then enter and repeat your new password in the **New Password** and **Confirm Password** fields. Click **OK**.

The screenshot shows the 'Change Password' form within the Allscripts interface. At the top left, there is a logo for 'QUILLEN ETSU PHYSICIANS' and a folder icon labeled 'INTERNAL CITRIX PORTAL'. Below the header, a warning message states: 'Your session will expire in less than a minute. If you need more time, click [more time required](#).' The form contains three input fields: 'Old password:', 'New password (Must be 8 characters or more consisting of Uppercase, Lowercase, Number or Character - Cannot include part of your name):', and 'Confirm password:'. At the bottom of the form are two buttons: 'OK' and 'Cancel'.

## Allscripts

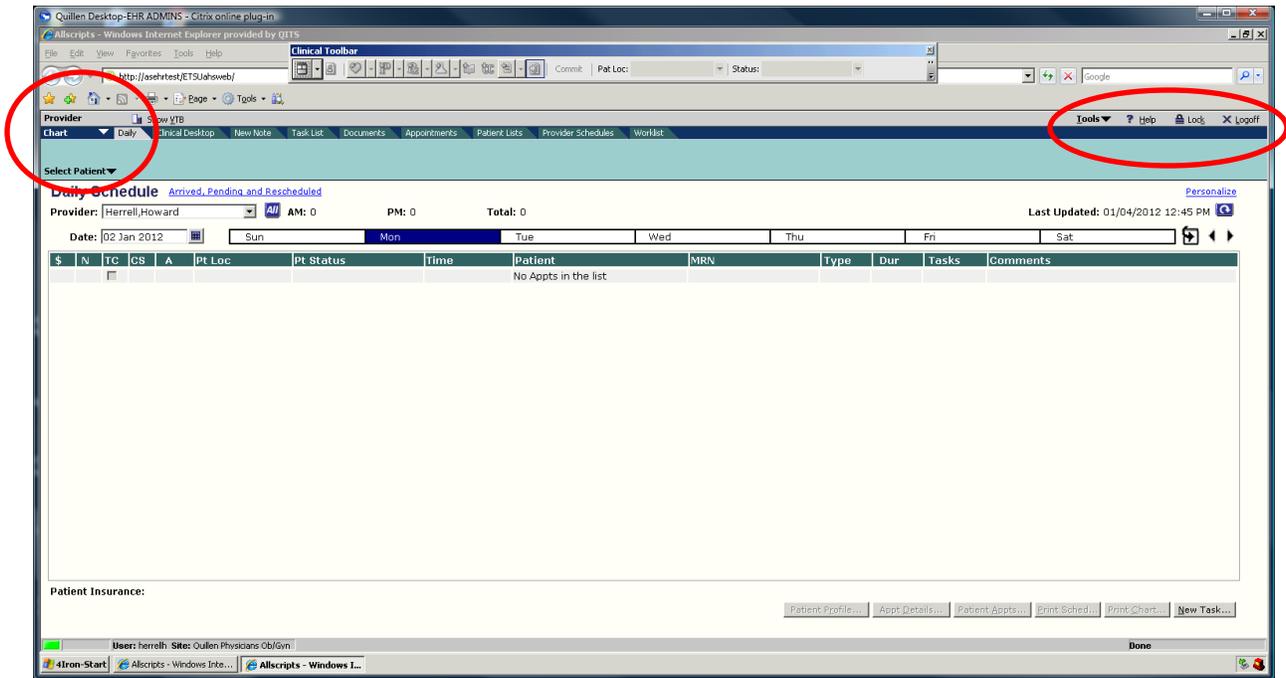
Once logged into **Allscripts**, click on **Tools** located in the right-upper section of the screen. Select **Settings** from the drop-down menu. Select the **Change Password** tab from the **HTB**, and follow the same steps as above.



## Workplace

The **workplace** is defined by the user role. Your workplace should display either “Provider” or “Resident” 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 providers, which is the **Daily** tab from the **Chart** menu.



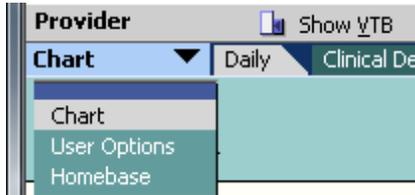
**Tools Menu**—Located in upper right-hand section of screen, you can reset your password, view keyboard shortcuts, and show/hide the clinical toolbar.

**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.



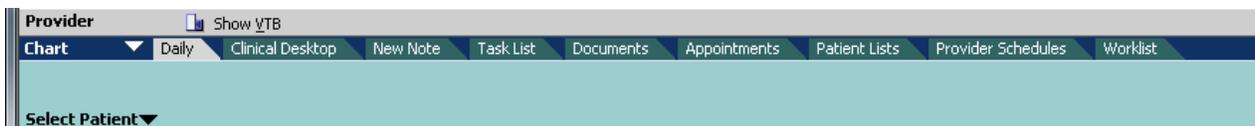
*The **VTB** can be hidden to expand the screen and eliminate scrolling. To hide the **VTB**, click on **Hide VTB**.*

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

**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.



**Daily**—The **Daily** tab allows you to view your daily schedule. You can also pull in another 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 (page 17).

**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.

**Documents**—allows users to view and perform your document related tasks.

**Appointments**—shows all of the patient's previous and upcoming appointments within the organization.

**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.

**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.

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

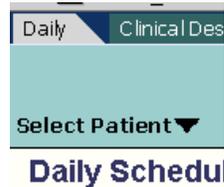
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## Select Patient

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**.



*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.*



## 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.

Patient	MRN	Other	PCP	DOB	Age	Sex	InA
Mouse,Dalton R	497691		Thode, Jeffr...	13 Oct 1995	15Y	M	N



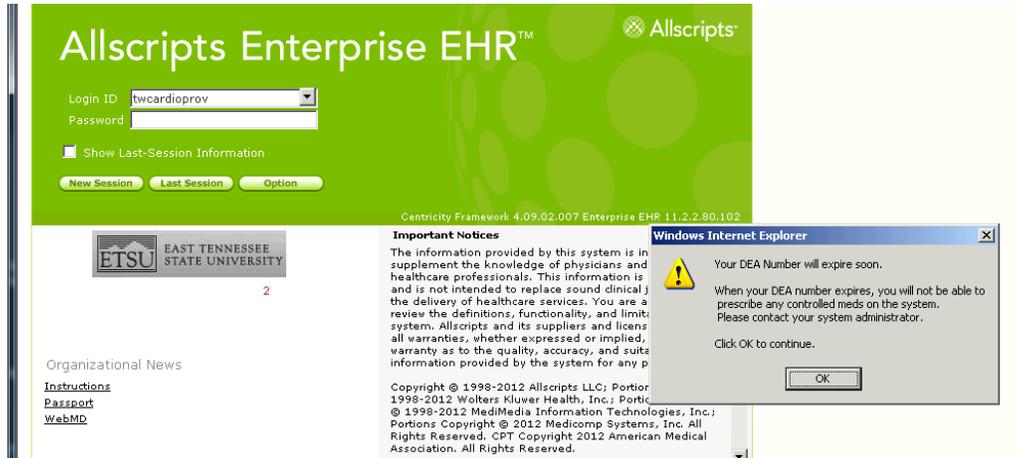
You can choose your default search criteria by clicking the blue personalize link in the search box. Notice the gray text listed above the type-in field that tells the format it accepts for the search.

## 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.

## DEA Expiration Warning

A warning displays when a provider's **Drug Enforcement Agency (DEA)** number will expire in one week.



## 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 **PM**; however, the pharmacy information, FYI, and Chart Alerts are entered in the **EHR** from the **Patient Profile** screen.

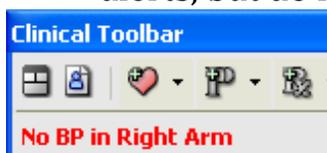
## Step-by-step: View the Patient Profile Dialog

1. Select a patient
2. Click the **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**

Select Retail Pharmacy

Personal
  Site List
  All
  Alpha
  Frequency of Use
  Save as Default View

Name:  Phone/Fax:

Address 1:

City:  State:

Zip:  -

Name	Address 1	Landmark	City	Stat	Phone	Fax	Type	Store Num
CVS/PHARMACY #3713	1940 S ROAN ST		JOHNSO...	TN	(423)928-7385	(555)555-5555	Script	
CVS/PHARMACY #3717	2111 NORTH ROAN STREE...		JOHNSO...	TN	(423)282-6176	(555)555-5555	Script	
CVS/PHARMACY #5636	840 W. MARKET ST.		JOHNSO...	TN	(423)979-2200	(555)555-5555	Script	
CVS/PHARMACY #7235 ( Boone...	4209 N ROAN ST.,		JOHNSO...	TN	(423)282-5372	(555)555-5555	Script	

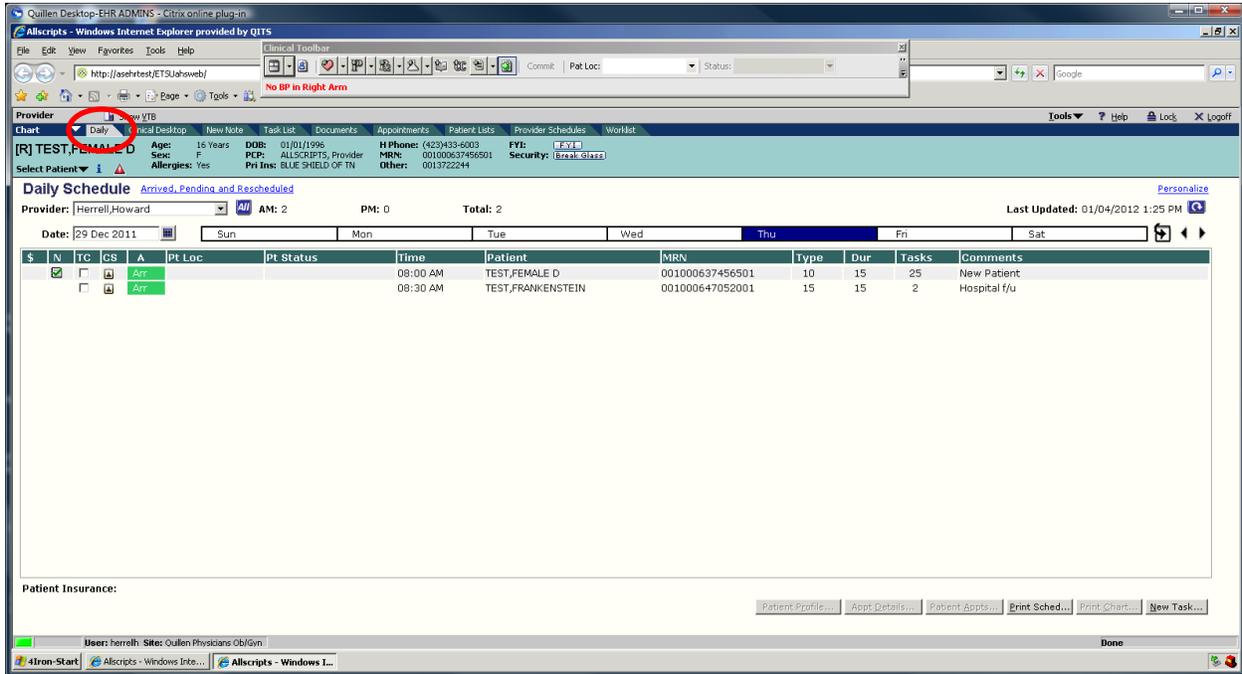
 Sometimes less information in the search fields will get you more accurate results. For example, if you type in the address: 123 North Street but it is listed in the system as 123 N. St., you will not get any results. Also, the most recently added pharmacy becomes the default pharmacy. To change the default pharmacy, click on the pharmacy you want as the default and then click the Make Default button.

**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.

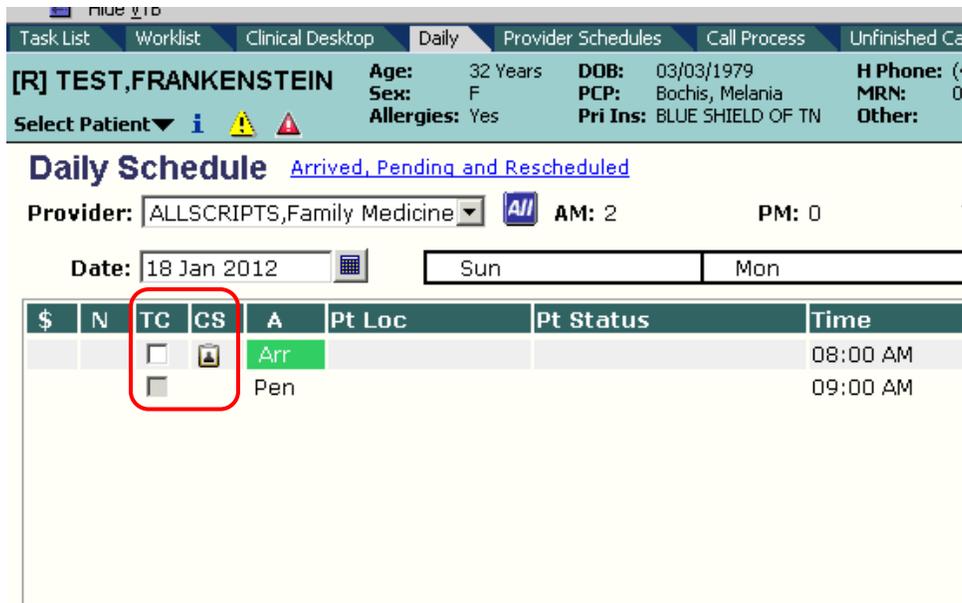


**Changing the Schedule Date**—The daily schedule will default to today’s date; however there are several options to navigate to other dates.

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.

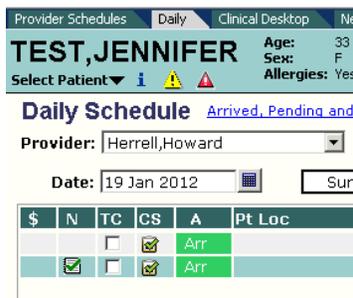
## Clinical Summary

**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**.
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**.

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

\$	N	TC	CS	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			08:00 AM	TEST, FEMALE D	001000637456501	10	15	21	New Patient
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			08:30 AM	TEST, FRANKENSTEIN	001000647052001	15	15	2	Hospital f/u

- **\$ – 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 “Arr” 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.
- 

## 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 to 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.

---

## 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”.

## 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 screenshot displays the Allscripts Clinical Desktop interface. At the top, the patient information bar shows the patient's name, age (16 Years), sex (F), DOB (01/01/1996), and various contact numbers. Below this, the main workspace is divided into several panes. On the left, the 'Active Problems' pane shows a list of problems, including 'Acute Sore Throat 462' and 'Health Maintenance Risks'. On the right, the 'Current Medications' pane displays a list of medications, such as 'Amoxicillin 250 MG Oral Capsule' and 'Ciprofloxacin HCl 250 MG Oral Tablet'. At the bottom right, the 'Vital Signs/Findings' table shows data for various vital signs across different dates. The table includes columns for 'Item Name', 'Graph', and dates: '29 Dec 2011', '22 Nov 2011', '27 Oct 2011', and '25 Oct 2011'. The table contains rows for 'Systolic', 'Diastolic', 'Temperature', 'Heart Rate', 'Pulse Quality', 'Respiration', 'Respiration Quality', 'Pain Scale', 'LMP', 'O2 Saturation', 'FIO2', and 'Last Pap Smear'. A toolbar at the bottom of the interface contains various icons for actions like 'Commit', 'New', 'Edit', and 'Resolve'.

**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.



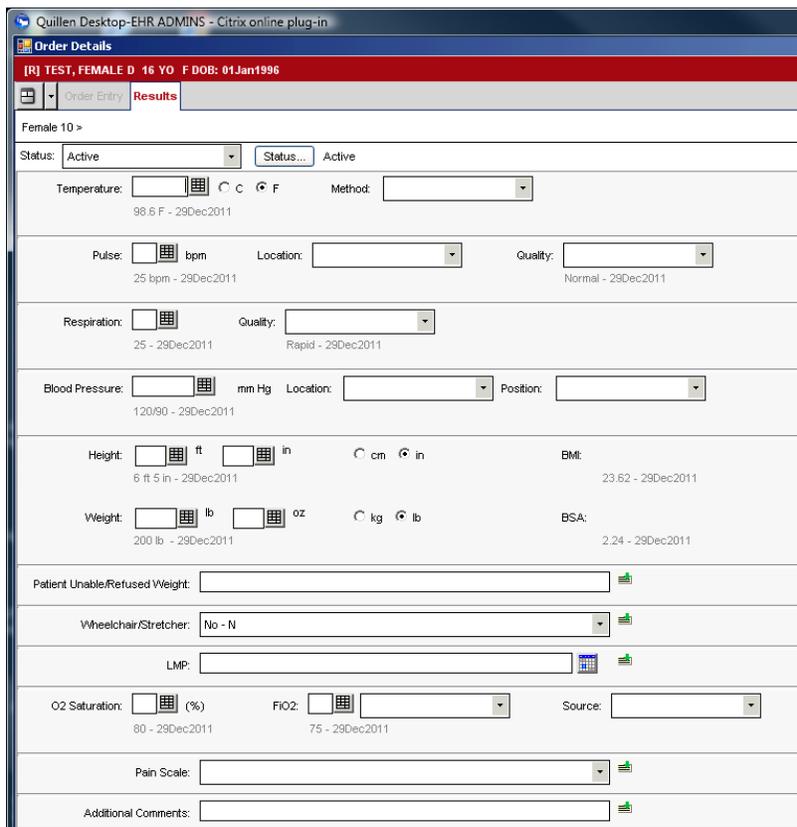
- 
**Q-Chart** allows users to have a second window open displaying the chart. When the user clicks this icon, the system launches the **qChart** page. The qChart page is a floating version of the **Clinical Desktop** (Chart). This allows a user to keep a separate workspace open with the chart displayed 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.



Quillen Desktop-EHR ADMIN - Citrix online plug-in

**Order Details**

[R] TEST, FEMALE D 16 YO F DOB: 01Jan1996

Order Entry Results

Female 10 >

Status: Active  Active

Temperature:    F

Pulse:  bpm   Quality:

Respiration:

Blood Pressure:   mm Hg   Position:

Height:  ft  in  cm  in

Weight:  lb  oz  kg  lb

Patient Unable/Refused Weight:

Wheelchair/Stretcher:

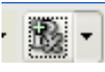
LMP:

O2 Saturation:  (%)

Pain Scale:

Additional Comments:

-  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.
- 

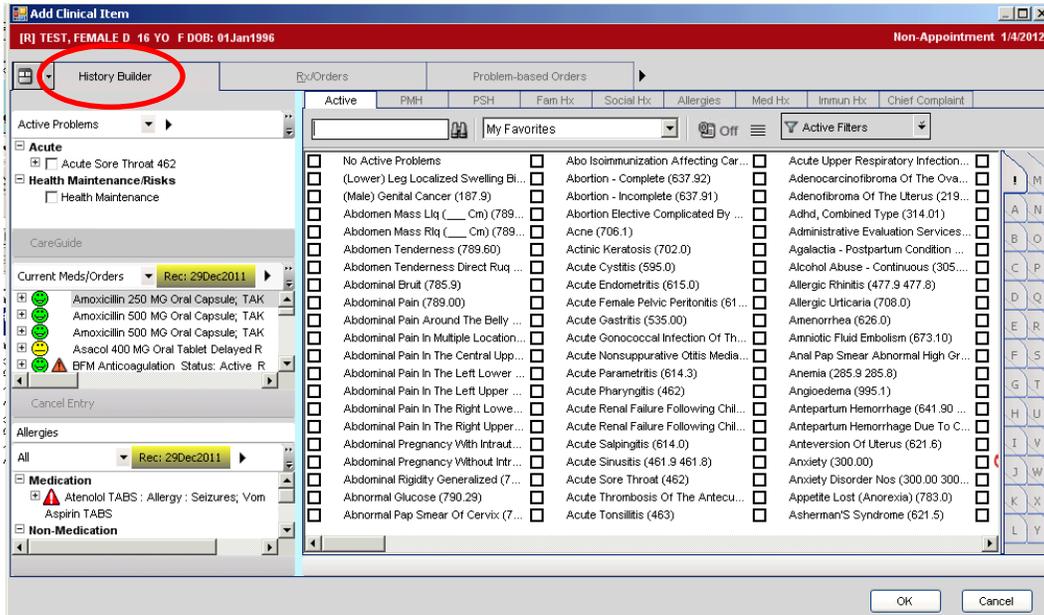
-  When the user clicks the **Post to Encounter** icon, the system posts the activities that have not yet been saved to an encounter. If an encounter is not in context, the system displays the **Encounter Selector**.
- 

-  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.
-

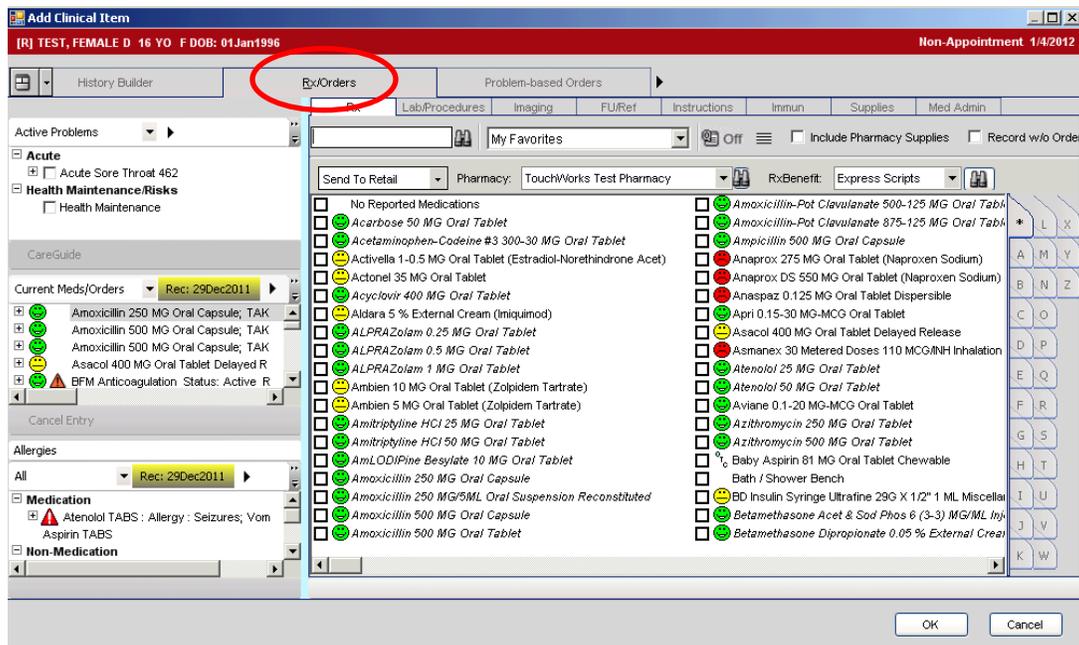
## Add Clinical Item (ACI)

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.

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

### Step-by-step: Adding Patient History Data

1. From the clinical toolbar, click on the “**Add New Problem**” button.
2. Add three active problems:
3. Abdominal Pain—add to **Quick List**, with onset date approximately two weeks prior to visit date, severity: Episodic
4. Type II Diabetes Mellitus—add to **Favorites List**, with onset date approximately six years prior to visit date, include in **PMHx**
5. Esophageal Reflux (can also type in “gerd”)
6. Add two **Past Medical History** items:
7. Diabetic Dermatitis
8. Foot Ulcer – diabetic related; left fourth toe; approximately one year prior to visit date
9. Add two **Past Surgical History** items:
10. Gallbladder surgery
11. Appendectomy
12. Add two **Family History** items:
13. Father – Type II diabetes
14. Maternal GM – breast cancer
15. Add two **Social History** items:
16. Denies smoking
17. Alcohol—two mixed drinks daily
18. Add two **Allergies**:
19. Tetracyclines – Note that it causes nausea as a reaction
20. Shellfish – Note that symptoms include anaphylaxis and hives
21. Add two **Medications**:
22. Claritin D – 24 hr. tablets as needed
23. Omeprazole 20 mg – 1 daily
24. Afrin nose spray – was taking but stopped one week ago
25. Add one **Immunization** item:
26. Tetanus—given approximately March 2008.
27. Add **Chief Complaints**:
28. Abdominal Pain
29. Fever
30. Click OK
31. Click **Commit**
32. Review **Encounter summary**
33. 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).

**Component 3** contains four tabs: Vital Signs, Immunizations, Flowsheets, and the Health Management Plan (HMP).

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**.

The screenshot displays the Allscripts EHR Clinical Desktop interface for a patient named [R] TEST, FEMALE D. The interface is divided into three main components:

- Component 1 (Left):** Shows the 'Active Problems' tab with a list of conditions including Depression 311, Acute Sore Throat 462, and Health Maintenance Risks.
- Component 2 (Top Right):** Shows the 'Meds' tab with a list of medications, including Roxibone HCl 20 MG Oral Tablet and Robtusin Cough/Cold CF Max 5-10-200 MG/5ML Oral Liquid.
- Component 3 (Bottom Right):** Shows the 'Vital Signs' tab with a table of vital signs data for dates 29 Dec 2011, 22 Nov 2011, 27 Oct 2011, and 25 Oct 2011.

Item Name	Graph	29 Dec 2011	22 Nov 2011	27 Oct 2011	25 Oct 2011
Systolic		120	120	120	120
Diastolic		90	90	80	80
Temperature		98.6 F			97.5 F
Heart Rate		25			62
Pulse Quality		Normal			
Respiration		25			
Respiration Quality		Rapid			
Pain Scale		4.5			
LMP		2003		27 Oct 2011	
O2 Saturation		80			
FiO2		75		27 Oct 2011	
Last Pap Smear				27 Oct 2011	
BMI Calculated		23.6/male?		20.6/male?	

When a provider 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.

Notice the **Medication Reconciliation** icon circled in red above. To comply with **Meaningful Use** regulations, 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.

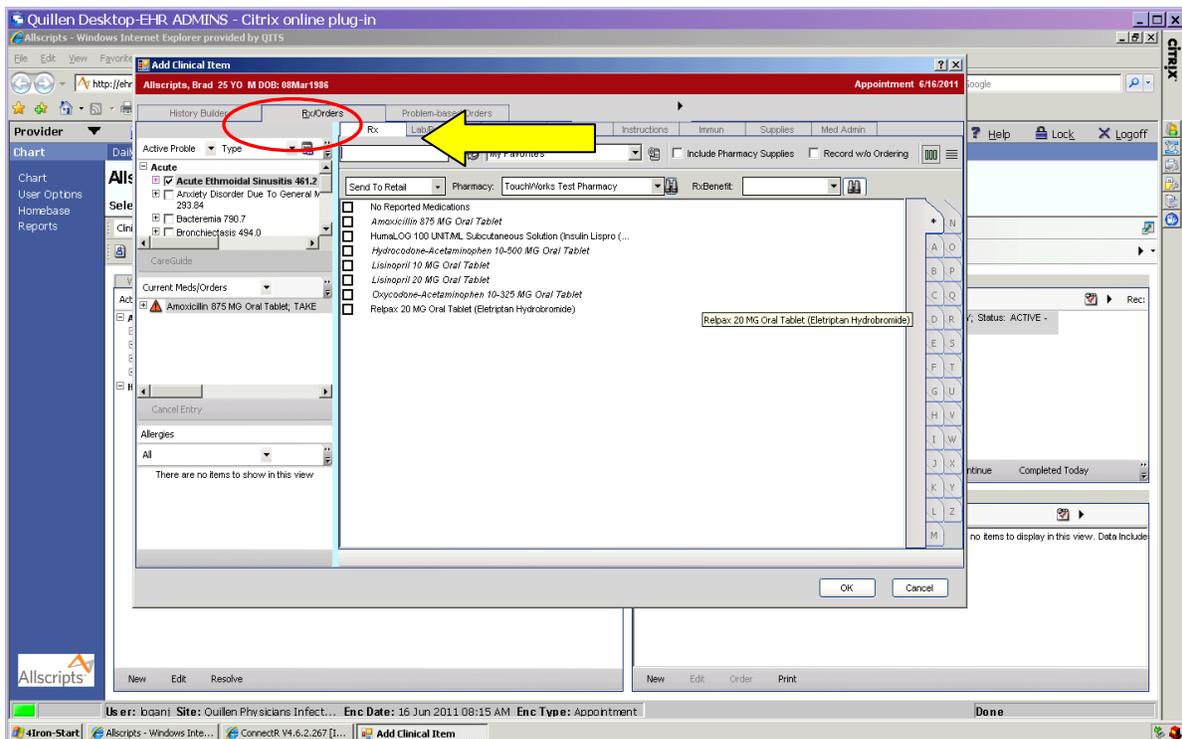
The **Clinical Desktop** can be viewed in one large component rather than three. Click on the **Full Screen** icon (circled in purple above) to change the view.

## 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.

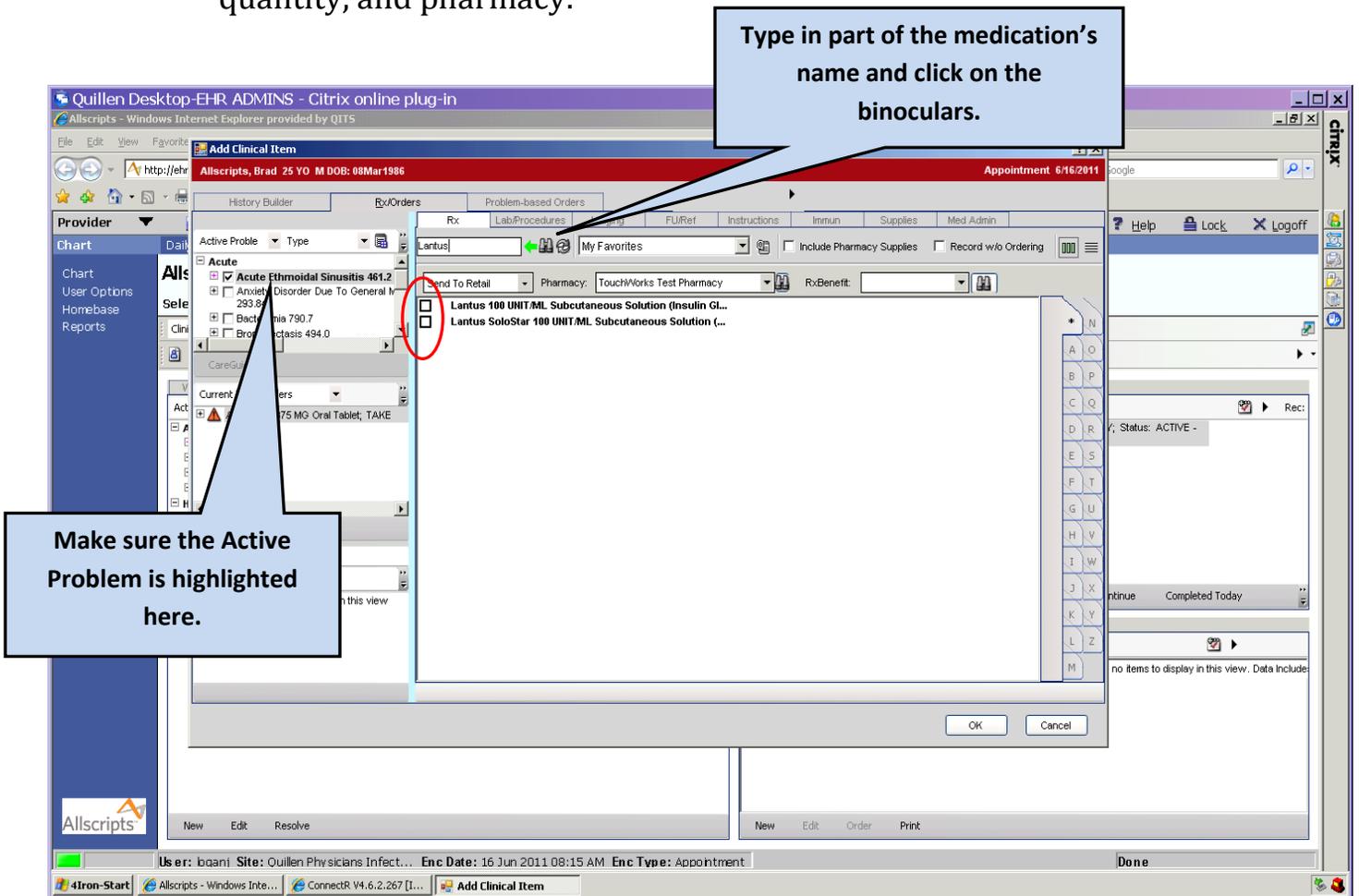
### Rx/Orders

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,

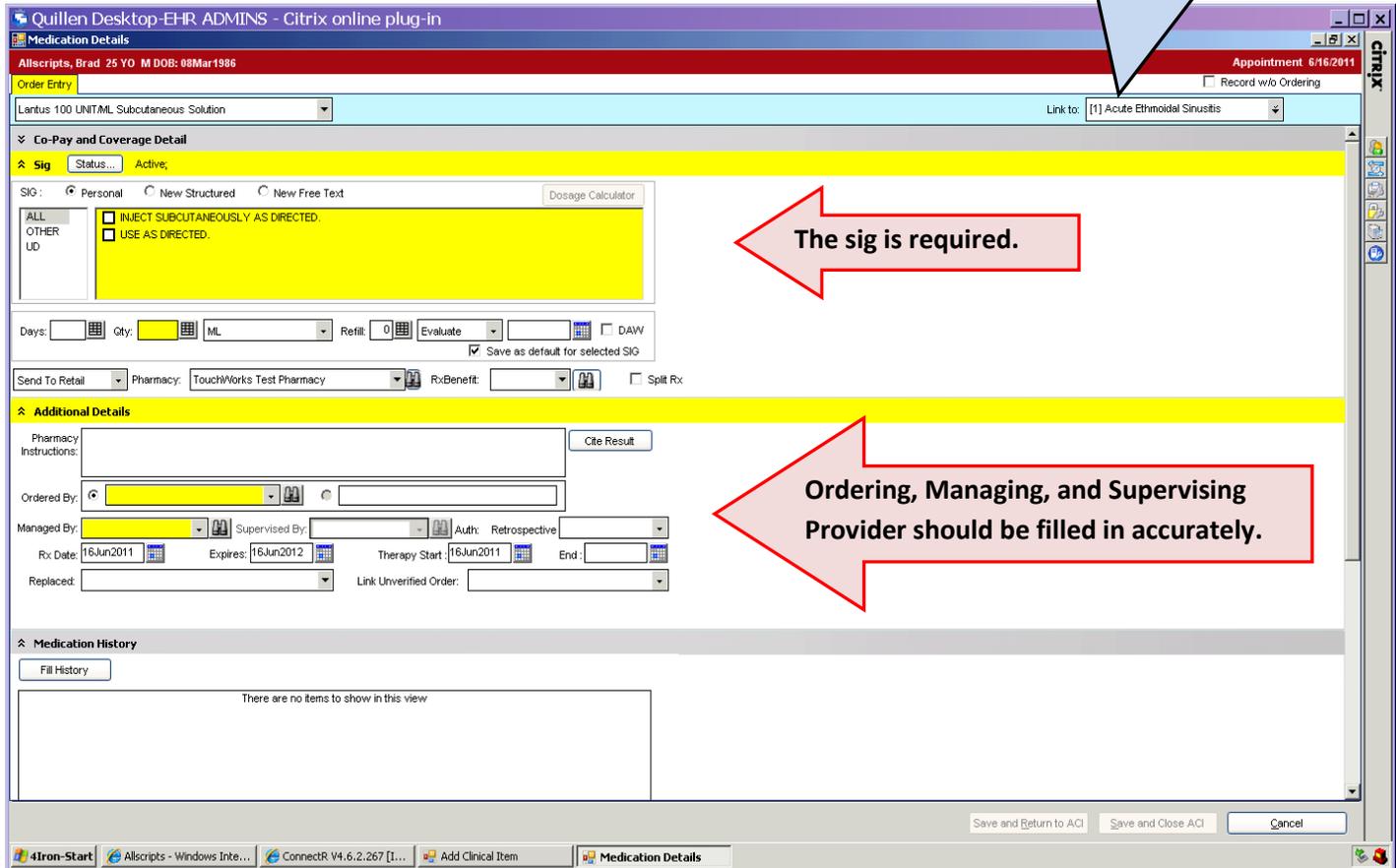
1. Make sure that your active problem is highlighted in the History Builder section.
2. Type your medication into the search field and hit “enter” (or click the binoculars). **Note: It is often better to enter only a few letters rather than the entire name of the medication.**
3. Check the box next to 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.

5. Once you have filled in all of the required fields, you will be able to click off the screen and finish your order.

Always double check that the Active Problem is linked and accurate.



## Additional Options

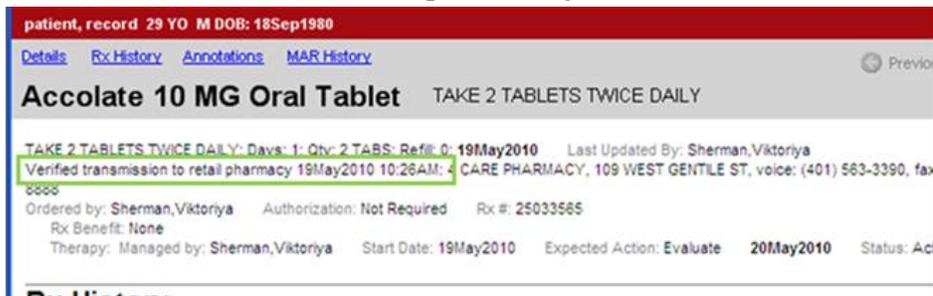
There are several other options on this screen that you might find useful.

**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



**labelling 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

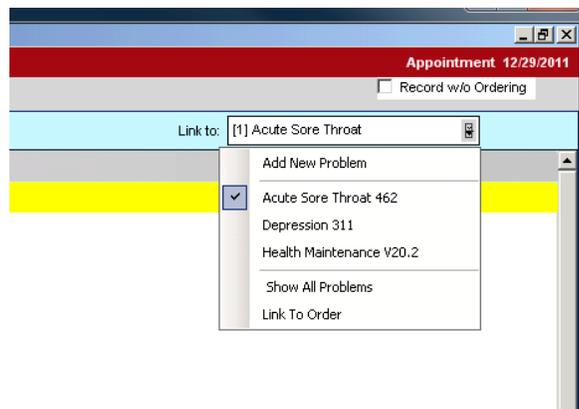


- After denial of cancellation by the pharmacy



### 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**.

The screenshot shows the 'Medication Details' window for a patient named Brad. The medication is 'Lantus 100 UNIT/ML Subcutaneous Solution'. Under the 'Co-Pay and Coverage Detail' section, the 'Sig' field is highlighted in yellow. It contains three radio button options: 'Personal', 'New Structured', and 'New Free Text'. The 'New Structured' option is selected and circled in red. Below the radio buttons, there are fields for 'INJECT', 'UNIT', 'Total Daily Dose', 'PRN', 'Reason...', 'Maximum Daily Dose', and 'Additional Instructions...'. At the bottom, there are fields for 'Days', 'Qty', 'ML', 'Refill', 'Evaluate', and 'DAW'. A checkbox at the bottom right is labeled 'Save as default for selected SIG'.

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 screenshot displays the 'Medication Details' form for a patient named Brad, 25 years old, male, with a date of birth of 08Mar1986. The medication is 'Lantus 100 UNIT/ML Subcutaneous Solution'. The 'Co-Pay and Coverage Detail' section shows the medication is 'Active' and the 'Sig' is 'Personal'. The 'Refill' field is set to '0' and the 'Evaluate' dropdown is circled in red. The 'Additional Details' section includes fields for 'Pharmacy Instructions', 'Ordered By', 'Managed By', 'Supervised By', 'Auth', 'Rx Date', 'Expires', 'Therapy Start', 'End', 'Replaced', and 'Link Unverified Order'.

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  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.



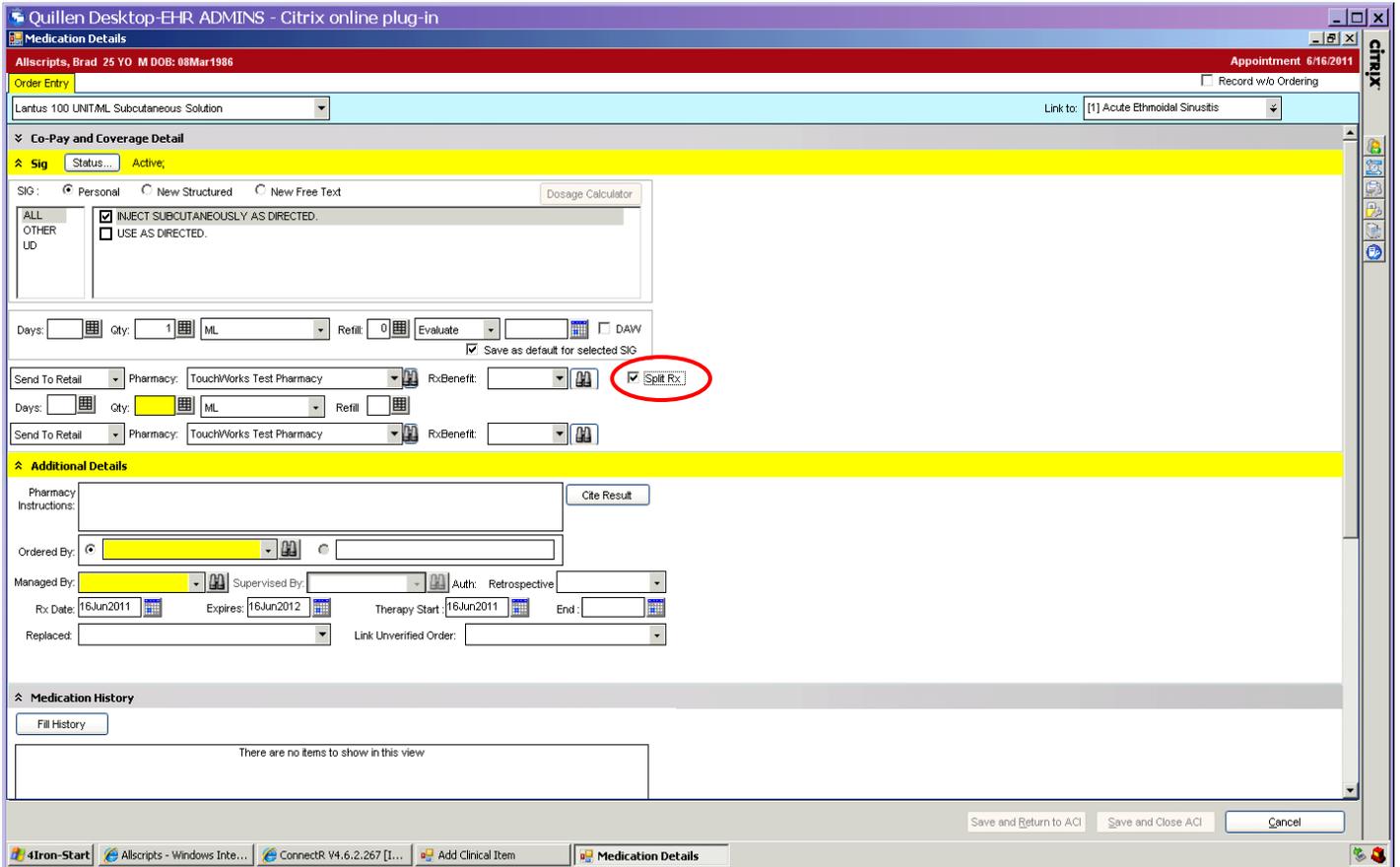
**Scheduled drugs** cannot be electronically sent, but will need to be printed and signed. After a wet signature has been added, the schedule 3 through 5 drugs can be faxed to the pharmacy, but **they cannot be sent electronically through Allscripts**. Schedule 2 drugs will need to be printed, wet-signed, 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.

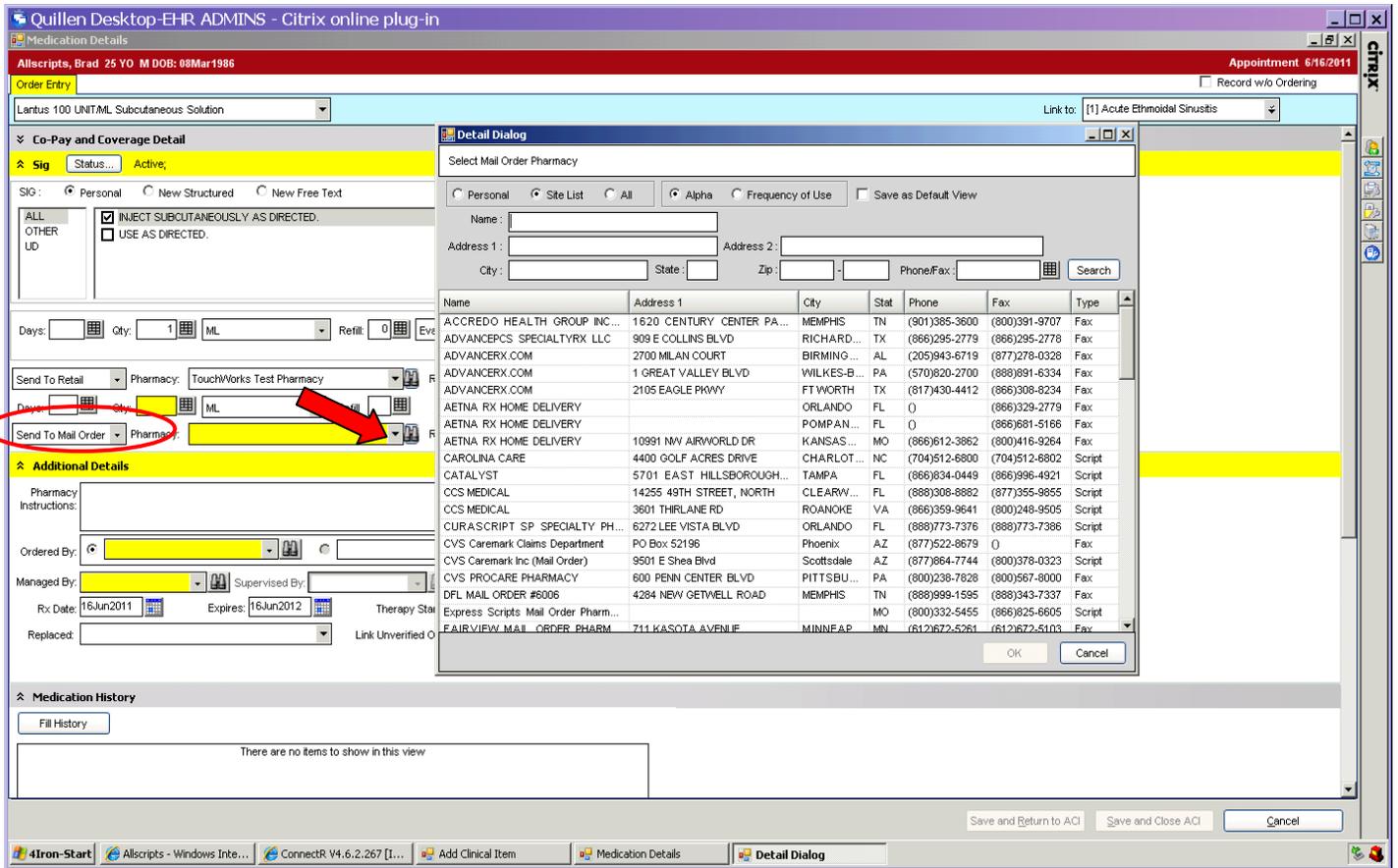
## Split Rx

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.



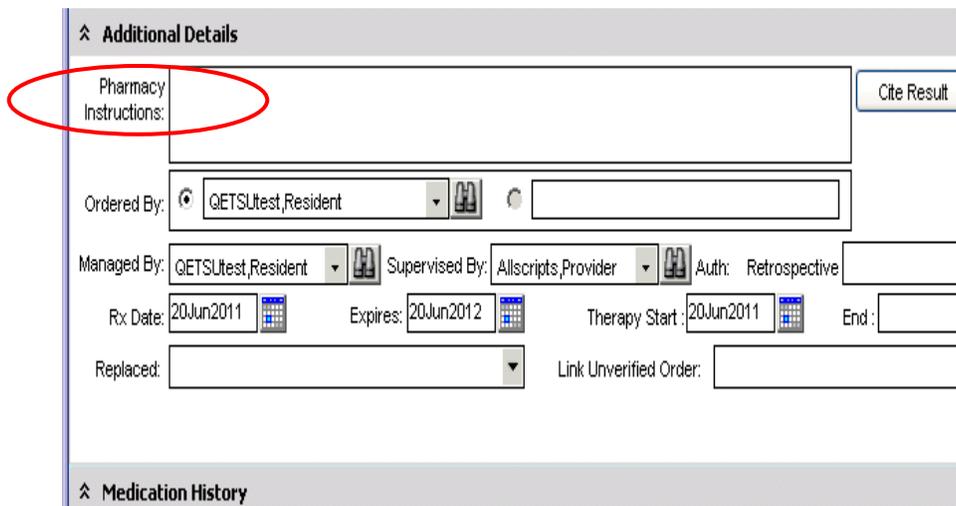
### *Choosing a Mail Order Pharmacy*

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.

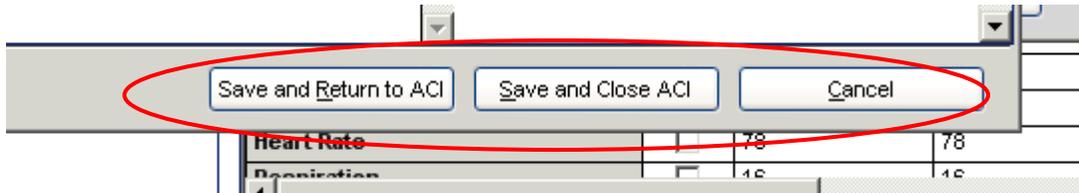
- **Providers'** names should be prepopulated in these fields.
- **Residents** (with DEA numbers in the system) should order medications with their names in the **Ordered By** and **Managed By** fields, but the **Supervised By** field should be the preceptor's name.
- **Residents** (without DEA numbers) need to have their preceptor's name in the Ordered by and Supervised by fields.

### Dates

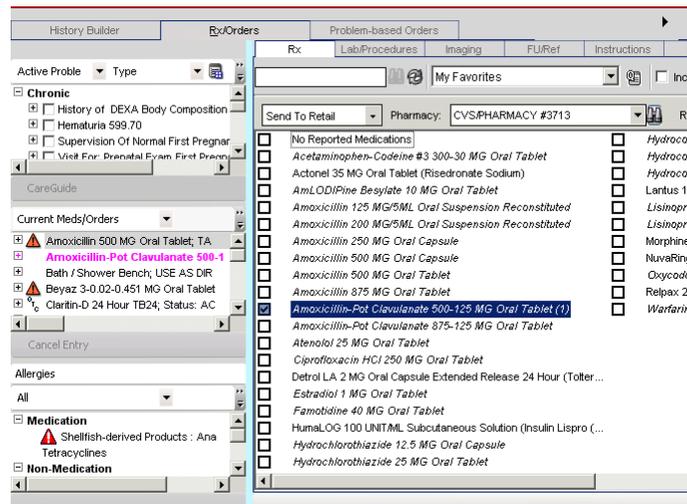
The **Rx Date and Expires date** are not in yellow, and therefore, do not need to be changed. However, if you have a patient who is on a pain contract, and you want to write two distinct scripts, for example, a one-month supply of a particular medication, you can do this by changing the dates in these 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 2<sup>nd</sup> 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).

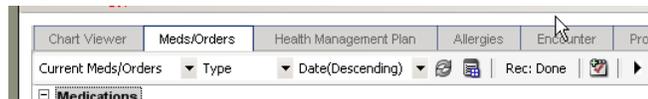
## Reconcile Meds/Allergies

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

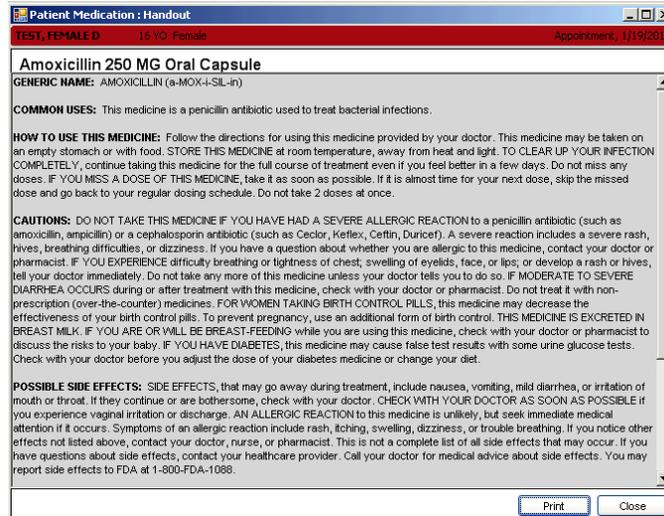
Once a drug has been entered in the Electronic Health Record, drug education information can be printed for distribution to the patient if desired.

### 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.
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.




---

## 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.

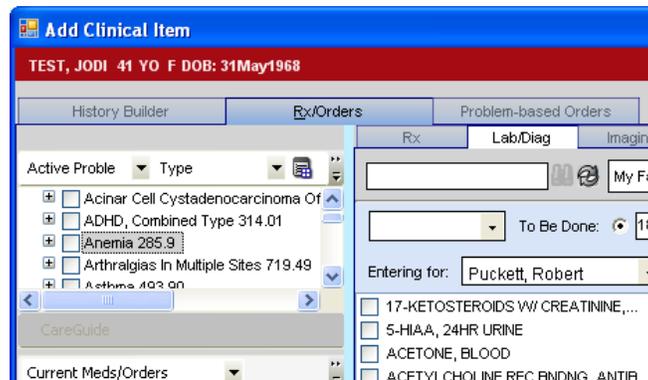
### **Ordering Tests for Different Problems**

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

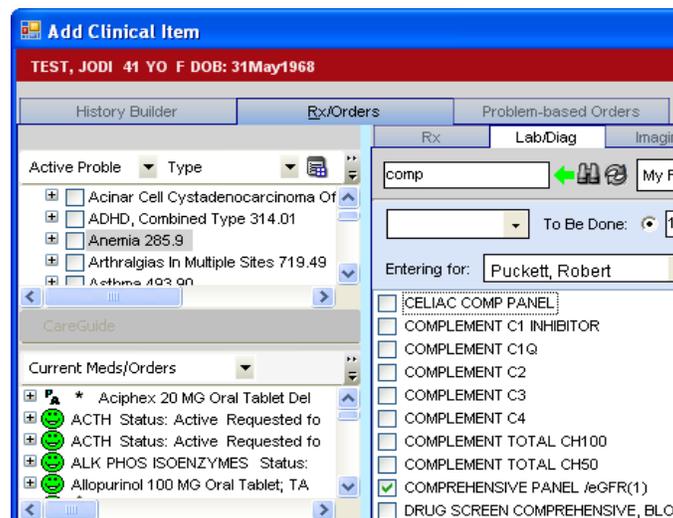
ordered items to automatically populate your note, order from the open note by clicking the note section “Orders” and the “Add” button to bring up the ACI.

### Step-by-step

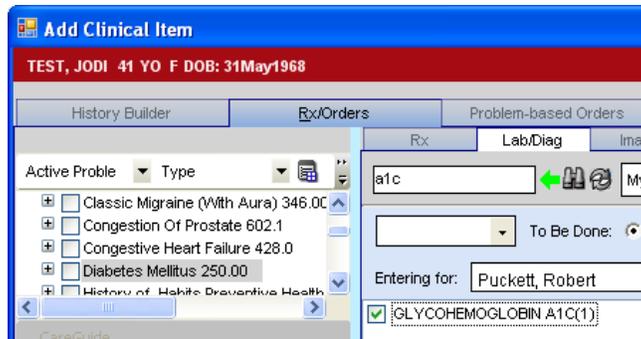
1. In the ACI, Rx/Orders tab, click on the name of the active problem in the upper left corner. This will highlight the problem name. Do not check the box next to the problem name.



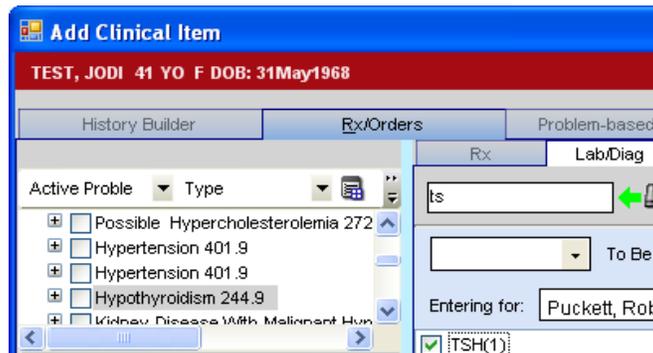
2. Once you have highlighted the problem, search for the appropriate orderable test and check the box beside it.



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.

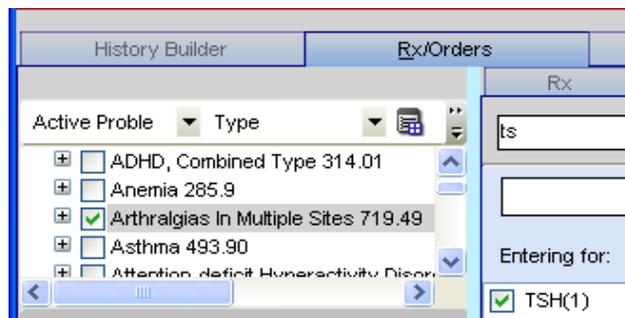


5. Continue these steps for each orderable item.



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.

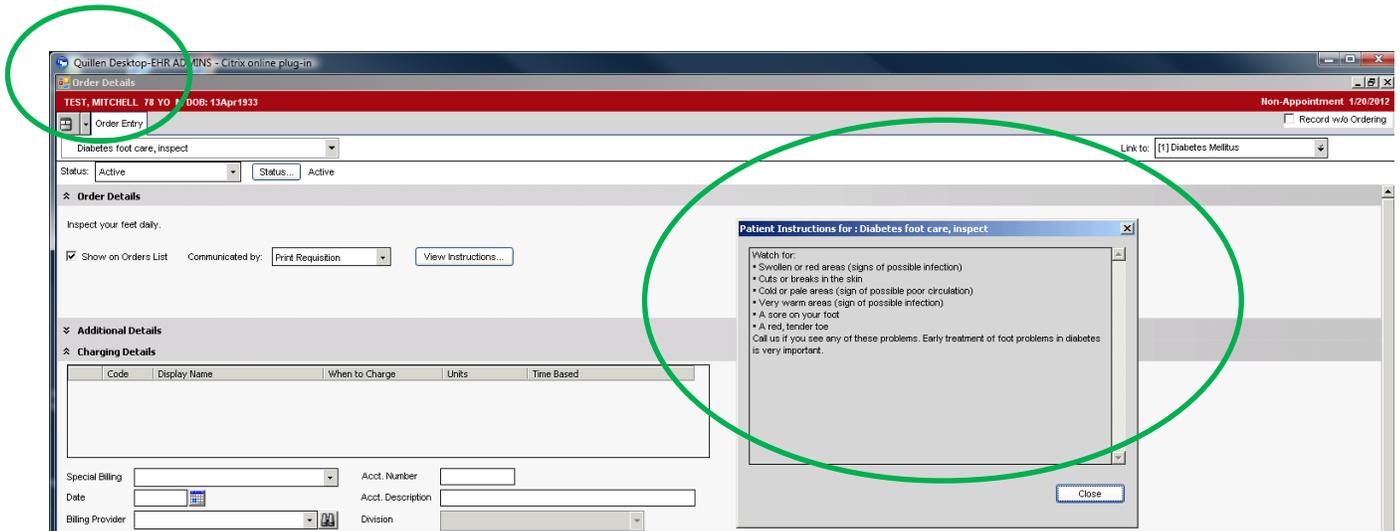
## Ordering Interventions for Meaningful Use

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.



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.



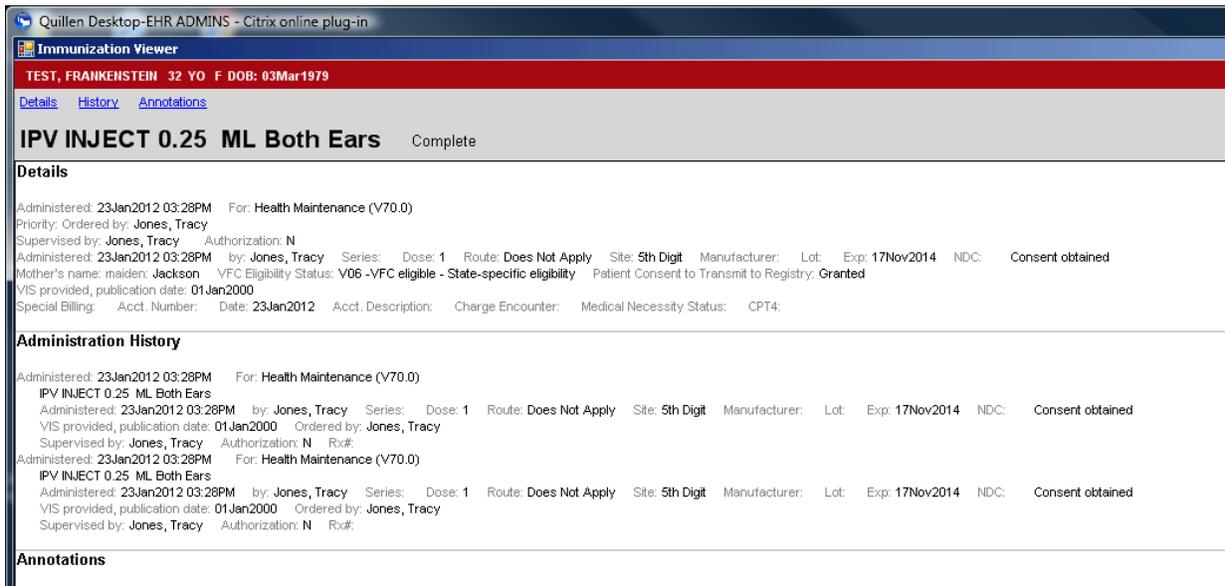
As mentioned above, the light yellow **Clinical Questions** box indicates that the order will go into an “On Hold” status, if the answer is not entered. An **Immunization Documentation** task will be generated, which is in a **Hold for Documentation** status.

### 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**.

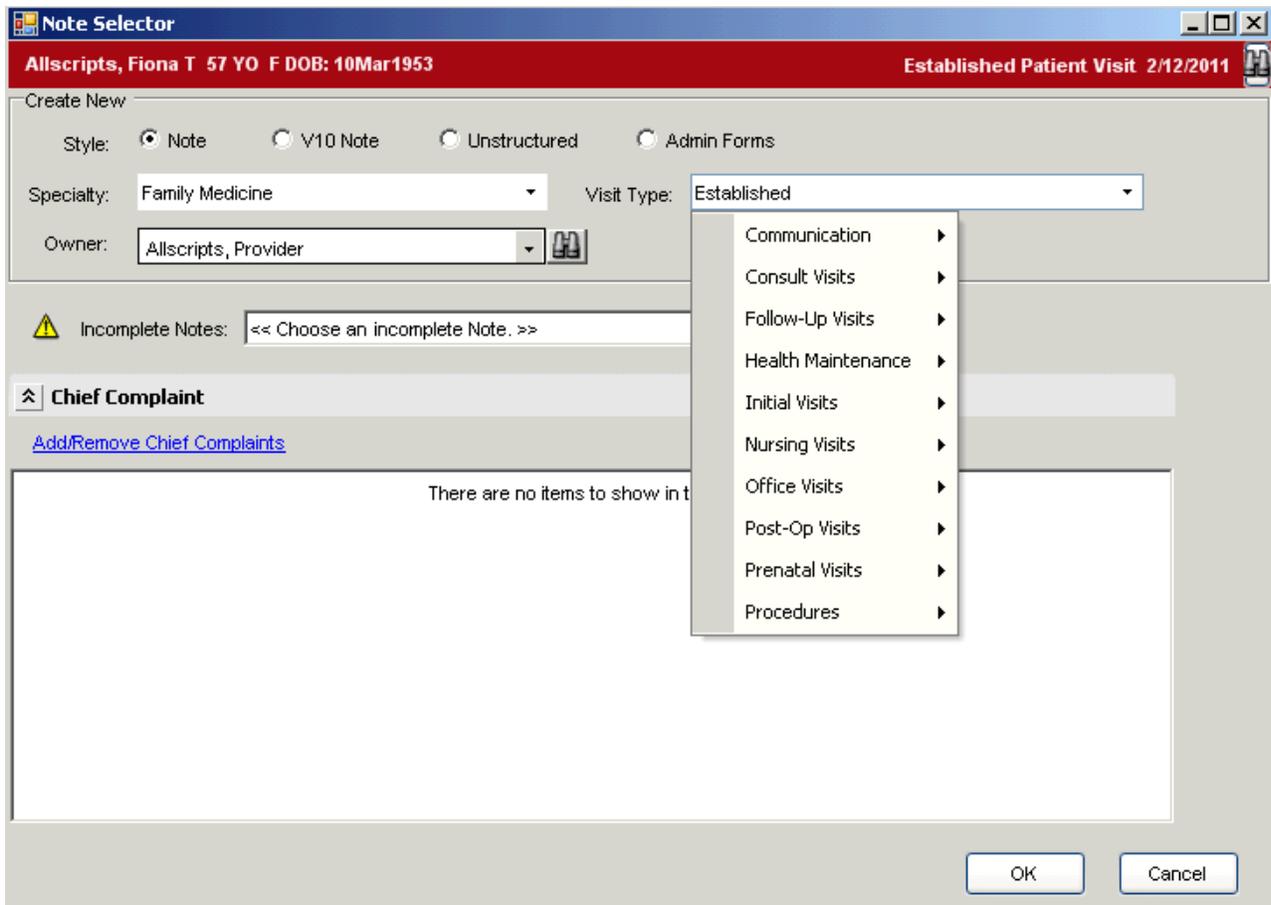
In the **Immunization Viewer**, you can see a record of the immunization data that was sent to the Registry Region.



## 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.



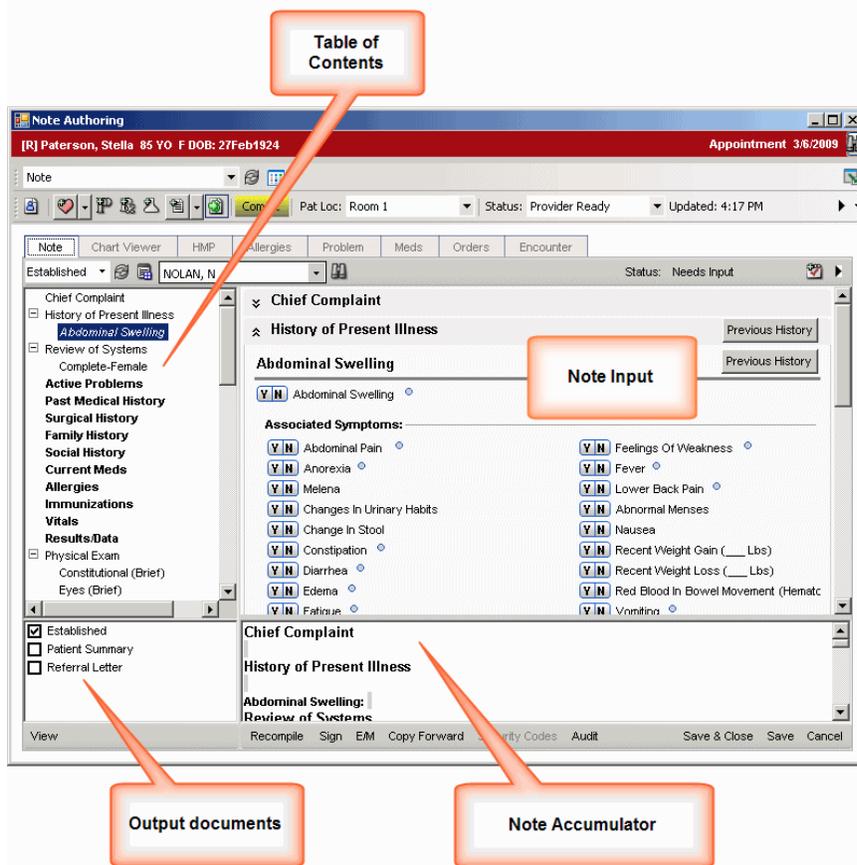
The **Note Selector** screen will open.

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

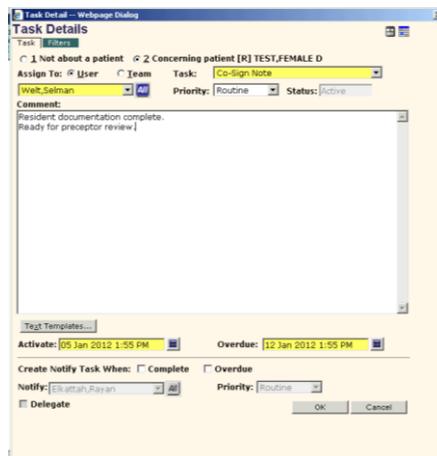
A note form typically has various controls within them:

- 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**.



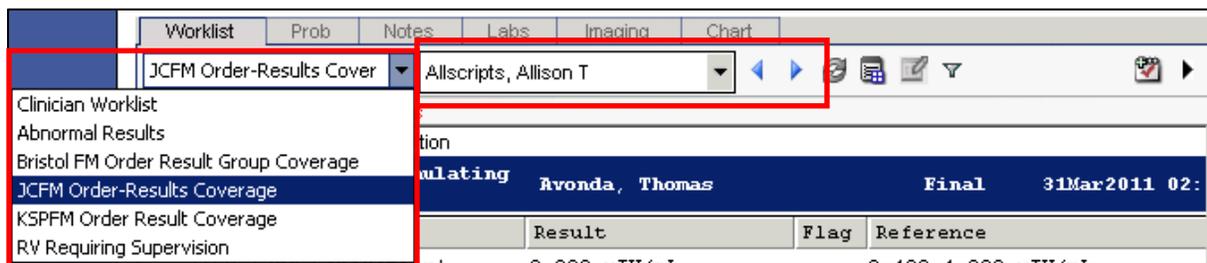
## Order/Result Management

### 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.



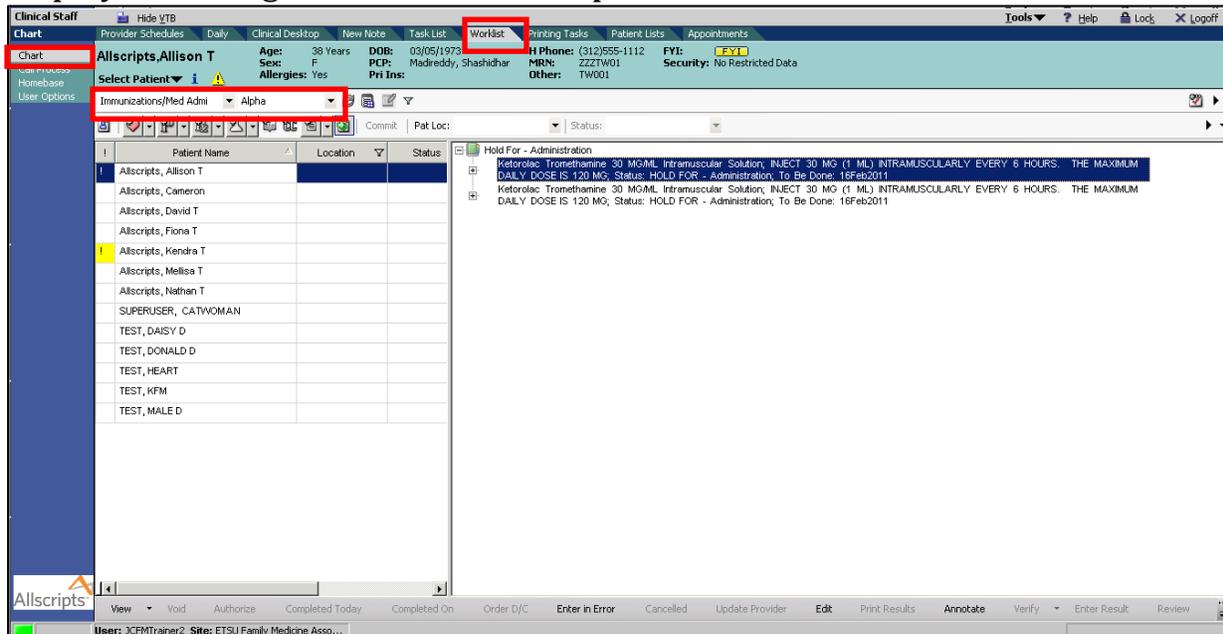
1. Begin from the **Task List** and double-click the appropriate task. Examples include: Verify Patient Results or Authorize Medication. The **Clinical Desktop** displays with the **Worklist** component tab active in the appropriate view for the task being worked.

**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.

## Result Management: Entering Results, Result Verification, and Result Communication

Results may be delivered to the EHR by means of interface with a lab vendor or entered manually. These results are then verified or invalidated, as

appropriate. The following sections will discuss how to enter results manually and verify results.

### Manually Entering Results

There may be workflows where the results for an order will need to be entered into the system manually.

These include:

- Hard-copy results received from an outside facility that is not interfaced for receiving electronic reports.
- In-house testing and resulting.

### Step-by-step: Entering a Manual Result

1. Add a new in-house order: Strep screen. **Commit** to the patient chart.
2. From the **Clinical Desktop**, go to the **Orders** tab and locate the Strep Screen order.
3. Right-click on the order, and select **Enter Result** from the menu.
4. Complete required fields.
5. Click **Save and Close ACI**.
6. Click **Commit** and **Save and Continue**.

### Verifying Results

All results requiring verification are managed from a **Worklist**. The **Worklist** contains the tools to facilitate the physician's review, acknowledgement, and communication of all unverified results.

From the **Worklist**, the user can perform the following actions from the drop-down menu when right-clicking on a result:

- **QVerify**—is used to verify one or more selected results without making changes to default settings, or entering annotations and/or messages. The **Results Verification** page will not be displayed.
- **QVerify All**—is used to verify **all** results that are displayed for a patient without making changes to default settings, or entering annotations and/or messages. The **Results Verification** page will not be displayed.
- **Verify...**—is used to verify one or more selected results. The provider is able to make changes to the default settings and enter annotations and

messages to staff or patients regarding the selected result. When this item is clicked, the **Results Verification** page is displayed.

- **Verify All...**—is used to verify all results that are displayed for a patient. The provider is able to make changes to the default settings and enter annotations and messages to staff or patients regarding the selected results. When this item is clicked, the **Results Verification** page is displayed.
- **Order**—allows the provider to re-order a test if needed.
- **Annotate**—The **Add Annotation** dialog box displays so the provider can add an annotation on a single result.
- **Enter in Error Results**—invalidates the results.
- **Enter in Error**—allows you to invalidate both the Order and the Result.
- **Review**—(only for the selected resultable item) marks an item as reviewed which will remove it from the **Worklist** and allow verification to be performed at a later time. This option (and Review All) enables the user to designate directly in the **Patient Worklist** (or Order Viewer) that results are reviewed, which is indicated by a yellow pencil before the unverified result icon. This option may be useful for covering providers who may still need to review the results for a patient.
- **Review All**—(all resultable items for the selected patient) marks all items as reviewed which will remove them from the **Worklist** and allow verification to be performed at a later time. This action may be useful for covering providers.
- **Update Provider**—allows the provider to route the result to the appropriate provider, in the case it's assigned to the incorrect one.

## Result Communication

The user can choose to communicate the patient's results in the following ways on the **Results Verification** screen (accessed by right clicking, and choosing "**Verify...**")

- **Call patient with Results**—A "Call Results to Patient" delegated task and a "Note" are generated.
- **Schedule Results F/U**—Sends a delegated task to schedule a follow up appointment for the patient.
- **Mail Results to Patient**—A "Mail Patient with Results" delegated task and a "Note" are generated.
- **Discussed results with patient**
- **No patient communication needed at this time**
- **Assign delegated task to**—defaults the provider and sends a delegated task to staff assigned.
- **Task Priority**
- **None**—No note is needed at this time.
- **Incomplete**—Select an incomplete note from the drop-down to add the results.
- **New**—Allows the user to select a **New Note** for the results.
- **To/CC** - Allows the user to send a carbon copy to another staff member. The staff member that receives this CC does not need to act on the results. The CC is for viewing only.

- **Free Text Fields/ Text Templates**—Typing into these fields or selecting the (TT) **Text Template** buttons to add text will display in the Comments section of the Task
- **Message to Staff**—Displays a message to the staff in the "Message" section of the Note.
- **Message to Patient**—Displays a message to the patient in the Discussion/Summary section of the Note.
- **Append Staff Message to Task Comment**—When this box is selected, the **Message to Staff** will appear in both the Note and the Comments section of the Task.
- **Annotations to Apply to All Results Being Verified**—Text entered here will appear after each result being verified. (For example: If five results are being verified, then all five results will have the same annotations listed.)
- **Verify & Go To Note**—Select this button to verify the result(s) and prompt the note for review and signature.
- **Verify & Next Patient**—Selecting this button will verify the result(s) and prompt the next patient needing verification.
- **Verify**—Selecting this button verifies the result(s), and then returns the user back to the **Clinical Desktop**.
- **Cancel**—cancels the **Results Verification Dialog** page.

### Step-by-step: Verifying Results

1. Click on the **Task List** tab from the **HTB**
2. From the **My Active Tasks** view, find the task **Verify Patient Results**
3. Double-click on the task. This will take you to the **Worklist**.
4. Locate the test that requires verification and highlight it by single clicking it.
5. Right click and select **Verify...** from the menu
6. This will open the **Result Verification Dialog** box. Check the **Call Pt. with Results** and add "All test results came back within normal limits."

### Step-by-step: QVerify Results

1. Click on the **Task List** tab from the **HTB**
2. From the **My Active Tasks** view, find the task **Verify Patient Results**
3. Double-click on the task. This will take you to the **Worklist**.
4. Locate the test that requires verification and highlight it by single clicking it.
5. Right-click and select **QVerify** from the menu. This will remove the result from the **Worklist**.

## Citing Results to a Clinical Note

Two options are available in the context menu that the system displays when you right-click on an item in the **Chart** component on the **Clinical Desktop**. These options allow providers to review patient results from the **Chart** and cite relevant results to a clinical note.

### Cite Selected

When the user clicks the **Cite Selected** context menu item, the system does the following based on the note in context:

- The selected result is cited into the **Result Data** section of the Note.
- If there is no note in context, the user is prompted to select a note. The selected result is cited into the note as defined above. This is the same functionality that is implemented in the **Worklist** component on the **Clinical Desktop**. This option applies to results only. It is not available when an item other than a result is selected. The result cannot be a work in progress.

### Advanced Result Citation

When the user clicks the **Advanced Result Citation** menu item, the system displays the **Results Citation Selection** page with results listed in reverse chronological order. This allows the user to select multiple results.

- If the user clicks **OK**, all the selected results are cited to the current note in the Result Data section.
- If there is no current note, the system prompts the user to select a note.

### Types of 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.

**Task List** [Personalize](#)

**Total Active Tasks:** 0

**View:** Rx Renew Request View Desc... **Last Updated:** 09/12/2011 12:09 PM

Y	Rx Renew Request	Copeland,Rebecca	System	09/10/2011 08:26	Active	173907	
Y	Rx Renew Request	Copeland,Rebecca	System	09/11/2011 04:27	Active	174020	
	Rx Renew Request	Moore,Jason	System	09/11/2011 04:27	Active	174025	
	Rx Renew Request	Moore,Jason	System	09/11/2011 04:27	Active	174026	
	Rx Renew Request	Moore,Jason	System	09/11/2011 04:27	Active	174028	
	Rx Renew Request	Moore,Jason	System	09/11/2011 04:27	Active	174029	
	Rx Renew Request	KFM Suite B Coverage	System	09/11/2011 09:58	Active	174086	
Y	Rx Renew Request	Copeland,Rebecca	System	09/12/2011 08:12	Active	174101	
	Rx Renew Request	Moore,Jason	System	09/12/2011 08:31	Active	174165	
	Rx Renew Request	Moore,Jason	System	09/12/2011 08:31	Active	174166	
Y	Rx Renew Request	Copeland,Rebecca	System	09/12/2011 09:17	Active	174311	
	Rx Renew Request	Schweitzer,Janice	System	09/12/2011 09:35	Active	174394	
	Rx Renew Request	E Chirculescu,Camelia	System	09/12/2011 10:06	Active	174522	
Y	Rx Renew Request	McCormick,Mary	System	09/12/2011 10:40	Active	174688	
Y	Rx Renew Request	Nguyen,Todd	System	09/12/2011 10:41	Active	174691	
▲	Rx Renew Request	Culp,John	System	09/12/2011 08:12	Active	174106	
	Rx Renew Request	Carpent,William	System	09/12/2011 12:01	Active	174001	

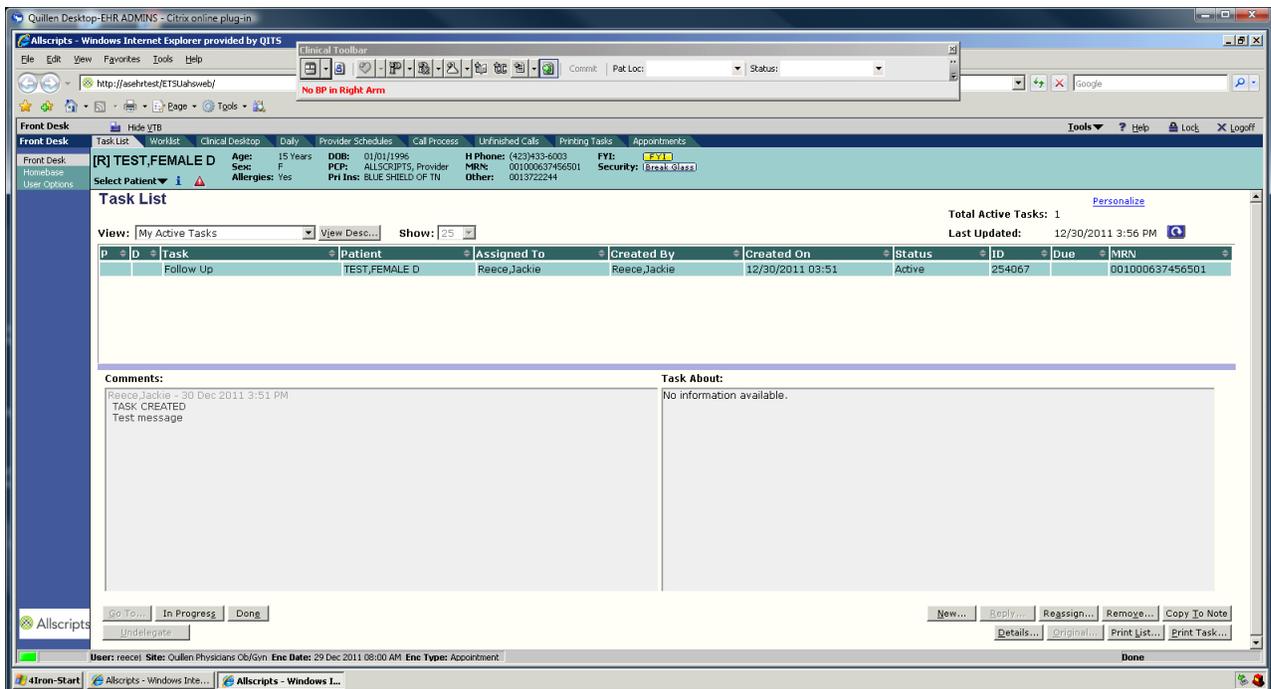
**Comments:** **Task About:**

**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.

The screenshot shows a web-based dialog box titled "Script Message -- Webpage Dialog". It contains the following information:

- Pharmacy:** WALGREENS 5597
- Phone:** (423) 246-0234
- Drug Name in TouchWorks:** Cetirizine HCl 5 MG Oral Tablet Chewable
- Considerations and Disclosures:** No Considerations and Disclosures (with a "Full text" button)
- Rx Info in Response:**
  - Drug:** CETIRIZINE 5MG CHEWABLE TABLETS
  - Days Supply:** 0
  - Qty:** 30
  - Each:** (checkbox)
  - Total Fills:** 1
  - Refills:** 0
  - SIG:** CHEW AND SWALLOW ONE TABLET DAILY
- Rx By:** Blackwelder, Reid (with a "DAW" checkbox)
- Message to Pharmacy:** (empty text area)
- Problem:** N/A
- Post Text to Current Note:** (checkbox)

At the bottom of the dialog, there are three buttons: "Grant", "Refuse", and "Cancel". These buttons are circled in red in the original image.

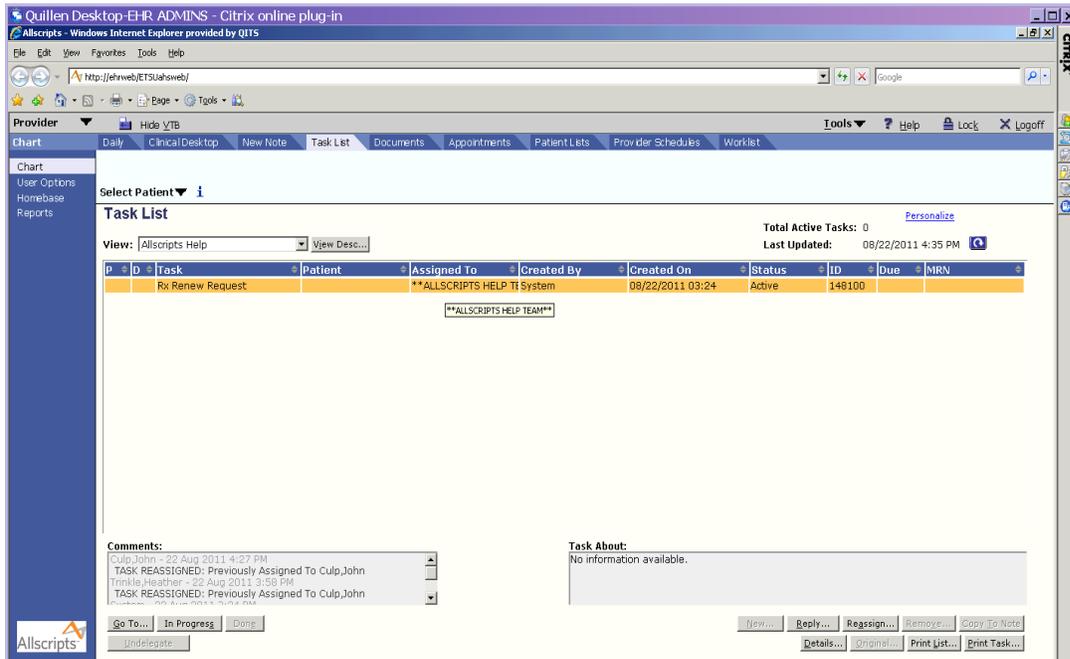
The **Rx Renew Request** contains all of the patient’s demographic information (which we have removed from the above screen shot, as it was on a real patient), as well as the name of the medication, and the sig information from the previous prescription, which can be altered. The Rx Renew Request can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

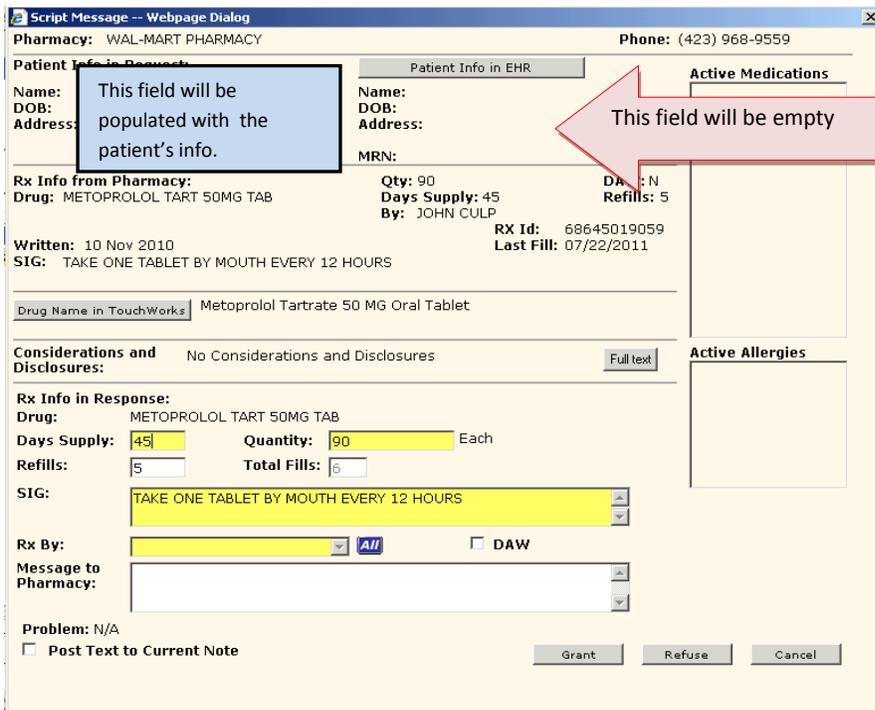
### ***Rx Renew Requests without a name in the Patient Field***

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.

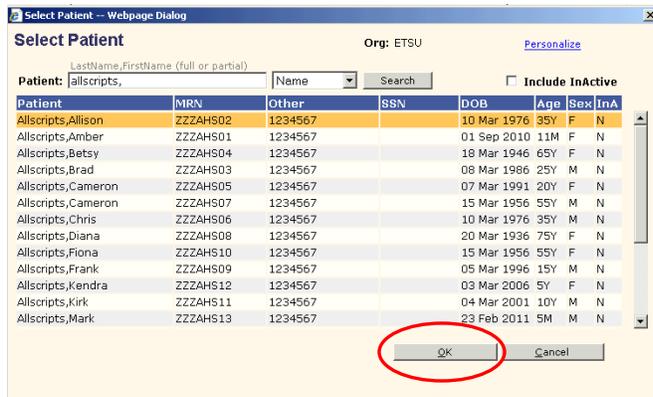


The following box will open. The “Patient Info in Request” field should have the patient’s name, DOB and address, but the Patient Info in EHR field will be empty.

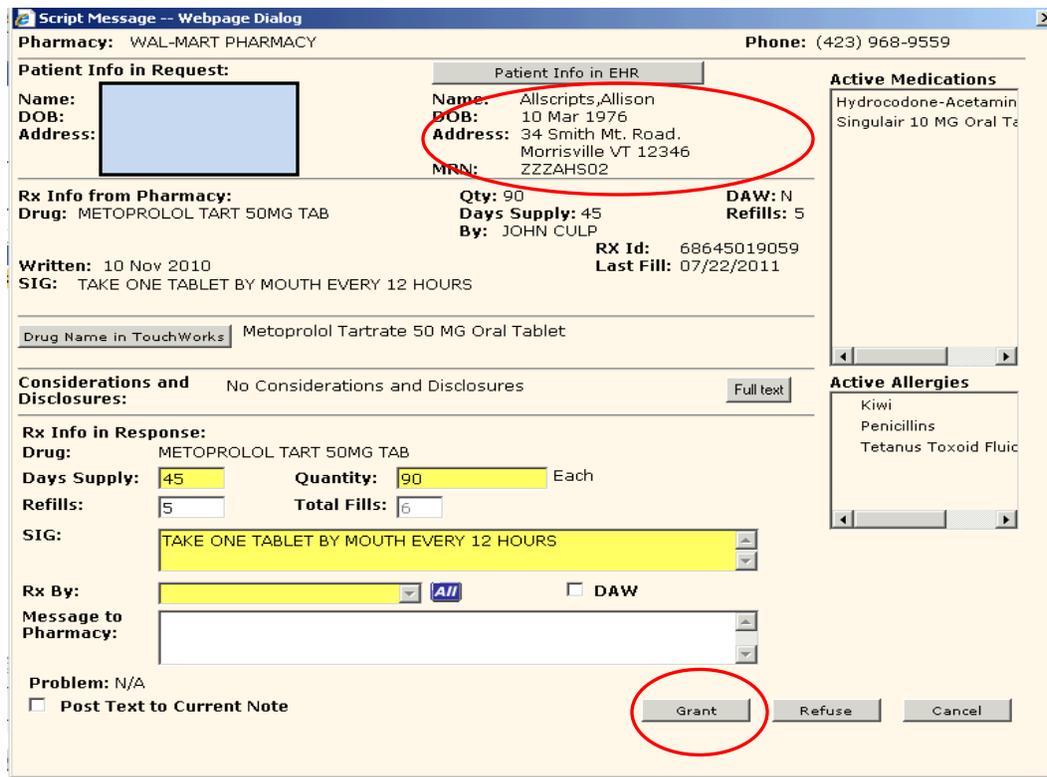


Trying to grant or refuse this request without having the patient's name in this field will generate an error.

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.

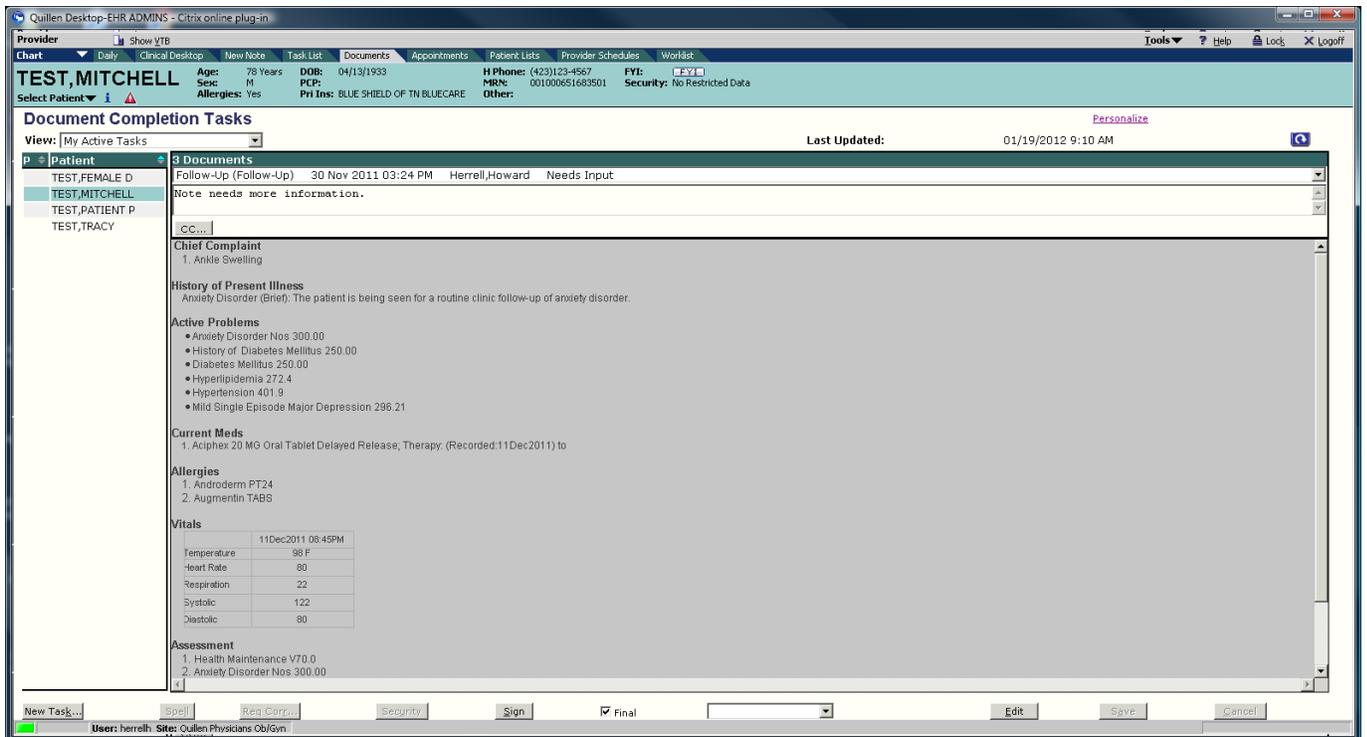


Fill the rest of the script out as normal, and click "Grant."



## Documents Tab

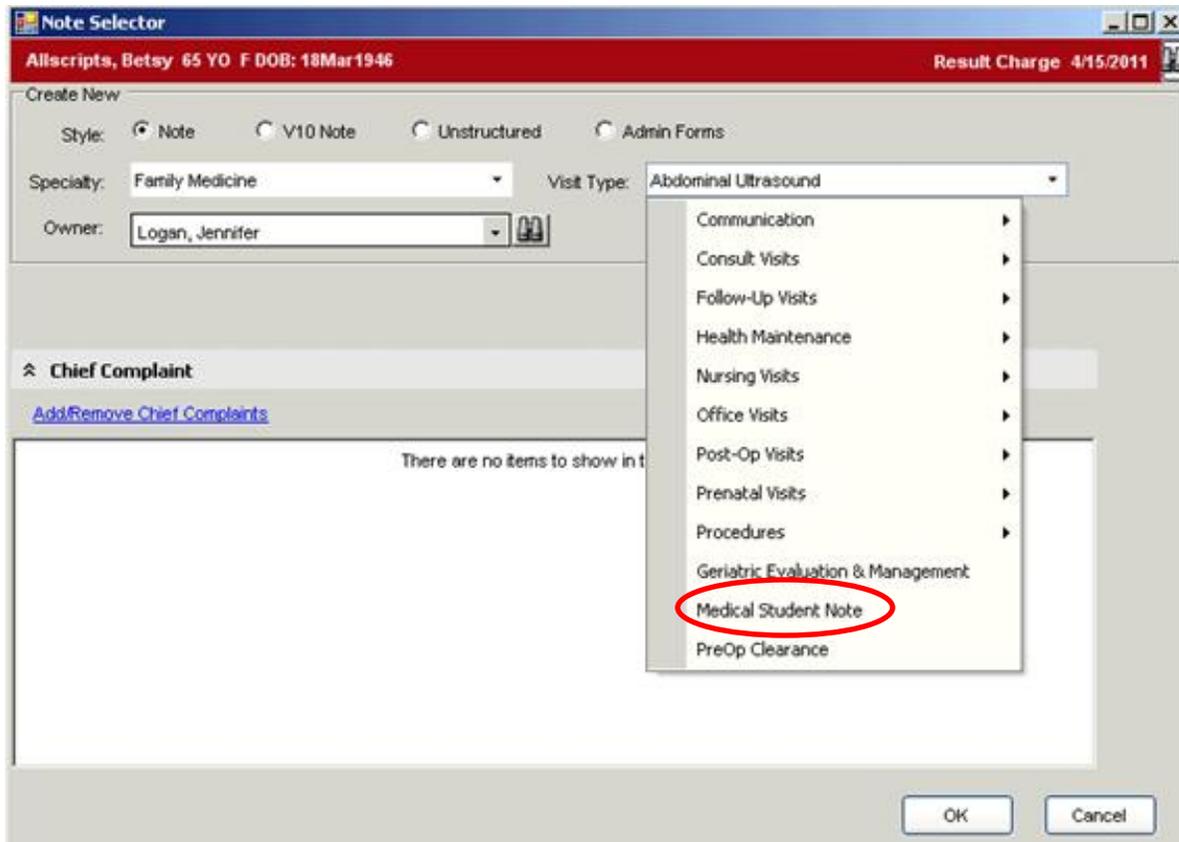
The **Documents** tab on the **HTB** displays the tasks associated with documents allowing physicians to view, edit, or sign directly from this screen. Simply highlight a patient name, and perform the necessary actions (see below).



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

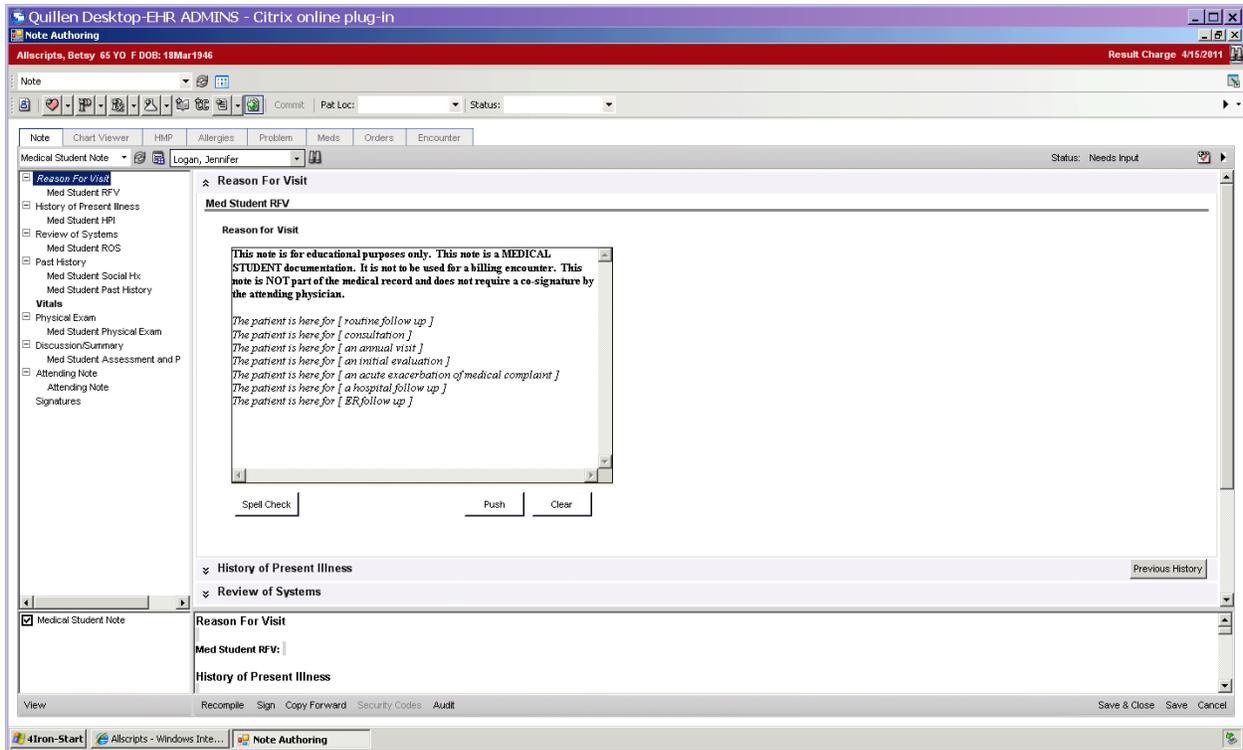
## Medical Student Note

To create a **Medical Student Note**, with a patient in context, click on the **New Note** tab on the **HTB**. When the **Note Selector** opens, select the Visit Type of **Med Student Note**. Click OK.



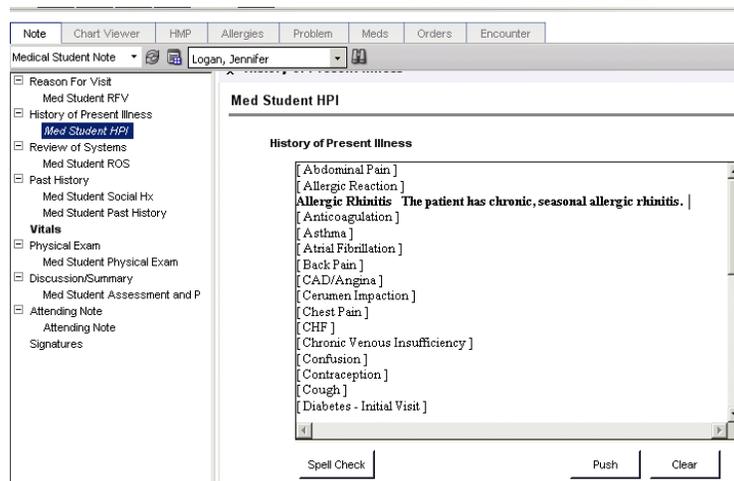
When the Note opens, the first section will be expanded (as below). To choose an option in a **Med Student** form, the student will double click the items that are within the brackets, and then click **Push** at the bottom of the form.

For example, to choose a **Reason for Visit**, they will double click on the words “**routine follow up**” or “**ER follow up**” as appropriate. Also, please note that the disclaimer at the top of the Reason for Visit section **needs to be included in the note**, and unless a Reason for Visit is double clicked and added to the note, this disclaimer will not appear.



The subsequent sections will be chosen by navigating through the **Table of Contents** on the left-hand side of the page. The next section they will click on is the **HPI**. This section has a variety of options which the students can choose from. Again, to choose a diagnosis, they will just double-click on the word in the bracket.

If they would like to add some free text, they can either free text it in the HPI box, next to the symptom name, or they can free text in the **Note Accumulator** at the bottom of the page. Once finished, click **Push**.





# Help Desk Support

*Utilizing the Help Desk is simple:*

- Select the QITS Help icon on the desktop

Or

- Send an e-mail to: [EHRhelp@getsu.org](mailto:EHRhelp@getsu.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.getsu.org** in the browser window (no www or http).

# Visit The Quillen Physicians EHR Website

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 \*  
First  Last

## Quillen Physicians EHR



### Training Manuals

Front Desk Manual  
Download File

Basic Navigation for Clinical Staff  
Download File

Clinical User Manual  
Download File

Basic Navigation for Residents/Providers  
Download File

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.

## Quillen Physicians EHR



### Quillen Helpdesk



To open a ticket about an EHR issue or an IT hardware issue, click the link and describe the issue you are having.

### Facebook



Invite the Quillen EHR Team to be your friend on Facebook to be updated on tips and tricks, to be informed about new workflows, and to view photos of our users.

### Quillen Physicians



Find out more about the Quillen Physicians organization by visiting their website.

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/](http://quillenphysiciansehr.weebly.com/)

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